Country Specific

Health Sector Accountability Report

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Country:
Nigeria

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List of Abbreviations

ATBUTH	Abubakar Tafawa Balewa University Teaching Hospital
BCHPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
BOQ	Bills of Quantities
CACOVID	Coalition Against COVID-19
CBHI	Community-Based Health Insurance
CCD	Community Charter of Demand (CCD)
CCT	conditional cash transfers
CCTV	CSOs closed-circuit television (CCTV)
CODE	Connected Development
CRF	Consolidated Revenue Fund
CTAP	COVID-19 Transparency and Accountability in Africa Project
FCDO	UK Foreign Commonwealth & Development Office
FG	Federal Government
FMOH	Federal Ministry of Health
FOIA	Freedom of Information ACT
GDP	Gross Domestic Product
HMO	Health Maintenance Organisations
IMR	Infant Mortality Rate
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
KII	Key Informant Interviews
LGHA	Local Government Health Authorities
MMR	Maternal Mortality Rate
NASS	National Assembly
NHA	National Health Act
NHIS	Nigerian Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
OECD	Organisation for Economic Co-operation and Development
OGP	Open Government Partnership
OOP	Out of Pocket
PHC	Primary Healthcare Centres
SFTAS	States Fiscal Transparency, Accountability and Sustainability Programme
SHIA	State Health Insurance Scheme
SMOH	State Ministries of Health
SOML	Saving One Million Lives
SPHCDA	State Primary Healthcare Development Agency
T&A	Transparency and Accountability
U5MR	Under-5 Child Mortality Rate
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
VSF	Victims Support Fund
WHO	World Health Organisation

List of Figure(s) & Tables

Figure 1 Health expenditure as share of GDP in Nigeria from 2006 to 2019

Table 1 Percentage of National Budget Allocated to the Ministry of Health- 2010- 2021

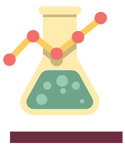
Table 2 Capital Expenditure, % of Release and Utilisation

Table 3 Nigeria's health sector budget (recurrent and capital) from 2010 to 2020

Executive
Summary

At the federal level, the average budgetary allocation to the sector in the last 2 decades has been around

4.7%



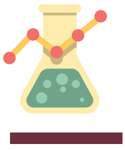
Nigeria in the last two decades has failed to meet the 15% annual budgetary commitment to healthcare at the national and sub national levels.

The study evaluates the political economy of healthcare delivery in Nigeria, highlighting its governance architecture and failures, the interests and incentives of stakeholders, financing and accountability patterns and gaps, systemic challenges, and snapshot of citizens' perception of healthcare access and quality. Commissioned under the COVID-19 Transparency and Accountability Project (CTAP) – a collaboration between BudgIT, CODE and Global Integrity – the study is qualitative and descriptive.

Utilising both secondary and empirical data, the study focuses on Nigeria's national government and six purposively selected focal states: Anambra, Bauchi, Kaduna, Lagos, Rivers and Sokoto. The researchers undertook a qualitative research approach in the focal states, documenting the experiences of some critical stakeholders through key informant interviews. The qualitative interviews were cluster based to provide a better context to the literature and present the experiences of stakeholders in a systemic way.

The study finds that the access to healthcare in Nigeria, particularly for the poor and the vulnerable is challenging and where access is available, the quality is questionable, underscoring the state of crisis in the Nigerian healthcare system. A systemic failure that is driven by decades of governance failures, corruption, failing infrastructure, policy inconsistencies, resourcing shortfalls, capacity gaps, brain drain, perennial strike actions and acute underinvestment, amongst other factors.

Nigeria in the last two decades has failed to meet the 15% annual budgetary commitment to healthcare at the national and sub national levels. At the federal level, the average budgetary allocation to the sector in the last 2 decades has been around 4.7% in spite of this commitment and even at the peak of the Covid-19 pandemic, the country's allocation to health for the 2021 fiscal year is 4.1%.



Current gaps in the Nigerian healthcare system and limited resourcing opportunities, call for innovative methods to protect the poor and vulnerable populations against financial risk of ill-health.

After almost 2 decades, the country's health insurance scheme has only provided coverage to an estimated 5% of the country's population, while Out-of-Pocket expenditure has remained the major source of healthcare financing in the country. With Nigeria's 2021 health budget of N549 billion, health expenditure per capita was at a marginal $7 (N2,745). There is also the problem of geographical and economic inequity in access to healthcare services in Nigeria.

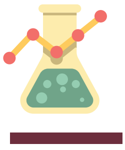
Across the country's sub-national entities, medical facilities are concentrated in urban centres, while rural communities, with more substantial populations in some states, do not have functional health facilities and personnel to attend to their health needs. There is also the North-South geographical divide in availability of healthcare services.

Nigeria has made appreciable progress in the areas of public accountability, transparency, and citizen participation in health sector spending at the federal level and across several states. This improved openness is the product of consistent campaigns by civil society actors across Nigeria, as well as leverage of international T&A mechanisms by the civil society.

However, there are remaining transparency, accountability and participation gaps where continuous advocacy is required for further desirable social accountability outcomes. Post-bid evaluation data is mostly not available in the public domain. Health sector budget making processes are still not participatory in most states and even at the federal level. It's often difficult for citizens and civil society groups to link a health project from the budget to procurement and then audit.

Current gaps in the Nigerian healthcare system and limited resourcing opportunities, call for innovative methods to protect the poor and vulnerable populations against financial risk of ill-health. Addressing the healthcare crisis requires active collaboration of multiple stakeholders within and outside Nigeria. The precarious financial position of the Nigerian state calls for a rethinking of the current healthcare resourcing model. To improve the country's health sector accountability, shore up health financing and resourcing, as well as speed up universal health coverage, the study hazards multidimensional and coherent recommendations, and call to action points for the government and civil society in the last section.

Background and Methodology



After almost 2 decades, the Nigeria Health Insurance Scheme (NHIS) has only provided coverage to an estimated 5% of the country's population.

For a considerable number of decades, Nigeria's healthcare system has underperformed across a variety of indicators such as; life expectancy at birth, maternal mortality rate (MMR), infant mortality rate (IMR) and under-5 child mortality rate (U5MR). A 2021 World Health Organisation (WHO) global survey placed the country's healthcare system at the rank of 163 out of 191 countries, from the lenses of performance and efficiency.[1]

Challenges facing the sector are enormous and include deficient political will to implement sweeping reforms, poor accountability, legislative failures, dismal health infrastructures, underinvestment, policy ineffectiveness, ineffective decentralisation and fragmentation, poor coordination of donor funds as well as corruption etc.

After almost 2 decades, the Nigeria Health Insurance Scheme (NHIS) has only provided coverage to an estimated 5% of the country's population,[2] while Out-of-Pocket (OOP) expenditure has remained the major source of healthcare financing in the country. In addition, the federal government's health spending share of the total budget has remained far below 15% of the 2001 Abuja Declaration.

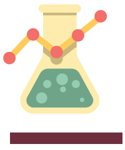
The primary health care system has continued to suffer from inadequate funding and equipment for decades while there has remained a shortage and inequitable distribution of health workers across the country. Evidently, the Nigerian health sector has failed to effectively address the numerous challenges confronting it and the COVID-19 pandemic accentuated the enormity of these challenges.

To properly examine Nigeria's downcast health sector situation, this study evaluates the country's healthcare system from the lenses of accountability, governance structures, fiscal management and financing, reforms, legislative oversight, and citizen engagement and access, across both national and sub-national levels of governance.

This is in a bid to inform high-bandwidth, multidimensional and coherent recommendations, with specific call to action points for different categories of stakeholders including government, private sector and civil society, as regards mechanisms to improve health sector public accountability, shore up health financing and resourcing, and speed up universal health coverage in the country.

1 - The Guardian Ng, Nigeria improves on WHO health system ranking, says ACPN, 2021 (https://guardian.ng/news/nigeria-improves-on-who-health-system-ranking-says-acpn/))

2 - C.A Onoka, O.E Onwujekwe, B.S Uzochukwu, N.N Ezumah, "Promoting universal financial protection: constraints and enabling factors in scaling-up coverage with social health insurance in Nigeria,' Health Res Policy Syst., 2013;11:20. doi:10.1186/1478-4505-11-20



CTAP was commissioned as a civil society-led effort to bolster citizen engagement and promote change in the ways that governments use public resources, and increase the capacity of governments to meet people's needs.

The study was commissioned under the COVID-19 Transparency and Accountability in Africa Project (CTAP) Phase II - a collaboration between BudgIT, Connected Development (CODE), Global Integrity, as well as partners in 9 African countries: Cameroon, Ghana, Kenya, Liberia, Malawi, Nigeria, Zimbabwe, Senegal and Sierra Leone.

Following African governments' response to COVID-19 which was characterised by instances of mismanagement, waste, blatant corruption, unlawful procurement, political use of monetary and other reliefs, diversion of funds which all reproduced increased inequality, CTAP was commissioned as a civil society-led effort to bolster citizen engagement and promote change in the ways that governments use public resources, and increase the capacity of governments to meet people's needs.

Under CTAP phase I (2020 - 2021), these partners used a combination of approaches to generate information on how COVID-19 funds were used by governments and leveraged that information to advocate and collaborate with governments to bring about change. Specifically, these partners advocated for accountability, open government, strengthened civic awareness and ensured governments use COVID-19 intervention funds transparently.

In CTAP phase II, these partners are working with diverse stakeholders including government and communities to institute mechanisms for health sector accountability, foster effective and equitable COVID-19 vaccine distribution and mount effective advocacies that mainstreams health sector's best practices in focal countries.

Research Questions

01

What are Nigeria's health sector performance, governance structures and tiers of responsibility (management, funding and policy making) and universal healthcare coverage dynamics at the national and sub-national levels, including the role of stakeholders?

02

What are the features and extent of reforms in Nigeria's health sector including political economy analysis, as well as the nature and extent of corruption?

03

What are the role and impact of oversight institutions on health sector systemic efficiency?

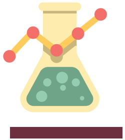
04

In what ways has healthcare financing and fiscal management at national and sub-national levels evolved, including the existing financing patterns, forms of expenditure, gaps and issues of citizen participation and accountability?

05

What are citizens' perceptions and vision on healthcare access and quality of service of healthcare as a public good?

Methodology



Respondents were selected in both rural and urban communities to provide insight into the peculiarities faced by different communities as regards healthcare.

The approach of this study is qualitative and descriptive. Secondary data from books, journals, magazines, policy documents, unpublished works, dailies, periodicals, and other online sources were extensively reviewed and analysed to provide insight on the nexus between Nigeria's poor socio-economic performance and poor health outcomes. The study reviewed budgetary allocations to the Ministries of Health at the national and sub national levels, basic information on health facilities in Nigeria and proxied fatality figures to measure performance.

The study adopted purposive sampling, which is a non-probability sampling method in selecting the six focal states for subnational analysis. These states include Anambra, Bauchi, Lagos, Rivers, Kaduna and Sokoto. The selection was informed by the state's geographical position, population, records of investment in healthcare, history of health reforms, socioeconomic and health outcomes. For proper examination of the healthcare systems across these states from the perception of citizens, the study undertook empirical qualitative research in the focal states to document the experiences of some critical stakeholders through key informant interviews (KII). The qualitative interviews were cluster based in providing better context to literature and presenting the experience of stakeholders in a systematic way.

60 respondents were interviewed across the 6 selected states and this list of critical stakeholders include- leaders of civil society organisations and community-based organisations working on health sector accountability, community leaders and gatekeepers, women leaders in communities, healthcare workers, religious leaders and cultural leaders. Respondents were selected in both rural and urban communities to provide insight into the peculiarities faced by different communities as regards healthcare. Key emphasis was placed on gender and vulnerable populations. Due to the sensitivity of the theme and ethical considerations, the identity of the respondents is protected. The consultants adhered to considerations such as professional practice by ensuring data validity and research instruments reliability.

Study Limitations

The purposive selection of 6 out the 36 states in-country without studying all the other states might impact on the ability of the study to generalise some of the findings, as there are subtle differences in healthcare management and governance at the sub-national level in Nigeria.

There is also the question of access to budgetary and procurement information across the 23 years of democratic governance in Nigeria, particularly at the sub-national level in order to have a full picture of public investment in healthcare. Projection and analysis were made on publicly available data.

Section Two

Health Sector Overview, Governance and Stakeholders

As of 2021, Nigeria's life expectancy rate at birth was

60.87 years

which was amongst the lowest in the world.

In 2021, 805 Nigerian medical doctors migrated to the UK, as reported by the British General Medical Council.

The Nigerian healthcare system is in a state of crisis. Access to healthcare in Africa's most populous state has remained challenging and quality questionable - especially in the rural areas - which affects the productivity of Nigerians and the country's economic growth, by extension.

The situation of the sector is demonstrated through Nigeria's performance across several health indicators such as life expectancy at birth, MMR, IMR and U5MR. As of 2021, Nigeria's life expectancy rate at birth was 60.87 years,[3] which was amongst the lowest in the world. Nigeria contributes 10% of global deaths for pregnant mothers with an MMR of 576 per 100,000 live births,[4] the fourth highest in the world. Each year, an estimated 262,000 babies die at birth; the world's second highest national total.[5] In 2020, Nigeria's IMR stood at 59.2 per 1,000 live births. U5MR was at 95.2 per 1,000 live births in the same year.[6,7]

For decades, while the country's health sector has suffered from severe underfunding, the country's political elite travel to the United Kingdom, Germany, United Arab Emirates etc. for medical care which they have denied their fellow citizens and patronising health services built by their peers in other countries, at great cost to the Nigerian treasury.[8,9]

More vexatious is the exodus of Nigerian medical workers to several destinations overseas, following poor conditions of service and poor health sector human resource management. To exemplify this, in 2021, 805 Nigerian medical doctors migrated to the UK, as reported by the British General Medical Council. Furthermore, data from the British Nursing and Midwifery Council[10] reveal that between 2016 and 2021, 15,049 nurses migrated to the UK from Nigeria.[11] This means for each year in those 5 years, Nigeria lost 3,009 nurses annually, 228 per month, 57 per week or 8 daily to the UK health system.

3 - Statista, Life Expectancy in Nigeria, 2021 (https://www.statista.com/statistics/1122851/life-expectancy-in-nigeria-by-gender/#:~:text=In%202021%2C%20life%20expectancy%20at,well%20as%20in%20the%20world.)

4 - UNICEF, Situation of Women and Children in Nigeria, 2018 (https://www.unicef.org/nigeria/situation-women-and-children-nigeria#:~:text=While%20the%20country%20represents%202.4,the%20fourth%20highest%20on%20Earth.)

5 - Ibid

6 - MacroTrends, Nigeria Infant Mortality Rate 1950-2022 (https://www.macrotrends.net/countries/NGA/nigeria/infant-mortality-rate)

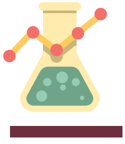
7 - Knoema, Under 5 Mortality Rate in Nigeria, 2020 (https://knoema.com/atlas/Nigeria/topics/Demographics/Mortality/Under-5-mortality-rate#:~:text=Nigeria%20%2D%20Under%2Dfive%20mortality%20rate&text=In%202020%2C%20under%2D5%20mortality,thousand%20live%20births%20in%202020.)

8 - Premium Times, Nigeria's Health Sector in Crisis, 2021 (https://www.premiumtimesng.com/opinion/477854-nigeria-a-health-sector-in-crisis-by-emmanuel-nwachukwu.html)

9 - Premium Times, TIMELINE: Buhari has spent 200 days in UK for treatment since assuming office, 2021 (https://www.premiumtimesng.com/news/headlines/477336-timeline-buhari-has-spent-200-days-in-uk-for-treatment-since-assuming-office.html)

10 - MSN, 805 Nigerian doctors got British license in six months, total now 9,189 –British Agency, 2021 (https://www.msn.com/en-xl/africa/nigeria/805-nigerian-doctors-got-british-license-in-six-months-total-now-9-189-british-agency/ar-AAS97nd)

11 - Punch Ng, 15,049 Nigerian nurses move to UK in five years, 2021 (https://punchng.com/15049-nigerian-nurses-move-to-uk-in-five-years/)



Workers cite woeful work conditions, poor remunerations, being overworked and delayed salaries which often prompt the health unions to embark on regular strikes.

This situation is frightening and worrisome considering that as against the WHO recommended 1:600 doctor-to-patient ratio, Nigeria is at 1:2630.[12] While this is the case, a 2018 survey by Nigeria Health Watch estimated that 88% of Nigerian doctors are actively seeking opportunities abroad.[13] Canada, UK, United States and the Middle East have become top destinations for Nigeria's health workers, whose value grows instantaneously in those climes where there are proper health infrastructures, and much higher remuneration packages. The shortage is worse in the hinterland, following statistics from the National Association of Resident Doctors which states that 70% of doctors practice in urban areas whereas only 30% are in the rural areas.

Human resource management in the Nigerian health sector has been abysmal, despite the formulation and approval of the 2007 National Human Resources for Health Policy by the Federal Ministry of Health and the National Council on Health respectively.

The policy's aim of ensuring adequate availability and equitable distribution of the required numbers of skilled and well-motivated health workers was not met.[14] However, workers cite woeful work conditions, poor remunerations, being overworked and delayed salaries which often prompt the health unions to embark on regular strikes. In states such as Abia, Imo, Ondo and Ekiti, doctors and other health workers are owed months of salaries and arrears.[15] While medical doctors at entry level earn less than $1,000 per month in Nigeria, their counterparts in South Africa earn approximately $3,000. This variance shows clearly how underpaid Nigerian healthcare workers are.

12 - Global Citizen, 5 Facts Every Nigerian Should Know About Our Health Care, 2020 (https://www.globalcitizen.org/en/content/health-care-facts-nigeria-covid-19/#:~:text=Of%20health%20care%20spend%20in,access%20to%20quality%20health%20care.)

13 - Aljazeera, As Nigeria's healthcare bleeds, striking doctors pledge to fight, 2021 (https://www.aljazeera.com/news/2021/9/17/nigeria-healthcare-bleeds-striking-doctors-pledge-fight)

14 - FN Monye, "An Appraisal of the National Health Insurance Scheme of Nigeria," Commonwealth Law Bulletin, 2006, 32 (3): 415–427.

15 - Tribune, Resident Doctors Implore FG To Increase Health Budget To 15%, Curtail Brain Drain https://tribuneonlineng.com/resident-doctors-implore-fg-to-increase-health-budget-to-15-curtail-brain-drain/, 2022 (https://tribuneonlineng.com/resident-doctors-implore-fg-to-increase-health-budget-to-15-curtail-brain-drain/)

Nigeria's universal health coverage (UHC) is one of the poorest in the world, with the country ranked 163 out of 191 countries in the world as of 2021.[16] According to the Nigerian Health Insurance Scheme (NHIS) in 2021, about 5% of Nigerians (10 million estimated) have taken up health insurance since the launch of the scheme in 2005 by the Federal Government to achieve UHC, with financial risk protection mechanisms.[17] The 10 million persons are covered under various programmes of the scheme including state agencies and private plans by Health Maintenance Organisations (HMOs). This implies the rest – 95% of Nigerians - continue to finance their healthcare needs through out-of-pocket expenditure. Currently, there is the 2019 National Health Insurance Commission Bill which seeks to address NHIS challenges and make health insurance mandatory. Several states have established their health insurance schemes while others are at various stages of setting up their own programmes.[18]

As regards health sector governance, this is decentralised across the three (3) tiers of government in Nigeria -the federal, state and local governments- in terms of management and funding. Policymaking is mainly at the federal and state levels.

Through the Federal Ministry of Health (FMoH), the Federal Government (FG) is responsible for tertiary care where it: coordinates the affairs of university teaching hospitals, orthopaedic hospitals, national eye centres and federal medical centres; formulates and implements national health policies; provides technical assistance to state ministries of health (SMOH) and local government health authorities (LGHAs); as well as supervises several agencies and centres under it. State governments through State Ministries of Health manage general hospitals (secondary healthcare), make regulations as well as provide technical assistance to LGHAs. Local governments focus on primary healthcare centres (PHC) which are regulated by the federal government through the National Primary Health Care Development Agency (NPHCDA).[19]

Furthermore, away from the public health sector, Nigeria's health system includes private operators. The private health sector comprises of private-for-profit hospitals, private-not-for-profit hospitals, small clinics, pharmacies, patent medicine dealers, faith-based health facilities, maternity homes, traditional healers and alternative health care providers.

Stakeholders in Nigeria's health system also include non-governmental organisations, development partners, international organisations, donors and foundations who carry out health-related advocacy, as well as finance and implement various public health interventions across the country. Additionally, there are professional associations such as the Nigerian Medical Association, Pharmacists Council of Nigeria, Institute of Chartered Chemists of Nigeria, National Association of Nigeria Nurses and Midwives etc.

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16 - The Guardian Ng, Nigeria improves on WHO health system ranking, says ACPN, 2021 (https://guardian.ng/news/nigeria-improves-on-who-health-system-ranking-says-acpn/)

17 - The Guardian, Over 170 million Nigerians without health insurance, 2020 (https://guardian.ng/features/over-170-million-nigerians-without-health-insurance/)

18 - Ibid

19 - http://www.docstoc.com/docs/21999635/Federal-Medical-Centre_-Abeokuta_-A-Case-Study-in-Hospital-Management

Political Economy of the Health Sector

The country has the second highest unemployment rate in the world at

33%

Nigeria's healthcare failures are situated in the context of the country's peculiar political economy.

Studies have established the link between the quality of healthcare delivery and a country's overall political and economic system, considering medical development is an extension of economic development.[20] Nigeria has performed poorly on almost all indicators benchmarking economic development even before the advent of the COVID-19 pandemic. In 2018, Nigeria emerged as the poverty capital of the world, with around 87 million people living in extreme poverty.[21] The country has the second highest unemployment rate in the world at 33%,[22] and around 12 million children are out of school across the country.[23]

Corruption is endemic and it has been projected that corruption in Nigeria could cost up to 37% of Nigerian Gross Domestic Product (GDP) by 2030.[24] This poor socio-economic performance is compounded by pervasive insecurity that has seen the military involved in internal security operations in 30 of Nigeria's 36 states.[25]

It is therefore not strange that Nigeria's health indicators are some of the worst in Africa, with a life expectancy that is amongst the lowest in the world.[26]

Nigeria's conceptualisation and management of healthcare diametrically contradicts the established position of experts about the linkage between healthcare and other areas of socioeconomic life. Healthcare in Nigeria has historically been conceptualized as an autonomous, self-determining area of public life without links to the other areas. Morbidity and mortality problems are generally explained as driven by internal factors, such as inadequate hospitals, clinics, equipment and materials and a lack of the necessary personnel.

The structural and economic foundations of these internal problems are assumed inconsequential and are largely ignored. Nigeria's healthcare failures are situated in the context of the country's peculiar political economy.[27]

20 - S Alubo, 'Underdevelopment and the health care crisis in Nigeria', Medical Anthropology, 1985, 9(4), 319

21 - V Oluwole, Nigeria is no longer the poverty capital of the world but still has over 70 million people living in extreme poverty - the highest in Africa', Business Insider Africa, March 10, 2022

22 - Ruth Olurounbi, 'Nigeria Unemployment Rate Rises to 33%, Second Highest on Global List', Bloomberg News, March 15, 2021

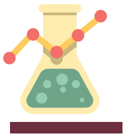
23 - 'Insurgency, Banditry Have Forced Over 12m Children Out Of School, Says Presidency', Channels TV, October 27, 2021. Available at: https://www.channelstv.com/2021/10/27/insurgency-banditry-forcing-children-out-of-school-says-presidency/

24 - PWC, Impact of Corruption on Nigeria's Economy, (2016) 3

25 - 'Insecurity: Soldiers deployed in 30 of Nigeria's 36 states – Report', Premium Times, August 4, 2016 (https://www.premiumtimesng.com/news/more-news/208055-insecurity-soldiers-deployed-30-nigerias-36-states-report.html)

26 - The World Bank, Life expectancy at birth, total (years) - Sub-Saharan Africa (https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=ZG&name_desc=true)

27 - V. Echebiri, 'The factors affecting Nigeria's success toward implementation of global public health priorities', Global Health Promotion, 2015, 22(2), 75



The bulk of health expenditure in Nigeria is provided out-of-pocket by private individuals. Expenditure from all tiers of governments amounts to less than 6% of total government expenditure and less than 25% of total health spending in the country.

Health services in Nigeria as mentioned earlier are provided by the three tiers of national and sub-national governments as well as by private providers. This has resulted in fragmentation and poor coordination among all the institutional providers of healthcare in the country. Available statistics show that health institutions rendering healthcare in Nigeria are 33,303 general hospitals, 20,278 primary health centres and posts, and 59 teaching hospitals and federal medical centres.[28] The private sector accounts for over 60% of healthcare services in Nigeria. However, there is regional variation across the North-South divide. In Northern Nigeria, the public sector accounts for 90% of all health services, while in the Southern part, the private sector provides over 70% of health services.[29]

This domination of healthcare by private interests makes it difficult to create clear rules of engagement and where regulations exist, they are most theoretical.

The bulk of health expenditure in Nigeria is provided out-of-pocket by private individuals.[30]

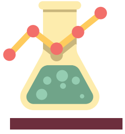
Expenditure from all tiers of governments amounts to less than 6% of total government expenditure and less than 25% of total health spending in the country. The balance of 75% is provided by the private sector. Household out-of-pocket expenditures account for over 95% of the private sector expenditure and out-of-pocket expenditures account for nearly 70% of the entire expenditure in the health sector.[31] This highlights the disconnect between the state at all levels and the citizenry resulting in near total indifference to the electorate's need for quality healthcare.

28 - A Omoruan, A Bamidele and O Phillips, 'Social health insurance and sustainable healthcare reform in Nigeria', Studies on Ethno-Medicine, 2009, 3, 106

29 - H Ichoku. and C. Okoli, 'Fiscal Space for Health Financing in Nigeria', African Journal of Health Economics, 2015, 2 (1) 15

30 - World Bank, Out-of-pocket expenditure (% of current health expenditure) - Nigeria, 2019 (https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG)

31 - World Bank, First Lagos State Development Policy Operation, Poverty Reduction and Economic Management 3, Nigeria Country Unit Africa Region, 2011



Public corruption manifests during processes for the construction and rehabilitation of health facilities, purchase of equipment and supplies.

Asides the sparse government presence in health financing in Nigeria, another dominant feature of healthcare delivery in Nigeria is its systemic inequality and class factor in the distribution of healthcare services in Nigeria. There are more and better healthcare facilities in the cities where the more privileged social class live than in the rural areas, which are predominantly inhabited by the peasants. Even in urban centres there are hospitals that are built and reserved for the political class.

An example is the budgetary appropriation to build the 14-bed presidential hospital in the State House in 2022, which was more than the sum appropriated for capital expenditure across the 25 Federal Medical Centres in Nigeria.[32] Systemic inequality in healthcare delivery is stark in rural-urban health financing in Nigeria. While around 49% of the Nigerian population live in rural communities, some rural areas have only one clinic for every 200 square kilometres. Yet annually governments appropriate funds for specialist hospitals and treatment centres, even though the main cause of death in Nigeria is from infectious and preventable diseases, and not cancer or other diseases of affluence.

Corruption and patronage systems are distinct features of the healthcare system in Nigeria. Public corruption manifests during processes for the construction and rehabilitation of health facilities, purchase of equipment and supplies, including drugs, distribution and use of drugs and supplies in service delivery, regulation of quality in products, services, facilities and professionals, education of health professionals and medical research.

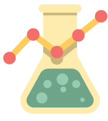
There is also corruption by health workers, which include prescription by health workers influenced by pharmaceutical companies, diversion of patients from public hospitals to private hospitals, informal payments by patients to health workers, diversion of drugs etc.[33]

32 - 'N21bn 14-bed Aso Rock clinic's construction begins November', The Punch Newspapers, October 29, 2021

33 - Onwujekwe O, Agwu P, Orjiakor T, Mbachu C, Hutchinson E Odii A et al. Corruption in the health sector in Anglophones West Africa: Common forms of corruption and mitigation strategies. Anti-Corruption Evidence (ACE) Research Consortium; 2018.

Section Four

Legislative Oversight



Revenue cannot be raised, be it a tax, custom dues, and/or other charges like the imposition of license fees, without the authority of the National Assembly.

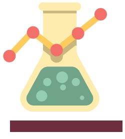
The National Assembly (NASS) with its political and administrative structures comprising the Senate with 109 members and a House of Representative of 360 members, is part of the Nigerian healthcare delivery ecosystem, with its unique broad oversight functions. The Assembly is vested with the powers to constitute committees of its members for the purpose of examining the bills brought to it and scrutinising the conduct and activities of government institutions and officials.

Also, NASS has the exclusive legislative power to make legislations on drug production and usage in Nigeria.[34] NASS is the only organ of government at the national level clothed with the constitutional powers to raise government's revenue and authorise expenditure of those revenue. Revenue cannot be raised, be it a tax, custom dues, and/or other charges like the imposition of license fees, without the authority of the National Assembly. The Assembly equally authorises expenditure through budgetary allocation and finalisation and has enormous powers in setting legislative agenda for areas of governance priority and overseeing it.

Table 1: Percentage of National Budget Allocated to the Ministry of Health- 2010- 2021

Year	Percentage
2010	3.73%
2011	5.75%
2012	6.08%
2013	5.75%
2014	5.63%
2015	5.78%
2016	4.13%
2017	4.15%
2018	4.51%
2019	4.75%
2020	3.38%
2021	4.05%
2022	4.6%

34 - Section 4, 1999 Constitution of the Federal Republic of Nigeria.



Nigeria, in the last twenty years has failed in its Abuja Declaration commitment of ensuring 15% of its annual budgetary allocation going toward health.

Legislative failure as it relates to healthcare in Nigeria is two fold-failure to enforce budgetary commitments to healthcare and compromised oversight. Nigeria, in the last twenty years has failed in its Abuja Declaration commitment of ensuring 15% of its annual budgetary allocation going toward health. In April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector, a commitment Nigeria signed up to.[35]

The average budgetary allocation to the sector in the last 2 decades has been around 4.7%, in spite of this commitment and even at the peak of COVID-19 pandemic. The country's allocation to health for the 2021 fiscal year is 4.05%.[36] Not only has the legislature, in its yearly budgetary allocation failed to balance dwindling resources with Nigeria's health commitment, budgetary allocations in the last 20 years have been skewed towards recurrent expenditure.

Table 2: Capital Expenditure, % of Release and Utilisation

Year	Released as % of Allocation	Utilized as of % of Allocation
2009	95.75%	48.24%
2010	63.33%	33.47%
2011	69.99%	58.08%
2012	78.93%	31.80%
2013	47.99%	37.72%
2014	41.32%	53.86%
2015	72.52%	97.06%
2016	99.79%	87.84%
2017	94.68%	61.26%
2018	73.39%	54.11%
2029	56.59%	45.12%
2020	95.53%	54.45%

Source: The Development Research and Project Centre

35 - Who Health Organization, The Abuja Declaration: Ten Years On, 2011 (https://www.who.int/healthsystems/publications/Abuja10.pdf)

36 - DRPC, 15% Benchmark to Health Sector in Nigeria- The Journey so Far, 2021. (https://drpcngr.org/15-benchmark-to-health-sector-in-nigeria-the-journey-so-far/)

Despite these unsatisfactory allocations, budgeted funds are routinely returned to the treasury for non-utilisation (see table 2 above). Between 2009 and 2020, 25.35% of the released funds for capital expenditure were not utilised. These significant changes and trends in the Nigerian budget and expenditure for the healthcare system have significantly impacted on healthcare indicators over the years. Mortality data are essential sources of demographic, geographic and cause-of-death statistics and can be used to quantify the efficiency of a health system, as well as to define and evaluate a country's healthcare priorities.

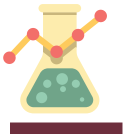
Legislative oversight failures are also evident in the failure to monitor health targets and indicators, effective implementation of health care laws and policies, address challenges, and foster more coordination across agencies in Nigeria. In 2017, legislators across all levels of government in Nigeria established the Legislative Network for Universal Health Coverage to identify ways in which legislators can use their statutory functions to achieve universal health coverage. This alliance of political actors across Nigeria has not improved access to healthcare across the country.

Financing and Fiscal Management

Public expenditure on health has been below

30%

for decades



With the 2021 health budget of NGN 549 billion, health expenditure per capita was at a marginal $7 (N2,745) which clearly shows the health sector underinvestment is dire.

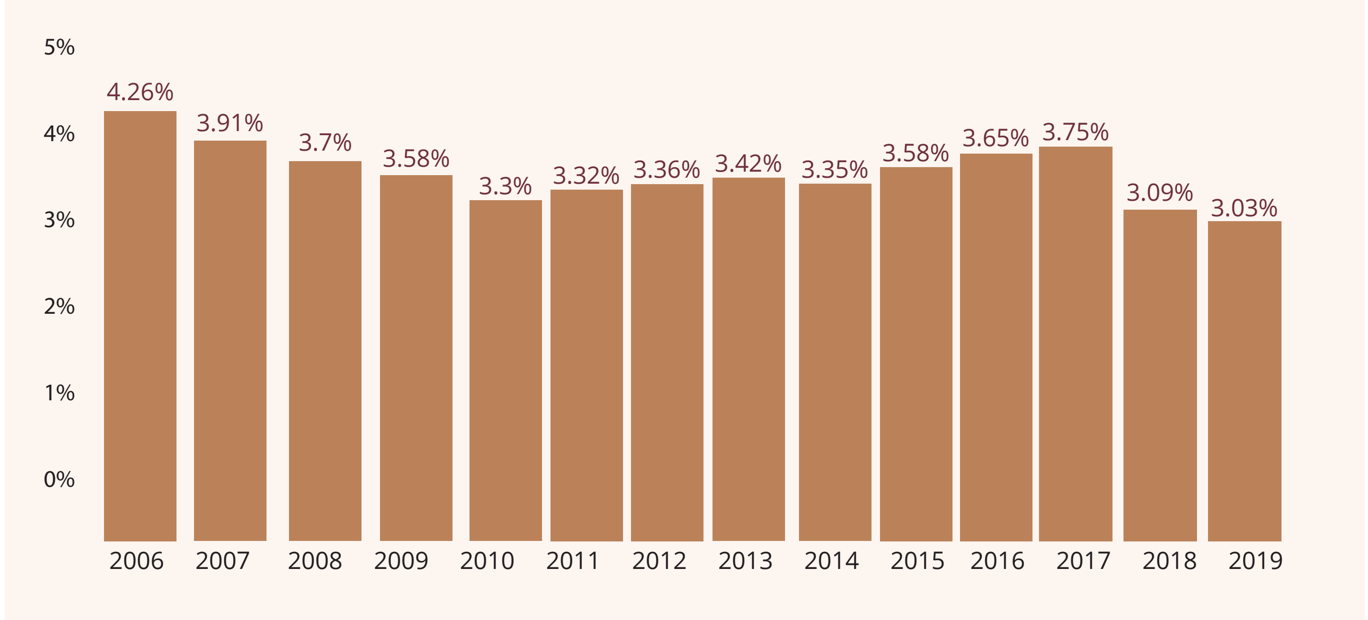
Nigeria's ecosystem of health financing is made up of several mechanisms including government budget, direct citizen out-of-pocket payments (OPP), the private sector, NHIS, development partners and donor agencies, demand-side financing via conditional cash transfers (CCT) and community-based health insurance (CBHI). Considering the country's constitution places health on the legislative concurrent list, the federal, state and local governments have the responsibility of mobilising and deploying resources for the provision of health services within their jurisdictions.

In 2019, government spending on health was approximately 28.3% of total health expenditure in the country.[37] Table 1 below shows the percentage of the health budget against the total budget between 2010 and 2022 of the federal budget. The highest was 5.8% in 2015, as against the 15% Abuja Declaration. Part of the reasons why this has not been met include competing interests from different sectors of the economy such as education, security, agriculture, works, power etc., as well as dwindling government revenues following the fall in oil prices and the COVID-19 pandemic macroeconomic effects. With the 2021 health budget of NGN 549 billion, health expenditure per capita was at a marginal $7 (N2,745) which clearly shows the health sector underinvestment is dire.

Similarly, as of 2019, the expenditure on health in Nigeria as a share of GDP was at 3.03% which is the lowest since 2006. In the Organisation for Economic Co-operation and Development (OECD) countries, the average percentage of GDP spent on healthcare was 8.8% in 2019, although member countries of OECD are mostly high-income countries, whereas Nigeria is a lower-middle income country.

37- Knoema, Nigeria - Private expenditure on health as a share of total health expenditure, 2019. (https://knoema.com/atlas/Nigeria/topics/Health/Health-Expenditure/Private-expenditure-on-health-as-a-share-of-total-health-expenditure)

Figure 1: Health expenditure as share of GDP in Nigeria from 2006 to 2019



Source: Statista[38]

To address the systemic governmental underfunding of the health sector and facilitate access to healthcare primarily for rural Nigerians, the Basic Health Care Provision Fund (BHCPF) was established under the National Health Act.

Regardless of this, more worrisome is the health sector capital expenditure allocation, which has been less than 25% in the past decade except for 2010, 2013 and 2018 (see table 3 below). This implies a large chunk of the annual federal health sector budget is spent on recurrent expenditure, despite the impecunious infrastructural situation of the health sector, especially at the primary healthcare level. It is estimated that Nigeria requires an extra 386,000 hospital beds at an estimated cost of $82 billion dollars to bring the country up to the global average of 2.7 beds per 1,000 people.[39] To address the systemic governmental underfunding of the health sector and facilitate access to healthcare primarily for rural Nigerians, the Basic Health Care Provision Fund (BHCPF) was established under the National Health Act.The Fund aims at: financing the Basic Minimum Package of Health Services (BMPHS); strengthening the national health system (particularly at primary health care level) by making provision for routine daily operating cost of PHCs; increase the fiscal space for health; and ensure access to healthcare for all, particularly the poor.[40, 41]

The BHCPF is funded through an annual grant from the Federal Government of not less than 1% of the Consolidated Revenue Fund (CRF); grants by international donor partners; and funds from any other source, inclusive of the private sector.

38 - Statista, Current health expenditure as share of GDP in Nigeria from 2006 to 2019 (https://www.statista.com/statistics/1126455/health-expenditure-as-share-of-gdp-in-nigeria/)

39 - Investment Monitor, Can FDI fix Nigeria's broken healthcare infrastructure?, 2021 (https://www.investmentmonitor.ai/sectors/real-estate/can-fdi-fix-nigerias-broken-healthcare-infrastructure)

40 - NPHCDA, BHCPF (https://nphcda.gov.ng/bhcpf/)

41 - The BHCPF is implemented through 3 gateways including the NPHCDA which provides for the operational cost and Human Resource for Health (HRH) for PHCs through the State Primary Health Care Board, the NHIS which insures the most vulnerable Nigerians to access the BMPHS through the State Social Health Insurance Agencies (SSHIA) and the National Emergency Medical Treatment (NEMT) which is expected to cater for emergency ambulance services.

Table 3: Nigeria's health sector budget (recurrent and capital) from 2010 to 2020			
Year	**Total (N'Bn)**	**Recurrent (N'Bn)**	**Capital (N'Bn)**
2010	164.91	111.91	53.01
2011	235.87	202.34	33.53
2012	282.77	225.76	57.01
2013	282.50	222.45	60.05
2014	264.46	214.94	49.52
2015	259.75	237.08	22.68
2016	250.06	221.41	28.65
2017	308.46	252.85	55.61
2018	411.60	269.97	86.49
2029	423.92	315.62	57.09
2020	427.92	336.32	46.48

Source: Premium Times, Budget Office of the Federation

Development partners, donor agencies, international non-governmental organisations and foundations on their part contribute to Nigeria's health outcomes improvement through financial assistance (loans and grants), commodities (drugs and medical equipment), technical expertise, training, research funding and implementation of critical health interventions.

They include United Nations Children's Fund (UNICEF), World Bank, Save the Children, UK Foreign Commonwealth & Development Office (FCDO), Bill and Melinda Gates Foundation, GAVI Alliance, the Global Fund, Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO), FHI 360 etc.

Their interventions range across family planning, vaccination, tuberculosis and malaria, healthcare services, and HIV/AIDS etc. Notable examples include the World Bank $500 million 'Saving One Million Lives (SOML)' program for results (PforR) which aimed to increase the utilisation and quality of high impact reproductive, child health, and nutrition interventions in Nigeria.

For the private sector, they include foundations, and corporate organisations who earmark resources for corporate social responsibility activities for the health sector. At the advent COVID-19, through the Coalition Against Covid (CACOVID) and Victims Support Fund (VSF) vehicles, the private sector donated billions of naira for several interventions across the country.

According to the WHO in 2017, 77% of healthcare spend in Nigeria is out-of-pocket.

With respect to the phenomena of accountability, transparency, and citizen participation in health sector spending-at the federal level and across several states-there are improvements. Improvements in the sense that citizens can access the federal and health sector budgets of many states, as well as be invited to budget public hearings at the federal and state levels.

At the federal level, the health budget can be accessed through the Budget Office's Nigeria Budget Info. At the state level, they can be accessed on the websites of various state governments alongside the overall budget. This is following first, years of advocacy and campaigns by several civil society organisations for government MDAs to open their books to public scrutiny and mainstream social accountability. Such campaigns culminated into the emergence of several social accountability initiatives who mount pressure on the government to stay accountable and transparent through mobilising communities.

These initiatives also have platforms that facilitate access to government health spending data such as Budeshi, iFollowTheMoney, Tracka, etc. Second, international transparency and accountability (T&A) mechanisms such as the Open Government Partnership (OGP) which Nigeria signed in 2016,[43] as well as national ones such as the 2011 Freedom of Information ACT (FOIA)[44] were utilised in changing the dynamics of T&A and participation in Nigeria's fiscal governance.

Sub-nationally, fiscal openness was also driven by the World Bank-assisted States Fiscal Transparency, Accountability and Sustainability (SFTAS) programme. Through the programme, benefitting states access performance grants after they have met a considerable number of criteria, including publishing their annual budgets and audited financial statements online, enhancing citizen's engagement in its budget process and improving procurement practices.[45]

However, it is still not yet 'uhuru' – there are still several gaps and areas of improvement across the country at both national and sub national levels. While it is easier for citizens to access health budgets, other important data such as the post-bid evaluations are not in the public domain, which is more accurate in terms of the updated project amount (in some instances) and the contractor who has been selected for the implementation of the project. Such bid evaluation data, as well as bills of quantities (BoQs) should be in the public domain (readable and accessible to citizens that can afford to make copies in the case of BoQs across the federal and state levels).

In addition to this, civil society is often not aware or invited to bid evaluation and contract award ceremonies by several health sector national and subnational parastatals.

43 - ONE Africa, Nigeria Joins 69 Countries in the Open Government Partnership, 2016 (https://www.one.org/africa/press/nigeria-joins-69-countries-in-the-open-government-partnership/)

44 - Vanguard Ng, At last, Jonathan signs FOI bill into law, 2011 (https://www.vanguardngr.com/2011/06/at-last-jonathan-signs-foi-bill-into-law/)

45 - Premium Times, Fiscal Transparency: 24 states get N43.4bn World Bank performance grants, 2020 (https://www.premiumtimesng.com/news/top-news/390572-fiscal-transparency-24-states-get-n43-4bn-world-bank-performance-grants.html)

Beyond this, participation in health budgeting has remained low. Many a times, projects such as construction or rehabilitation of PHCs in communities are captured on the budget without the prior knowledge of the communities. Needs assessment leading to projects' inclusion on the budget are often not carried out, leading to incongruity between what communities want and what was proposed.

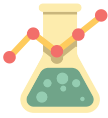
This further makes it elusive for communities to adequately provide the necessary public oversight and ensure effective service delivery on projects meant for them. In furtherance, it's often difficult for citizens and civil society groups to link a project from the budget to procurement and then audit, while FOI responses are often not guaranteed, and defaulting MDAs are not sanctioned.

Citizens Voices on Healthcare Access, Quality and Vision

more than

90%

of the Nigerian population are without health insurance coverage and the right to health



Only 11% of births to uneducated mothers occur in health facilities, while 91% of births to mothers with more than secondary education occur in health facilities.

Quality of healthcare and citizen satisfaction are key elements in determining the performance of a country's healthcare system. Nigeria's demographic characterisation adds a different perspective to the idea of health as public good. With a 2.5% annual population growth rate and a median age of 18.1 years, the demographic feature of Nigeria's large population means increasing demand on public service and puts pressure on existing public infrastructure.

In the context of healthcare, social protection includes all the programmes and measures aimed at removing financial barriers preventing access to health care services and protecting poor and vulnerable populations from the impoverishing effects of medical expenditures.[46] Inherent in this is a financial risk protection component under a universal health coverage system that ensures access to quality health care services without suffering financial hardship.[47]

As it stands, Nigeria has a very limited scope of legal coverage for social protection. More than 90% of the Nigerian population are without health insurance coverage and the right to health as public good is not an enforceable right in the Nigerian legal system.[48] The Nigerian National Health Policy aims[49] to provide financial risk protection to all Nigerians (particularly the poor and most vulnerable groups). However, in reality, there is a lack of effective social and financial risk protection for Nigeria's vulnerable population and this remains one of the main drivers of poverty, vulnerability and inequality in health, in the country.

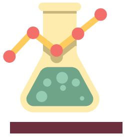
There is also the problem of geographical and economic inequity in access to healthcare services in Nigeria. For instance, only 11% of births to uneducated mothers occur in health facilities, while 91% of births to mothers with more than secondary education occur in health facilities.

46 - C Hormansdorfer , Health and social protection. In: Promoting pro-poor growth: Social Protection, OECD, 200, 145, (http://www.oecd.org/dac/povertyreduction/promotingpro-poorgrowthsocialpr)

47 - Bolaji Aregbeshola, Health care in Nigeria: Challenges and recommendations, 2019 (https://socialprotection.org/discover/blog/health-care-nigeria-challenges-and-recommendations)

48 - Obiajulu Nnam, 'The right to health in Nigeria' in Right to health in the Middle East' project, Law School, University of Aberdeen, 2007 (http://www.abdn.ac.uk/law/hhr.shtmluchi)

49 - National Health Policy,2016, 1



Community members prefer to visit patent medicine vendors or traditional medicine practitioners or resort to traditional herbs for their healthcare needs as the first port of call.

86% of mothers in urban areas receive antenatal care from skilled providers, compared to only 48% of mothers in rural areas, while antenatal care coverage in the Northwest is 41%, compared to 91% in the South East.[50]

Studies have identified five key elements impeding universal and equitable healthcare access in Nigeria and these include: **lack of political will and commitment by successive governments that ruled the country and poor governance; corruption; an underfunded health system; high informal sector economy; extreme poverty and the poor's inability to pay health insurance premiums.**[51] Current gaps in the Nigerian healthcare system and limited resourcing opportunities call for innovative methods to protect the poor and vulnerable populations against financial risk of ill health. The National Health Act entitles Nigerians to a basic minimum package of health care services, yet eight years after, little has changed the plight of Nigeria's poor and highlights the limitation of laws without the essential governance structures.

Primary data collected from Anambra, Bauchi, Lagos, Kaduna, Rivers and Sokoto states are in consonance with the narration above on health care access and quality. The respondents (community leaders, healthcare workers and civil society stakeholders) agreed that access to healthcare is a public good.

In Anambra, Kaduna and Lagos, community respondents responded in the affirmative as regards having access to healthcare through PHCs, private hospitals, patent medicine vendors (chemists), birth attendants and traditional medicine practitioners. In Rivers, Sokoto and Bauchi, the situation is contrasting. Sampled communities in the 3 states do not have any PHCs or private hospitals and rely completely on patent medicine vendors (chemists) and traditional medicine practitioners.

On preferred healthcare choices across the sampled communities, community members prefer to visit patent medicine vendors or traditional medicine practitioners or resort to traditional herbs for their healthcare needs as the first port of call. Only a few in these communities call on private nurses or visit health centres. It is only when the issue becomes serious that community members who can afford it, go to hospitals or health centres in the nearest communities when they do not have any. This is because of the high cost of accessing formal and public healthcare institutions as explained by the community gatekeepers. Their first port of call is further determined by the exposure of the community member involved, proximity to healthcare providers or health centres, and affordability.

50 - National Health Policy 2016, 13

51 - J Balogun, the Vulnerabilities of the Nigerian Healthcare System. In: The Nigerian Healthcare System. Springer, 2021, 3

On how equipped health facilities-such as PHCs-are in these communities, respondents mentioned that many of the PHCs are not well equipped. Certain numbers of drugs are usually found to be out of stock and there are also instances where there are not enough beds for pregnant women. On the same note, as regards human resource adequacy at the sampled PHCs and according to data from respondents, some of them are staffed by one or two nurses and/or midwives which requires patients to queue for long hours before being attended to. In a few PHCs that have doctors, these doctors are not resident. Respondents also agreed the facilities are not enough for community members.

As submitted by the community respondents and leaders, they envision fully equipped and functional health centres in their communities with trained doctors and nurses, where quality healthcare is accessible and affordable by all, most especially women and PLWDs.

They also envision a scenario whereby most of the community members are health-insured so that poor community members can access improved healthcare delivery.

Finally, with respect to holding the government to account for quality healthcare access, respondents outlined several strategies including continual consultations with their local authorities and political representatives; engaging government authorities at local and state levels through letter writing and visitation to bring their health challenges to government attention; building on existing collaborations and mobilising community members; monitoring the implementation of health projects in their communities or supply of hospital equipment; as well as asking questions, and demanding accountability and transparency.

Subnational Health Sector Accountability and Political Economic Analysis

Anambra State

In the 2018 Nigeria Demographic and Health Survey, the state had the highest basic vaccination coverage across the country at 76%.

Anambra state, with a population of 5.8 million people has about 575 PHCs and 37 secondary health facilities.[52] As of 2013, the state had 1.3 million women of reproductive age, a maternal mortality rate of 286 per 100,000 live births, as well as an infant mortality rate of 112 per 100,000 births. However, between 2013 and 2018, the ratios have dropped to 93 per 100,000 births for maternal mortality and 73 for infant mortality (following governmental reforms and investments).[53] In the 2018 Nigeria Demographic and Health Survey, the state had the highest basic vaccination coverage across the country at 76%. In terms of nutritional status, stunting is lowest in Anambra at 14%.[54]

The Anambra State Ministry of Health manages general hospitals in the state, makes regulations, provides technical assistance to LGHAs and supervises the affairs of agencies under the ministry, such as the State Primary Healthcare Development Agency (SPHCDA), State Health Insurance Scheme (ASHIA) etc. The Anambra SPHCDA coordinates all the primary healthcare activities, such as routine immunisation, deworming exercises and rendering support to ruralists on ways of maintaining proper hygiene. ASHIA on its part, was launched in 2018 and has the mandate of providing quality and affordable healthcare to Anambra State citizens.

52 - https://tciurbanhealth.org/wp-content/uploads/2020/01/ANAMBRA3.pdf

53 - Vanguard Ng, We've reduced maternal/infant mortality in Anambra — Obiano, 2017. (https://www.vanguardngr.com/2017/07/weve-reduced-maternalinfant-mortality-anambra-obiano/)

54 - 2018 Demographic and Health Survey Key Findings (https://dhsprogram.com/pubs/pdf/SR264/SR264.pdf)

Anambra's health sector

between 2013 and 2021

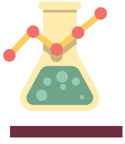
575 PHCs

37 Secondary Health Facilities

Maternal Mortality Rate of **93** per **100,000** live births

Infant Mortality Rate of **73** per **100,000** live births

76% vaccination coverage



As of 2021, the state had more than 30 general hospitals, while each of the 326 political wards in the state has at least a Primary Healthcare Centre.

The state health insurance scheme has an estimated 150,000 enrollees as of mid-2021[55] up from 80,000 enrollees in early 2020.[56] The enrollees include civil servants, vulnerable populations, informal sector operators etc. Healthcare in the state is provided by the government through general hospitals and PHCs, private hospitals, mission owned hospitals and traditional healthcare practitioners.

Anambra's health sector has undergone several reforms since 2003. In 1999, the state had only a functional general hospital, while others were glorified health centres that lacked basic facilities required in a general hospital. However, as of 2021, the state had more than 30 general hospitals, while each of the 326 political wards in the state has at least a Primary Healthcare Centre.[57] Health facilities in the state have also been upgraded in recent years. For instance, the Awka General Hospital has been upgraded to a teaching hospital, serving also as the medical school for the state's Chukwuemeka Odumegwu Ojukwu University. Similarly, the Onitsha General Hospital has become an arm of the Guinness Eye Hospital, while the Federal Government-owned Nnamdi Azikiwe University Teaching Hospital, Nnewi, is among the top tertiary health institutions in the country.

Furthermore, the state also incorporated churches as part of the state's healthcare delivery where the government also provided resources for their upgrading and equipment. Such mission owned hospitals include the Iyi Enu and Amichi diocesan Hospitals owned by the Anglican Church, the Amichi Diocesan Hospital, as well as Our Lady of Lourdes Hospital, Ihiala, Waterside Hospital, Onitsha, and St. Joseph's Hospital, Adazi, owned by the Catholic Church. As part of the reforms also included, is facilitating the accreditation[58] of relevant hospitals in the state for the training of nurses and midwives. PHCs were not left out in the reforms that took place. Many of them have been renovated and cold stores were installed to ensure proper storage of drugs and other medicines.

Recently, the state established a School of Health Technology at Obosi and some of the courses offered by the school have been accredited. At sampled PHCs in Anambra, community members access immunisation, general treatment, antenatal and postnatal services. As regards affordability of healthcare, the community respondents mentioned that services at PHCs are mostly affordable and that some of the services such as antenatal, postnatal and HIV treatment are free.

55 - Premium Times, 65,000 from informal sector enroll in Anambra health insurance scheme – Official, 2021 (https://www.premiumtimesng.com/regional/s-south-east/465125-65000-from-informal-sector-enroll-in-anambra-health-insurance-scheme-official.html)

56 - Nigeria Health Watch, Be Your Brother's Keeper: Anambra's Adoption Model for Health Insurance, 2020 (https://nigeriahealthwatch.com/be-your-broth-ers-keeper-anambras-adoption-model-for-health-insurance/)

57 - Vanguard Ng, HEALTH CARE: From one general hospital to 20 in 21 years in Anambra, 2020. (https://www.vanguardngr.com/2020/05/health-care-from-one-ge-neral-hospital-to-20-in-21-years-in-anambra/)

58 - Ibid

Healthcare financing is through vehicles such as the government budget, OOP, private sector, community health insurance scheme and development partners and donor agencies. Health sector share of the state's total budgets in 2020, 2021 and 2022 stood at an 8% estimate.[59] The state has signed into law the OGP in a bid to boost fiscal transparency, as well as adopt global best practices' on public procurement and open contracting standards.[60] Anambra state is also the only state in the country that ensures citizens participation in budgeting through its Community Charter of Demand (CCD).

The Charter enables communities to nominate 3 priority projects in every budget cycle that should be included in the budget.[61,62] Beyond this, the state's budgets, fiscal documents, audited financial statements etc., are all in the public domain.[63] On public procurement, the state has a procurement law as well as a Public Procurement Council and Public Procurement Bureau in place.[64] Anambra is a beneficiary of the World Bank-assisted SFTAS programme which mandates benefiting states to improve practices in fiscal transparency, accountability and sustainability.

59 - https://www.anambrastate.gov.ng/wp-content/uploads/2022/01/APPROVED-2020-ESTIMATES-OF-ANSG.pdf

60 - https://www.anambrastate.gov.ng/open-governance/anambra-launches-open-governance-partnership-for-transparency/

61 - https://www.anambrastate.gov.ng/wp-content/uploads/2022/01/ANAMBRA-SOUTH-CCD.pdf

62 - https://www.anambrastate.gov.ng/wp-content/uploads/2022/01/CCD-BY-SENATORIAL-ZONE-SOUTH-NORTH-CENTRAL-28-Feb-2019-11-10-031-2.pdf

63 - https://www.anambrastate.gov.ng/documents-list/

64 - ABS,Obiano Inaugurates Public Procurement Council And Public Procurement Bureau, 2020 (https://www.absradiotv.com/2020/05/30/obiano-inaugurates-public-procurement-council-and-public-procurement-bureau/)

Lagos State

The Health sector share of the total state budgets in 2019, 2020, 2021 and 2022 stood at 9.81%, 9.57%, 9.11% and 8.87% percentages, respectively.

Lagos state has an estimated 329 primary health care centres,[65] 26 general hospitals and 2,886 private hospitals (or diagnostic centres[66] or specialist clinics) and laboratories in addition to an estimated 160 trado medical centres. The 2018 Nigeria Demographic and Health Survey estimated a malaria prevalence rate of 2% in Lagos, as the lowest across the country.[67] U5MR in Lagos is at 90/1,000 live births.[68] The Lagos State Ministry of Health has the responsibility of planning and implementing health policies in the state. The ministry manages the Lagos State Health Management Agency, Lagos State Health Scheme, Lagos State Health Fund, Lagos State Primary Healthcare Board etc.

The Lagos State Health Scheme is a health insurance initiative that was established in 2015 and is regulated and administered by the State's Health Management Agency. As of September 2021, the number of enrollees in the state's health insurance scheme stood at 526,846.[69]

As obtainable across other states and at the federal level, healthcare financing in the state is through mechanisms including the government budget, OOP, community health insurance scheme, private sector and development partners and donor agencies. The Health sector share of the total state budgets in 2019, 2020, 2021 and 2022 stood at 9.81%,[70] 9.57%,[71] 9.11%[72] and 8.87%[73] percentages, respectively.

65 - Tribune Ng, Lagos Govt Assesses 329 Primary Health Care Centres, To Commission 23 More Centres, 2020 (https://tribuneonlineng.com/lagos-govt-assesses-329-primary-health-care-centres-to-commission-23-more-centres/)

66 - agos State Government, LAGOS AND EQUITABLE HEALTHCARE SERVICES, 2017. (https://lagosstate.gov.ng/blog/2017/07/05/lagos-and-equitable-healthcare-services/#:~:text=Statistics%20from%20the%20Healthcare%20Facilities,to%20an%20estimated%20160%20tradomedical)

67 - 2018 Demographic and Health Survey Key Findings (https://dhsprogram.com/pubs/pdf/SR264/SR264.pdf)

68 - https://www.healthynewbornnetwork.org/hnn-content/uploads/NIgeria-State-Profiles-Lagos-Zamfara.pdf

69 - Guardian Nigeria, Lagos unveils plans to achieve Universal Health Coverage, 2021. (https://guardian.ng/features/science/lagos-unveils-plans-to-achieve-universal-health-coverage/)

70 - http://mepb.lagosstate.gov.ng/wp-content/uploads/sites/29/2019/11/CITIZENS-GUIDE-TO-Y2019-BUDGET.pdf

71 - https://mepb.lagosstate.gov.ng/wp-content/uploads/sites/29/2020/03/2020-Lagos-Budget.pdf

72 - https://lagosmepb.org/wp-content/uploads/2021/05/Citizens-Budget-v2.pdf

73 - Guardian Ng, Lagos budgets N1.38tr for 2022 as education takes N171.6, 2021. (https://guardian.ng/news/lagos-budgets-n1-38tr-for-2022-as-education-takes-n171-6b/)

Lagos's health sector

329 PHCs

2,886 private hospitals

160 trade medical centres

Under-5 Child Mortality Rate of **90** per **1000** live births

526,846 enrollees in the state's health insurance scheme

Being a beneficiary of the World Bank-assisted SFTAS implies Lagos state's approved annual budgets, budget performance reports and audited financial statements are in the public domain, and the state government could have reforms in place to increase openness and citizen's engagement in its budget process.[74,75] It also implies the existence of efforts by the state government to improve procurement practices for increased transparency and value for money. However, the state government has still not joined the OGP for continuous institutionalisation of transparency and accountability in the use of public resources in the state.

On citizens' perception of healthcare access and quality, according to the respondents in Lagos, healthcare services are not affordable. A respondent from Owode Ibeshe had this to say, **"No they are not affordable. Money for cards most times is an issue, then they will direct you to their preferred pharmacy to buy prescribed drugs at exorbitant prices".**

74 - Premium Times, Fiscal Transparency: 24 states get N43.4bn World Bank performance grants, 2020. (https://www.premiumtimesng.com/news/top-news/390572-fiscal-transparency-24-states-get-n43-4bn-world-bank-performance-grants.html)

75 - https://lagosstate.gov.ng/vital-data-lagos-bureau-of-statistics-2/

Rivers State

Budget preparation processes in the state are not participatory and citizens do not have access to post-bid evaluation data etc.

The Rivers State Ministry of Health drives healthcare policy in the state, especially in the provision of an effective healthcare delivery system. The ministry's activities cover primary, secondary and tertiary health services, while local government councils have the responsibility for providing primary healthcare services. The state has 386 primary healthcare facilities, 18 secondary facilities, 4 tertiary facilities, as well as more than 200 private health facilities that are registered with the state government.[76] The health ministry manages the state's hospitals management board, primary healthcare management board, School of Nursing, School of Midwifery and Agency for the Control of Aids. According to the 2018 Nigeria Demographic and Health Survey, malaria prevalence rate in Rivers' state was pegged at 11%. U5MR in Rivers is at 91/1,000 live births.[77] The healthcare financing ecosystem in Rivers is made up of similar mechanisms in Anambra and Lagos. Rivers is a beneficiary of the World Bank-assisted SFTAs programme which suggests the existence of ongoing reforms on fiscal transparency, accountability and sustainability. The state's budgets and audited financial statements are accessible online. However, budget preparation processes in the state are not participatory and citizens do not have access to post-bid evaluation data etc.

As regards citizens' perception on healthcare access and quality, a community leader in one of the sampled communities stated, *"Our only choice are chemists and traditional medical practitioners because we do not have any hospitals or PHCs. There is no other healthcare centre available unless you go to Nonwa, Kuruma and Bori and before you can get there, the person could already be dead".*

76 - https://rsmoh.riversstate.gov.ng/

77 - https://www.healthynewbornnetwork.org/hnn-content/uploads/Nigeria-State-Profiles-Lagos-Zamfara.pdf

Rivers's health sector

386 PHCs

18
secondary
health facilities

4
tertiary
facilities

200
private
health facilities

Under-5 Child
Mortality Rate of
91 per **1000**
live births

Kaduna State

Despite this very bleak security outlook, Kaduna State remains the commercial gateway to the North with a young working age and consumer population.

In terms of socio-economic development, Kaduna State is one of the most prominent states in North-Western Nigeria. Created in 1967 as North-Central State which also encompassed the current Katsina State, Kaduna State achieved its current borders in 1987. With a population projection of around 9.4 million,[78] the state is the third most populous state in Nigeria and has a 46,053 square kilometres landmass that makes it the fourth largest territory in Nigeria. The state has one of the youngest population demographics in Nigeria, with 75% of its inhabitants under 35 years.

Although region-wise, the state has a relatively high literacy rate of 47%, unemployment rate is at 30% and 75% of the state's population live in rural areas.[79]

In terms of security, Kaduna is one the troubled states in Nigeria and has a long history of violent conflicts over access to resources, community leadership, control of markets and religious freedom.[80] Despite this very bleak security outlook, Kaduna State remains the commercial gateway to the North with a young working age and consumer population. In addition, it is one of the fastest reforming states in Nigeria, attracting foreign direct investments of $500 million dollars in the last two years.[81]

78 - https://kdbs.ng/

79 - National Bureau of Statistics, 2017

80 - SBMorgen, Southern Kaduna, A Critical Look (2017) (https://reliefweb.int/sites/reliefweb.int/files/resources/Southern-Kaduna.pdf)

81 - https://kdsg.gov.ng/about-kaduna/

Kaduna's health sector

5263
health facilities

a staff strength of
30,172

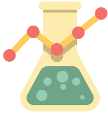
11,249
positive COVID-19 cases and
88
fatalities between 2020 till date

2428
maternity beds

2089
delivery couches

268
incubators

521,096
enrollees in the state's health insurance scheme



24% of health facilities in Kaduna State are not connected to electricity and more than 60% do not have toilet facilities, while over 15% have no source of water.

Kaduna State had 5263 health facilities with a staff strength of 30,172. More than 79% of the facilities were privately owned, with pharmacies constituting more than half of the health facilities at over 56%. Primary Health Centres (PHCs) constituted a little over 5%, health posts and maternity and child health clinics constituted 22% and 4.5% respectively. 29% of health facilities in the state provide antenatal services while 26% provide postnatal services. Only 27% provide nutrition counselling while 19% carry out immunisation outreaches.[82]

In terms of equipment, the entire state has a total number of 2,428 maternity beds, 2,089 delivery couches and 268 incubators. 24% of health facilities in Kaduna State are not connected to electricity and more than 60% do not have toilet facilities, while over 15% have no source of water.[83] The state in the last seven years has effected some of the most progressive reforms in governance and in 2019 the state emerged the number one state in the World Bank-Assisted SFTAS Programme-for-Results.[84]

The government is investing in public healthcare infrastructure in the state in partnership with business firms and international development collaborators.

Under a particular agreement with global corporate giant, General Electric, 278 healthcare facilities in the state were equipped and several units of relevant medical technology-including ultrasound, heart monitors, neonatal incubators and anaesthesia machines-were made available to medical professionals.[85]

Kaduna State is operating a contributory health insurance scheme for residents of the state, with significant subsidies for maternal and child health services for pregnant women and children under 5 years. 521,096 people are currently enrolled in the health insurance scheme.[86] The state is also one of the few states that allocates around 15% of its budget for healthcare. Kaduna State had the fourth highest COVID-19 disease burden in Nigeria, recording 11,249 positive cases and 88 fatalities between 2020 till date. The state's comparatively higher COVID-19 survivability reflects its higher level of healthcare.[87]

82 - Kaduna State Health Facility Analytics (HEFA) platform, 2020 (https://hefa.kdbs.ng/analytics)

83 - Bashar Abubakar, Mining HEFA: How Kaduna's facility census data can be used to improve health care delivery, 2020 (https://nigeriahealthwatch.com/mining-hefa-how-kadunas-facility-census-data-can-be-used-to-improve-health-care-delivery/)

84 - Emmanuel Ado, 'Kaduna: The benefits of reforms', The Vanguard Newspaper, July 4, 2020

85 - 'Kaduna: Lessons in healthcare reforms', the Vanguard Newspapers, November 29, 2016

86 - 'Kaduna: 521,096 enrol in health insurance scheme amid cry of inadequate hospital bed space, doctors ', The Vangaurd Newspaper, December 4, 2021

87 - https://covid19.ncdc.gov.ng/

Citizen perception of the state is positive. According to some respondents, "Healthcare is accessible to citizens. There are hospitals, clinics and other health facilities in most of the areas in Kaduna state. Kaduna state has the highest number of doctors in the north. Healthcare services are not entirely free. It depends on the medical centres visited and the type of illness in question. There are free drugs and services in some PHCs and general hospitals especially in rural areas where there is high level of poverty. There are different types of health facilities, from primary to tertiary healthcare centres. but PHCs and secondary healthcare centres have predominance in Kaduna state".[88]

According to another respondent, "Villages need to be taken care of. That is where problem is. We don't have much problem here in the urban area. There are health facilities around. Awareness and enlightenment are high too here. But all those things are lacking in rural areas. Healthcare investment in rural communities is still inadequate".[89]

Also, another respondent stated that, "Majority of citizens living in the state can now access healthcare services provided by the government. But this is not to say that there are no places that still need those facilities. Rural areas lack a lot of those services though things have started to change even there. Healthcare services are not free. It is paid services, but the charges are dependent on the hospital and the nature of the illness".[90]

88 - Key informant interview with a respondent who is a medical practitioner at Kusfa Area Zaria, Kaduna State

89 - Key informant interview with civil society actor in Kabala Area Kaduna, Kaduna

90 - Key informant interview with a community leader in UnguwarMu'azu, Kaduna

Sokoto State

The state has been ranked by the NBS as the poorest state in Nigeria with an 81.2% poverty rate.

Situated in the North-western corner of Nigeria, Sokoto State is the 16th largest state in Nigeria in terms of landmass and occupies 25,973km2 square kilometres. The state has an estimated population of 3,702,676 million persons (2006 Census) and has performed poorly on almost all indexes benchmarking socio-economic development in Nigeria. The state has been ranked by the NBS as the poorest state in Nigeria with an 81.2% poverty rate.[91] Sokoto ranked 34 out of 36 states in adult literacy.[92] And beyond that, the state faces desertification, land degradation and drought among other ecological challenges.

The provision of healthcare in the state is jointly borne by the national and the state government teaching hospital, neuropsychiatry hospital and the state specialist hospital. The state has 20 general hospitals, 45 PHCs and 501 clinics. There are 38 private health facilities in the state.[93] There are around 4972 health workers in the state. Sokoto's State health indices are some of the deprived in Nigeria. The Neonatal mortality rate is 44 per 1000 (the national average is 37 per 1000).[94] Crude Birth Rate is 41.7 per 1000, IMR is 100 per 1,000 live births, U5MR is 166/1000 live births and MMR 850/100,000. On the current use of contraception (i.e., the rate), 'any method' is 2.1%, with 'any modern method' as 1.9%.

91 - The Vanguard Newspaper, August 27, 2016

92 - UNESCO, State of Education in Nigeria (http://www.unesco.org/fileadmin/MULTIMEDIA/HQ/ED/pdf/Nigeria.pdf)

93 - Sokoto State Health Manpower survey, Sokoto State Health Systems Project II, SMOH, 2005

94 - JSI, Advancing Maternal, Newborn, Child Health in Sokoto State: The Progress So Far 2009-2015, Final Dissemination Meeting July 2, 2015 (http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15968&lid=3)

Sokoto's health sector

45 PHCs

20 general hospitals

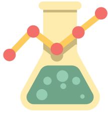
501 clinics

Maternal Mortality Rate of **850** per **100,000** live births

Neonatal Mortality Rate of **44** per **1000**

Infant Mortality Rate of **73** per **1000** live births

Under-5 Child Mortality Rate of **166** per **1000** live births



While the state has made improvement in budgetary allocations to healthcare, allocations are still below the 15% benchmark agreed in the Abuja declaration of 2010.

Other maternal health indicators in the state include 13.8% receiving antenatal care from a health professional; 6.8% of pregnant women whose last live birth was protected against NNT; the percentage of children delivered by a health professional at 5.1%; and the percentage delivered in a health facility is 4.4%.[95]

Childhood immunisation indicators are 4.5% BCG coverage, 2.0% DPT3, 10.9% OPV3, 3.5% Measles with fully immunised children standing at 1.0% and zero dose of 64.7%. Other indications of poor utilisation of health services are illustrated by the fact that only 30.4% of children with fever received treatment from a health facility/provider, 33.8% of children with diarrhoea were treated in a health facility/provider and 12% of children with diarrhoea were given any ORT.[96]

While the state has made improvement in budgetary allocations to healthcare, allocations are still below the 15% benchmark agreed in the Abuja declaration of 2010. In addition, the state operates a health insurance scheme-enrolment figures are unknown. Sokoto is a beneficiary of the World Bank-assisted SFTAs programme which suggests the existence of ongoing reforms on fiscal transparency, accountability and sustainability.

According to multiple respondents engaged across the state, healthcare services are not free. According to a medical doctor in Sokoto, **"Health services are not free. You have to pay for the professional service offered, but at a lower cost compared to private hospitals".**

According to another respondent, **"Government is not serious. Our healthcare is not effective due to inadequate funding and corruption. People are dying because they cannot afford drugs and other medical consumables. Good hospitals are only in the metropolis. An average bill for malaria treatment is N5000. How can a poor widow afford it? Price of our health services is soaring. That is why people don't want to go to hospital".**[97]

95 - Sokoto State Government, Strategic Health Development Plan, 2010

96 - Sokoto State Government, Strategic Health Development Plan, 2010

97 - Chief executive of a community based organisation that promote women health, Gawon Nama Area, Sokoto

Beyond the question of unavoidability of healthcare in a state with an over 80% poverty rate, respondents pointed to the neglect of rural communities in healthcare coverage, while 80% of the state population is rural. According to a respondent, **"Most citizens here live-in rural communities far away from medical centers. They hardly come to hospital unless if there are very serious conditions that defy all home remedies".**

Also, another respondent stated, **"There are many communities that have no single healthcare unit. Even those communities that have clinics, they are mostly in bad conditions".**[98] According to a healthcare worker in the state, **"There are still villages that don't have health centres currently [...] and even when there are such centres, they are mostly dysfunctional. So, access to quality healthcare is still a problem to people in villages and even to people with little income irrespective of where they live".**[99]

98 - Public health educator, Mabera Sokoto North LGA, Sokoto

99 - Healthcare worker in a specialized clinic, Gidadawa Area, Sokoto

Bauchi State

The state has debilitating health outcomes and is one of the states in Nigeria, where health outcomes grew worse over time.

Bauchi State has the fifth of all states in Nigeria with a land area of 49,259 square kilometres and a population of 4.65 million, making it the seventh most populous state in the country. 55.4% of the population of the state is under the age of 19 years and 7% of the population is 65 years and older. 80% of the state's population live in the rural communities, while only 16% reside in urban centres.[100]

The state has some of the poorest socio-economic indicators in Nigeria; over 80% of its population live below the poverty line and 85% of the population are rural with low literacy level.

The state has 1,002 primary health care facilities, has 22 secondary health-care facilities and of recent a tertiary health facility-Abubakar Tafawa Balewa University Teaching Hospital (ATBUTH)-was established in the state. A Federal Medical Centre owned by the Federal Government is also located in the state. In addition to all these, there exist 74 registered private health facilities and several mission hospitals/clinics in the state.[101]

The state has debilitating health outcomes and is one of the states in Nigeria, where health outcomes grew worse over time. IMR increased from 98/1000 live births in 1990 to 132/1000 live births in 2006.

100 - National Demographic & Health Survey, 2008

101 - Bauchi State Primary Health Care Development, Agency Directory of Health facilities in Bauchi State, 2009

Bauchi's health sector

Neonatal Mortality Rate of **41** per **1000**

Infant Mortality Rate of **81** per **1000** live births

Under-5 Child Mortality Rate of **161** per **1000** live births

only **19%** of children were fully immunised

45,000 enrollees in the state's health insurance scheme

Only 20% of women gave birth under the care of a skilled health provider. The state has 41 neonatal deaths per 1,000 live births, 81 infant deaths per 1,000 live births, 161 under 5 deaths per 1,000 live births and only 19% of children were fully immunised.[102] On the matter of health resourcing, the state is one that surpasses the 15% budgetary commitment to healthcare.[103] The state has a health insurance scheme and 45,000 residents are subscribed across 323 wards in the state. Bauchi is a beneficiary[104] of the World Bank-assisted SFTAs programme which suggests the existence of ongoing reforms on fiscal transparency, accountability and sustainability.

Stakeholders' perception about access and quality of healthcare offered in the state varies. According to stakeholders, health care services in urban centres in the state are subsidised but not free; citizens have to pay to access services.

There is a dearth of healthcare facilities in rural areas in the state. According to a stakeholder, **"Here in Bauchi at least 70% of the population live in the rural areas that have no access to healthcare. In the same vein, majority of this population are living below poverty line, incapable of affording good healthcare. As a private practitioner, I know what is happening. Many people cannot even afford to pay based line diagnostic tests needed to identify the real cost of their problems, needless to mention the cost of treatment. More than 90% of healthcare centres in Bauchi state are public healthcare centres built and managed by government; private healthcare centres are very few and are concentrated in the state capital".**[105]

102 - USAID, Bauchi State Health Profile, 2017 (https://www.hfgproject.org/bauchi-state-health-profile/)

103 - https://www.bauchistate.gov.ng/budget-reports/; USAID, Bauchi State Health Profile, 2017 (https://www.hfgproject.org/bauchi-state-health-profile/)

104 - '45,000 People To Benefit From N400m Healthcare Insurance Scheme In Bauchi', Nigerian Tribune, march 11, 2021

105 - Key informant interview with a medical worker in Tafawa Balewa Road, Bauchi

Conclusion and Route to Reforms

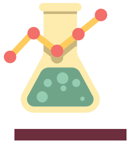
The Nigerian health system requires radical transformation which must be accompanied by strong political will and commitment from policymakers and political actors.

The discussions and findings above showcase how Nigeria has struggled for decades to fix its poor healthcare system, which has had weighty effects on the country's productivity and economic growth. Issues of poor policy implementation, tenth-rate healthcare infrastructures, underinvestment, ineffective decentralisation and fragmentation, poor coordination of donor funds, poor government commitment, corruption (by public officials and health workers) and brain drain in the health sector have held sway. To address this, Nigeria needs to strengthen its health system to effectively respond to emerging and re-emerging public health challenges, including disease outbreaks, antimicrobial resistance, non-communicable diseases, lack of financial protection and humanitarian crisis, amongst many others. The challenges confronting the country's health system over the decades create both the need and opportunity for reforms, regarding the improvement of health outcomes. The Nigerian health system requires radical transformation which must be accompanied by strong political will and commitment from policymakers and political actors. This report hazards the following set of multidimensional recommendations and call-to-action points for the government and civil society from the lenses of health sector public accountability, shoring up health financing and resourcing and speeding up universal health coverage in the country.

Government

Health sector underinvestment and dwindling public finances suggest that compulsory universal health insurance is one of the most effective means to funding the sector. The government both at the national and state levels has a huge task of getting more citizens into the insurance net as this is the surest means of improving access for the millions of citizens who are unable to afford healthcare.

Contributions into the NHIS and CBHI should be on a sliding scale, considering individual earnings, while the poorest and most vulnerable citizens should be entitled to free health insurance. A close compass country for Nigeria in this respect could be Rwanda where universal health insurance has been a great success, with over 90% coverage. Health insurance should be made mandatory for all citizens while implementation of the scheme moving forward should be complemented by revision of benefit packages, strict oversight, and regulation of HMOs.



The government both at the national and state levels has a huge task of getting more citizens into the insurance net as this is the surest means of improving access for the millions of citizens who are unable to afford healthcare.

Furthermore, the NHIS and state health insurance agencies/schemes need to be strengthened to effectively perform its regulatory and quality assurance roles to identify loopholes in the system and institute measures to block them. CSOs should be engaged in sensitising the informal sector through collaborative development of proper advocacy tools to reach the end users. There is currently lack of evidence of impact of NHIS and CBHI at the state level and to address this requires commissioning a study to assess the programmes and produce evidence on impact.

Government

With inflation, a declining revenue base of the government and naira depreciation; the absolute size of the 1% CRF which is allocated to BHCPF has been on the downward trend since 2018, from about N55 billion in that year to N35 billion in 2021.[106] As such, it is highly imperative the statutory allocation to BHCPF is increased to 2% of CRF for effective BMPHS financing and health service inequity reduction. Another option is imposing health taxes on consumption of unhealthy food and items such as alcohol, tobacco, refined sugar-based beverages and channelling the accruing additional resources to the BHCPF. It is also essential to ensure the principle of shared responsibility resonates clearly with sub-national governments if the catalytic potential of the BHCPF will be realised.

In the past 10 years, Nigerians have spent $11 billion dollars on medical services abroad.

It is time for the country's political elite to start building those hospitals in Nigeria, that in Dubai and London they so delight to patronise. Through this, they can spare the country the costs and mortification of depending on other countries for the healthcare services they should be providing Nigerians. COVID-19 travel restrictions that prevented many of them from jetting out of the country for health emergencies-having had to resort to poor healthcare in Nigeria-should have taught them a hard lesson. In the past 10 years, Nigerians have spent $11 billion dollars on medical services abroad – average of $1.1 billion dollars per year, which is half of the country's health sector share of the 2022 national budget.[107] This is a crucial waste of scarce forex for the country. Imagine if this amount is plugged back into the country's health sector annually and the direct and indirect impacts it would have on the economy.

106 - Premium Times, Basic Health Care Provision Fund: A Slow Start to a Long Journey, 2021. (https://www.premiumtimesng.com/health/457060-basic-health-care-provision-fund-a-slow-start-to-a-long-journey.html)

107 - Naira Metrics, Nigerians spend $11 billion on medical services abroad in 10 years, 2021 (https://nairametrics.com/2021/08/31/nigerians-spend-11-billion-on-medical-services-abroad-in-10-years/)

Government

The government must reverse this noisome trend by leveraging domestic and foreign investors for investments in the 4 most sought-after medical services that take Nigerians overseas such as: oncology, orthopaedics, nephrology, and cardiology. Nigeria has a huge medical care market; what is remaining is a conscious government effort to provide an enabling environment for investors to bring in resources. A low hanging fruit is Nigerian health professionals in the diaspora whose expertise could be leveraged in building world-class health facilities in the country.

Nigeria can and should strategically establish itself as a medical tourism destination for the continent through using India as a compass country instead of being a key source of outbound medical tourists. India through conscious efforts has developed a fast-growing medical tourism sector which offers low-cost health services and long-term care. The sector is estimated to worth $7 billion dollars in 2020,[108] while as far back as 2014, the country had 184,298 foreign patients who travelled to India to seek medical treatment.[109] However, Nigeria cannot do this with the brain drain in the health sector. To do this also requires strategic emphasis in producing, training and retaining the best of healthcare professionals, increasing the capacity of health training institutions, reforming the country's health sector human resource management to manage health sector talents.

Nigeria has a huge medical care market; what is remaining is a conscious government effort to provide an enabling environment for investors to bring in resources.

Beyond this, Nigeria must shore up public investments in the health sector, especially in secondary and primary healthcare facilities. PHCs have to be rehabilitated, upgraded and properly equipped to take care of poor Nigerians who cannot afford secondary and tertiary health services. PHCs and other tiers of healthcare facilities have to be manned with an adequate number of healthcare workers. Urgent steps must be taken to address the inadequacy of healthcare workers in the country.

108 - Economic Times, Indian medical tourism industry to touch $8 billion by 2020: Grant Thornton, 2015 (http://economictimes.indiatimes.com/industry/healthcare/bio-tech/healthcare/indian-medical-tourism-industry-to-touch-8-billion-by-2020-grant-thornton/articleshow/49615898.cms)

109 - Ibid

Government

There is a need to address issue of ineffective decentralisation and fragmentation of the Nigerian health system with duplication of responsibilities among the tiers of government, insulate health sector reforms from political power transfers, as well as strengthen better coordination and sustainability of donor funds through counterpart funding.

The government needs to tackle corrupt practices of health workers by ensuring improved working conditions, timely payment of salaries and provide improved remuneration and wages for health workers. Following this, effective sanctions should be instituted on practices like prescription by health workers influenced by pharmaceutical companies, diversion of patients from public hospitals to private hospitals, and informal payments by patients to health workers.[110]

It is also important the government reduces bureaucracy and ensures prompt service delivery through the provision of mechanisms that captures details of time when patient got to the hospital to time when patient was attended.

Health workers involved in theft and diversion of drugs should be prosecuted and jailed. Health workers should also be made to clock in and out to address the issue of absenteeism. Cash payment for health services should be replaced with bank payments/online transactions. The government should also establish automated auditing processes and institute surveillance system using closed-circuit television (CCTV).[111]

It is also important the government reduces bureaucracy and ensures prompt service delivery through the provision of mechanisms that captures details of time when patient got to the hospital to time when patient was attended. SERVICOM should be leveraged for bridging the gap between health care performance and expectations of patients in health facilities. Setting up of a fraud unit and advertising the consequences of giving bribe by patients to health workers is equally essential. These reforms could be initiated first at the tertiary and secondary healthcare levels, and cascaded to primary level through collaborations with state and local governments.

110- Onwujekwe O, Agwu P, Orjiakor T, Mbachu C, Hutchinson E Odii A et al. 'Corruption in the health sector in Anglophones West Africa: Common forms of corruption and mitigation strategies,' Anti-Corruption Evidence (ACE) Research Consortium; 2018.

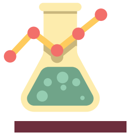
111 - Ibid

Government

There is urgent need to address public health sector corruption by making sure that political appointees and top medical personnel that are found wanting are severely dealt with by the law. Prosecute and jail contractors who fail to deliver on construction and rehabilitation of health facilities. Institute mechanisms that ensure adequate financial management, effective store management procedures and proper documentation.

91

There is a need for continuous institution of mechanisms for transparency, accountability and participation in health spending is paramount as well as continuous adoption of best procurement practices in the health sector. Efficiency in health spending needs to be enhanced while wastages must be reduced to ensure health spending is results-driven and performance-based. In this light, there is a need for the government to democratise spaces for fiscal discussions through budget public presentations, budget public hearings, having citizens making inputs to health projects sited in their communities etc. The government should also consider the establishment of toll-free lines with which citizens could reach out to and report any corruption cases regarding public projects implementation.



Efficiency in health spending needs to be enhanced while wastages must be reduced to ensure health spending is results-driven and performance-based.

Civil society

The most important ingredient for expeditious reforms in the health sector is political will. However, it will remain in short supply unless the Nigerian public officials are banned by law from accessing medical care abroad. To realise this is a tall order, however, the civil society should kickstart rigorous advocacy on this.

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While national and most subnational health sector budgets are in public domain, there are still many transparency and accountability gaps where continuous advocacy is required for further desirable social accountability outcomes. First, post bids evaluation data are mostly not available in the public domain. Health sector budget making processes are still not participatory in most states, and even at the federal level - NPHCDA budget. Third, its often difficult for citizens and civil society groups to link a health project from the budget to procurement and then audit. There is a need for a system that can harmonise such across the states. The civil society has to continue engaging and capacitating communities for collective advocacies and engagements with the government for transparency, accountability and participation improvements in these aforementioned gaps.

The civil society has to continue engaging and capacitating communities for collective advocacies and engagements with the government for transparency, accountability and participation improvements in these aforementioned gaps.

The civil society should also continue to leverage the Freedom of Information (FOI) Act to access public information and continue mounting pressure on government institutions to open official data locked away from citizens' scrutiny and utilisation for engagement. The sector should continue simplifying budget and fiscal data for citizens to easily understand. Such simplified information should be disseminated using electronic media such as Facebook, Twitter, Instagram, WhatsApp platforms; as well as through the radio to elicit effective public oversight.

Civil society

There is also the need for advocacy as regards the institution and effective implementation of M&E frameworks for effective oversight purposes on government health projects and budgets implementation across all the tiers of government. Such M&E systems within health facilities are also required in the procurement of drugs, supplies and medical equipment.

In addition, civil society needs to mount pressure on the government to increase BHCPF to 2% of CRF leveraging the current National Health Act (NHA) amendment. Beyond this, advocacies are required for more public investments in the health sector as part of which it is utmost important the health sector share of the total annual budget is increased, while continuous budget tracking is key to ensure effective service delivery.

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There is a need for collaboration with the government in sensitising communities and citizens in a bid to shore up the number of enrolees in the NHIS and CBHI. UHC will not be possible in the country unless the percentage of health insurance coverage shifts significantly upwards. Citizens following years of disappointments and lack of trust in government are showing apathy in taking up health insurance. The civil society therefore must leverage the trust they have built with communities and the informal sector and encourage them to significantly enrol. CSOs should also provide oversight in the administration of the NHIS and CBHI across states including assessing quality of care so that issues with implementation and enrolees' concerns are documented, forwarded to the government and swiftly addressed. This is one of the principal ways to build confidence in the insurance scheme and have more citizens enrol.

The civil society therefore must leverage the trust they have built with communities and the informal sector and encourage them to significantly enrol.

Appendix

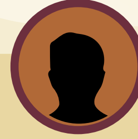
Citizen's Voices

Sokoto State

Q. From your experience, do you think healthcare is a public good that citizens in your community/state have access to? Is healthcare free? If not free, can most citizens afford it? What type of health care facilities are available in the state/communities?

All hospitals across the state are open to the general public, without restriction or discrimination. Everybody can go there if they wish to go and if they have the means to do so. The services are not free. You have to pay for the professional service offered, but at a lower cost compared to private hospitals. We have general hospitals at LGAs and PHCs in villages.

Dr. Kabiru U.



Yes, it is good. We attend to all types of patients without discrimination and prejudice. But patient have to pay for lab test, drugs and other services. We are not offering charity. Government is generating income from our health centers.

Mr. Aliyu L.

It is not. Government is not serious. Our healthcare is not effective due to inadequate funding and corruption. People are dying because they cannot afford drugs and other medical consumables. Good hospitals are only in the metropolis. An average bill for malaria treatment is N5000. How can a poor widow afford it? Price of our health services is soaring. That is why people don't want to go to hospital.

Mrs. Aishatu Y.

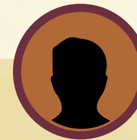
Healthcare facilities in our community are readily accessible. They are our collective belongings that we all have access to. They are not free in the strict sense of the world, but services are heavily subsidized. Who ever tried private hospital knows that our health centers are subsidized. Most of our facilities are PHCs, maternity clinics and general hospitals.

Alh. Shehu B.

Q. Are there health challenges and concern peculiar to the community/state?

There is need for emergency preparedness on the part of the government. We had cases of gastroenteritis (GE) last year. It was so bad, it killed many people especially in villages due to slow response on the part of the government.

Dr. Kabiru U.



Malaria is the most stubborn among our health challenges. It is the most prevalent illness in this community. More than half of patients we treat daily are malaria patients. It is the no.1 killer of pregnant women and children in this community.

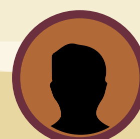
Mr. Aliyu L.

Citizen's Voices

Q. How would you rate healthcare facility, services and coverage in your community?

So far so good but there is need for improvement especially on equipment and personnel training.

Dr. Kabiru U.



It is good. Our facility is the best among its peers though WCWC are not many in the state. WCWCs are women and children friendly unlike other health centers.

Mr. Aliyu L.

It is not effective. There are no enough health centers in remote areas, even those in our towns are not functioning optimally. Lack of skilled personnel, inadequate equipment and gadgets characterized most of our hospitals even those in urban areas.

Mrs. Aishatu Y.

They are fair. But government needs to focus on quality and standard. Building new hospitals are not enough. Standardization and quality assurance is what is needed now.

Alh. Shehu B.

Q. From your experience, what was the health and socioeconomic impact of COVID-19 pandemic on your community?

There was not much health challenge. We had very few recorded cases in the state.

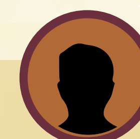
Dr. Kabiru U.

The curfew was so bad that many families could not even feed themselves three times a day since people are confined to their homes.

Mr. Aliyu L.

What concerns us here is not COVID. We have greater public health challenges such as malnutrition in children and pregnancy related sicknesses.

Mrs. Aishatu Y.



There was a lockdown. All businesses and other social engagement were suspended throughout the period. People suffered. It was devastating in terms of economic wellbeing of our people.

Alh. Shehu B.

Citizen's Voices

From your experience, do you think healthcare is a public good that citizens in your community/state have access to? Is healthcare free? If not free, can most citizens afford it? What type of health care facilities are available in the state/communities?

Healthcare is accessible to citizens. There are hospitals, clinics and other health facilities in most of the areas in Kaduna state. Kaduna state has the highest number of doctors in the north. Healthcare services are not entirely free. It depends on the medical centers visited and the type of illness in question. There are free drugs and services in some PHCs and general hospitals especially at rural areas where there is high level of poverty. There are different type of health facilities, from primary to tertiary healthcare centers. But PHCs and secondary healthcare centers have predominance in Kaduna state.

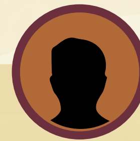
Dr. Alkaseem L

Samaru community is one of the communities in Zaria that have high level of literacy and education. People around this area come to hospital even for minor diseases. Our facility here is always full with various classes of patients. But I don't know of other places.

Mrs. Sadiya H

Absolutely our healthcare is open. We don't discriminate. There is no state in Nigeria that offers free healthcare to all citizens. But Kaduna state stands out in terms of healthcare subsidy for all and free medical services to certain vulnerable group of people such as neonatal, infants and pregnant woman. It is mostly general hospital like this one. But in rural communities it is either PHCs or dispensaries.

Dr. Sani A.



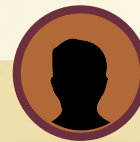
I have a mixed feeling. Healthcare is a public good but not in absolute terms. People in villages are not even aware of healthcare centers. there are many communities that have no single clinics or even a dispensary. All those villagers rely on herbalists for their medical treatment. While we in the city can access all the available services provided we have the means. Forget about the word free. It is not free. The first thing you do if you go to hospital is to pay for patient's registration card, then see a doctor, go to lab for test that you have to pay and drug that you must buy and things like that.

Mrs. Debora B.

Are there health challenges and concern peculiar to the community/state?

It was mostly malaria, typhoid, cardiovascular diseases especially hypertension.

Dr. Alkaseem L



Maternity problems; pregnant women are often attacked by malaria, anemia and other problems because of their week immunity during pregnancy. There is alarming rate of maternal mortality in the state.

Mrs. Sadiya H

Meningitis is common and peculiar. Every year in hot season we get cases on meningitis.

Dr. Sani A.

You should ask doctors. They are the right people to answer this question.

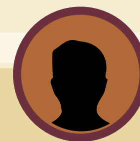
Alh. Mustapha D.

Citizen's Voices

How would you rate healthcare facility, services and coverage in your community?

It is good. The government has invested heavily in healthcare and education in recent times.

Dr. Alkaseem L

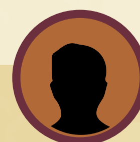


It is fine though there is still need for improvement especially in terms of personnel matters: professionalism, salary packages and other benefits for health workers.

Mrs. Sadiya H

All is fine. There is progress. Things have changed since the coming of this administration.

Dr. Sani A.



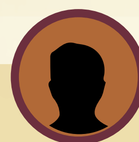
There are hospitals and clinics all around here. You can see a doctor anytime you wish, and the services are ok.

Mrs. Debora B

From your experience, what was the health and socioeconomic impact of COVID-19 pandemic on your community?

There were many recorded cases of COVID-19 here especially among elderly people there was mild fertility but the suffering due to complication was severe. The lockdown was the strictest in Kaduna state. Everything came to a standstill including religious activities in churches and mosque.

Dr. Alkaseem L

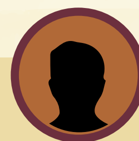


I have not met a single person who contracted the virus in the cause of my work. I heard it in the media like everyone else.

Mrs. Sadiya H

The health impact of COVID-19 was not as devastating as socioeconomic impact in Kaduna state. The health impact is not up to 1% of the population but, the socioeconomic impact has affected more than 95% of the population.

Dr. Sani A.



Is COVID-19 a reality (Laugh)? Honestly the lockdown and its accompanied hardship were so bad on us. There were health effects also. COVID-19 is real and dangerous.

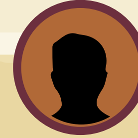
Mrs. Debora B

Citizen's Voices

Q. From your experience, do you think healthcare is a public good that citizens in your community/state have access to? Is healthcare free? If not free, can most citizens afford it? What type of health care facilities are available in the state/communities?

There are healthcare facilities across the state. There are PHCs, maternity clinics, dispensaries and general hospitals throughout the state. The one we have at Sabon Gari Area is mostly serving the people that are living around this area. It is accessible to our people. it is not entirely free but we charge a very small amount of money for some services we are rendering here. I don't know of other PHCs but here it is cheap, affordable and accessible.

Junaidu Gwani

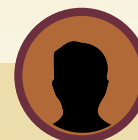


We are always encouraging our people to go to hospital, to see professionals whenever something is wrong with their health. Those facilities are for the people. They are built by the government with their own money and I can tell you people have now accepted our appeal. They are now bringing their families and themselves to hospitals for treatment. It is almost free considering what you pay. It is not the same as private hospitals where you have to pay for everything at prevailing market prices.

Alhaji Umaru T.

Yes that is what I believe. It is public service that we are benefiting from irrespective of our religion or ethnic group. It is not free. Even Universal Basic Education is not free. But we hope that it will be free of charge in the nearest future. It is dependent on your income; and income of most citizens in the country is one of the lowest in the world. The per capita income is very low, not enough for citizens to afford basic health need.

Pastor Peter L.



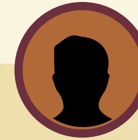
That is what the government is saying. It is a deception. Hospitals are not sending people away by force, but by means of exhortation that is too rude. Healthcare services are not accessible since many of us cannot afford it considering the meager income most of us are having.

Sheikh Ahmad I.

Q. How would you rate healthcare facility, services and coverage in your community?

The Sabon Gari facility needs to be expanded. It is too small for Sabon Gari population. It should be upgraded to general hospital at least.

Junaidu Gwani

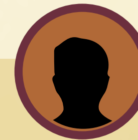


It is fine. But we need more. They are building schools now. So we want them to build more hospitals also. And I believe this government would do that in the nearest future.

Alhaji Umaru T.

In urban areas like this it is ok. There are combination of different types of hospitals: tertiary, secondary and primary healthcare centers.

Dr. Lawal A.



It should be improved. It should be free at least for the children, women and the elderly who are the most vulnerable categories among the people.

Pastor Peter L.

Citizen's Voices

Q. Are there health challenges and concern peculiar to the community/state?

As I have said, the Sabon Gari PHC should be upgraded. Many of the existing PHCs commensurate with the growing population of such communities.

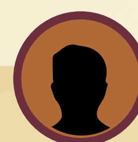
Junaidu Gwani

I just gave you examples. Malaria has killed a lot of people, and it will continue to kill people if government and other development partners have not done something truthfully ad diligently.

Sheikh Ahmad I.

The health challenges are many. Challenges of community health are huge and varied in the state. If you look at the available statistics, mortality rate during outbreak is high, maternal and child mortality is also high. Bauchi, Jigawa, Zamfara, Sokoto and Yobe states have the greatest public health challenges in the country.

Dr. Lawal A.



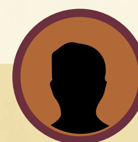
Health of an individual person is closely linked to his economic ability. There is high level of poverty in Bauchi state. Most citizens cannot afford good healthcare services. The healthcare services need to be free; or people should be economically empowered.

Pastor Peter L.

Q. From your experience, what was the health and socioeconomic impact of COVID-19 pandemic on your community?

The health and socioeconomic impacts were not very severe. Even during the lockdown, we used to go about some of our activities including business. The lockdown was more enforced in the state capital.

Junaidu Gwani



The hardship was greatly alleviated during the lockdown through private charity by the well to do people in the community. The impact of COVID-19 was minimized by the kind gestures of philanthropists. Even though that could not put flesh and bone together were then able to feed their family from palliative packages they collected. I personally supervised the exercise, and it was fine and good though critics are still condemning the exercise.

Alhaji Umaru T.

Citizen's Voices

Lagos State

Q. What type of healthcare facilities are available in your state/community – public, private and traditional?

We have a public and several private hospitals

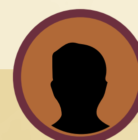
Bankole S.

We have a healthcare centre in owode here, some private hospitals as well, although they are not well equipped. We also have people who treat people with herbs

Bolanle A.

Government hospital and private as well as traditional herbs doctors

Samson O.



Well I will stick with what i know here, we have a standard primary healthcare centre that comprises of 6 doctors 15 nurses, 2 dental and optical physicians and 1 surgeons

Rufiat A.

Q. For most citizens/community members with health challenges, how do they go about it: What is their preferred healthcare choices (traditional medical practitioners, PHCs, private providers etc.)

Well, once anyone has any health issues they are taken to the hospital that either closest to them or affordable. Mostly traditional, but many others still prefer health centres

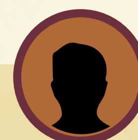
Bankole S.

Most citizens do so by calling on private nurses, some by going to the hospitals around them either private, public or even to traditional treatment centres.

Linda U.

They go by most times taking herbs first, its when it is probably serious that they visit the health centre here. Alot of people rely on traditional treatment i must confess. But some others go to hopsital mostly when it has to do with child birth

Bolanle A.



I know very well they come here for most of their ailments and their preferred choice is medical care

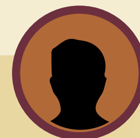
Rufiat A.

Citizen's Voices

Q. What is your opinion as regards healthcare facilities, services, and coverage in your community? How equipped are they?

We dont have enough centres to take care of our people.

Bolanle A.



As for facilities, we still have a long way to go no doubt, It can only get better. There is a deliberate attempt to improve service delivery but we are still lagging behind in terms of coverage.

Rufiat A.

As for coverage, its still a far fetched reality. Alot has to be done to bring the more health care centres to our community. They are not well equipped as far as am concerned

Samson O.

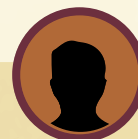
I think alot has to be done in terms of building more centres so that our people can easily go to the ones that are close to them especially during emergencies. What we have are not equipped. Most times simple surgeries are taken to bigger general hospitals far away from us.

Bankole S.

Q. Are the facilities enough for all the community members?

No they are not.. we need much more

Bankole S.

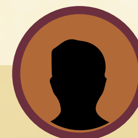


No at all. We need more

Bolanle A.

Facilities are not enough

Samson O.



No. Population is increasing astronomically, there is high stretch of the current facilities

Elizabeth B.

Citizen's Voices

Rivers State

Q. What type of healthcare facilities are available in your state/community – public, private and traditional?

We go to Chemist shop or patent medicine dealers.

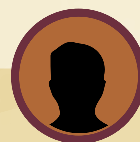
Dorathy G.

We don't have any health care centre around us here. The only available health care facility here is Chemist shop or patent medicine dealers.

Tambari

We don't have any health care centre here in Gbaken. The only available health care facility here is Chemist shop or patent medicine dealers.

Don B.



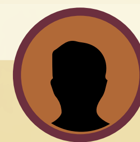
We don't have any health care centre here in Duburo though we have a dilapidated building for that.

James D.

Q. For most citizens/community members with health challenges, how do they go about it: What is their preferred healthcare choices (traditional medical practitioners, PHCs, private providers etc.)

We go to Chemist shop or patent medicine dealers.

Dorathy G.

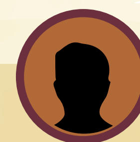


They go to Chemist shop or patent medicine dealers. There is no other health care alternative here.Though we have some traditional medicine men

Tambari

We go to Chemist shop or patent medicine dealers. There is no other health care alternative here.

Esther F.



They go to Chemist shop or patent medicine dealers.There is no other health care alternative here.

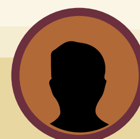
Don B.

Citizen's Voices

Q. What is your opinion as regards healthcare facilities, services, and coverage in your community? How equipped are they?

We don't have any health care facility here

Dorathy G.



We don't have any health care facility at all.

Tambari

The ones in the city here are somehow equipped

Veronica

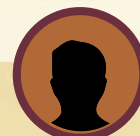
We don't have any health care facility at all.

James D.

Q. Are the facilities enough for all the community members?

We don't have any health care facility here in duburo

Dorathy G.

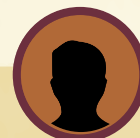


We don't have any health care facility here in Gbaken

Tambari

The government has been trying in the area of provision of medical facilities.

Veronica



We don't have any health care facility here in Duburo

James D.

Citizen's Voices

Q. What type of healthcare facilities are available in your state/community – public, private and traditional?

There are no private healthcare institutions here, but you often find retired nurses who come home to set up a sort of clinic, sometimes you may have someone who just had some years of experience as nurse and then they operate as birth attendants and as patent Medicine vendors. Luckily for our community we have 2 public health care facilities, that is the PHC and general hospital. And like I said there a number of traditional medicine practitioners, many of whom are prepare herbal drugs.

Chukwudifu M.

All types of health care facilities are available here. Like I said, there are two public health facilities here but the majority of the health care provider in our community comprises of patent medicine vendors (chemist). I know there are traditional and even religious healers, but I don't know how those ones operate because I don't go to them.

Greg O.

Here we have a primary healthcare centre and a general hospital both of which are public facilities, traditional birth attendants and patents medicine vendors (chemists) also operates here

Chinyere B.

The traditional health institutions have been with us for a long time and there a number of practitioners who claim expertise in treating people of all manner of ailments. We still have them today. There is also the Umunankwo PHC. Others include private patent medicine vendors and birth attendants some of whom are experienced as nurses while other are native/traditional birth attendants.

Christopher U.

Q. Are the facilities enough for all the community members?

I will say because we also have a general hospital, I think the health care facilities is enough for our people.

Chukwudifu M.

Except for those living across the river Niger, the facilities are adequate on this side of the river. There is no public health care centre on the other side. Some of them go through a lot of stress to come over to this side for medical services.

Greg O.

No. Osamalla is quite big and the people living on the other side of the River Niger seems to be cut-off from the available health care facilities on this side. It will be good if another PHC or a health post is sited on that other side

Chinyere B.

No. while we our population may not be that much, the only available PHC incidentally is located far from the from the people living across the road. So, I don't think the facility is enough for the community.

Christopher U.

Q. For most citizens/community members with health challenges, how do they go about it: What is their preferred healthcare choices (traditional medical practitioners, PHCs, private providers etc.)

Our prople hardly go to the hospital, as such I think the patent medicine vendors attracts the most number people in this community.

Chukwudifu M.

To my knowledge our people mostly visits the public health facilities

Greg O.

To my knowledge, many of them come her to the Primary Health Centre. There are others who also visit tradition health care providers such as herbalists

Chinyere B.

A lot of people are beginning to embrace modern medical solution so they prefer going to the PHC

Christopher U.

Q. What is your opinion as regards healthcare facilities, services, and coverage in your community? How equipped are they?

I can't say, the resident nurse will be in a better position to answer

Greg O.

Yes, they have adequate equipment

Susu N.

Not well equipped. In fact, it is of recent that Senator Stella Oduah began renovating the place otherwise the facility used to be in shambles and in disrepair.

Azuak O.

For now, I don't think there is anything we lack in our PHC. As a member of the world bank project committee, I know we installed there a solar powered freezer for the purpose of storing vaccines. If there are other things that are lacking there, I wouldn't know.

Chukwudifu M.

Annexes

KII Tool: https://forms.gle/N8zZKVGUWkWYq7bv5

COVID-19 TRANSPARENCY &
ACCOUNTABILITY IN AFRICA