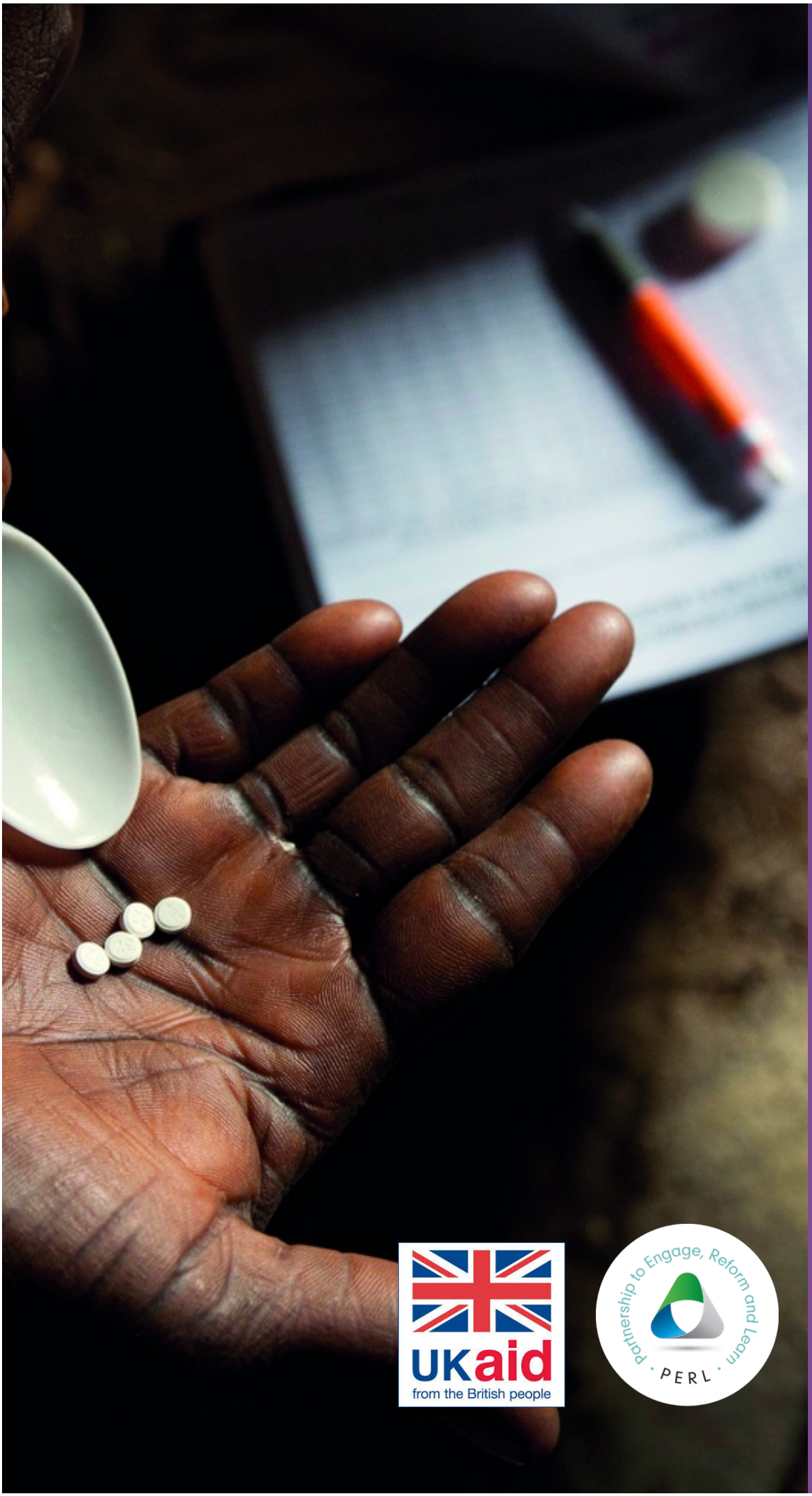


HEALTH FINANCING IN NIGERIA

Study Report

04.05.2018

UKaid
from the British people

Partnership to Engage, Reform and Learn
PERL

Acknowledgement
This report was authored by Alozie Ananaba, Firdausi Umar Sadiq and Laure-Hélène Piron. Responsibility for any inaccuracies or omissions in this first draft lies with the authors. Feedback on this draft will be appreciated.

Photography: All copyright reserved with Kate Holt/Sightsavers (cover), and Albert Gonzalez Farran/UNAMID (Executive Summary)

Disclaimer

This material has been funded by UK aid from the UK government; however, the views expressed do not necessarily reflect the UK government's official policies.

Contents

Acronyms and definitions

BHCPF	Basic Health Care Provision Fund
CSO	Civil Society Organisation
DFID (N)	UK Department for International Development (Nigeria)
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
NDHS	National Demographic and Health Survey
NHA	National Health Act
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
NGO	Non-Governmental Organisation
OOP	Out of pocket (expenditure)
PATH	The Partnership for Transforming Health Systems
PBF/P	Performance Based Financing/Programme
PEA	Political Economy Analysis
PERL	Partnership to Engage, Reform and Learn
PFM	Public Financial Management
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PRRINN-MNCH	Programme for Reviving Routine Immunisation in Northern Nigeria –Maternal, New-born and Child Health
PPP	Public-Private Partnership
MNCH	Maternal, Newborn and Child Health
SMOH	State Ministry of Health
SOML-PfR	Saving One Million Lives – Program for Results
SPARC	State Partnership for Accountability, Responsiveness and Capability
SPHCDA/B	State Primary Health Care Development Agency/Board
THE	Total Health Expenditure
WHO	World Health Organization

Executive Summary

DFID Nigeria is currently considering a new strategy for its support to health, shifting from financing service delivery to strengthening health systems. It has commissioned this study to inform its strategy and the design of a new health sector programme.

Healthcare provision and funding

Private sector provision accounts for 60% of health services in Nigeria. However, in Northern Nigeria, the public sector provides over 90% of all health services, while in Southern Nigeria, the private sector provides over 70% of health services. The private sector is very diverse; from upmarket formal medical facilities to informal providers, such as medicine vendors or traditional birth attendants who may be the most accessible and trusted for the poorest.

Out of pocket (OOP) expenditures account for 60%-70% of total health expenditure (THE). This means that funding for healthcare comes principally from individual payments at the point of accessing a service, whether public or private. A high share of OOP is inequitable and regressive, as poor households are considerably exposed to risk and often pay a large proportion of their income. The percentage of Nigerians covered by any form of pre-payment or risk pooling schemes is less than 5% of the population, mostly civil servants and formal private sector workers.

Nigeria has one of the world's lowest rates of public investment in health as measured by various indicators. Public health expenditure is only estimated to account for 20-30% of total health expenditure. The share of the federal budget allocation to health is only 8%, far below the Abuja declaration target of 15%. Overall, funding is not strategically allocated; the majority goes to tertiary or curative care which benefits the richest. Development partners have filled some of the funding gaps for the most pressing diseases, though total aid financing is less than 5% of total health expenditure.

Political economy of health provision

To understand why the Nigerian health sector continues to be underfunded by comparison to peer countries, and suffers from leakages and inefficiencies, it is essential to understand the responsibilities, interests and incentives of the main organisations and individuals that make up the sector. Structural and institutional factors help explain why many of these actors seek to perpetuate the current system and where there might be opportunities for change.

Fundamentally, in a rentier state dependent on oil and gas resources, politicians and officials can use the state to seek rents and support their patronage networks. This leads to the prioritisation of health sector salaries and tertiary infrastructure, where rents can easily be created and captured, over primary health care (PHC), which provides few rent opportunities. Public expectations of government are low and there is little public accountability to citizens.

The fragmentation, confusion over roles and responsibilities and poor coordination of health across and between Nigeria's three levels of government undermines performance. Politically salient health issues are related to control over financial resources, at federal, state and local levels. This can block reform or slow down implementation, as seen through the slow evolution of the National Health Act (NHA) over a ten-year period, and detract attention from other priorities which do not offer rent-seeking opportunities. As a result, horizontal accountability for health (within state institutions) is low, and vertical accountability (to citizens) is also weak. The 'long route' to accountability is not effective as citizens do not elect politicians based on expectations of improved service delivery, and in turn policy-makers have little oversight over public or private health service providers. Not surprisingly, regulatory capacity is weak. The 'short route' to accountability might be more visible for those clients with the power to choose providers, but many have no real choices. The nature of health services means there are few incentives for collective action, as the need for healthcare is less frequent, less predictable and consumed individually.

Improvements have been achieved when the main health sector individuals and organisations have been incentivised to strengthen the system and support service delivery. Policy-making is personalised, so the President, Governors and key ministers will be highly influential, and are often lobbied personally. DFID has senior access, convening power and the capacity to stay engaged over the long term in the health sector. It has a track record of supporting health advocacy. DFID also needs to be cognisant of incentives that work against improving health systems. Wealthy Nigerians can 'opt out' entirely by travelling abroad, and organised health professionals can block or reverse reforms.

Assessments of past programmes

Health systems strengthening (HSS) programmes target a number of the 'building blocks' of health systems. DFID, through programmes, such as the Partnership for Transforming Health Systems (PATHS) and the Programme for Reviving Routine Immunisation in Northern Nigeria – Maternal, Newborn and Child Health (PRRINN-MNCH), has direct experience of each of those dimensions. It has been able to achieve results in terms of policy-making and sector-wide governance, such as the National Health Act and improved linkages between different levels of government, as well as sustainable improvements in medicine supply through the use of drugs revolving funds. State level initiatives, for example in Jigawa, have also shown progress in achieving more coherent primary health care and improved public financial management, such as through better execution of health budgets and clearer linkage of health budgets to sector strategies and plans. However, human resources management and information systems remain weak at federal and state/local levels, the former due to the strong incentives generated by patronage networks and rent-seeking, and the latter because data is seen as a donor-driven need. Demand-side initiatives should be considered as part of health systems strengthening and have contributed to some 'short route' accountability improvements. Finally, vertical programmes, such as Gavi which suffered from a $5.4m fraud in Nigeria, have identified the need to integrate health systems strengthening as part of their portfolio and in their exit transition planning.

The current legal and policy frameworks provide opportunities to leverage more domestic resources for health, such as provisions for a Basic Health Care Provision Fund (BHCPF) and incentives to create state social insurance schemes. Performance-based programmes, which release funding against pre-determined results, have shown some positive results, such as the $150m National State Health Investment Project, although the World Bank supported $500m Saving One Million Lives still needs to demonstrate its benefits. Results-based financing initiatives should be seen as a form of strategic health purchasing, and therefore as part of wider health systems strengthening to incentivise not just specific results, but systemic improvements.

Finally, health sector public-private partnerships are developing with a policy currently under revision and a range of interventions with formal private providers, for example collaboration on insurance schemes and public-private referrals. DFID also has experience working with the non-profit sector (e.g. faith-based organisations), and can learn from the last years of PATHS2, in Enugu in particular.

Recommendations

The choice facing DFID N does not seem to be between health systems strengthening and service delivery, but selecting the right blend between the two to meet realistic objectives (R1). A share of the DFID N portfolio can be justified for service delivery but should be directed in a way that does not undermine domestic incentives to fund health services for the poorest communities (R2). A transition strategy will be needed as DFID moves out of certain service delivery activities (R3).

In terms of process, DFID N should combine political economy and systems thinking approaches to identify priorities at the federal and state levels, and promote a mix of public and private initiatives covering systems strengthening, service delivery, advocacy and policy (R4). In terms of its overall objective, DFID should use its limited financial and technical resources and its advocacy influence to help Nigerian stakeholders achieve efficiencies and leverage more domestic resources for health (R5) by:

- supporting existing reforms at the federal level and in focal states
- creating incentives for better and new private sector provision with state regulation
- encouraging innovations

In terms of which places to focus the strategy, DFID will need to continue to work at both federal and state levels in order to improve the performance of the health sector. Supporting the implementation of the National Health Act is an obvious entry point (R6). DFID should also build on its past record and continue to strengthen 'citizens voice' and advocacy on health financing (R7).

DFID N should explore incentive mechanisms to encourage private provider involvement and effective regulation, which will be differentiated between the South and North of the country (R8).

Finally, DFID N should encourage innovations to leverage more resources for health, ensuring that lessons are learned, and promising initiatives can be scaled up. This includes strategic purchasing mechanisms; demand-side financing approaches (e.g. vouchers, conditional cash transfers); and incentivising state health insurance schemes or testing the creation of a 'health bank' (R9).

1. Introduction

Health outcomes in Nigeria are extremely poor despite decades of international assistance. Nigeria's health system remains among the worst performing globally. In 2017, the Legatum Institute ranked Nigeria 142 out of 149 countries in terms of health performance.[1] Nigeria's recent move to lower middle-income country status is leading development partners to exit the health sector. This puts pressure to mobilise domestic resources for health to achieve universal health coverage.

DFID Nigeria is currently considering a new strategy for its support to health, shifting from financing service delivery to strengthening health systems. It has commissioned this study to inform its strategy and the design of a new health sector programme. The study's objectives are to:

- Understand how health is financed across public and private sector health providers in Nigeria, and how spending trends compare with peer countries.
- Understand the political incentives behind the low priority accorded to health.
- Provide evidence on what has worked and what has not worked in past government reforms and development partner programmes to: a) make local spending more efficient, b) leverage more resources for healthcare and c) work better with the private sector.
- Assess the feasibility, risks and probable implications of the proposed system strengthening approach for DFID N's new programme.

This research project was undertaken by two Nigerian researchers who adopted a qualitative approach with a desk review, key informant interviews and a roundtable discussion, based on consultations with the PERL team in Abuja and the DFID N health adviser. The draft report was quality assured by a LEAP international consultant who undertook further desk research, including to review PATHS2 and LEAP lessons and complete the political economy analysis.

- The literature review included peer reviewed academic journal articles; national health sector policies and programmes; development partners' programme documents and evaluations; health sector performance reports; and political economy assessments. The literature review helped identify key informants and generated interview and roundtable discussion guides.
- Semi-structured, in-depth face-to-face and phone interviews with 19 key informants. They were selected to offer diverse perspectives on health financing and political economy including: former and current government officials from the Federal and State Ministries of Health, Budget and Planning; Non-Governmental Organisations (NGOs) and Civil Society Organisations (CSOs); academia; the private sector; and development partners.
- A Roundtable Discussion on 12th February 2018 with participants from the private sector, government; CSOs; and development partners to get insights on Nigeria' political economy.

Key informants and roundtable participants were informed of the purpose of the research. Quotations are anonymous and are depicted by codes in this report.

The structure of the report follows the study's objectives. It begins with a summary of health provision and financing (section 2) and then explores the political economy reasons for the low prioritisation of health (section 3). It reviews selected government policies and development partners-supported programmes, covering the three elements of DFID N's proposed new programme (section 4) and concludes with recommendations for DFID N's future health system strengthening approach.

Annex 1 provides the list of documents reviewed and Annex 2 the list of interviews.

[1] *The Legatum Prosperity IndexTM (2017) Creating the Pathways from Poverty to Prosperity London: The Legatum Foundation, available at http://www.prosperity.com/rankings?pinned=&filter=. The health index is based on an assessment of basic physical and mental health outcomes, health infrastructure and preventive care.*

2. Health provision and financing in Nigeria

2.1 Health provision

Health services in Nigeria are provided by the public sector at all three levels of government (federal, state and Local Government Authorities – LGAs) and by private providers (whether formal for profit, non-profit or informal). The private sector is estimated to account for over 60% of healthcare services.[2] However, there are significant regional differences. **In Northern Nigeria, the public sector provides over 90% of all health services, while in Southern Nigeria, the private sector provides over 70% of health services**.[3]

A number of factors influence whether and where Nigerian access healthcare. There are variations in access on the basis of gender, age, wealth, rural/urban, North/South and other characteristics. The 2013 National Demographic and Health Survey (NDHS) identified the following main barriers: cost of services, distance to the facility, health workers' attitudes, inadequate information, financial barriers and lack of access to transport.[4] In the survey, 53% of women reported that at least one of these problems posed a barrier in seeking health care for themselves. Women in rural areas were twice as likely as their urban counterparts to cite the need to get permission as a barrier to going to the health facility.

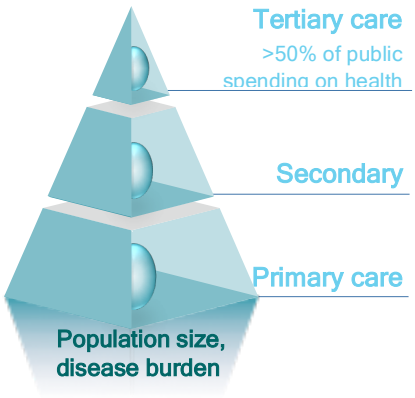
Informal private sector health providers include: traditional medicine healers, itinerant drug peddlers and hawkers, mixed trade dispensers and unlicensed patent medicine dealers. The poorest sections of society are most likely to use this sector. For example, a study of two states in South-East Nigeria found that "the poorest households were most likely to use low level and informal providers, such as traditional healers, whilst the least poor households were more likely to use the services of higher level and formal providers such as health centres and hospitals."[5] A 2007 study of three regions in Nigeria found that 39% reported obtaining treatment for their last episode of malaria from a medicine vendor and another 25% took medicine they had previously obtained from a shop.[6]

While there are concerns about the quality of informal providers, for example due to poor regulations, there is a strong sense of trust in traditional medicine. For example, a study on healthcare-seeking behaviour during pregnancy in Ogun state, in the South West, showed that women utilised multiple caregivers during pregnancy, with a preference for traditional birth attendants who were long-term residents in the community.[7]

2.2 Health funding allocation

The purchasing of health services is neither efficient nor strategic. Resource allocation is not based on evidence. According to the National Health Financing Policy and Strategy developed in 2017, it is more efficient to use public resources where they have most impact on a greater number of persons and disease burden. Investments in PHC and endemic disease control represent such efficiencies.[8]

However, in Nigeria, more than 50% of public health financing goes to the tertiary level, with the secondary and primary care levels getting smaller shares.[9] Between 1998 and 2005, curative care received 70% of total health expenditures (THE), compared to 15% for preventive services despite the National Health Policy's focus on PHC, which is the main point of provision of preventive services.[10]



[2] *FMOH (2009) The National Strategic Health Development Plan Framework (2009-2015).*
[3] *Ichoku. H. and Okoli, CI. (2015) 'Fiscal Space for Health Financing in Nigeria'. African Journal of Health Economics cited in USAID (2016) Health Financing profile: Nigeria. African Strategies for health.*
[4] *Nigeria Demographic and Health Survey (2013).*
[5] *Onwujekwe, O.E., Uzochukwu, B.S., Obikeze, E.N., Okoronkwo ,I., Ochonma, O.G., Onoka, C.A. (2010) 'Investigating determinants of out- of- pocket spending and strategies for coping with payments for healthcare in southeast Nigeria' BMC Health Serv Res 210:67.*
[6] *Bloom, G., Oladepo, O., Salami, K.K., Adeoye, B.W., Oshiname, F., Ofi, B., Oladepo, M., Ogunbemi, O., Lawal, A., Brieger, W.R., Peters, D.H. (2007) 'Malaria treatment and policy in three regions in Nigeria: the role of Patent Medicine Vendors' Working Paper 1, Nigeria Series, 29.*
[7] *Akeju, D.O., Oladapo, O.T., Vidler, M. (2016) 'Determinants of health care seeking behaviour during pregnancy in Ogun State, Nigeria' Reproductive Health; 13(Suppl 1): 32–32.*
[8] *FMOH (2017) National Health Financing Policy and Strategy.*
[9] *Soyibo, A., Olaniyan, O., Lawanson, A. (2009) National Health Accounts of Nigeria, 2003-2005, submitted to Federal Ministry of Health, Abuja. Yanfang, S. (2012) 'An Inverted Pyramid: Three-tier Public Financing for Health in Nigeria' Harvard College Global Health Review. Available at: http://www.hcs.harvard.edu/~hghr/wp-content/uploads/2012/11/12S-Issue.12.pdf.*
[10] *FMOH (2016) End Term Evaluation of National Strategic Health Development Plan (2010-2015), December.*

2.3 Health funding sources

Out of pocket expenditure

Private health expenditure accounts for 70-80% of THE[11], while public expenditure is only 20-30%.[12] OOP health expenditure is estimated to stand at 95.7% of private expenditure.[13] This means that health financing in Nigeria principally comes from payments by individuals at the point of accessing a health service, from public or private providers.

Studies estimate that OOPs account for 60%-70% of THE.[14] The Federal Ministry of Health (FMOH) estimates that OOPs as a proportion of THE is in relative decline, from 78% in 2010 down to 73% in 2014.[15] This is still extremely high compared to the World Health Organization's (WHO) recommendation of 30-40%, and to other African countries. The World Bank 2014 database shows OOPs in Nigeria at 71.6%, compared to a Sub-Saharan Africa average of 34.5% with OOPs only at 6.5% in South Africa, another large economy, and 34% in Niger, one of Nigeria's neighbours with similar health indices.[16]

A high share of OOP is inequitable and regressive, as poor households are considerably exposed to risk and often pay a large percentage of their income. A literature review concluded that "On an average, about 4% of households spend more than half of their total household expenditures on healthcare and 12% spend more than a quarter"[17]. When expenditure on health exceeds a certain percentage of household income, it is defined as catastrophic. A study of households in South-East Nigeria found that 14.8% had experienced catastrophic health expenditure (defined as a non-food expenditure threshold of 40%), with 22.6% of the poorest and only 7.6% of the richest quintiles experiencing catastrophe.[18] A study in South-West Nigeria found that catastrophic expenditure occurred in 10.9% of the households in the lowest quintile compared to 2.5% in the highest wealth quintile.[19]

Data was not found on the overall percentage of OOPs allocated to private health services (for profit, traditional and non-profit) and for public services at the different tiers of government. Evidence by regions, income, gender and other characteristics would be useful. It would also be important to identify reliable estimates of illicit payments (bribes) made to access different services.

Insurance

Less than 5% of Nigerians are covered by any form of a pre-payment scheme or risk pooling scheme, mostly civil servants and formal private sector workers. This is well below the WHO recommendation of 90%, and leaves out the poorest and most vulnerable segments of the population, who are in most need of protection.

The larger and more diverse the health insurance pool, the more viable it becomes. While a centralised national pool is the most desirable, this has not currently proven feasible in Nigeria under the National Health Insurance Scheme (NHIS). However, mandatory state health insurance (contributory) schemes in Nigeria could reach a sufficient size to enable adequate spreading of risk.

Public funding

Public health expenditure is only estimated to account for 20-30% of THE.[20] As Table 1 below shows, Nigeria has both the lowest public expenditure and some of the worst health indicators of its peers. World Bank data show that health as a share of general government expenditure was 8.1% for Nigeria, much lower than for example South Africa (14.2%),[21] and somewhat lower than the regional average (9.9%).[22] It is well below the 15% to which Nigeria committed in the Abuja Declaration, which calls for increased spending on health as a proportion of total public expenditure.

In 2015 the Work Bank calculated that public expenditure on health represented less than 2% of GDP and might go down to 1% or 1.2% following a re-basing of GDP.[23] One reason is the low share of taxes as a proportion of GDP, which translates into a low share of GDP for public services. The IMF notes that "in terms of economic capital (electricity, roads) and social

---

[11] *National Health Accounts Nigeria accessed on 17 April 2018 https://knoema.com/WHONHA2018Feb/national-health-accounts?country=1000340-nigeria.*
[12] *World Bank (2014) https://data.worldbank.org/indicator/SH.XPD.PUBL Accessed on 28 March 2018.*
[13] *World Bank (2014) https://data.worldbank.org/indicator/SH.XPD.OOPC.ZS. Accessed on 28 March 2018.*
[14] *FMOH (2016) National Health Policy.*
[15] *FMOH (2017) First draft National Health Financing Policy and Strategy*
[16] *World Bank 2014. https://data.worldbank.org/indicator/SH.XPD.OOPC.ZS. Accessed on 28 March 2018.*
[17] *Uzochukwu, B.S.C., Ughasoro, M.D., Etiaba, E., Okwuosa, C., Envuladu,E., Onwujekwu, O.E. (2015) 'Health care financing in Nigeria: Implications for achieving universal health coverage' Nigerian Journal of Clinical Practice, Jul-Aug 2015, Vol 18 Issue 4, p.44.*
[18] *Onoka C.A., Onwujekwe, O.E., Hanson K., Uzochukwu B.S. (2011) 'Examining catastrophic health expenditures at variable thresholds using household consumption expenditure diaries' Trop Med Int Health 2011;16:1334- 41.*
[19] *Ilesanmi O.S., Adebiyi A.O., Fatiregun A.A. (2014) 'National health insurance scheme: how protected are households in Oyo State, Nigeria from catastrophic health expenditure?' International Journal of Health Policy and Management. 2014, 2(4), pp.175-180.*
[20] *World Bank database (2014) https://data.worldbank.org/indicator/SH.XPD.PUBL.*
[21] *World Bank Database (2018) https://data.worldbank.org/indicator/SH.XPD.PUBL.GX.ZS.*
[22] *WHO (2017) World Health Statistics 2017: monitoring health for the SDGs, Sustainable Development Goals Geneva: WHO.*
[23] *World Bank (2015) 'Programme Appraisal Document: Program for Results to support The Saving One Million Lives Initiative' Washington, DC: World Bank p104.*

capital (education and health infrastructure), Nigeria's infrastructure is generally less than half the size than in the average sub-Saharan Africa country and only a fraction of that in emerging market economies." [24]

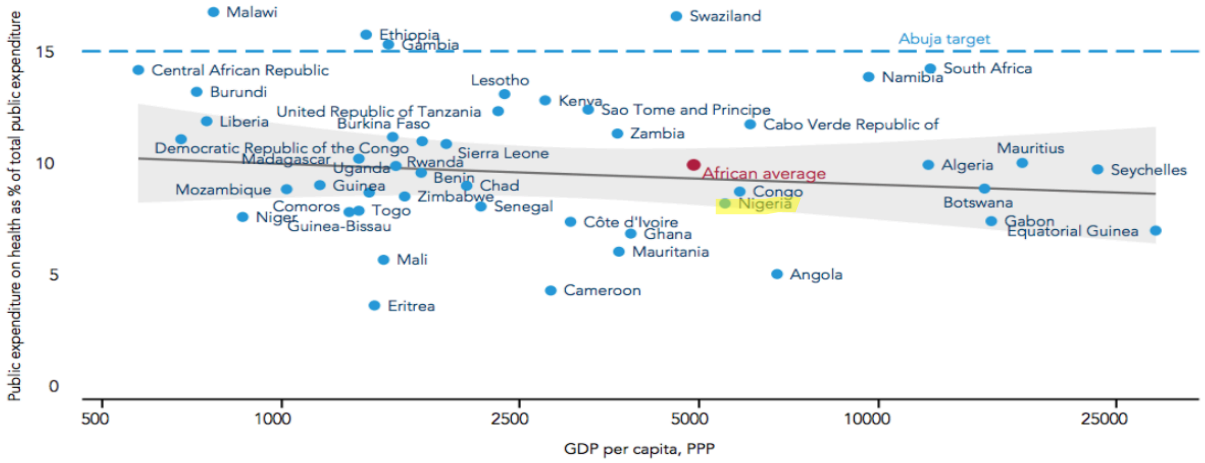
Accurate and detailed data for the provision of primary, secondary and tertiary care or by levels of government are hard to find. The World Bank has found it challenging to assess resources used for PHC as they come from different sources. It estimated that the federal government contributes about 22% of all PHC funding, including a greater proportion of non-salary expenditure (e.g. commodities, schemes such as the Midwife Service Scheme or the Millennium Development Goals fund for health facilities construction). This is consistent with the FMOH statement that an estimated 80% of resources at the federal level are spent on curative care.[25]

Table 1: Health expenditures and health Indicators across selected African counties

	Nigeria	Ghana	South Africa	Rwanda	Kenya	Regional average
Public health expenditure as a share of government expenditure (%, 2014)	*8.2*	*6.8*	*14.2*	*9.9*	*12.8*	*9.9*
**General government expenditure on health as a share of THE (%, 2014)	25.1	59.8	48.2	38.1	61.3	49.3
**Private expenditure on health as a share of THE (%, 2014)	74.9	40.2	51.8	61.9	38.7	50.7
* THE per capita (US dollars in 2014)	118	58	570	52	78	98
*Total health expenditure as a share of GDP (%, 2014)	3.7	3.6	8.8	7.5	5.7	5.5
* Maternal mortality ratio (deaths per 100,000 live births) 2015	814	319	138	290	510	547
Under five mortality rate (deaths per 1,000 live births, 2016)	104.3	58.8	48.3	38.5	49.2	78

Source: World Data Atlas (2014), * World Bank (2014), Sambo et al 2009**.[26]

Figure 1: Comparison of government health allocation and GDP per capita in Africa, 2014



Source: Global Health Expenditure Database, WHO, 2016

[24] *IMF (2018) 'Nigeria: Staff Report for the 2018 Article IV Consultations' 15 February, page 59.*
[25] *Gbenga-Ogunbare, Y. (2017) 'Primary Healthcare In Nigeria Is Dysfunctional—Health Minister' Nigerian Tribune, 6 October http://www.tribuneonlineng.com/primary-healthcare-nigeria-dysfunctional-health-minister/*
[26] *Sambo, L. G., Kirigia, J.M. and Nabyonga Orem, J. (2013) 'Health Financing in the African Region: 2000–2009 Data Analysis.' International Archives of Medicine 6 (2013): 10. PMC.*

Donor funding

Development partners' contribution to health financing is less than 5 % of THE.[27] However, this is significant as the majority of donor funds are channelled through vertical programmes that are the main vehicles for tackling specific diseases. Nigeria is one of largest country programmes for the Global Fund for HIV, TB and Malaria (the Global Fund). For the 2017-2019 funding cycle, Nigeria was allocated $660.7 million for the three diseases. Total disbursements to date are over $1.9 billion.[28] Funding for HIV and TB is heavily donor-dependent: while domestic resources make up nearly half of the funding, Global Fund resources make up about a quarter and another quarter comes from other aid programmes, including the US President's Emergency Plan for AIDS Relief.[29] In 2011, total aid for health in Nigeria was $528 million. 95.7% went to PHC service delivery with only 4% on health system strengthening.[30]

There is poor coordination between government, development partners and NGOs activities, and poor alignment to national priorities and programmes as expressed in the National Health Policy.[31] For example, a study has calculated that in 2011, 57% of total health sector assistance was for sexually transmitted diseases and HIV/AIDS, whereas Nigeria's burden of diseases associated with HIV/AIDS/TB was estimated to be less than 5%.[32] This is despite Nigeria having signed up to the Global Compact of the International Health Partnerships and related initiatives in 2008, and to a complementary country compact with its development partners in 2010, which follows the established principles of one plan, one budget, one Monitoring and Evaluation (M&E) framework based on the National Strategic Health Development Plan and National Results Matrix.[33]

Most respondents in our research felt that development partners had contributed to health, although a minority considered that aid had been used inefficiently. One interviewee stated that "Because there is no critical monitoring, there is little or no achievement with the donor investment in health" (AC01). Interviewees also considered that external funding had distorted both health financing and the political prioritisation of health by the government: "Donor presence removes the urgency that political actors give to health priorities. Donor ethical and humanitarian posture allows government to shirk its responsibilities. They should concentrate on health system strengthening" (CS01). "There is an element of total dependence. There is no appetite for government to drive" (DN03).

In summary, funding for healthcare comes principally from individual, out of pocket payments at the point of accessing a service, which is inequitable and regressive. Nigeria has one of the world's lowest rates of public investments in health as measured by various indicators; half of public funds go to hospitals which are not used by the poorest. In addition to low public funding, there is a very low rate of insurance which would pool risks and provide better protection. Overall, funding is not strategically allocated; the majority goes to tertiary or curative care which benefits the richest. Development partners have filled some of the funding gaps for some diseases. The next section examines why healthcare in Nigeria is under-funded and not meeting the needs of its most vulnerable population.

---

[27] FMOH (2009) National Strategic Health Development Plan (2010-2015).
[28] The Global Fund website: https://www.theglobalfund.org/en/portfolio/country/?loc=NGA&k=430b8acd-ef36-4ef1-8231-0e730499d19a.
[29] Oberth, G. (2017) 'Nigeria's TB/HIV funding request to the Global Fund sent back for iteration' Global Fund Observer. Accessed 18th April 2018. http://www.aidspan.org/gfo_article/nigeria%E2%80%99s-tbhiv-funding-request-global-fund-sent-back-iteration
[30] Shaw, R.P., Wang, H., Kress, D., Hovig D. (2015) 'Donor and Domestic Financing of Primary Health Care in Low Income Countries' Health Systems & Reform,1:1, 72-88, DOI: 10.1080/23288604.2014.996413
[31] FMOH (2016) National Health Policy (2016) and FMOH (2017) National Health Financing Policy and Strategy
[32] Shaw et al. (2015).
[33] FMOH (2010). Achieving measurable results for help through the National Strategic Health Development Plan 2010-2015. Country compact between federal government of Nigeria and development partners.

3. Political economy of healthcare financing and provision

In this section, we undertake a light touch political economy analysis (PEA) of the Nigerian health system. It is based on PERL's suite of PEAs on Nigeria; two recent LEAP health sector studies; and confirmed by insights gained during the interviews and roundtable discussion.

To understand why the Nigerian health sector continues to be underfunded by comparison to peer countries, and suffers from leakages and inefficiencies, it is essential to understand the responsibilities, interests and incentives of the main organisations and individuals that make up the sector. Structural and institutional factors help explain why certain actors may seek to perpetuate the current system but also where there might be opportunities for change.

3.1 Structural factors

The structure of Nigeria's economy and the relationship between the state and citizens have resulted in a state that is not responsive to the population's need for better access to quality healthcare. Nigeria is a 'rentier' state, dependent on the resources generated by oil and gas revenue. It does not need to tax citizens to the same extent as non-rentier states to finance its essential expenditures. A weak social contract means that public expectations of government are low and there is little public accountability to citizens. This was reinforced through decades of military dictatorship.[34]

At the federal level, the political settlement depends on a balance between different ethnic groups in terms of access to political and official positions. This balance of power is reflected at the state and local levels and has led to the multiplication of sub-national entities over the years with an extension of the bureaucracy to match them. Once in power, elites can award jobs and contracts based on the rents generated by oil and gas revenues to sustain their patronage networks.[35]

In the health sector, this translates into the prioritisation of salaries for the recurrent budget, with many appointments to reward supporters rather than on the basis of professional qualifications or evidence-based workforce plans. **Politicians have a preference for infrastructure** (e.g. tertiary hospitals) which are more visible to voter and provide more opportunities for awarding and manipulating public contracts than investments in systems strengthening and service delivery improvements. . Our roundtable discussion also found that health did not present a viable avenue for bulk graft, which reduces its political prioritisation in comparison to other sectors.

Patronage politics means that policy-making is highly personalised around individuals with political power, and their financial backers. At the federal level, the President faces few constraints. However, since the return to democracy, parliamentarians, civil society and the media are providing more checks and balances. At the state level, Governors are particularly influential. The civil service has weak policy-making capacity; its professionalism was undermined under military rule; and it is affected by ethnic divisions and corruption.[36]

As a result, health policy-making is primarily determined by a few politicians at the federal and state levels, who are mainly interested in how they can use health sector spending to boost their political support. Because of weak state-society relations, politicians are not incentivised to stand for elections on the basis of public policies. They are supported by their ethnic groups or other patron-client relations, who hope to benefit from the short-term rewards they can generate. Patronage politics thereby militates against the long-term investments and reforms needed to increase access and quality of health services in Nigeria.

The health sector is also influenced by the legacy of British colonialism, under which the formal system provided better access to health in the South. The extension of healthcare in the post-colonial era followed the British-model centered on hospitals, doctors and treatment, with greater access in urban areas and poor provision in rural areas where trained professionals did not want to live. Private and traditional healthcare became more important in the 1980s as a result of rising costs and governments cuts, which undermined the public health system.[37]

There is little that a DFID programme could do to influence these structural factors in the short-term. However, it needs to be cognisant of them, and identify trends that could support 'transformational' change over the medium to longer-term. For example, in the last two decades, the expansion of new private businesses has challenged state patronage; mobile technologies have facilitated a range of heath delivery innovations, as well as provided new channels of accountability through access to information.[38]

---

[34] Utomi, P., Duncan A., Williams G. (2007) 'Nigeria: The Political Economy of Reform. Strengthening the Incentives for Economic Growth', Brighton: The Policy Practice.
[35] Anyebe, W., Bezzano J., Foot S. (2005) 'Country level testing: the health sector in Nigeria. An analytical framework for understanding the political economy of sector and policy arena'.
[36] Heymans, C. and Pycroft, C. (2003) 'Drivers of Change in Nigeria: A Preliminary Overview'. DFID Nigeria discussion document.
[37] Anyebe et al (2005).
[38] Anyebe et al (2005) anticipated some of those changes.

3.2 Institutional factors

The health sector is characterised by fragmentation and poor coordination which emanates from the formal legal framework, starting with the Constitution. Health is a "concurrent" responsibility of the three levels of government. By convention the federal government is responsible for setting policy, coordination, training, sector programmes and for tertiary care; states are responsible for secondary care; and LGAs are responsible for PHC.

There are challenges within each of these three tiers of government. Patronage and rent-seeking explain the proliferation of parastatals in the health sector. LEAP's case study of the difficulties of passing the NHA and agreeing how it should be implemented clearly illustrates the greater relevance of financial over non-financial health sector issues for politicians. The Act was caught in inter-ministerial tensions between the Federal Ministry of Finance, Federal Ministry of Health and its parastatals because it required a shift in the control of financial resources (how the new funding should be managed and by whom).[39] At the state level, there is a confusion of roles. While LGAs are meant to be responsible for the delivery of PHC, the management and supervision of these services is carried out by State Ministries of Health (SMOHs), State Ministries of Local Government and the Local Government Service Commission.[40]

There are also challenges to ensuring coordination between these three levels, as the institutional framework is unclear. Bodies meant to facilitate coordination do not always function well, such as National and State Councils on Health. Corruption and patronage networks encourage different levels to extend their mandate, for example the proliferation of tertiary hospitals set up by states, in theory a federal responsibility.[41] The federally-introduced PHC reform is meant to clarify roles and responsibilities and provide a more coherent PHC framework for policy, funding and delivery. However, it cannot be simply mandated through a federal law, but has to be domesticated by each state through their own state laws to establish state-level bodies and negotiate with their LGAs (see next section).

Reform implementation requires continued and relentless advocacy coupled with incentives to facilitate the effective transfer of responsibility to lower levels of government with implementation power. A comparative study of the performance of the midwives' service scheme in two Nigerian states concluded that sustaining health system initiatives in decentralised systems is dependent on strengthening political commitment at sub-national level.[42] LEAP case studies, and DFID's own current strategy for engaging with health delivery also show that the federal level cannot impose health reforms on states and LGAs. Reform will happen or be blocked for varied reasons connected to the specificity of each region, state and LGA.

The diversity of the private sector makes it difficult to identify one clear set of 'rules of the game'. For example, large, for-profit organisations have the resources to organise and lobby effectively, whereas very localised traditional healers do not. DFID should undertake PEAs of the different segments of the private sector, including differences between the North and the South, to inform it strategy for private sector engagement in health.

Private health sector regulation is mostly theoretical. A private health sector assessment found that the vast, diverse, fragmented and highly unregulated nature of Nigerian private health sector makes it difficult to measure the quality of services it provided.[43] SMOHs issue licenses and are responsible for ensuring that facilities comply with licensing regulations. However, in reality SMOHs have few resources to conduct any quality-control or monitoring activities.[44]

Professional bodies, which also act as trade unions for their professions, can have conflictual relationships with government. Public-private relationships can be mutually beneficial but not always in the public interest (e.g. public and private actors may collude to sustain the fake drugs trade or manipulate procurement or inspections). Our roundtable showed that the private sector is cynical about policies that do not get implemented. One participant said: "We, in the private sector, when we hear civil servants and the government speak on policy document gathering dust somewhere, we see the futility in such approaches."

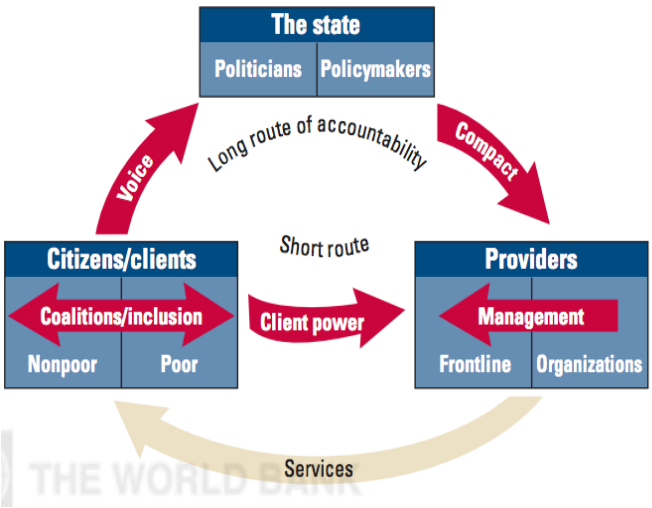
As a result of this complex system, and the combination of formal rules and informal norms that are found across Nigeria's public sector, **horizontal accountability for health (between different government agencies) is poor across all levels of government**. In the states without State Primary Health Care Development Agency or Board (SPHCDA/B), there is no central point of accountability for the PHC system. And when they exist and function well, they may be challenged by the SMOH so it can assert its own direct control over resources, as Jigawa's Gunduma reform experience has shown.[45] Financing for health comes from different private and public sources; actual public funding is unpredictable and unrelated to budgets. This makes financial accountability hard to achieve. Health data quality is also poor. Even armed with better quality data, politicians and civil servants have little incentive to use evidence to assess and manage health sector

---

[39] Tulloch, O., Cummings, C., Ogunbayo, D and Oreh, C. (2017) 'A Case Study of the Implementation of the 2014 National Health Act', Abuja: PERL-LEAP, October.
[40] Piron, L.H. and Ogunbayo, D. (2017) 'Jigawa health sector governance reform case study' Abuja:PERL-LEAP, November.
[41] Anyebe et al (2005).
[42] Okpani, A. and Abimbola, S. (2016). 'The midwives service scheme: a qualitative comparison of contextual determinants of the performance of two states in central Nigeria'. Global Health Res Policy. 2016; 1:16. doi: 10.1186/s41256-016-0017-4.
[43] SHOPS Project (2012) 'Nigeria Private Health Sector Assessment. Brief.: Strengthening Health Outcomes through the Private Sector Project', Bethesda, MD: Abt Associates.
[44] Barnes, J., Chandani, T., Feeley, R. (2008). 'Nigeria Private Sector Health Assessment' Private Sector Partnerships-One project, Bethesda, MD: Abt Associates.
[45] Piron and Ogunbayo (2017).

performance. Our review did not examine the role of the judiciary and independent bodies that could enforce accountability and lead to improved performance. For example, an effective federal-led fight against fake drugs was a success factor which combined with state-level initiatives in Jigawa.

Vertical accountability (between the state and citizens) is also weak. The 'long-route' to accountability, as described by the 2004 World Development Report[46], is not effective (see diagram). First, health is not a political issue: politicians are not held to account at the ballot box for their performance in office or their future health policy commitments. Some interviewees described the situation as follows: "There is no citizen's voice. Citizens have low expectations. The segment of the population that has a voice does not use it. Even when voting, they are told who to vote for" (DN01). "Many are not aware of the value of investing in health and that the government can actually be held accountable for not investing in health" (DN04). Second, policy-makers have little capacity to hold health providers to account, due to the complex relationships within the state system, and weak regulatory capacity.



The 'short route' to accountability is more clearly visible for those Nigerians who can exercise their 'client power' to choose between alternative public and private providers. However, many have little option but to access to the nearest or most affordable provider. Asymmetric information (between the patient and health provider) means that it is hard to assess quality. **The need for healthcare is less frequent, less predictable and more individual than other services, such as education, which creates fewer incentives for collective action**.[47]

3.3 Key actors and how they might drive change

This section maps stakeholder interests and influence (see summary matrix at the end) and indicates some entry points for positive engagement or to manage resistance This can at first appear like a black box. The World Bank noted in the design of its $500m MNCH loan that there is "a very large variation in the extent to which [MNCH] performance has improved [between 2008 and 2013]. Importantly, baseline level of performance does NOT appear to be a predictor of success. Also, the most improved States come from all over the country and are NOT concentrated in any particular geopolitical zone."[48] DFID should undertake targeted PEAs and stakeholder mappings as it designs different interventions, for example through a well-structured workshop to test some pre-identified hypotheses that justify its theory of change and investment choices.

Policy-making is highly personalised. As a result, the personal decisions of a President, Federal Minster of Health or Governor are crucial, and they will be lobbied personally. As noted in the roundtable, the constant change in political leadership (due to set terms in office) prevents more continuous implementation of reforms and programmes, which often last more than a political cycle. However, the personalisation of policy-making can also be a driver of reform, as indicated in Jigawa where successive governors (Turaki, Lamido, Abubakar) have each shaped the direction of health reforms.[49] Our interviews and roundtable identified Kano and Ondo states as examples where positive changes were taking place (health trust fund, contributory scheme and private hospital management board in the former, and partnerships with the private sector in the latter). These could be further researched to assess whether reform is indeed happening, who is driving it and whether it could be supported to achieve durable improvements that would last beyond a political cycle.

DFID has senior access, convening power and the capacity to stay engaged over the long term in the health sector. It has a track record of supporting health advocacy, such as the creation of HERFON and lobbying for the NHA over more than a decade. As politicians prepare for the next round of elections, DFID could consider what coalitions it could support to maintain health on the political agenda.[50] The roundtable discussion suggested that presenting health benefits in economic terms, rather than solely a social service, could increase its political prioritisation, or considering the

[46] *World Bank (2003) World Development Report 2004: Making Services Work for Poor People. Washington DC: World Bank. https://openknowledge.worldbank.org/handle/10986/5986.*
[47] *Batley, R. and Mcloughlin, C. (2015) 'The Politics of Public Services: A Service Characteristics Approach' World Development Vol. 74, pp. 275–285.*
[48] *World Bank (2015) p.95.*
[49] *Piron and Ogunbayo (2017); SPARC (2012) 'Executive Summary of Political Economy Analysis for Nine States', Final Report.*
[50] *See specific recommendations in Tulloch et al (2017).*

non-health sector interventions that will benefit health outcomes. These recommendations could be tested in further advocacy work.[51]

Demands for improvements to health service delivery could potentially come from the wealthiest segment of society, able to organise and put pressure on government. However, **Nigerian elites can not only afford private treatment but can 'exit' entirely by travelling abroad**. For example, President Buhari spent several months in the UK in 2017 for medical treatment at taxpayers' expense and his son recently returned from medical treatment in Germany. Some civil society actors (Femi Falana and the Campaign for Democracy) are trying to hold the President to account for his use of health services abroad.[52]

There is a wide range of health professional bodies with memberships across the private and public sectors. **However, professional bodies are organised to defend their interests and will seek to undermine reforms that they consider inimical**. For example, in Jigawa, the Gunduma system brought together primary and secondary health care under district-level councils. This brought medical doctors under the responsibility of medically trained staff appointed to run the councils, which generated tension and was reported as one of the reasons for opposition to the system and its replacement in 2016.[53]

DFID N should undertake a **deeper review of the factors that drive the various institutions and actors involved in private health sector delivery in order to identify how it could leverage improvements**. DFID N will also be able to draw on comparative lessons from its other programmes involved in Public-Private Partnerships (PPP) and regulating service delivery. For example, there is evidence on how Nigeria telecom's regulation has improved. The profit motive could be an incentive for private for-profit health service providers to ensure they provide quality services to the widest population. This hypothesis should be tested through further research, including on the type of regulation that the government would be in a position to provide, and support required to achieve effective, leakage-free enforcement.

In summary, as DFIDN develops its new strategy, it needs to take into account both the contextual factors that constrain or facilitate health financing and more equitable provision in Nigeria, and how they might influence key organisations and individuals responsible for health. Table 2 below provides a matrix of key stakeholders in terms of their interests and influence over greater political prioritisation of health (i.e. more and better allocated public resources for healthcare; implementation of existing laws and policies including better private sector regulation). DFID could use it as a starting point to refine its strategy. DFID overall has a track record of integrating such analysis as part of programme designs and implementation.[54] It has already adopted such approaches in Nigeria, including in health. The next section examines government and development partners track record in health policy and programmes, to identify some lessons for DFIDN's health systems strengthening strategy.

[51] *See also FMOH (2016) National Strategic Health Development Plan (2010-2015) End Term Evaluation Report.*
[52] *Maymaygist (2017) 'How much was Buhari's Medical Bill Abroad: Nigerians', 18 March at http://www.maymaygist.com/2017/03/18/how-much-was-buharis-medical-bill-abroad-nigerians/*
[53] *Piron and Ogunbayo (2017).*
[54] *Piron and Ogunbayo (2017).*

Table 2: Stakeholders' interests in reform and influence over the political prioritisation of healthcare in Nigeria

Influence over the political prioritisation of health: High	Interest in the political prioritisation of health: Low	Interest in the political prioritisation of health: High
	Little interest but a lot/some influence **Most politicians at federal/state/local levels** are able to veto laws and resource allocation decisions and they do not see health as a source of electoral success, patronage or leakages opportunities **Most health sector civil servants** benefit from the current system (jobs and leakages opportunities) **Most non-health sector civil servants** would not want to see resources redirected to health **Wealthy citizens** could lobby but can afford expensive care or travel abroad for treatment	**A lot of interest and a lot/some influence** **Some Presidents, Governors, Ministers and Legislators** make health a personal priority (personal legacy, ideological persuasion, technical background, pressure from family) **Some civil servants** want to make the health system work (personal legacy, ideological persuasion, technical background, social pressure in community) and can resist pressures from politicians/peers for leakages **Some health professional bodies** if specific reforms benefit their members **Some formal private sector health providers** if they are organised and reforms could create new market opportunities **Some health CSOs/NGOs** are particularly well-connected or funded (e.g. HERFON, former politicians/civil servants defending their personal legacies)
Influence over the political prioritisation of health: Low	**Little interest and influence** **Middle class or urban citizens** can afford and access private healthcare under the present system so do not lobby for better services **Informal private health sector providers** benefit from the current unregulated system and would find it difficult to organise to respond to reform.	**A lot of interest but little influence** **Most service users** (poor women and men, children, youths, rural populations) do not receive adequate healthcare but they do not expect/organise to demand better services **Most health CBOs/CSOs/NGOs** deliver/monitor health services but cannot lobby effectively **Most formal private sector health providers** would benefit from greater market opportunities but do not have political influence **Development partners** are interested in improved health outcomes to meet SDGs given Nigeria's large population but need to find alternatives strategies as Nigeria reaches middle-income status

4. Assessment of past government and donor programmes

The Nigerian government has put in place various policies, plans and programmes to improve health outcomes, some of which have been co-funded by development partners. Large vertical programmes have targeted specific illnesses, whereas other programme have aimed to strengthen the health system as a whole or some of its 'building-blocks' (defined by the WHO as: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance - stewardship).[55]

This section reviews the available evidence about some of Nigeria's recent HSS programmes to identify what has worked, what has not worked, and why. It looks at initiatives to: (i) improve efficiency in health spending; (ii) leverage more resources for health; and (iii) work better with the private sector.

4.1 Making health spending more efficient

Simply raising more money for health without considering how it is used is unlikely to translate into significant improvements in outcomes. African economies have been found to have the lowest efficiency in health spending.[56] This is characteristic of public service delivery.[57] The appraisal document for Saving One Million Lives – Program for Result (SOML-PfR) found that funding alone does not have much influence on health services in Nigeria: there was no correlation between state level expenditures in health and health outputs (e.g. skilled birth attendance).[58]

A range of policy instruments can be used to improve the mix of health sector inputs (e.g. health workers, infrastructure, drugs, etc) to deliver a range of health sector goods and services. Policy reforms can improve the allocative efficiency (doing the right thing) and technical efficiency (doing things the right way) of health systems, and there are international lessons to inform Nigerian choices.[59] The programmes we review below focus on initiatives that aim to improve: (i) the entire health system and its stewardship; (ii) basic service delivery; (iii) human resources; (iv) information; (v) medicine supplies; (vi) governance, in particular public financial management reform, as well as (vii) the demand-side. Financing and private sector initiatives are examined in the next sections.

Health Systems Strengthening (HSS)

PATHS was a DFID-funded development initiative over 2001 to 2016 which adopted a comprehensive HSS approach. The goal of PATHS2 (£177m, 2008-2016) was to support Nigeria in using its own resources efficiently and effectively to achieve health-related Millennium Development Goals. Its outcome was to improve the planning, financing and delivery of sustainable, replicable, pro-poor MNCH services in up to five states. PATHS2 evolved from an initial focus on sector governance over 2008-2011 (national stewardship, state-level systems, engaging civil society and informed citizens), to a focus on service delivery during 2012-2014 (policy, systems, and community levels) with a 2014-2016 consolidation phase that included private sector partnerships.[60]

PATHS2 covered a very large number of interventions and has produced a comprehensive set of evidence products. **PATHS achieved important health system governance achievements**:[61]

- A unified policy framework, the National Strategic Health Development Plan (2010-2015) and state plans, against which development partners could align their support.
- Facilitating the passage of the NHA and a range of policies (National Health Policy, financing, human resources, public-private partnerships, etc.).
- A multi-layered approach, with the ability to work at the federal, state and LGA levels, including with health facilities and communities; improving federal-state linkages and health sector coordination; and sharing lessons from the states where it operated.
- Targeting HSS reforms towards the weakest points of financial, human resources and information management. The final evaluation concluded that it had built capacity at the federal level across those three areas.[62]

---

[55] WHO (2007) Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: WHO.
[56] Grigoli, F. and Kapsoli, J. (2013) 'Waste Not, Want Not: The Efficiency of Health Expenditure in Emerging and Developing Economies' WP/13/187. IMF Working Paper.
[57] Yaqub, J.O, Ojapinwa T.V, Yussuff R.O (2012) 'Public Health Expenditure and Health Outcome in Nigeria: The Impact Of Governance' European Scientific Journal June edition vol. 8, No.13 ISSN
[58] World Bank (2015) Figure 13, p.92.
[59] Yip, W. and Reem, H. (2015) Improving Health System Efficiency: Reforms for improving the efficiency of health systems: lessons from 10 country cases. Health Systems Governance and Financing. Geneva: WHO. WHO/HIS/HGF/SR/15.1 page 5.
[60] PATHS2 (2016) End of Programme Technical Report.
[61] PATHS2 (2016); Independent Monitoring and Evaluation Project for the State Level Programmes (IMEP) (2016a) Study on PATHS2 Capacity Development: Final Report.
[62] IMEP (2016a).

- It added a demand-side element to the WHO HSS framework, to stimulate demand for health services, with community mobilisation and accountability measures.
- Long-term engagement and commitment, with well-embedded and trusted national teams, meant it achieved both improved sector management and health outcomes.[63]

However, the PATHS2 capacity development final evaluation was particularly **concerned by the lack of sustainability of some of these gains in the absence of adequate federal government funding** for implementation and maintenance of the systems that have been built. Sustaining these gains through future HSS programmes will require understanding the political incentives within the health sector.[64] PATHS2 management itself had identified the importance of programming in a way consistent with the politically-informed approach we recommend, including:[65]

- Flexibility and the ability to respond to demand.
- Interventions tailored to the context and needs of each state.
- Building consensus to ensure a common understanding of the problems and solutions to overcome them. Coalition-building to achieve legislative progress. Professional groups as strong gatekeepers that need to be engaged early on.
- The fundamental importance of state leadership responsiveness, with ongoing PATHS2 advocacy to make the health sector a priority.

Decentralised Service Delivery

The National Primary Health Care Development Agency (NPHCDA) collaborated with PATHS and another DFID programme, PRRINN-MNCH, to improve PHC through decentralised management called **Primary Health Care Under One Roof** (PHCUOR). Introduced in 2005, this was adopted as a national policy agenda in 2011. The policy aims at integrating PHC structures and programmes under one state level body (a PHC Development Agency or Board - SPCHDA/B) to reduce fragmentation by having one plan, one management structure and one M&E system. States are required to have functioning SPHCDA/B in order to access the BHCPF under the 2014 NHA. Progress is assessed through the PHCUOR National Scorecard. The NPHCDA has produced guidelines and self-assessment diagnostic tools to assist states.[66]

By 2015, 28 states had PHCDA/Bs and PHCUOR uptake was greater in Northern states. [67] The best ranking state was Jigawa which in 2007 had established Gunduma, a decentralised system combining both primary and secondary health care in a structure comprised of a Board and 9 Gunduma Councils operating at arms-length from the SMOH. The LEAP case study has identified the political economy factors which facilitated this. They included: successive governors' commitment to innovation and improved healthcare; long-lasting financial and technical support through DFID programmes in the state; and a process of consensus-building amongst reform-minded civil servants, with evidence, study tours and other advocacy activities. Gunduma achieved some concrete organisational improvements, such as integrating planning, budgeting, human resources, and operational PHC delivery with improved accountability. In 2016, the new Jigawa government abolished Gunduma and replaced it with a SPHCDA which was more integrated within the SMOH and no longer included secondary health care (opposed by the medical profession).

Human resources for health (HRH)

Health spending in Nigeria is particularly inefficient as the majority is spent on salaries; there is little non-salary recurrent budget to enable these health professionals to operate. The World Bank has found that the ratio of health workers to the population was substantially higher in Nigeria than in neighbouring countries (twice the sub-Saharan average).[68]

Human resources management measures, such as ensuring that staff with the right skills and training are allocated to priority roles, can contribute to improving technical efficiency. PATHS2 and other programmes (PRRINN-MNCH, WHO, USAID Capacity Plus, etc.) have undertaken a range of HRH interventions at the federal level, such as a health workforce profile, workload analysis to improve HRH planning, recruitment and training. PATHS2 has also helped some states, for example in Jigawa to improve their HRH policies and systems, by introducing performance management systems, databases of staff, and state capacity to train nurses, midwives and health scientists. The PATHS2 evaluation concluded that HRH federal-level interventions remained heavily aid-dependent and that PATHS2-supported states had not yet developed health-sector workforces of an adequate size and skill-set, and deployed and managed to achieve the most efficient result.[69]

---

[63] *For the case of Jigawa see Piron and Ogunbayo (2017).*
[64] *IMEP (2016a).*
[65] *PATHS2 (2016).*
[66] *See https://phcuor.org.*
[67] *NPHCDA (2015). Primary Health Care Under One Roof Implementation Scorecard III Report, National Primary Health Care Development Agency. Available at: https://niftng.com/wp-content/uploads/2016/04/PHCUOR-Scorecard-3-Narrative-Report-final.pdf)*

[68] *World Bank (2015) p91.*
[69] *IMEP 2016a.*

Task-shifting is one HRH way of improving efficiency of health spending in resource-constrained settings.[70] It ensures that the comparatively costlier human resources do not carry out tasks that could be accomplished by the comparatively less costly human resources. In 2014, the National Task Shifting/Task Sharing Policy was introduced.[71] However, Nigeria is yet to fully operationalise task-shifting in healthcare delivery. Existing initiatives could be reviewed to learn lessons.[72]

To make progress in this area, HRH needs to be understood from a political perspective given the share of the public health budget it represents. Senior officials have the power to recruit and deploy staff, a significant source of patronage. They have little incentive to improve staff performance, given poor accountability and low public expectations on the public health sector. Opportunities for improvements may come from wider HR management reforms beyond the health sector and from external pressures from service users. Lessons from other sectors should be reviewed and are likely to be transferable to the health sector. DFID can draw on lessons from PERL's Accountable, Responsive and Capable Government programme.

Health information management system (HIMS)

Quality data are essential for evidence-based policies and to reallocate resources to improve health systems efficiency. Nigeria's federal system means that information is generated at different levels with little coordination. Vertical programmes and other health development programmes incentivise reporting around their objectives, without necessarily using similar data.

There have been efforts to improve health information. For example, PATHS2 supported federal level improvements, such restructuring and training the FMOH Planning Department and reviewing the HMIS policy and plan. It assisted states to implement the national HIMS. While the PATHS2 evaluation identified some improvements, such as a shift from annual paper-based collection to routine data collection at state level, it found that HMIS activities were particularly aid-dependent and would likely come to an end once external funding stopped.

Concerns remain in terms of data quality. A dedicated DFID monitoring project, the Independent Monitoring and Evaluation Project for the State Level Programmes, found HIMS data in North West states over 2012-15 to be unreliable, with sporadic reporting and overstated results.[73] While some Nigeria-wide survey data were more reliable than DFID programme data, they are not all as rigorous or comparable.[74] Such DFID investment are important as they contribute to improving the evidence-base for government (at all three levels), advocacy and development partners.

Supply chain management

Weak governance and coordination system for the supply chain management of medicines and health products may result in stock outs, damages, expires, and other forms of wastage. In 2014, the Nigerian government with support from development partners decided to integrate all supply chain systems of health products for public health programmes, which were running in parallel through separate vertical programmes. The **Nigeria Supply Chain Integration Project** seeks to optimise the supply chain of all health programmes at federal and state levels. It reports considerable improvement.[75]

The literature review could not find independent evidence of the performance of the national programme to identify lessons. However, the **PATHS2 independent evaluation concluded that PATHS2 had achieved "remarkable gains in most of the States** in terms of establishing apparently flourishing, appropriately governed and managed and potentially sustainable operations for efficient procurement, storage and distribution of medicines and health related commodities together with functioning [Drugs Revolving Funds] that enabled capitalised facilities to supply as required high quality drugs to clients at affordable prices."[76]

LEAP research has demonstrated that such **supply-chain management reforms can be introduced in ways that take into account political economy challenges**. For example, in Jigawa, the DRF and Jigawa Medicare Supply Organisation (JIMSO) were developed from what was already there (a World Bank-funded medical store) and grew over time progressively. By not creating an independent parastatal, JIMSO did not threaten the interests of the SMOH. It started from a one-off capitalisation and the mark-up system seemed to incentivise stakeholders to make the system work, as they could all identify benefits. Those who had the most to lose (e.g. illegal vendors) were not powerful enough to undermine it.[77]

---

[70] *Seidman, G. and Atun, R. (2017) 'Does task shifting yield cost savings and improve efficiency for health systems? A systematic review of evidence from low-income and middle-income countries' Human Resources for Health (2017) 15:29.* https://doi.org/10.1186/s12960-017-0200-9

[71] *FMOH (2014) Task Shifting and Task Sharing Policy for Essential Health Care Services in Nigeria. Available at:* http://www.health.gov.ng/doc/TSTS.pdf

[72] *Association for Family and Reproductive Health (2014) 'Increasing access to contraceptives in Nigeria through task-shifting to community health extension workers (CHEWS), 3rd February available at* http://arfh-ng.org/increasing-access-contraceptives-nigeria-task-shifting-community-health-extension-workers-chews/

[73] *IMEP (2016b) Report on the results of the Data Quality Review of MNCH indicators in HMIS*

[74] *Omoluabi, E., Megill, D., Ward, P. (2015) 'Assessment of Nigeria's Maternal Health Data Sources', IMEP.*

[75] *National Product Supply Chain Management Program (2017) 'Second Quarter Report on LMCU Performance and Progress' Available at:* https://npscmp.gov.ng/second-quarter-report-lmcu-performance-progress/*. Accessed on: 6 February 2018.*

[76] *IMEP (2016a) p.32.*

[77] *Piron and Ogunbayo (2017).*

Public financial management (PFM)

Poor PFM undermines the performance of the health sector and PFM improvements, have to be part of any initiatives to improve health financing and strengthen systems.[78] This was a key issue identified in the round table discussion (see box). Research evidence indicates that health spending is held back by weak budget preparation (disconnection from strategy and planning) and disconnection between the Federal Ministries of Finance, Budget and Planning, Health and the National Assembly. There are weaknesses within the FMOH, with no formal channels of communication between strategy development (Department of Planning, Research and Statistics) and budgeting (Department of Finance and Accounts). [79] Weak budget execution (budgeted expenditure is delayed or not released) at all levels of government also undermine health spending efficiency. A 2012 study reported that only about 55.3% of the total amount budgeted for capital projects in health were actually utilised, indicating wide variance between approval and execution.[80]

> Budget performance has been historically poor. Late release of funds results in limited spending of released sums. There is a strategy budget disconnect, no policy-based budgeting, and no evidence for how things are prioritized. Appropriation doesn't take consideration of priority. Bridging this gap will improve allocative efficiency
> **– Roundtable Discussion**

A number of HSS programmes target PFM reforms. PATHS2 for example focussed on improving policy, strategy and planning at the federal level using mechanisms such as the National Strategic Plan for Health, and joint annual reviews of progress against plans, as well as improved policy, planning and budgeting in states. As with other reforms, they will only be sustained if there is political commitment to transparent and evidence-based management of public finances. The Jigawa case study showed how the combination of a Governor committed to improved healthcare, reform-minded professionals and long-term PATHS2 support to the state could deliver important improvements, such as increased budget allocations (17% of the state's budget in 2012) and high budget execution rates of 90%.[81]

PFM reforms wider than the health system are also important and call for coordination between governance and sector programmes. The literature review and interviews identified relevant reforms, such as the introduction of a Treasury Single Account by the federal government or the Open Contracting Platform initiated by the Bureau of Public Procurement, which could reduce graft and other financial crimes across sectors, including health.[82]

Health systems strengthening and vertical programmes

The share of aid funding for HSS in Nigeria reduced dramatically, from 17.2% in 2000 to 4.3% in 2011 in favour of vertical programmes.[83] The latter have been criticised for ignoring, and sometimes undermining, the integrity of national health systems, as they prioritise political attention and resources towards specific diseases. However, it has become clear that the two sets of programmes are inter-dependent.

An example of how poor PFM systems undermine vertical programmes is provided by Gavi, the global vaccine alliance, which has disbursed $732m to Nigeria over 2001-2017.[84] PRRINN-MNCH collaborated with Gavi to improve states' access to its funds. It provided training for accounts staff and new financial procedures. PRRINN-MNCH claims this helped release Gavi funds for routine immunisation. It notes that Gavi disbursements to its partner states (Jigawa, Katsina, Yobe and Zamfara) increased significantly between 2009 and 2012 as a result of its technical advice to improve transparency in fund management.[85]

Learning from past mistakes, funders of vertical programmes are now paying more attention to HSS. An audit of Gavi's cash-based support for immunisation found that $2.2m had been misused during 2011-2013, due to weaknesses in national partners' controls and procedures (the NPHCDA in particular).[86] Immunisation activities were transferred to Unicef, new programmes were put on hold and the federal government was requested to refund a total of $5.4m following further audits.[87] Gavi is now in the process of transitioning out of Nigeria by January 2022. Gavi assessed that major health systems issues constrained progress with immunisation and its transition planning includes a focus on HSS and financial management at federal and state levels to ensure sustainability.[88]

---

[78] FMOH (2017) National Health Financing Policy and Strategy.
[79] Results for Development/Health Systems Consult Limited Consortium (2017) 'Moving Towards Evidence-Based Federal Health Budgets in Nigeria, challenges and recommendations' Submitted to Federal Ministry of Health, Abuja.
[80] Hamid, K. (2013) 'Good Governance and New Public Sector Financial Management Reform in Nigeria' Paper Presented at the Executive Mandatory Professional Training Programme for Fellows of the Chartered Institute of Finance and Control of Nigeria, Abuja on 15-16 June 2013.
[81] Piron and Ogunbayo (2017).
[82] Okerekeoti, U., Chinedu, Okoye, E. (2017).'Treasury Single Account in Nigeria: A Theoretical Perspective', paper presented at the Faculty of Management Sciences International Conference on African Entrepreneurship and Innovation for Sustainable Development, At Nnamdi Azikiwe University, Awka, Nigeria, July 2017.
[83] Shaw et al (2015).
[84] Bijleveld, P. (2017) 'Successfully transitioning Nigeria and Papua New Guinea from Gavi support' ppt presentation for Board meeting 29-30 November, Vientiane, Lao PDR.
[85] PRRINN-MNCH (2015?) "Strengthening the Gavi system through sound financial management', Governance and Systems Summary.
[86] Gavi Secretariat (2014) 'Federal Republic of Nigeria Audit Report' August.
[87] Gavi Secretariat (2017) 'Report to Board, Appendix D: Report on Specific Countries' June.
[88] Bijleveld (2017).

A desk-based evaluation of Gavi's Nigeria's HSS programme was undertaken in 2009. Proposal drafting had started in 2006, but the $44m programme had not yet begun. Its objective of was to "develop the Ward Health System in 960 wards (covering about 100 LGAs and 20m people) to deliver PHC services on a minimum healthcare package by 2010". Activities focused on re-habilitating and re-equipping PHC infrastructure, training and supervision. The evaluation found that the programme had been designed in a country-driven and participatory way, and would provide necessary and additional resources. Programme delays were due to a "turf war" between the FMOH and the NPHCDA regarding who would control the funds.[89] This significant risk was not properly managed, given the fraud later identified. For example, the Gavi Country Tailored Approach 2014-2018 did not identify financial management and fraud as particular risks.

Gavi has undertaken a meta-review of the evaluations of its country-level HSS programmes. While the meta-review notes a number of Gavi management weaknesses, it also finds that "There is emerging evidence of Gavi HSS support contributing to health system strengthening" (key finding 14).[90] The review finds positive results on government policy and planning, human resources, service delivery, integration of vertical programmes in the health system and better partner coordination and joined up planning, among other results.

Demand side and accountability initiatives

DFID has supported a range of demand-side activities for service delivery improvements which should be considered part of HSS. SAVI, PATHS, PRRINN-MNCH and other programmes will provide lessons not all reviewed here that need to be incorporated in DFID N's new strategy.

DFID N has the resources and influence to fund national advocacy. The LEAP case study of the NHA highlights the importance of DFID's long-term engagement with the Health Reform Sector Coalition and other civil society advocacy for reform.

PATHS2 offers examples of **local level, 'short-route' accountability mechanisms**, through facility or ward health committees established in five states, which enabled citizens to participate in health delivery, and tools such as scorecards and resource tracking data to highlight shortfalls in the performance of health facilities and availability of drugs. In Jigawa, for example, PATHS2 facilitated meetings between local committees, CSOs and Gunduma councils to discuss local area health concerns. Beneficiary participation in the governance of health facilities "seem to have had a positive impact on performance", but may also be compensating for poor local government processes.[91]

In summary, achieving efficiency in health requires considering the different constituent elements of health systems. DFID has already supported HSS programmes which have achieved results. Vertical programmes in Nigeria, such as Gavi, have identified the need to integrate HSS as part of their portfolio and in their exit transition planning.

4.2 Leveraging more resources for health

Efforts to improve health sector financing need to be considered in the broader context of how the health system functions, as financing is one of several inter-dependent 'building blocks'. Systems thinking is particularly relevant, as changes in financing will create new incentives which may lead to sometimes unpredictable changes across different aspects of a health system.[92]

This section reviews efforts to generate more financial resources as a result of national policies; insurance schemes; and aid approaches such as counterpart funding and performance-based approaches. Other financing approaches not reviewed here include: user fee exemptions, demand-side financing which put the purchasing power in the hands of citizens to access health services (such as vouchers, conditional or unconditional cash transfers[93]), as well as new targeted taxes (e.g. on air travel, mobile technology or "sin" taxes e.g. on tobacco).

Basic Health Care Provision Fund (BHCPF)

The NHA aims to mobilise more money for health through provisions for a BHCPF. A minimum of 1% of consolidated revenue fund and contribution from development partners should fund the BHCPF which is to be managed by the

---

[89] *Lewis, D. (2009) 'Gavi Health System Strengthening Support Evaluation: Nigeria Desk Study', HLSP, August.*
[90] *Cambridge Economic Policy Associates Ltd (2016) 'Meta-review of country evaluations of health system strengthening support' March, pp23-24.*
[91] *DFID (2016) PATHS2 Project Completion Review.*
[92] *De Savigny, D. and Adam, T. eds. (2009) Systems thinking for health systems strengthening. Alliance for Health Policy and Systems Research, Geneva: WHO.*
[93] *Hunter, B.M. and Murray S.F. (2017) "Demand-side financing for maternal and newborn health: what do we know about factors that affect implementation of cash transfers and voucher programmes?" BMC Pregnancy and Childbirth. 2017;17:262. doi:10.1186/s12884-017-1445-y. Gupta, I., William, J., Rudra, S. (2010) "Demand Side Financing in Health: How far can it address the issue of low utilization in developing countries?" World Health Report Background Paper, No 27.*

NPHCDA. 50% will be allocated to a minimum health package through the NHIS; 45% for PHCs; and 5% for emergency health. States and LGAs can only access the fund if they contribute 25% counter-part funding and if they have established SPHCDA/Bs.

However, four years after the enactment of this law, the BHCPF is yet to be implemented. The LEAP case study examines the **various interests which are slowing down the implementation of the BHCPF, in particular the shift in control over financial resources**, illustrated by a tussle over who should write the financial guidelines and manage disbursements.[94] A $20m pilot project started in 2017 in Abia, Niger and Osun aiming to show how the BHCPF can be implemented using Global Financing Facility Funds. DFID should seek evidence of emerging lessons learned to understand how implementation can be incentivised, as the NHA and associated reforms provide the most significant entry point to HSS and leveraging domestic resources.

Health insurance

The National Council on Health has directed state governments to create **State Social Health Insurance Schemes** which would increase risk-pooling for health. The NHA incentivises the establishment of such schemes by allocating 50% of the BHCPF to state-managed insurance schemes. By February 2018, 14 states had passed laws setting up insurance schemes with Bayelsa, Cross River, Delta, and Lagos as frontrunners and another dozen in preparation.[95]

The LEAP NHA case study identified some of the main reasons behind the slow progress: the loss of credibility of the federal health insurance scheme managed by NHIS which has been mired by fraud; and the absence of technical expertise at state level to design and manage such schemes.[96]

Some demand-side financing interventions have been initiated by the Bill and Melinda Gates Foundation in selected states in Nigeria. It is anticipated that significant lessons will be learned from these.[97] The Africa Health Markets for Equity partnership, co-funded by DFID and the Gates Foundation, aims to increase the scale and scope of private provider networks and demand-side financing including in Nigeria. It ended in November 2017 and is subject to an impact evaluation.[98]

DFID should work with other development partners to review the range of insurance initiatives in Nigeria which are not covered here. It should also consider whether it has or is willing to develop a comparative advantage to enter into this field, given other development partners' expertise.

Counterpart funding

The counterpart funding approach adopted by the Global Fund, Gavi, World Bank and other development partners aims to leverage more resources for health from the government and incentivise more government commitment through the use of their own resources. For example, the Global Fund's new funding model includes mandatory counterpart financing requirements and uses 'willingness to pay' as an important criterion in determining the volume of funding. PATHS2 found that counterpart funding and setting of targets by the government could engender commitment and sustainability.

However, this approach was criticised in our interviews due to poor implementation and political commitment. **DFID could review the evidence of the effectiveness of counterpart funding in its programmes** to decide which method to adopt in the future.

> Matching funds hasn't worked because partners wait until the end of a programme before they say what it is the sustainability plan, which government is to continue. Matching funds must be given at the start of the programme, so that as the donor fund is tapering off, government funding should be increasing.
> **– Roundtable Discussion**

Performance-based programme (PBP)

PBPs pay for pre-determined results, rather than providing financial inputs, and thereby aim to incentivise different behaviours. The government of Nigeria with support from the World Bank has invested in two such health programmes:

---

[94] *Tulloch et al (2017).*
[95] *They are: Lagos, Oyo, Ekiti, Delta, Bayelsa, Cross River, Akwa Ibom, Kwara, Abia, Adamawa, Kano, Anambra, Sokoto, and Enugu. See Nigeria Health Watch (2018) 'Great expectations for Nigeria's health sector: Top five priorities in 2018'. Businessday Media Accessed on 5th April 2018 on http://www.businessdayonline.com/great-expectations-nigerias-health-sector-top-five-priorities-2018/ abd Health Insurance Affairs (2018) 'A New Dawn for Social Health Insurance in Nigeria' Care Net Nigeria. Issue number 14. ISSN 2006 – 7658. http://carenet.info/blog/2018/02/14/a-new-dawn-for-social-health-insurance-in-nigeria/*
[96] *Tulloch et al (2017).*
[97] *Bill and Melinda Gates Foundation Grants for Demand Side Financing Mechanisms. Grant database. Available at: https://www.gatesfoundation.org/How-We-Work/Quick-Links/Grants-Database/Grants/2017/10/OPP1173066*
[98] *See Africa Health Markets for Equity http://www.sfhnigeria.org/?p=679.*

The National State Health Investment Project (NSHIP) and the Saving One Million Lives – Program for Results (SOML-PfR).[99]

The **NSHIP** ($150m over 2012 -2020) operates in Nasarawa and Ondo states, as well as in all North-Eastern states and reaches an estimated 10.5m persons. It includes supply-side Performance Based Financing (PBF) measures to deliver a pre-defined package of MNCH services, improve the quality of care and enhance equity. PBF is also used to tackle demand-side constraints with free paediatric and obstetric care, and mobile teams to reach conflict-affected communities. It works through the NPHCDA and SPHCDA/Bs to reach primary and secondary health facilities with payments made after the verification of achieved results on a quarterly basis.

NSHIP was first piloted in three states. A household survey compared three PBF LGAs with nearby control LGAs that did not implement PBF. It found that "health outcomes such as contraceptive prevalence, antenatal care, and utilisation were significantly higher in the PBF LGAs. Routinely collected data also suggests large improvements in service delivery in PBF facilities. In addition, implementing PBF also provides opportunities to leverage existing investments making the cost of implementation of PBF to be modest at about US$1.20 per capita per year."[100] Positive results were also identified for the 2015-2016 period and an impact evaluation is due to be published in 2018.[101]

Success factors identified by the Bank included: the importance of state leadership, clear priorities and rewards for staff, legitimate operating funds at the facility level, and stronger supervision. Challenges included: the negative effects of delayed payments, the poor quality of facilities management, the requirement of independent and robust performance assessments, and the need to address demand-side barriers.[102]

The **SOML-PfR** ($500m over 2015-2019) is a nation-wide PBP. Its objective is to increase the utilisation and quality of high impact reproductive, child health and nutrition interventions. Untied fiscal transfers from the federal government are disbursed on the basis of independently verified results (namely vaccination coverage, rates of contraceptive use, Vitamin A supplementation, skilled birth attendance, HIV counselling and testing among women attending antenatal care, and the use of insecticide- treated bed nets for under-5). The programme also aims to improve transparency, accountability and innovation in PHC. Each state received $1.5m at the start of the programme.

SOML-PfR progress to date has been rated as "moderately satisfactory". In the last quarter of 2017, 12 states performed well enough to receive payments. Overall in 2018, the country's performance had declined by 29 percentage points from the previous year, with progress on the use of bednets and births assisted by skilled personnel, but a reduction in immunisation coverage and contraceptive prevalence rates. A significant number of states appeared to have introduced performance management systems.[103] It would be useful for DFID to discuss these challenges with the Bank.

A critique of results-based health financing approaches argues that it is best to consider them a form of strategic health purchasing which depends on the wider environment and relations between providers and purchasers of health services. The debate has "too often focused on the trees (e.g. specific payment arrangements focused on boosting a few indicators) but ignoring how these fit within and are affected by the wider forest (larger health system reforms)".[104] Similarly, **DFID should consider PBP as a part of wider health system and financing reforms for Nigeria, to incentivise not just specific results, but systems improvements**.

4.3 Working better with the private sector

There are avenues to work better with the private sector to make health spending more efficient, leverage more resources for health and expand access to quality-assured health services. In particular in Southern Nigeria, the private sector is a key provider of health services. A differentiated strategy will be required given the wide range of domestic private providers, from upmarket providers for the wealthy, patent medicine sellers for urban dwellers and traditional healers in rural areas servicing the poorest communities, as well as non-profit providers with whom DFID has more track record, such as NGOs and faith-based providers.

This section reviews recent policy changes; provides a few examples of PPPs; and notes some of the recommendations from our interviews and roundtable. It only scratches the surface. DFID should undertake a more in-depth review, making the most of its own experiences to date in Nigeria and elsewhere.

---

[99] *FMOH (2016). 'Saving One Million Lives – Program for Results Project Implementation Manual' Available at: http://somlpforr.org.ng/wp-content/uploads/2017/02/SOML-PIM.pdf*
[100] *World Bank (2015) p.93.*
[101] *RBHealth (2017) 'Result Based Financing – Nigeria Project Information' Available at: https://www.rbfhealth.org/rbfhealth/country/nigeria. Accessed on: 12 February 2018.*
[102] *World Bank (2015) and RBHealth (2017).*
[103] *World Bank (2018) 'SOML-PfR Implementation Status & Results Report' February.*
[104] *Soucat, A., Dale, E., Mathauer I., Kutzin, J. (2017) 'Pay-for- Performance Debate: Not Seeing the Forest for the Trees' Health Systems & Reform, 3:2, 74-79, DOI: 10.1080/23288604.2017.1302902, p.75.*

Nigeria developed a **Public-Private-Partnership Policy for Health in 2005**. It was designed to promote and sustain equity, efficiency, accessibility and quality in healthcare provision, through a collaborative relationship between the public and private sectors. The policy is yet to be implemented and is currently under review. The legal framework for PPPs includes the provisions of the NHA 2014[105] (a system for ensuring quality of healthcare services in public and private health facilities through certification of standards for registration and a monitoring mechanism) and the Infrastructure, Concession and Regulatory Commission.

The final phase of **PATHS2 included engagement in Enugu and Lagos to articulate PPP approaches** that states could implement. It used the NDHS to prioritised high maternal mortality despite good access to antenatal care and skilled-birth attendants. It worked with the SMOH and their agencies on regulations to address standard quality; recognised the variations between rural and urban LGAs; engaged with formal private providers to improve access but also incorporated informal providers; and strengthened linkages between public/private, formal/informal and primary/secondary/tertiary delivery. Short and longer-term strategies were developed in 2015. PATSH2 also supported faith-based community-based insurance schemes in Enugu.[106] The establishment of private sector-funded and -operated medical store and laboratory endorsed by the Enugu government was highlighted by DFID N as a good model for improving private participation in public health delivery.[107] DFID N could review lessons and uptake following the end of PATHS2 in these states in 2016.

The literature review identified other examples of PPPs:

- The **Private Sector Health Alliance** is a coalition of private sector funders dedicated to providing financing to drive innovation in healthcare delivery and shape health markets. It contributed supply chain measures to reduce medical stock-outs; human resource, capacity building for the public healthcare sector; health advocacy; and the establishment of an impact investment fund.[108]
- **Aliko Dangote**, a Nigerian billionaire and leading businessman in Africa, has proposed the introduction of a health fund financed by private companies.[109]
- The **Obio Community Health Project in Rivers state** is a partnership between the Shell Petroleum Development Company, the Obio Community and the Rivers state government. A benefit-incidence analysis found that "Collectively, the poorest 20% of the population received 12% of benefits while the richest quintile received the largest share (23%). Inpatient and outpatient benefits are weakly regressive (pro-rich), statistically significant at a 10% level of significance." The study recommended "Removing co-payments for the poorest, reducing long wait and visit times and using community volunteers to help increase access to health services may improve benefits for the poor."[110]
- The **Health Insurance Fund** was established in 2006 by the Dutch government and is managed by PharmAccess Group. One of its areas of work is to develop private pre-payment mechanisms and risk pooling structures. The Fund has reported progress in Lagos state in moving from subsidised to non-subsidised health care for market women and petty traders, and co-financing in Kwara state between the state and participants, with private providers earning enough income to invest in their healthcare provision. The Fund is also testing mobile technologies for insurance, such as in Lagos for school students.[111]
- The **SOML-PfR Innovation Fund** does not yet appear operational. It will promote innovation and private sector participation through grants targeted at improving maternal and child health.

DFID has in the past supported non-profit providers, such as Christian Health Association of Nigeria and could review lessons learned. **Evidence is also needed on public-private partnerships with traditional / informal non-state providers**.

Strategies to engage better with the private sector identified in interviews and as part of the roundtable discussion include:

- state capacity to enable a competitive health market, develop and implement regulatory frameworks e.g. quality accreditation and standards of care
- improving access to finance for healthcare investments
- reviewing impact of trade and competition policies on private sector health provision (e.g. tariffs and import duties)
- state purchasing of private health provision and ways of improving the referral system between public and private care

---

[105] *Okowa, I. (2015) 'National Health Act: Translating the Law into Quality and Accessible Healthcare' Vanguard, 16 August see https://www.vanguardngr.com/2015/08/national-health-act-translating-the-law-into-quality-and-accessible-healthcare/*
[106] *PATHS2 (2016).*
[107] *DFID (2016).*
[108] *United Nations Foundation (2016) 'Every woman every child' Report on Private Sector Engagement Activities 2015*
[109] *Owoseye, A. (2018) 'How Nigerian gvt can make private companies fund public health - Dangote' Premium Times, 22 March at https://www.premiumtimesng.com/news/more-news/262753-how-nigerian-govt-can-make-private-companies-fund-public-health-dangote.html*
[110] *Vaughan, K., Akwataghibe, N., Fakunle, N., Wolmarans, L. (2016) 'Who benefits from the Obio community health insurance scheme in Rivers state, Nigeria? a benefit incidence analysis' International Health, Volume 8, Issue 6, 1 November, pp.405–412, https://doi.org/10.1093/inthealth/ihw040 [only summary was accessible online]*
[111] *Ajanwachuku, E., Serrano, A., Yahaya, A.F.T. (2016) 'Taking healthcare to slum schools in Nigeria through a Mobile Money School Health Fund'. mHealth Research Lab. PharmAccess Foundation, December https://www.pharmaccess.org/wp-content/uploads/2017/01/2016_12_Lessons-learned-from-saving-on-a-digital-platform.pdf*

- enabling private sector voice in health policy making, for example by creating platforms and incentives to improve the organisation of private sector providers
- creation of a 'Health Bank' which would provide reduced interest loans to the private sector to invest in healthcare provision (e.g. infrastructure, tools), and which would be funded by private individual contributions (e.g. through mobile phones in exchange for services) without passing through a state institution

The private sector could also:

- contribute funding as a form of social corporate responsibility
- improve health data generation and usage
- support policy change through advocacy
- develop technology and innovation, for example pharmaceuticals

In summary, formal PPPs for health are relatively recent in Nigeria, though private providers play an essential role in health provision, in particular in the South of the country. DFID should undertake a wider review beyond the information provided here to inform its strategy.

5. Recommendations for DFID's proposed system strengthening approach

DFID N is considering adopting a HSS approach for its new health sector programme, rather than supporting health service delivery. This section highlights the benefits and risks of a HSS approach and provides some advice on how to design such a strategy.

As the review of past programmes has shown in the previous section, DFID has a long track record in supporting HSS, through PATHS1 and PATHS2, PRRINN-MNCH and successor programmes in Northern Nigeria such as MNCH2. In addition, even vertical programmes targeted at specific diseases have HSS elements to ensure sustainability, such as in the Gavi portfolio.

R1: The choice facing DFID N does not seem to be between HSS and service delivery but selecting the right blend between the two to meet realistic objectives, in the context of declining international financial support for health in Nigeria and a low domestic financing to date. DFID N's ability to stay engaged for decades, as it has in Jigawa for example, means that it can invest in long-term processes required for HSS, rather than be driven solely by shorter-term results.

The **main benefits** of HSS are that it is the best way to improve efficiencies within a funding envelope. It can also leverage new resources by changing incentives within the health system. It will be more sustainable over the long-term. It could make universal health coverage a reality, which would not be affordable for development partners under a service delivery-focused strategy. The roundtable discussion supported this position: HSS is a means to allow service delivery to thrive.

The **main risk** of reducing current DFID support for service delivery, in particular in Northern states with the worst outcome indicators, would be to see a reversal in health gains achieved through past assistance. The current political economy of health provision means that federal and state governments may not step up to quickly match the decline in DFID support.

R2: A share of the DFID N portfolio can be justified on humanitarian grounds, to save lives, but should be done in a way that does not undermine domestic incentives to fund health services for the poorest communities. Delivering measurable results in terms of health outputs and outcomes, rather than just systems, will also have two other benefits: it can act as a motivator to demonstrate to domestic stakeholders that improvements can be achieved, and it will maintain UK political and taxpayers support to continue DFID N programmes.

R3: DFID N will need to prepare a transition strategy. As DFID moves out of certain service delivery activities, it could consider how to bolster the systems required for responsibility for those services to be taken up, with adaptation if necessary, by public, for profit or non-profit providers. It should not assume its service delivery funding will be immediately taken up by others.

R4: In terms of process, DFID N should combine a political economy and systems thinking approach to identify priorities at the federal and state levels, and promote a mix of public and private initiatives covering systems strengthening, service delivery, advocacy and policy. The systems thinking approach to HSS is consistent with a PEA approach and could guide DFID's process to design and manage its new programme, including adapting faster to changes in the political economy or to evidence on the performance of particular interventions.

R5: In terms of overall objective, DFID should use its limited financial and technical resources and its advocacy influence to help Nigerian stakeholders to achieve efficiencies and leverage more domestic resources for health by:

- supporting existing reforms at the federal level and in focal states
- creating incentives for better and new private sector provision with state regulation
- encouraging innovations

R6: DFID will need to continue to work at both federal and state levels in order to improve the performance of the health sector. Supporting the implementation of the NHA is an obvious entry point which links the two levels, as it is meant to unlock federal funding for PHC and insurance. A HSS approach would be based on alignment with the NHA, National Health Policy, and the compact signed for the implementation of the National Strategic Health Development Plan.

R7: DFID should also build on its past record and **continue to strengthen 'citizens voice' and advocacy on health financing**, not just in terms of volume, but also in terms of quality, access and equity at the various tiers of government.

R8: DFID N should explore incentive mechanisms to encourage private provider involvement in health and effective regulation. DFID N should engage with different segments of the private health providers (for profit, non-profit, traditional), which will be differentiated between the South and North of the country given their distinctive characteristics. This will require a base assessment of the composition and level of maturity of the private sector systems in

the focus states before deciding on interventions, and a specific strategy for the North where private provision is less developed.

R9: DFID N should encourage innovations to leverage more resources for health, ensuring that lessons are learned and promising initiatives can be scaled up. This includes:

(i) **Strategic purchasing mechanisms** such as PBF model to improve service access in areas where the private sector is mature and of the right quantity and quality.

(ii) A **demand-side financing approach** could be used to improve access to existing public-sector providers for the poorest, with incentives to improve the quality of care (e.g. vouchers, conditional cash transfers, etc).

(iii) Incentivising **state health insurance schemes**.

(iv) Testing the creation of a **'health bank'** as discussed during the roundtable.

Annex 1 - Bibliography

Publications

Ajanwachuku, E., Serrano, A., Yahaya, A.F.T. (2016) 'Taking healthcare to slum schools in Nigeria through a Mobile Money School Health Fund' mHealth Research Lab, PharmAccess Foundation, December

Akeju, D.O., Oladapo, O.T., Vidler, M. (2016) 'Determinants of health care seeking behaviour during pregnancy in Ogun State, Nigeria' Reproductive Health; 13(Suppl 1): 32–32

Anyebe, W., Bezzano J., Foot S. (2005) 'Country level testing: the health sector in Nigeria. An analytical framework for understanding the political economy of sector and policy arena'

Association for Family and Reproductive Health (2014) 'Increasing access to contraceptives in Nigeria through task-shifting to community health extension workers' (CHEWS), 3rd February

Barnes, J., Chandani, T., Feeley, R. (2008). 'Nigeria Private Sector Health Assessment' Private Sector Partnerships-One project, Bethesda, MD: Abt Associates

Batley, R. and Mcloughlin, C. (2015) 'The Politics of Public Services: A Service Characteristics Approach', World Development Vol. 74, pp. 275–285

Bijleveld, P. (2017) 'Successfully transitioning Nigeria and Papua New Guinea from Gavi support' ppt presentation for Board meeting 29-30 November, Vientiane, Lao PDR

Bloom, G., Oladepo, O., Salami, K.K., Adeoye, B.W., Oshiname, F., Ofi, B., Oladepo, M., Ogunbemi, O., Lawal, A., Brieger, W.R., Peters, D.H. (2007) 'Malaria treatment and policy in three regions in Nigeria: the role of Patent Medicine Vendors' Working Paper 1, Nigeria Series, 29

Cambridge Economic Policy Associates Ltd (2016) 'Meta-review of country evaluations of health system strengthening support', March

DFID (2016) 'PATHS2 Project Completion Review'

De Savigny, D. and Adam, T. eds. (2009) Systems thinking for health systems strengthening. Alliance for Health Policy and Systems Research, Geneva: WHO

FMOH (2009) National Strategic Health Development Plan (2010-2015)

FMOH (2010) Achieving measurable results for help through the National Strategic Health Development Plan 2010-2015. Country compact between federal government of Nigeria and development partners

FMOH (2014) Task Shifting and Task Sharing Policy for Essential Health Care Services in Nigeria.

FMOH (2016) National Health Policy

FMOH (2016) 'End Term Evaluation of National Strategic Health Development Plan (2010-2015)', December

FMOH (2016) 'Saving One Million Lives – Program for Results Project Implementation Manual'

FMOH (2017) National Health Financing Policy and Strategy

Gavi Secretariat (2014) 'Federal Republic of Nigeria Audit Report', August

Gavi Secretariat (2017) 'Report to Board, Appendix D: Report on Specific Countries', June

Gbenga-Ogunbare, Y. (2017) 'Primary Healthcare In Nigeria Is Dysfunctional—Health Minister' Nigerian Tribune, 6 October

Grigoli, F. and Kapsoli, J. (2013) 'Waste Not, Want Not: The Efficiency of Health Expenditure in Emerging and Developing Economies' WP/13/187. IMF Working Paper.

Gupta, I., William, J., Rudra, S. (2010) 'Demand Side Financing in Health: How far can it address the issue of low utilization in developing countries?' World Health Report Background Paper, No 27.

Hamid, K. (2013) 'Good Governance and New Public Sector Financial Management Reform in Nigeria' Paper Presented at the Executive Mandatory Professional Training Programme for Fellows of the Chartered Institute of Finance and Control of Nigeria, Abuja on 15-16 June 2013

Health Insurance Affairs (2018) 'A New Dawn for Social Health Insurance in Nigeria' Care Net Nigeria, issue number 14. ISSN 2006 – 7658.

Heymans, C. and Pycroft, C. (2003) 'Drivers of Change in Nigeria: a Preliminary Overview'. DFID Nigeria discussion document

Hunter, B.M. and Murray S.F. (2017) 'Demand-side financing for maternal and newborn health: what do we know about factors that affect implementation of cash transfers and voucher programmes?'BMC Pregnancy and Childbirth. 2017;17:262. doi:10.1186/s12884-017-1445-y.

Ichoku, H. and Okoli, CI. (2015) 'Fiscal Space for Health Financing in Nigeria' African Journal of Health Economics

Ilesanmi O.S., Adebiyi A.O., Fatiregun A.A. (2014) 'National health insurance scheme: how protected are households in Oyo State, Nigeria from catastrophic health expenditure?' International Journal of Health Policy and Management. 2014, 2(4), pp.175-180

Independent Monitoring and Evaluation Project for the State Level Programmes (IMEP) (2016a) Study on PATHS2 Capacity Development: Final Report

Independent Monitoring and Evaluation Project for the State Level Programmes (2016b) Report on the results of the Data Quality Review of MNCH indicators in HMIS

IMF (2018) 'Nigeria: Staff Report for the 2018 Article IV Consultations', 15 February.

Lewis, D. (2009) 'Gavi Health System Strengthening Support Evaluation: Nigeria Desk Study', HLSP, August.

Maymaygist (2017) 'How much was Buhari's Medical Bill Abroad: Nigerians', 18 March

National Primary Health Care Development Agency (2015). Primary Health Care Under One Roof Implementation Scorecard III Report, Abuja: NPHCDA

National Product Supply Chain Management Program (2017) 'Second Quarter Report on LMCU Performance and Progress'

Nigeria Demographic and Health Survey (2013)

Nigeria Health Watch (2018) 'Great expectations for Nigeria's health sector: Top five priorities in 2018'. Business day Media

Oberth, G. (2017) 'Nigeria's TB/HIV funding request to the Global Fund sent back for iteration' Global Fund Observer

Okerekeoti, U., Chinedu, Okoye, E. (2017).'Treasury Single Account in Nigeria: A Theoretical Perspective', paper presented at the Faculty of Management Sciences International Conference on African Entrepreneurship and Innovation for Sustainable Development, At Nnamdi Azikiwe University, Awka, Nigeria, July 2017

Okowa, I. (2015) 'National Health Act: Translating the Law into Quality and Accessible Healthcare' Vanguard, 16 August see https://www.vanguardngr.com/2015/08/national-health-act-translating-the-law-into-quality-and-accessible-healthcare/

Okpani, A. and Abimbola, S. (2016). 'The midwives service scheme: a qualitative comparison of contextual determinants of the performance of two states in central Nigeria'. Global Health Res Policy. 2016;1:16. doi: 10.1186/s41256-016-0017-4

Omoluabi, E., Megill, D., Ward, P. (2015) 'Assessment of Nigeria's Maternal Health Data Sources', IMEP.

Onoka C.A., Onwujekwe, O.E., Hanson K., Uzochukwu B.S. (2011) 'Examining catastrophic health expenditures at variable thresholds using household consumption expenditure diaries' Trop Med Int Health 2011;16:1334- 41

Onwujekwe, O.E., Uzochukwu, B.S., Obikeze, E.N., Okoronkwo ,I., Ochonma, O.G., Onoka, C.A. (2010) 'Investigating determinants of out- of- pocket spending and strategies for coping with payments for healthcare in southeast Nigeria' BMC Health Serv Res 210:67

Owoseye, A. (2018) 'How Nigerian government can make private companies fund public health - Dangote' Premium Times, 22 March at https://www.premiumtimesng.com/news/more-news/262753-how-nigerian-govt-can-make-private-companies-fund-public-health-dangote.html

PATHS2 (2016) 'End of Programme Technical Report'

Piron, L. H. with Baker, A. Savage, L, Wiseman, K. (2016). 'Is DFID Getting Real About Politics? A stocktake of how DFID has adopted a politically-informed approach (2010-2015)'. London: DFID.

Piron, L.H. and Ogunbayo, D. (2017) 'Jigawa health sector governance reform case study' Abuja: PERL-LEAP, November

PRRINN-MNCH (2015) 'Strengthening the Gavi system through sound financial management' Governance and Systems Summary

RBHealth (2017) 'Result Based Financing – Nigeria Project Information'

Results for Development/Health Systems Consult Limited Consortium (2017) 'Moving Towards Evidence-Based Federal Health Budgets in Nigeria, challenges and recommendations' Submitted to Federal Ministry of Health, Abuja.

Sambo, L. G., Kirigia, J.M. and Nabyonga Orem, J. (2013) 'Health Financing in the African Region: 2000–2009 Data Analysis.' International Archives of Medicine 6 (2013): 10. PMC.

Seidman, G. and Atun, R. (2017) 'Does task shifting yield cost savings and improve efficiency for health systems? A systematic review of evidence from low-income and middle-income countries' Human Resources for Health (2017) 15:29

Soucat, A., Dale, E., Mathauer I., Kutzin, J. (2017) 'Pay-for- Performance Debate: Not Seeing the Forest for the Trees' Health Systems & Reform, 3:2, 74-79, DOI: 10.1080/23288604.2017.1302902

Shaw, R.P., Wang,H., Kress,D., Hovig D. (2015) 'Donor and Domestic Financing of Primary Health Care in Low Income Countries' Health Systems & Reform,1:1, 72-88, DOI: 10.1080/23288604.2014.996413

SHOPS Project (2012) 'Nigeria Private Health Sector Assessment. Brief.: Strengthening Health Outcomes through the Private Sector Project', Bethesda, MD: Abt Associates

Soyibo, A., Olaniyan, O., Lawanson, A. (2009). National Health Accounts of Nigeria, 2003-2005, submitted to Federal Ministry of Health, Abuja.

SPARC (2012) 'Executive Summary of Political Economy Analysis for Nine States', Final Report

The Legatum Prosperity IndexTM (2017). *Creating the Pathways from Poverty to Prosperity* London: The Legatum Foundation available at http://www.prosperity.com/rankings?pinned=&filter=.

Tulloch, O., Cummings, C., Ogunbayo, D and Oreh, C. (2017) 'A Case Study of the Implementation of the 2014 National Health Act', Abuja: PERL-LEAP, October

United Nations Foundation (2016) 'Every woman every child' Report on Private Sector Engagement Activities 2015

USAID (2016) 'Health Financing profile: Nigeria'. African Strategies for Health

Utomi, P., Duncan A., Williams G. (2007) 'Nigeria: The Political Economy of Reform. Strengthening the Incentives for Economic Growth', Brighton:The Policy Practice..

Uzochukwu, B.S.C., Ughasoro, M.D., Etiaba, E., Okwuosa,C.,Envuladu,E., Onwujekwu, O.E. (2015)
'Health care financing in Nigeria: Implications for achieving universal health coverage' Nigerian Journal of Clinical Practice, Jul-Aug 2015, Vol 18 Issue 4

Vaughan, K., Akwataghibe, N., Fakunle, N., Wolmarans, L. (2016) 'Who benefits from the Obio community health insurance scheme in Rivers state, Nigeria? a benefit incidence analysis' International Health, Volume 8, Issue 6, 1 November, pp.405–412, https://doi.org/10.1093/inthealth/ihw040

World Bank (2003) *World Development Report 2004: Making Services Work for Poor People*. Washington DC: World Bank.

World Bank (2015). 'Program-for-Results to Support the Saving One Million Lives Initiative Technical Assessment Report' March 31, 2015.

World Bank (2018) 'SOML-PfR Implementation Status & Results Report', February

WHO (2007) *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: WHO

WHO (2017) *World Health Statistics 2017: monitoring health for the Sustainable Development Goals* Geneva: WHO

Yanfang, S. (2012) 'An Inverted Pyramid: Three-tier Public Financing for Health in Nigeria' Harvard College Global Health Review

Yaqub, J.O., Ojapinwa T.V., Yussuff R.O. (2012) 'Public Health Expenditure and Health Outcome In Nigeria: The Impact Of Governance' European Scientific Journal June edition vol. 8, No.13 ISSN 1857- 7431

Gbenga. Y. (2015). Primary Healthcare In Nigeria Is Dysfunctional—Health Minister. Tribune On Line

Yip, W. and Reem, H. (2015) 'Improving Health System Efficiency: Reforms for improving the efficiency of health systems: lessons from 10 country cases' Health Systems Governance and Financing Geneva: WHO, WHO/HIS/HGF/SR/15.1

Websites

Africa Health Markets for Equity http://www.sfhnigeria.org/?p=679
Gates Foundation https://www.gatesfoundation.org/
Primary HealthCare Under One Roof https://phcuor.org
The Global Fund https://www.theglobalfund.org
National Health Accounts, Nigeria https://knoema.com/WHONHA2018Feb/national-health-accounts?country=1000340-nigeria
World Bank database https://data.worldbank.org/

Annex 2 - Interviews

Organisation	Name of Contributor
Research Consultant	Ifeanyi Chikezie
Research Consultant	Dr Tosin Adeyemo
Federal Ministry of Health	Dr. Akin Oyemakinde:
Federal Ministry of Health	Dr Emmanuel Meribole
Federal Ministry of Budget and Planning	Samson Ebimaro
UK Department for International Development	Ebere Anyachukwu
Bill and Melinda Gates Foundation	Benson Obonyo
The United States Agency for International Development / HFG Project	Dr Gafar Alawode
Health Reform Foundation of Nigeria	Emmanuel Abanida
Health Sector Reform Coalition	Dr Ben Anyene
ONE Campaign	Edwin Ikhuoria,
Private Sector Alliance of Nigeria	Dr Muntaqa Sadiq-
Association of General and Private Medical Practitioners of Nigeria	Dr Charles Cudjoe,
National Primary Health Care Development Agency	Dr Nnenna Ihebuzor
Federal Ministry of Budget and Planning	Prof. Olumide Ayodele
Academia – University of Nigeria	Prof. Hycinth Ichoku
Partnerships to Engage Reform and Learn (PERL) Programme, Abuja	Ishaya Bajama
Partnerships to Engage Reform and Learn (PERL) Programme, Kano	Auwalu Hamza
Partnerships to Engage Reform and Learn (PERL) Programme, Kano	Jibril Giginyu
Federal Ministry of Health	Dr. Nneka Orji-Achugo
Former Commissioner of Health, Ondo	Dr. Dayo Adeyanju

10 Bobo Street,
Maitama, Abuja, FCT,
Nigeria

info@leap-perlnigeria.net

www.perlnigeria.net