



## INNOVATIONS FOR SUCCESSFUL SOCIETIES

### MAKING GOOD ON A PROMISE: BOOSTING PRIMARY HEALTH CARE FUNDING IN NIGERIA, 2015 – 2019

#### SYNOPSIS

During the first decade and a half after Nigeria returned to democracy in 1999, the country struggled to adequately fund its primary health care system. Despite a nearly 10-fold increase in the size of the economy, Nigeria in 2014 was still spending only US\$11 per capita on health care—equal to only 6% of total government expenditure and far below regional norms and the nation’s own stated aspiration. As a result, Nigerian citizens were paying 69% of their medical expenses out of pocket, and the cost discouraged many from seeking treatment. A new National Health Act, adopted in 2014 after a decade of delay, raised hopes for a solution by stipulating that at least 1% of the government budget go into a new fund to improve basic services provided at the thousands of primary health care clinics located throughout the country. However, owing to Nigeria’s longstanding neglect of primary health care, there was a real risk that the fund might never become reality. To demonstrate the viability of the program and press for its implementation, the federal health ministry, led by Minister Isaac Adewole, developed operational procedures that spelled out crucial steps to ensure financial accountability and transparency, won international backing for a pilot project that would validate the system, and built a support coalition that spanned the government and civil society. The effort took three years, but in 2018 the Nigerian legislature passed an appropriations bill that for the first time included the 1% allocation for the fund—significantly boosting the resources available to improve the quality and accessibility of primary health care services across Nigeria. Even more significantly, in September 2019, the government declared the fund a statutory allocation that it would automatically renew every year, and clinics in three states began receiving the new resources in November 2019.

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#### INTRODUCTION

When President Muhammadu Buhari appointed him as Nigeria’s federal minister of health in November 2015, Isaac Adewole inherited a health system that faced an acute funding crisis. Adewole, a medical doctor and former university provost, was determined to improve Nigeria’s basic health care indicators,

which were among the worst in the developing world.

Adewole knew that money was his greatest challenge. Since returning to democracy in 1999 and despite hosting the African Union’s 2001 Abuja Declaration, in which Nigeria pledged to allocate at least 15% of its annual budget to the overall health sector, the country still was among

the world's weakest in public spending on health care.

In 2014, the Nigerian government spent just US\$11 per capita on health care—well below the benchmark of US\$86 per capita that the World Bank said was necessary to deliver key health services in low- and middle-income countries.<sup>1</sup> Health spending accounted for only 6% of the total government budget—far below the 10% average for sub-Saharan Africa and nowhere near the 15% target that Nigeria had itself set more than a decade earlier.

In the absence of adequate public funding, Nigerian citizens had to foot most of the country's health care bill out of their own pockets. Private out-of-pocket payments at the point of care accounted for 69% of all health spending in Nigeria, and the burden fell disproportionately on the poor. Although Nigeria had enjoyed a 10-fold increase in the size of its economy since 1999, citizens had not shared equally in the gains, and the country had one of the highest rates of poverty in the world. An estimated 87 million people lived on less than US \$1.90 per day,<sup>2</sup> and for many, illness could be a financial death sentence. In 2014, a World Bank paper reported that more than 24% of Nigerian households were subjected to catastrophic health care expenditures, which meant that they spent more than 10% of their total incomes on health care.<sup>3</sup>

The need to increase public spending on health care gained urgency as a result of Nigeria's impending graduation from low-income status to the ranks of middle-income countries. Gross national income per capita had increased to the point that the country no longer qualified as low-income by the standards of international financial institutions. Along with countries like Ghana and Angola, which also graduated to middle-income status around that time, Nigeria had to cope with the impending loss of external assistance for many of its important health care programs that focused only on low-income countries.

Financial support from the World Bank, as well as the Global Fund to Fight AIDS,

Tuberculosis and Malaria, was at risk. In addition, financing from the Global Polio Eradication Initiative was set to drop by 40% in 2019, and Gavi, the Vaccine Alliance—a public-private partnership that had spent hundreds of millions of dollars to expand vaccination coverage in Nigeria—planned to discontinue its funding in 2021.<sup>4</sup> The government had to fill the gap.

A solution was already on the table. A new National Health Act, adopted in 2014 after a decade of drafting and delays, included a provision that required the government to allocate at least 1% of its annual budget to improving primary health care, the basic services provided for people seeking initial medical help. The law provided for the allocation to flow into a Basic Health Care Provision Fund along with donor contributions. However, in a country that faced multiple competing priorities and had limited resources, there was a real risk that the fund would never become anything more than words on paper.

Adewole and his team at the federal ministry, which included his close adviser and fellow medical doctor Oyebanji Filani, were determined to implement the basic health care fund and thereby significantly boost the amount of government money available to improve health services and outcomes across the country.

## THE CHALLENGE

Even though Nigeria had signed the 2001 Abuja Declaration pledge to commit 15% of total government expenditure to health care, the country's average annual government spending on health care fluctuated from 4% to 6% of the national budget during the ensuing decade and a half. A World Bank discussion paper bluntly observed that “the [government of Nigeria] spends less on health than nearly every country in the world—a reflection of its under-prioritization of the sector.”<sup>5</sup>

Persistent underfunding meant that in 2015, Nigeria still had some of the world's poorest health indicators—even among countries with lower gross national income per capita. The

mortality rate for children under five years of age was 100.2 out of every 1,000 live births; the maternal mortality rate was 814 per 100,000 live births; and life expectancy was only 55 years.<sup>6</sup> By comparison, in Ghana, the rate was 48 per 1,000 live births, and in Ethiopia, 55 per 1,000 live births. Outside Africa, rates had fallen lower still.<sup>7</sup> Only a small cluster of Sahelian and central African countries had comparably high under-five mortality rates. Health system capacity was also precarious in Nigeria. According to the World Health Organization, only 43% of births were attended by skilled personnel, and the country had about three nurses and midwives for every 2,000 people and only one doctor for every 3,700 people.<sup>8</sup>

Adewole and his team were determined to use the basic health care fund to mobilize financing in order to improve both access to primary care facilities and the quality of services offered there. But the system they designed would have to deal with four major challenges that had impeded past initiatives. Long-standing lack of political will on the part of his own government was an overarching barrier to Adewole's quest to significantly boost spending on health. The government's consistent failure to prioritize health care spending manifested itself not only in the level of expenditure but also in the failure to implement programs that were meant to help.

Even the much-publicized 2005 launch of a contributory national health insurance program—heralded as a potential solution to the funding crisis—was never seriously put into operation, and it covered only about 3% of the population anyway, with most of the beneficiaries being federal government employees. In a 2018 interview, Eytayo Lambo, a respected former health minister who launched the health insurance program in 2005, blamed a lack of political commitment for such a poor track record and said slow progress jeopardized the country's efforts to achieve United Nations Sustainable Development Goals.<sup>9</sup>

To make the basic health care fund a reality, Adewole first had to build political support among senior government leaders and raise awareness among the Nigerian public. But doing that would require hard work and innovative thinking to change entrenched attitudes. Ifeanyi Nsofor, a public health physician and director of the advocacy group Nigeria Health Watch, said that lack of political commitment partly reflected a deeper challenge. “As a people, we don't prioritize health,” he explained. “Many Nigerians simply don't believe that they will fall sick.”

Second, Adewole's team had to navigate the complexities of Nigerian federalism. The key problem was that, in the context of Nigeria's complex institutional politics, fiscal federalism meant that the federal government had no say in revenue allocations made at the state and local levels. Under the country's revenue-sharing model, 24% of the federal government's annual funding went directly to state governments and 20% to local governments.<sup>10</sup> “The federal government could increase the budget for health, but only at the federal level,” Filani said. “It has no authority on how states and local governments choose to spend their funds.” (See Exhibit 1)

The problem was complicated by differentiations in health care responsibilities. The federal government took the lead in managing tertiary care facilities (which provided the most advanced consultative care for patients) and also played an important role at secondary care facilities (which provided specialist care for patients referred from primary facilities) in cooperation with state governments. However, local governments managed primary health care facilities, with support from state authorities and very little input from the federal government.

Because of that arrangement, any effort to boost funding for primary care required active support by politicians at the state and local levels. But politics at the subnational level often focused on immediate needs such as building roads rather than long-term projects such as improving health care.

Effective implementation of the basic health care fund could provide a solution. By creating a channel through which it could directly fund primary care managed by state and local governments, the fund could increase cross-tier accountability, thus circumventing the limitations associated with federalism. However, as Filani said, doing so would entail an “expansion of the federal government’s mandate to assume greater responsibility for primary care.” Moving in that direction would require careful negotiation with state and local governments. And it would require Adewole’s team to convince the federal government to actually deposit its commitment—1% of the budget—into the fund’s account. (Figure 1)

Devising an incentive system that would result in lower-cost primary care at the local level was the third challenge. Past approaches had failed for three main reasons. First, centralized planning did not account for local context. Filani noted, “In retrospect, it’s hard to sit down in Abuja and know the local issues that affect a particular community.” Local facilities had to be allowed to make some of their own decisions about services. Second, costs mattered. “A lot of

the things we did in the past focused largely on supply,” Filani said. “It assumed that if the supply [of better services] was there, the people would come. But such thinking overlooked the demand-side problem caused by high out-of-pocket costs.” Third, because previous efforts to boost funding for primary care had been made in a top-down manner, “there was also a lack of proper accountability and coordination,” he added.

The accountability problem was especially thorny. In 2015, Nigeria ranked 136th out of 175 countries in Transparency International’s Corruption Perceptions Index.<sup>11</sup> The year before, 72% of Nigerians had said corruption had “increased significantly.”<sup>12</sup> In order to build the kind of credibility required to persuade the finance ministry and the rest of the federal government to implement the fund, the health ministry had to ensure that its proposals included accountable and transparent financial controls.

If the health ministry failed to do so, it ran the risk that the government—specifically, the ministries of finance and of budget and national planning—would refuse to provide funding on the grounds that the money might not go to the purposes for which it was allocated. (Under the

**Figure 1. Division of responsibilities in Nigeria’s federal health system**

Responsibility	Tier of government		
	Federal	State	Local
Health policy making	***	**	—
Price regulation	***	**	—
Quality of care	***	*	—
Quantity of care	**	*	—
Resource generation	***	**	*
Planning, budgeting, and resource allocation	***	**	*
Primary care	*	**	***
Secondary care	**	***	—
Tertiary care	***	**	—
Monitoring and evaluation	***	**	**

\* indicates “minimally responsible.”

\*\* indicates “partly responsible.”

\*\*\* indicates “mostly responsible.”

Source: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4698843/>

Nigerian system at the time, the ministry of budget and national planning drew up the budget, and the finance ministry released the appropriation subject to the availability of funds.)

Filani added that because previous donor-funded programs had experienced “significant procurement issues” that sometimes involved corruption and in many cases led to supply shortages, there was also a risk that donors would similarly refuse to contribute to the fund if it did not feature robust governance structures.

Shortly after Adewole assumed office in late 2015, a fourth challenge emerged that made his task even more difficult. Following a 70% decline in global oil prices, Nigeria entered its first recession in nearly two decades. Government revenues declined as oil income plummeted, and the country entered a recession, with GDP declining by 1.6% in 2016.<sup>13</sup> The need for government spending on education, agriculture, and security (Nigeria faced an ongoing insurgency by terrorist group Boko Haram) meant that Adewole’s team would face stiff competition for scarcer resources.

## FRAMING A RESPONSE

Adewole’s first task upon assuming office was to broaden and deepen his understanding of the health care situation. Working with Filani and other officials, he wanted to make sure his team had a solid grasp of the problems facing Nigeria’s patchwork system. “We were really concerned about basic health indicators in the country, and we decided to look at the health system holistically and in totality, including funding challenges and service delivery,” he said.

The review identified four core areas that accounted for a significant part of Nigeria’s health crisis and that were suffering from lack of funding: reproductive, maternal, neonatal, child, and adolescent health; prevention and control of communicable diseases (including HIV and malaria); prevention and control of noncommunicable diseases (with specific focus on reducing rising cancer rates); and public health emergency preparedness and response.<sup>14</sup> The

team codified those four central needs in two new health ministry documents: the National Health Policy and National Strategic Health Development Plan.

Adewole’s team estimated that Nigeria could make significant gains in all four areas with the roughly US\$180 million that would become available if the government allocated 1% of its annual budget to the basic health care fund, as required by the 2014 National Health Act. The amount did not seem like much for a country with a population of more than 175 million, but it was equivalent to about 17% of the federal government’s health spending at the time.<sup>15</sup>

After nailing down the facts and sharpening its focus, Adewole’s team turned to its toughest task: figuring out how to implement the basic health care fund in a way that would satisfy the disparate needs and diverse desires of power centers at all levels of government. Without a detailed plan covering processes and procedures, the federal government was likely to continue to omit the fund from the national budget.

Adewole’s team had little guidance, because the National Health Act<sup>16</sup> included only a rough outline of how the fund would operate. For instance, section 11 stipulated that half of the money would be used to provide an unspecified “basic minimum package of health services for citizens” at eligible primary or secondary care facilities, and the ministry had to define what would be included in the package. That basic support would flow through the health insurance program in the form of a reimbursement to facilities that provided the services free at the point of care.

The health act specified that nearly all of the remainder of the fund would be used to improve the quality of care at facilities; to buy essential drugs, vaccines, and consumables; and to pay the costs of facility maintenance, equipment, transportation, and staff training. The money would be channeled through the National Primary Health Care Development Agency, a federal organization established in 1992 to provide technical support and to supervise and

monitor primary health care provision by state and local governments. The remaining small portion of the fund would go toward improving emergency medical services through the Nigeria Centre for Disease Control and the National Council on Health.

Adewole's team had to devise a system or process that would ensure that those resources translated into better service provision at lower cost—and that the money did not disappear en route. Nneka Orji, a public health physician and economist in the federal health ministry's department of planning, research, and statistics, defined the challenge: "Just having the paper was not enough. Now that we have this legal framework [created by the new National Health Act], what next?" Orji, who returned to Nigeria in 2015 after completing academic studies in Australia, recalled that Adewole assigned her the job of "understanding the tenets of the law, interpreting the law, and designing an implementation strategy."

The ministry team recognized that (1) creation of the implementation system should involve input from diverse participants and (2) the system's processes and procedures should be spelled out clearly for all concerned. Filani said the health ministry wanted as many people as possible to participate in developing an operations manual that would set forth a plan the budget minister and the president could embrace. "We had to have an operations manual to help everyone understand how the fund would be used," he said.

The ministry set up a subcommittee and assigned the group the task of creating the manual. Adewole included ministry officials like Filani and Orji and he also invited state health commissioners, heads of state health agencies, and representatives from the health insurance program and the national health agency to serve on the subcommittee.

According to Orji, the subcommittee had to figure out how the fund would carry out two "separate but interlinked" functions: improving primary health care facilities and reimbursing

facilities for providing a free basic health care package. With a variety of interested parties involved and an overall goal in place, the subcommittee began the job of ironing out the specifics of how the fund would work.

## GETTING DOWN TO WORK

Adewole's team had to assemble a system that would build confidence in the health sector's ability to run a fair and effective fund, and to write an operations manual that would elucidate the workings of the system. That meant (1) developing strict processes and procedures to ensure financial accountability and transparency, and (2) identifying ways to build support for the fund both within and outside the Nigerian government. Achieving success meant the team to deal with the disparate requirements of differing levels of government and the needs of various interest groups.

### *Attempting to bridge fragmentation*

Adewole received an early lesson in the depth of the problems he faced when the subcommittee he tasked with designing an operations manual for the fund broke down because of disagreements about who had the authority to do what, as well as how and where the money would flow.

Most members at both the federal and state levels agreed with the health ministry's suggestion to hold the pooled fund in a single Treasury account at the Central Bank of Nigeria. However, many of the state health agencies as well as the National Primary Health Care Development Agency fundamentally disagreed with the ministry's proposal that once a state joined the fund, the money would flow straight from the Central Bank account of the national health agency and the health insurance program to individual facilities—effectively bypassing state health agencies.

The logjam reflected the fragmented nature of the Nigerian health system, in which national and state agencies often operated in parallel with ministries and departments. Although they

existed within the ambit of federal and state health ministries, agencies had long enjoyed significant power and autonomy in implementing their respective mandates. As such, the national health agency claimed that the fund fell within *its* mission to support and monitor primary health care at the state level, whereas the health insurance program insisted that the proposed system of reimbursements to facilities was *its* responsibility to manage at the state level.

Orji explained that as the situation grew more fractious, representatives from the national primary health agency were questioning the federal ministry's authority by citing a section of the 2014 National Health Act that said the agency "shall develop appropriate guidelines for the administration, disbursement, and monitoring of the fund with the approval of the Minister."<sup>17</sup>

Adewole responded by citing the section's need for his approval of proposed guidelines, and he also noted that another section of the law gave him the power to establish advisory and technical committees.<sup>18</sup> "Everyone interpreted the law in a way that suited them . . . It became a battle between the agencies and the federal ministry of health, also involving some state ministries," Orji said.

Mustapha Jibril, a public health physician and health commissioner of the state of Niger who also served on the subcommittee, described the situation as a "power tussle [about] the unclear designation of where the power of the federal ministry of health ends and where the power of the agencies begins."

The disagreement reflected a lack of clarity about which level of government had the mandate to administer the fund. On the one hand and in line with the principles of federalism, state agencies wanted the power to manage the flow of funds through their own bank accounts. On the other hand, the federal ministry argued that the National Health Act gave it the power to directly manage the fund and that channeling the money through state accounts would set a precedent that limited its ability to directly improve primary health care funding.

As tensions mounted and agencies began to boycott meetings, Adewole dissolved the committee in late 2016.

### *Going it alone*

Concluding that a joint approach to creating such a complex system was doomed to failure, Adewole opted to handle the task within the health ministry and then to seek to enlist various stakeholders' support for the plan. He turned to Filani and his ministerial team to formalize their own proposal for the operations manual, which would specify in writing the fund's financial accountability framework and incentive design.

The initial draft of the manual reflected the principles Filani's team had prioritized, namely that (1) the main fund would be pooled in a single Treasury account at the Central Bank; (2) when a state joined the fund, the state's allocation would first be transferred laterally to (a) the health insurance program and (b) the national health agency accounts, which were also housed in the Central Bank; and (3) as a final step, money would be transferred from the health insurance program and health agency accounts at the Central Bank into the commercial bank accounts of individual health care facilities, after being approved by the appropriate states.

The manual's proposed governance mechanism and flow of funds reflected the federal team's desire to build a financing system that would be transparent and accountable, thereby building trust within the government, by the public, and by international partners. Filani highlighted three key aspects. First, the design built transparency into the flow of funds. "All of the money sits at the Central Bank of Nigeria. It's almost like saying you're putting money in the Federal Reserve in the United States. It's not typically done, but it gave everyone comfort," Filani said. Second, the design fostered accountability because the donor partners that also contributed to the fund could easily see how the money flowed. And third, the manual called for the creation of governance structures through national and state steering committees. (The state

committees would become active only after states formally joined the fund.)

Chaired by the health minister, the national steering committee would comprise all relevant stakeholders, including the permanent secretaries of the finance and budget ministries, the heads of the health insurance program and the national health agency, and representatives of donor partners and civil society organizations. “The minister recognized that this is not the sort of money you just give someone . . . We needed strong governance around the program,” Filani said.

Equally important was the inclusion of clearly stated accreditation criteria and effective mechanisms for monitoring and evaluation. A key requirement before any state could benefit from the fund was that the state government had to deposit 100 million nairas (equal to about US\$275,000) into the fund’s Central Bank account, said Emmanuel Meribole, federal director of health planning and statistics. The deposit was meant to cover the costs of meetings to prepare the state for enrollment in the fund, as well as for facility assessments and capacity building.

As a next step, each state that wanted to benefit from the fund had to identify one primary health care facility per ward. (Wards were subdivisions of the country’s 774 local governments; a typical ward was the home of about 10,000 people.) Meribole said the aim was to identify “eligible facilities, the better ones.” Next, the state had to put in place a service-level agreement with each facility and ensure that each facility had a commercial bank account.

The manual stipulated that only four people—the federal health ministry’s permanent secretary, the national health agency’s executive director, the executive secretary of the health insurance program, and the head of the new Nigeria Centre for Disease Control—could authorize any funds to be transferred from the Treasury single account. For the states, only the accountant general or the executive secretary of the state health care agency could approve

disbursement of funds into individual facilities’ commercial bank accounts. Finally, both the chair of the local ward development committee and the head of a primary health care facility had to sign off on any transfer out of the facility’s individual account.

Once a state had met the assessment criteria, it would receive its first quarterly payment through two main gateways: the health insurance program and the national health agency. However, each subsequent payment was contingent on the state’s (1) submission of a quarterly financial report, (2) submission of an interim financial projection, (3) compliance with

### **Figure 2. Basic Health Care Provision Fund monitoring and evaluation indicators**

#### **Process Measures**

- Funds transferred electronically in the correct amounts and in a timely fashion only to providers and facilities that were supposed to receive Basic Health Care Provision Fund (BHCPF) funds
- Appropriate use of BHCPF funds received by public health facilities
- Verification that services paid for under the health insurance program gateway were actually provided
- Actual cost of services to patients
- Patient satisfaction

#### **Output Measures**

- Antenatal-care coverage
- Skilled birth attendance
- Postnatal-care coverage
- Modern contraceptive prevalence rate
- Immunization coverage
- Common childhood illnesses treated

#### **Impact Measures**

- Neonatal mortality and stillbirth rates
- Maternal mortality rate
- Financial risk protection

service delivery data reporting requirements, and (4) resolution of any outstanding negative findings by an external audit or an ad hoc financial review.

Each of the gateways would conduct ongoing monitoring and evaluation of three particular aspects. The first would measure federal, state, and facilities' compliance with the fund's governance, administrative, financial, and operational process. The second would measure outputs by tracking the usage of health care services by the targeted population. And the third would track the socioeconomic impacts and outcomes of the fund's interventions. (Figure 2)

Last, the operations manual outlined the basic package of services that patients would receive free at the point of care at any facility participating in the fund. After developing a costing model with assistance from the World Bank, the manual specified that the basic package would include free care for:

- treatment of malaria for all Nigerians;
- four types of maternal health interventions for pregnant women (antenatal care, labor and delivery, emergency, obstetric and neonatal care, and caesarean section);
- curative care and immunization for children younger than five years;
- and urinalysis screening tests and blood pressure checks.

#### *Funding a pilot project*

After developing the detailed operations manual, Adewole's team still had to find a way to secure support from the health insurance program and from national and state agencies. Such backing was critical to the goal of persuading the government to make the first-ever 1% budget allocation under the 2014 National Health Act.

The team decided to launch a pilot project, funded by donor partners, that would demonstrate proof of concept to the budget ministry and the rest of the government. Convinced that its careful attention to accountability and transparency in the operations

manual would win support from donors, Adewole's team approached international partners already working on health care in Nigeria.

Filani said that the Global Financing Facility (GFF), a joint initiative launched by the United Nations and the World Bank in 2015 to improve health systems financing, had pledged US\$40 million to Nigeria when the country joined the initiative in mid-2016. By early 2017, half of the pledge had not yet been allocated. He said he and Adewole agreed that the remaining US\$20 million could be used to demonstrate proof of the fund concept.

The team approached the World Bank's office in Abuja, where health economist Ayodeji Ajiboye said the financial institution was impressed by the proposed funding flow. "You can see every move," Ajiboye said. The money "is totally open until it is disbursed to the individual facilities that have their own accounts . . . It flows and stays within the [Central Bank of Nigeria] almost all the time."

The World Bank offered advice on how to further improve the manual, and it helped calculate costs associated with the proposed minimum package of basic services. Most important, the GFF agreed to contribute the remaining US\$20 million to the fund. Shortly thereafter, the Bill & Melinda Gates Foundation agreed to contribute a further US\$2 million.

In October 2017, the ministry decided to launch the pilot project in the states of Abai, Niger, and Osun, and the team got to work on preparing for the rollout in an effort to demonstrate to the Nigerian government, Nigerian citizens, and international donors that the fund design could work in practice.

#### *Building international and domestic support*

While Adewole's team was negotiating to secure funding for the proposed pilot project, the team also launched a broad advocacy effort to mobilize a domestic and global coalition to support the implementation of the basic health care fund. To make it more relatable, the team

gave the fund the local name Huwe (“life” in Epira, a language spoken in central Nigeria). Adewole also set up dozens of personal meetings with the president, vice president, finance minister, budget minister, and leaders of both houses of the National Assembly.

Drawing on lessons learned at a Harvard University ministerial leadership summit he had attended in 2016, Adewole tailored his presentations for each of his audiences. At the Harvard gathering “we learned to frame issues with ministers. You cannot go far without support from the finance and budget ministers, the vice president, and the president,” Adewole said. “We learned to appreciate words that resonate with, for example, the finance minister, like accountability, transparency, and return on investment. It’s not enough to say that people are dying . . . I learned what the different ministers wanted, and I then framed the issues in those terms,” Adewole said. Overall, “I created a narrative that if we deliver on health, the people would see us delivering on our national mandate.”

The team enlisted international help to mobilize support for the fund, and the ministry’s efforts were buttressed by a concerted civil society campaign. Rock singer Bono visited Nigeria in August 2016 as part of the ONE campaign, which focused on fighting poverty and preventable diseases. (Bono cofounded ONE, which is a global movement funded by foundations, individual philanthropists, and corporations.) Serah Makka-Ugbabe, director of the ONE campaign in Nigeria, said Bono’s visit was only the start of a sustained advocacy campaign to fire up support for Adewole’s cause. “During the Commonwealth heads of government meetings, ONE helped get a letter to president Buhari published in the *Financial Times*, with Nigerian British citizens spotlighting the state of health care in Nigeria. At home in Nigeria, we found out which newspaper the president read, and we ran ‘Dear Mr. President’ advertisements every day for a month,” Makka-Ugbabe said.

At the same time, “we found allies like the head of the Senate health committee, Lanre Tejuoso, and met with him and other senators about the basic health care fund,” Makka-Ugbabe said. When the ONE campaign held a march to the National Assembly by hundreds of people carrying placards reading “1% is important for our women and children,” senators and members “came out to meet us, and the media publicized it.”

Further support came in January 2018, when Olusoji Adeyi, the World Bank’s director of health, nutrition, and population global practice, spoke to the president’s economic management team, said Filani. During the meeting, Adeyi, who was Nigerian and thus “able to speak frankly,” told the group that “we should not leave the health of Nigerians and our children to the mercy of foreigners,” Filani recalled.

In March of the same year, Adewole invited Bill Gates to Nigeria. The American entrepreneur and philanthropist made a presentation to the national economic council, which included the vice president and all state governors. At the meeting, “he spoke about what the Gates Foundation was doing in Nigeria and said the government should put more skin in the game,” Filani said. Makka-Ugbabe added that “his tone is usually mild, but this time it wasn’t. He said he was investing in Nigeria but that the government wasn’t doing enough on human capital development.”

The Gates presentation was followed by a meeting between Gavi representatives and Nigeria’s vice president “about the need to fund primary health care,” Filani recounted.

The advocacy offensive culminated in a visit by Tedros Adhanom, head of the World Health Organization, in April 2018. Filani said that during his visit, Tedros helped launch the logo for the fund and also met with the president, “urging him to put resources” into the fund.

Filani said the multidimensional push produced tangible gains: “Partners said they want to support this. All of these big names came into

the country to talk to government leadership. The awareness was there; the strategy was there. It all happened at the same time. And it started to [seem] inevitable that [the fund] would happen.”

But despite Adewole’s best efforts to demonstrate that the fund was both viable and urgent—and despite extensive lobbying of the executive branch of government—a final hurdle lay ahead.

## OVERCOMING OBSTACLES

In a demonstration of just how deeply entrenched the government’s neglect of health care had become in the preceding two decades, the first draft of the 2018 appropriations bill that the minister of budget and planning submitted to the National Assembly again failed to include the minimum 1% allocation for the fund that had been specified in the 2014 National Health Act.

The reasons for the omission were unclear. Tension lingered between the federal health ministry and the head of the national health insurance program, and Makka-Ugbabe said the decision may have reflected the federal government’s preference to spend money on projects that would yield tangible results before the 2019 election.

Regardless of the reasons for the roadblock, Adewole moved quickly to muster his supporters in the legislature, which had the power to amend the original appropriations bill that had omitted any allocation for the fund. He acknowledged that “in 2018, when first seeing the budget, I was disappointed . . . But we then started working very hard with the National Assembly.”

Adewole met privately with Tejuoso, a medical doctor and chair of the Senate health committee since 2015. They agreed that success hinged on their ability to persuade members of the Senate and House health committees to approve an amendment to include the 1% allocation to the fund.

Tejuoso and some of his colleagues had already laid the groundwork to support the fund. Since 2015, Tejuoso said, “the committee went the extra mile to convince everybody that [the

fund] was a game changer. We showed [fellow lawmakers] the disease-prone areas that needed attention . . . The reason for that was lack of funds.”

With the foundations already laid, “I attacked the sentiment,” Tejuoso recalled. He showed his colleagues in the legislature videos of some of the 2 million acutely malnourished children in Nigeria. “It’s one thing to see pictures of malnourished children in other countries, but once you sit down with someone [and say that] this is [happening] in the state next door, it made a big impact,” Tejuoso said. “I asked them, ‘What if this was your child?’”

Tejuoso specifically targeted the influential Senate president, Bukola Saraki, who he knew was also a medical doctor. In the House, Tejuoso worked closely with the deputy chairman of the health committee, who was a member of the same political party.

With general elections only months away, lawmakers also felt pressure from health-focused civil society groups that had become more vocal in response to the 2014 National Health Act and the health ministry’s advocacy work. For example, Nigeria Health Watch, an advocacy network founded by respected public-health physicians, wrote a May 2018 website article entitled “Will the 1% Be a Game Changer in Nigeria’s 2019 Elections?” In the article, the organization lamented that “incredibly, almost four years after becoming law and despite . . . affirmations, the 1% . . . is not currently included in the 2018 budget, according to the Honourable Minister of State for Budget and National Planning, Zainab Ahmed.”<sup>19</sup>

Ahmed responded to the article by describing the call for the fund to be implemented as a “clamour” and that the government had more pressing priorities. She said the fund allocation had been omitted from the 2018 appropriation bill for the “simple reason [that] there are several other commitments required in the same pattern—for education, for science and technology.”<sup>20</sup>

In an unusually powerful show of activism and solidarity, the health committees of both the Senate and House and the appropriations committees of both chambers voted to insert the 1% allocation for the fund into the 2018 appropriations bill. Tejuoso described the legislature's action as unprecedented. Previously, he said, "there have been some changes to the appropriations, but none as significant as this. Most of [the previous amendments] were just adjustments, but this was not an adjustment."

Filani explained that the government committed the 1% allocation while the team was still planning for rollout of the pilot project funded by the Global Financing Facility and the Gates foundation. With the government on board by mid 2018, the donors agreed to pool their US\$22-million collective contribution with the government's allocation to launch the fund across the entire country.

The National Assembly's intervention enabled the health ministry team to reconcile unresolved differences with the health insurance program and the national health agency. With the money now actually on the table, the health insurance program and development agencies returned to the negotiating table. Although Adewole's team compromised on certain aspects, for example by giving the development agencies stronger oversight powers and authorizing them to procure vaccines in certain emergency situations, the ministry held firm on the principle that money should flow directly from the Central Bank to the individual facilities.

To ensure stronger coordination and cooperation, Adewole also created a formal steering committee to manage the rollout of the fund, as agreed upon in the operations manual and approved by the national health council. He appointed Meribole, the federal director of health planning and statistics, as secretary to the steering committee. The secretariat also included two representatives from the health insurance program, two from the national health agency, and two from the Nigeria Centre for Disease Control. Before the creation of the steering

committee, "everyone had been working in silos, bringing their own organizational issues. Most of the meetings would be rowdy," Meribole said. "But now we've got trust."

With the first quarterly tranche of money set to be transferred in late 2019, the steering committee had a difficult job to do. "Our primary focus [shifted] to check the readiness of states that have applied to the fund and to do capacity building in the states," Meribole said. With funding in place and crippling disagreements behind them, the team could finally focus on providing crucial financial support to the health care facilities that served Nigerians.

## ASSESSING RESULTS

Three years of work—to prove that the fund was both urgently needed and doable—paid off when the National Assembly amended the 2018 appropriation bill. By changing the budget to allocate 1% of total government expenditure to the fund, the legislature released an additional US\$180 million to meet the fund's primary goals: to improve the quality of primary health care services and to provide a basic package of services free at the point of care.



Source: [This Day Live](#)

The legislature's determination to make the fund a reality, bolstered by a global and local groundswell of support, signaled to the executive branch of Nigeria's government that the fund could indeed become a significant tool for improving the quality and access to primary health care in Nigeria.

In late 2019, however, measuring results at the ground level remained problematic. Although the strict financial controls and other requirements put in place by the health ministry ensured transparency and accountability—considerations crucial to winning support for the fund—the stipulations also complicated implementation and delayed the initial disbursements to facilities. It wasn't until November 2019 that primary care facilities in the states of Abia, Osun, and Ebonyi became the first to receive money from the fund. And by late in the same year, eight of Nigeria's 36 states were still in the process of enrolling in the new system. The rest, as well as the federal region of Abuja, had joined.



Source: [Nigeria Health Online](#)

## REFLECTIONS

In a significant follow-on that ensured future government funding for primary health care in Nigeria, the finance ministry in mid-September 2019 declared that the 1% allocation to the Basic Health Care Provision Fund would become a permanent fixture of the annual federal budget rather than being reconsidered each year. The decision, included in the ministry's circular setting out requirements and instructions for the 2020 budget, acknowledged the fund's statutory status alongside that of other institutions such as the National Assembly, the National Judicial Council, the Niger Delta Development Commission, and the National Human Rights Commission. Health minister Isaac Adewole stressed that the Nigerian government's acceptance of the annual allocation as a statutory

item meant that funding for primary care “can no longer lapse at the end of the year if it's not fully disbursed, and it is automatically renewed every year.” He and his team had won their battle to make sure the fund received the full amount to which it was entitled by law.

Lanre Tejuoso, whose term as head of the Senate health committee expired with the February 2019 election, added that because it had been created by a law, “the [fund] was created to be statutory. But we didn't have time for it to *become* statutory. If we had gone that way, we would not have achieved [what we did] in 2018. We decided to do it now, and then it can become statutory later.” The plan had worked.

For World Bank health economist Ayodeji Ajiboye, it was clear that the fund “could be catalytic if implemented correctly. We see huge potential, and it is a bold step not just because the government is committing to it but also because it guarantees [primary care] for every Nigerian. It also has the potential to grow bigger.”

The opportunity for further growth arose from the law's stipulation that 1% was the *minimum* allocation; the transfer could increase in the future. Additional funding growth also could come from state contributions. Finally, as more donor partners began to trust the government's ability to manage the fund's resources they would be encouraged to contribute.

Ajiboye said: “What is key now is to bring in results... The advocacy campaign is still going on, but it will be stronger when we've treated millions of children and delivered several thousand babies. When we bring those results in, the conversation will change.”

As the first facilities in Abia, Osun and Ebonyi started benefiting from the fund in November 2019, Oyebanji Filani—appointed as technical director of the fund's steering committee by the new health minister after Adewole's departure earlier in the year—said he knew that “the battle had been fought and won: there is money in the budget.” Now it remained to be seen how effectively the money would be used to build a healthier Nigeria.

Exhibit 1



Source: [Wikimedia](#)

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