

Providing Healthcare in Armed Conflict: The Case of Nigeria

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This issue brief was drafted by Alice Debarre, Senior Policy Analyst at IPI. It accompanies a policy paper published in 2018 entitled “Hard to Reach: Providing Healthcare in Armed Conflict,” as well as another case study on provision of healthcare in Mali. These papers aim to assist UN agencies, NGOs, member states, and donor agencies in providing and supporting the provision of adequate health services to conflict-affected populations.

This issue brief is based on a combination of desk and field research. Thirty-one interviews were conducted in Abuja and Maiduguri from September 9 to September 21, 2018, with representatives of national and international non-governmental organizations, UN agencies, and the Nigerian Ministry of Health.

The views expressed in this publication represent those of the author and not necessarily those of the International Peace Institute. IPI welcomes consideration of a wide range of perspectives in the pursuit of a well-informed debate on critical policies and issues in international affairs.

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Introduction

Nigeria is facing multiple crises across the country. In the northeast, particularly in the states of Borno, Adamawa, and Yobe, the government is fighting the Boko Haram insurgency. Since the beginning of the conflict, over 20,000 people have reportedly been killed, over 2 million are internally displaced, and over 200,000 have fled to Cameroon, Niger, or Chad.¹ In the Middle Belt region, conflicts between herders and farmers escalated in 2018, killing over 1,300 over the course of the year, making it deadlier than the Boko Haram insurgency.² Climate change is one of the causes of this conflict, as it has brought about desertification, resulting in clashes over resources.³ Nigeria is also dealing with an influx of refugees fleeing the violence in Cameroon’s Anglophone region and arriving in Cross River, Benue, and Taraba States.⁴ Despite the humanitarian needs triggered by these other crises, the bulk of the humanitarian response and the only large-scale humanitarian structure are in the northeast. Therefore, this issue brief focuses on the humanitarian health response in the northeast.

The humanitarian situation in the northeast is deteriorating, with almost 8 million people heavily dependent on humanitarian aid.⁵ An estimated 823,000 people are out of the reach of aid organizations, and little is known about their health needs. According to the UN, 5.4 million people are in need of healthcare.⁶ People face significant risks of epidemic-prone diseases such as cholera, measles, and endemic malaria, as well as mental illness and sexual and gender-based violence.⁷ The Ministry of Health declared a cholera outbreak in

- 1 See John Campbell and Asch Harwood, “Boko Haram’s Deadly Impact,” Council on Foreign Relations, August 20, 2018; DTM Nigeria, available at <https://displacement.iom.int/nigeria>; Hajer Naili, “What You Should Know about the Humanitarian Crisis in North-East Nigeria,” Norwegian Refugee Council, June 21, 2018.
- 2 Philip Obaji, Jr., “Recharging Lake Chad Key to Ending the Conflict Between Nigeria’s Farmers and Herders,” *IPI Global Observatory*, September 5, 2018; International Crisis Group, “Stopping Nigeria’s Spiralling Farmer-Herder Violence,” Report No. 262, Africa, July 26, 2018.
- 3 Udo Jude Ilo, Ier Jonathan-Ichaver, and Yemi Adamolekun, “The Deadliest Conflict You’ve Never Heard Of,” *Foreign Affairs*, January 23, 2019.
- 4 Babar Baloch, “Fleeing Violence, Cameroonian Refugee Arrivals in Nigeria Pass 30,000,” UN Refugee Agency, November 9, 2018, available at www.unhcr.org/news/briefing/2018/11/5be551224/fleeing-violence-cameroonian-refugee-arrivals-nigeria-pass-30000.html; Médecins Sans Frontières, “Tens of Thousands of Cameroonians Seek Refuge in Southern Nigeria,” December 21, 2018, available at www.msf.org/tens-thousands-cameroonians-seek-refuge-southern-nigeria.
- 5 Luis Eguiluz, “The Situation in Northeast Nigeria Is Deteriorating after Years of Conflict,” Interview, Médecins Sans Frontières, July 18, 2018, available at www.msf.org/situation-northeast-nigeria-deteriorating-after-years-conflict; UN Office for the Coordination of Humanitarian Affairs (OCHA), *Nigeria: 2018 Humanitarian Response Plan*.
- 6 WHO and Government of Nigeria, “Nigeria: Northeast Response—Health Sector Bulletin No. 10,” October 2018, available at www.humanitarianresponse.info/en/operations/nigeria/document/nigeria-northeast-response-health-sector-bulletin-no-10-october-2018; UN OCHA, *Nigeria: 2018 Humanitarian Needs Overview*.
- 7 UN OCHA, *Nigeria: 2018 Humanitarian Needs Overview*; Nigeria Centre for Disease Control, “Disease Situation Reports,” available at <https://ncdc.gov.ng/diseases/sitreps>; Amnesty International, *They Betrayed Us: Women Who Survived Boko Haram Rape, Starved and Detained in Nigeria*, 2018, p. 52.

September 2018, which has led to 6,000 reported cases and seventy-three deaths as of November 2018.⁸

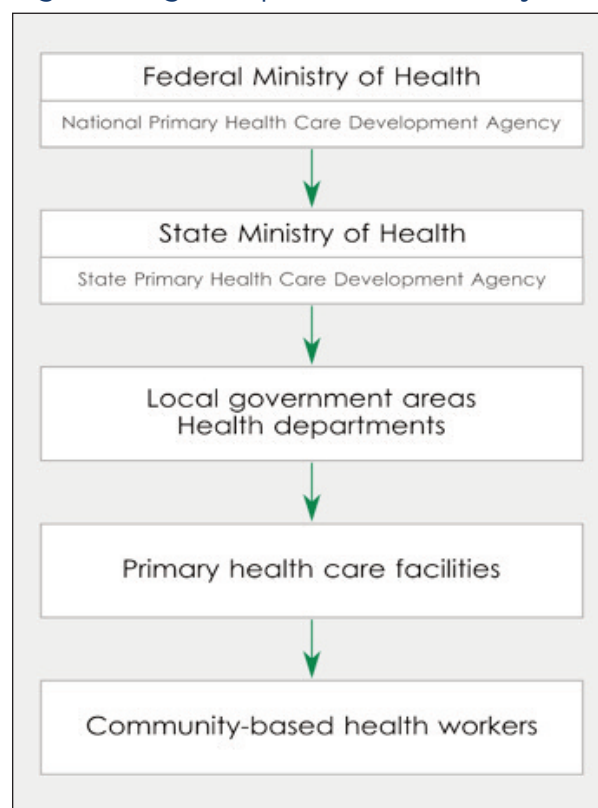
A recent upsurge in violence in the northeast has led tens of thousands of people to flee their homes, adding to already high levels of internal displacement.⁹ Among those internally displaced, malaria, acute respiratory infections, and watery diarrhea are the top three causes of illness, and levels of severe acute malnutrition are high.¹⁰ The needs generated by the crisis have been added to existing chronic development challenges, marginalization, poverty, and poor health.¹¹

This issue brief aims to assist UN agencies, NGOs, member states, and donor agencies in providing and supporting the provision of adequate health services to conflict-affected populations in Nigeria. It maps and explains the challenges health actors face, the understanding of which is key to ensuring that health policies are adequate. It also looks at the governance structures set up to operationalize those policies, seeks to identify and analyze gaps in policy and implementation, and provides recommendations for bridging those gaps. It focuses on the coordination of health actors, the prioritization of health services, the sustainability of health services and the transition to development work, context-specificity and localization, and accountability for healthcare providers.

The State of Healthcare in Nigeria

Nigeria has a decentralized, three-tiered health system.¹² The Federal Ministry of Health is responsible for setting standards, developing policies and guidelines, coordinating among healthcare providers, and providing tertiary healthcare. State ministries of health are responsible for providing

Figure 1. Nigeria's public healthcare system



secondary healthcare as well as technical assistance to local government area health departments. These health departments are responsible for providing primary healthcare through primary healthcare facilities. In 1992, the government established the National Primary Health Care Development Agency to support primary healthcare services, for example by developing human resources or standards and guidelines.¹³ In 2011, the Primary Health Care Under One Roof policy created state primary healthcare development agencies to reduce fragmentation and provide coordinated leadership for primary healthcare. Beyond the public health system, the private sector is a major provider of health care in Nigeria,

8 Borno State Ministry of Health, "Situation Report of Cholera Outbreak in Borno State," No. 80, November 24, 2018, available at www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/borno_state_cholera_daily_update_20_11_2018_no_80.pdf.

9 Internal Displacement Monitoring Center, "Nigeria Country Information," available at www.internal-displacement.org/countries/nigeria; UN Resident and Humanitarian Coordinator in Nigeria, "UN Humanitarian Coordinator in Nigeria Alarmed at Massive Civilian Displacement Caused by Recent Violence in North-East," UN OCHA, January 9, 2019, available at <https://reliefweb.int/report/nigeria/un-humanitarian-coordinator-nigeria-alarmed-massive-civilian-displacement-caused>.

10 UN OCHA, *Nigeria: 2018 Humanitarian Needs Overview*.

11 Naili, "What You Should Know About the Humanitarian Crisis in North-East Nigeria."

12 B. S. C. Uzochukwu, "Primary Health Care Systems, Case Study from Nigeria," Alliance for Health Policy and Systems Research and WHO, 2017, available at www.who.int/alliance-hpsr/projects/alliancehpsr_nigeriaprimsys.pdf.

13 Government of Nigeria, *National Primary Health Care Development Agency Act*, Decree No. 29, June 26, 1992.

accounting for 50 to 70 percent of the health infrastructure, depending on the region.¹⁴

Public healthcare in Nigeria has suffered from a state of chronic underfunding. In 2016, the minister of health stated that the country's budget for health was one of the lowest in Africa.¹⁵ In northeastern Nigeria in particular, the public health system is extremely poor. In Borno State, 50 percent of health facilities are non-functioning, with 39 percent fully destroyed.¹⁶ Only 18 percent of health centers in Borno can provide survivors of gender-based violence with integrated clinical management services.¹⁷ Furthermore, women face both political and cultural barriers to reproductive health information and care.¹⁸ The region also has a weak and poorly funded mental health system with even fewer mental health professionals than the rest of the country.¹⁹ The Federal Neuro-Psychiatric Hospital in Maiduguri is the only specialized mental healthcare hospital in northeastern Nigeria.

Nigeria has ratified the International Health Regulations (2005), and the Nigeria Centre for Disease Control was established in 2011 to detect, investigate, prevent, and control diseases of national and international public health importance. It works closely with the World Health Organization (WHO) and is guided by a 2017–2021 Strategy and Implementation Plan.²⁰ In November 2018, President Muhammadu Buhari signed a bill making the center an independent government agency, thereby reinforcing its commitment to prevent and respond to infectious diseases.²¹ In December, Nigeria launched a

National Action Plan for Health Security identifying key areas for action and ensuring national ownership of health security planning.²² All of these efforts are critically needed, as Nigeria's immunization coverage remains dangerously low.²³ Furthermore, recent reports have claimed that Nigeria will become ineligible for a range of external health financing in the next two decades, a worrying development, as many health interventions remain almost entirely dependent on foreign donors.²⁴

The government of Nigeria has a complex humanitarian coordination structure. The Presidential Committee on the North East Initiative was established in 2016—soon to be replaced by the North East Development Commission—coordinates and advises on all humanitarian and development efforts in the region. Under the vice president, the National Emergency Management Agency is responsible for developing policies, monitoring their implementation, and overseeing the various state emergency management agencies. The Federal Ministry of Budget and National Planning is the main interlocutor for humanitarian and development actors in Nigeria and oversees the Emergency Coordination Centre, which hosts the Humanitarian Coordination Working Group. The Presidential Committee on the North East Initiative, National Emergency Management Agency, and Federal Ministry of Budget and National Planning are all part of an interministerial task force established in 2016 to elevate the coordination of the humanitarian response by putting

14 Nigeria Centre for Disease Control, "Idea to Reality: Strategy and Implementation Plan 2017–2021," p. 43, available at https://ncdc.gov.ng/themes/common/docs/protocols/54_1510712457.pdf.

15 "Nigeria Has Lowest Health Budget in Africa—Adewole," *The Punch*, April 13, 2016, available at <https://punchng.com/nigeria-has-lowest-health-budget-in-africa-adewole/>.

16 WHO and Government of Nigeria, "Nigeria: Northeast Response—Health Sector Bulletin No. 10," October 2018.

17 WHO, "Borno State, HeRAMS Report," September 2017.

18 Ruth Olurounbi, "Nigeria's Restrictive Laws and Women's Sexual Reproductive Rights," *Nigerian Voice*, January 24, 2019.

19 UN OCHA, 2018 "Humanitarian Needs Overview."

20 Nigeria Centre for Disease Control, *Idea to Reality: Strategy and Implementation Plan 2017–2021*. It is interesting to note that this plan makes very few references to the conflict in the northeast.

21 "Ayodamola Owoseye, Buhari Signs Bill Establishing Nigeria Centre for Disease Control," *Premium Times*, November 13, 2018, available at www.premiumtimesng.com/health/health-news/295424-buhari-signs-bill-establishing-nigeria-centre-for-disease-control.html.

22 "FG Inaugurates 4-Year Action Plan for Health Security," *Nigerian Tribune*, December 17, 2018, available at www.tribuneonlineng.com/179692/. This was one of the recommendations of Nigeria's 2017 Joint External Evaluation Report. "Joint External Evaluation of IHR Core Capacities of the Federal Republic of Nigeria Mission Report: June 11–20, 2017," WHO, 2017, available at <http://apps.who.int/iris/bitstream/handle/10665/259382/WHO-WHE-CPI-REP-2017.46-eng.pdf?sequence=1>.

23 See, for example, WHO, "The Second Phase of Nigeria's Biggest-Ever Yellow Fever Vaccination Campaign Gets Underway," November 22, 2018, available at <https://afro.who.int/news/second-phase-nigerias-biggest-ever-yellow-fever-vaccination-campaign-gets-underway?country=979&name=Nigeria>.

24 Paul Adepoju, "Nigeria Faces a Health Financing Cliff Edge," *Devex*, January 7, 2019, available at www.devex.com/news/nigeria-faces-a-health-financing-cliff-edge-93968.

cabinet ministers in charge.²⁵ However, according to one interviewee, the task force has met only once or twice, and its role remains unclear.²⁶

Given the level of need and the poor state of the healthcare system in northeastern Nigeria, humanitarian and other nongovernmental health actors play an important role, both by directly providing services and by supporting governmental health structures. The Level 3 Inter-Agency Standing Committee (IASC) system-wide response was not activated in Nigeria at the start of the crisis. This means that the humanitarian response is not coordinated through the formal cluster system. According to a number of interviewees, this was due to reluctance on the part of the government, which was concerned about the perception of Nigeria being in a state of crisis, as well as the potential that it could hold up development funding.²⁷

Nonetheless, cluster-like sector working groups have been set up to coordinate activities in the various sectors, including health, at the federal, state, and sometimes local level. The humanitarian country team and inter-sector working group coordinate the humanitarian response at the federal level in Abuja. In Maiduguri, the operational humanitarian country team and operational inter-sector working group coordinate the response in the northeast. In 2017, local coordination groups were also established in twelve sites in Borno State. A number of other coordination structures exist, such as the new European Union (EU) coordination team for EU implementing partners in Borno. The Nigeria Humanitarian Fund is a country-based pooled fund that allows humanitarian actors to access more timely and flexible funding and is the first of its kind to be open to private sector donations.²⁸

For 2019, the priorities of the humanitarian health sector are to reestablish or strengthen the

disease surveillance system, strengthen preparedness for epidemic outbreaks, expand mobile health teams for hard-to-reach areas and populations, strengthen secondary health services, rehabilitate high-priority health facilities, and strengthen health sector coordination in local government areas.²⁹

Challenges to Providing Healthcare in Northeastern Nigeria

Humanitarian and health actors face a number of challenges in providing healthcare services to the Nigerian population in the northeast of the country. These include both constraints related to the existing healthcare system and the difficulty of accessing those in need.

The conflict in the northeast has led to the breakdown of health facilities and the complete collapse of public services—and this in a region that already faced neglect and underinvestment prior to the crisis. In Borno State, only around 30 percent of health facilities remain fully functional.³⁰ In most local government areas, primary health-care facilities have been partially or totally destroyed by Boko Haram. As people have been displaced to urban areas, health facilities in places like Maiduguri have become overstretched. The few remaining hospitals struggle with bad electricity supply. Even in areas of Adamawa and Yobe States where there are health facilities still standing, those facilities and their resources are often substandard.

The shortage of trained and skilled health workers in the northeast, particularly in Borno State, is a major challenge. Even prior to the conflict, there were insufficient human resources for health, and Nigeria suffers from “brain drain.”³¹

25 “Buhari Restructures Nigeria’s Handling of Persons Displaced by Boko Haram,” *Premium Times*, September 22, 2016, available at www.premiumtimesng.com/regional/north-east/211038-buhari-restructures-nigerias-handling-persons-displaced-boko-haram.html.

26 Interview with humanitarian expert, Abuja, September 2018.

27 One interviewee also mentioned that the UN likely accommodated this pushback by the government given the high number of Level 3 IASCs activated in other contexts and the already stretched UN capacities, as well as Nigeria being a middle-income country that did fit the usual criteria. Interview with humanitarian expert, Abuja, September 2018.

28 UN OCHA, “Nigeria Humanitarian Fund Partners with Nigerian Private Sector to Mobilize Resources for the Most Vulnerable,” November 16, 2018, available at www.unocha.org/story/nigeria-humanitarian-fund-partners-nigerian-private-sector-mobilize-resources-most-vulnerable.

29 WHO and Government of Nigeria, “Nigeria: Northeast Response—Health Sector Bulletin No. 10,” October 2018.

30 UN OCHA, *Nigeria: 2018 Humanitarian Needs Overview*, February 2018; Maria Paola Bertone et al., “Performance-Based Financing in Three Humanitarian Settings: Principles and Pragmatism,” *Conflict and Health* 12, No. 28 (2018); WHO and Government of Nigeria, “Nigeria: Northeast Response—Health Sector Bulletin No. 8,” August 2018.

31 See, for example, NOI Polls, “New Survey Reveals 8 in 10 Nigerian Doctors Are Seeking Work Opportunities Abroad,” August 3, 2017, available at <http://noi-polls.com/root/index.php?pid=447&ptid=1&parentid=14>.

When the conflict broke out, health workers were killed, and others fled. In September and October 2018, Boko Haram executed two health workers after holding them hostage for several months; one remains in captivity.³² Most health workers are unwilling to work in areas where the security situation is volatile. In Borno State, most health structures outside of the capital Maiduguri do not have Ministry of Health staff and are either empty, supported by NGO staff, or staffed by community health workers, who generally have less technical skill and expertise. Even where Ministry of Health staff are present, staff turnover is high, salaries are low, and payments are delayed, resulting in low commitment among workers and constant ruptures of services.

This overburdened system faces an increased health burden due to the displacement and increased vulnerabilities caused by armed conflict. Nigeria faces seasonal epidemics and outbreaks, the risk of which is augmented by displacement. The maternal mortality rate has increased from already high levels, and malnutrition levels are also extremely high. An estimated six out of ten women have experienced gender-based violence.³³ Continuous displacement increases risks to people's health and makes it difficult to access services.³⁴

Ongoing armed conflict also increases the security risk for all actors operating in Nigeria's northeast, particularly in Borno State. Despite recent claims by the Nigerian government that Boko Haram has been defeated, violence continues.³⁵ Reports have highlighted the challenges the Nigerian military is facing in its battle against Boko Haram, and the situation

remains unpredictable.³⁶ There are still ongoing hostilities, threats of attacks by armed groups, violence against civilians, remnants of explosives, and improvised explosive devices.³⁷ Insecurity and violence continue to cause internal displacement.³⁸

Insecurity also hinders the movement of humanitarian and health actors, makes transporting commodities challenging, and keeps large areas and populations out of reach. All interviewees stressed the challenge for humanitarian and health actors of accessing some parts of Borno State. Much of the territory remains under the control of non-state armed groups, and the government prohibits access to those areas, limiting humanitarian and health actors to working in military-controlled enclaves. There is little information on the needs of the people living outside of these enclaves, although information collected from displaced populations suggests many are in dire need of aid. Given the absence of Ministry of Health staff or humanitarian actors in those areas, there is little, if any, access to health services.

The only health intervention that has reportedly been undertaken in some of these inaccessible areas is a polio immunization campaign by an NGO, eHealth Africa, funded by the Bill and Melinda Gates Foundation. This organization is reportedly escorted by the Civilian Joint Task Force (a militia formed to fight Boko Haram) or the Nigerian military to distribute polio vaccines in areas where they are engaged in military operations.³⁹ The WHO also supports "hard-to-reach" teams in a number of local government areas to provide basic health services to remote and displaced communities.⁴⁰

32 ICRC, "Nigeria: Health Worker Hauwa Mohammed Liman Executed in Captivity," October 16, 2018, available at www.icrc.org/en/document/nigeria-health-worker-hauwa-mohammed-liman-executed-captivity.

33 UN OCHA, *Nigeria: 2018 Humanitarian Response Plan*, p. 12.

34 See, for example, Médecins Sans Frontières, "Nigeria: A Critical Humanitarian Situation Is Unfolding among Internally Displaced People in Bama, Borno State," August 17, 2018, available at <https://reliefweb.int/report/nigeria/nigeria-critical-humanitarian-situation-unfolding-among-internally-displaced-people>.

35 For example, a violent attack in Rann in January 2019 led to the displacement of several thousand people. Médecins Sans Frontières, "Thousands Fleeing Rann Attack Seek Refuge in Cameroon," January 16, 2019, available at www.msf.org/thousands-fleeing-rann-attack-look-refuge-in-Cameroon-Nigeria.

36 Paul Carsten, "Nigerian Military Struggles Against Islamic State in West Africa: Sources," Reuters, September 19, 2018, available at www.reuters.com/article/us-nigeria-security-military/nigerian-military-struggles-against-islamic-state-in-west-africa-sources-idUSKCN1LZ11F?feedType=RSS&feedName=worldNews.

37 UN OCHA, *Nigeria: 2018 Humanitarian Response Plan*, p. 20; "Boko Haram Threatens Civilians in Maiduguri-Army," Vanguard, January 10, 2019, available at www.vanguardngr.com/2019/01/boko-haram-threatens-civilians-in-maiduguri-army/.

38 IOM Displacement Tracking Matrix, "Flash Report: New Arrivals into MMC and Jere from Baga, 24–31 December 2018," DTM Nigeria, available at https://displacement.iom.int/system/tdf/reports/Nigeria%20%20New%20Arrivals%20into%20MMC%20and%20Jere%20from%20Baga%20Flash%20Report%20%200%2824%20-%2031%20December%202018%29_0.pdf?file=1&type=node&id=4926.

39 See WHO, "Joint External Evaluation of IHR Core Capacities of the Federal Republic of Nigeria, Mission Report: June 11–20, 2017," 2017, p. 42.

40 WHO and Government of Nigeria, "Nigeria: Northeast Response—Health Sector Bulletin No. 8," August 2018; WHO, "WHO Teams Assist People in Hard-To-Reach Areas of Nigeria," February 24, 2017, available at www.who.int/news-room/feature-stories/detail/who-teams-assist-people-in-hard-to-reach-areas-of-nigeria.

Pressed by donor agencies and some NGOs, the UN humanitarian country team developed an access strategy for Borno State in 2018. However, not everyone is ready to pursue access more aggressively given the government's sensitivity. Senior UN officials in particular are perceived as being reluctant to push further. Furthermore, some organizations feel that they need to improve the response in areas where they have access before expanding their operations. Efforts to expand access are ongoing, including during a joint mission by the UN Development Programme's (UNDP) administrator and the emergency relief coordinator in October 2018. Some worry, however, that the upcoming elections in February 2019 will further decrease the room for negotiation.

The government's role in blocking or granting access makes it extremely difficult for humanitarian actors to uphold the principles of neutrality and impartiality in northeastern Nigeria. Interviewees highlighted the politicization of aid as a key issue. Access constraints mean that humanitarian actors are only working on one side of the armed conflict. Furthermore, because of the security situation, many in the humanitarian community have agreed to use military assets or escorts. In some areas, humanitarian actors have been and still are collocated with the military, and most of their activities depend on military clearance. This can create the perception that humanitarian actors are aligned with the military. Some humanitarian actors mentioned that they are taking steps to be perceived as more neutral, such as by using military escorts only as a last resort, but given the security situation, this remains a challenge. Collocation also poses security risks for humanitarian actors, as exemplified during Boko Haram's attack on a military base in which NGO workers were living in Rann in March 2018. Some humanitarian actors mentioned that the government of Nigeria also does not perceive them as neutral. The government has complained that it is insufficiently aware of what aid actors are doing in some areas.

Beyond directly blocking access, the government

also imposes bureaucratic impediments on humanitarian and other health actors, including delays in obtaining registration for international NGOs and visas for international staff—although the situation has improved. There are also barriers to the provision of medications. Some governmental donors do not allow the purchase of local drugs due to the prevalence of fraud and counterfeit drugs in the country. At the same time, the Nigerian National Agency for Food and Drug Administration and Control (NAFDAC) prohibits the import of certain drugs, such as paracetamol, requiring organizations to obtain a customs and duty waiver, which can take several months. To tackle these challenges, and because UN agencies have had fewer issues importing drugs than NGOs, UNICEF has become the focal point for procurement. The US Agency for International Development (USAID) has also been looking into bulk procurement to assist health NGOs. However, even once the drugs are in the country, there is a need for military clearance to move them to the northeast, which can cause additional delays.

Working with and alongside the government also poses a number of broader challenges. Corruption hampers the delivery of services, particularly due to the diversion of funds.⁴¹ Several interviewees mentioned the government's lack of political will to ensure functioning social services in some areas of the northeast, even though it is perceived to have the means and capacity to do so. In addition, recent governmental policies pushing IDPs to relocate from camps to the military-controlled enclaves have concerned humanitarian actors, particularly given the perceived lack of consent of those being relocated and the absence of civil authorities and infrastructure in those areas.⁴² Given these concerns, the humanitarian community has worked with the government to develop a framework agreement on returns, which has put a temporary stop to the relocations. With the upcoming elections in February 2019, however, some worry that the government's desire to push the narrative that the crisis in the northeast is over will create additional challenges for humanitarian

41 See, for example, Maggie Fick, "Nigeria's President Orders Probe into Missing Aid Funds," *Financial Times*, April 19, 2017; Obinna Onwujekwe et al., "Corruption in the Nigerian Health Sector Has Many Faces. How to Fix It," *The Conversation*, July 9, 2018.

42 See, for example, Nigeria INGO Forum, "Humanitarians Express Concerns about the Ability to Meet the Needs of Civilians Relocated to Bama," Press Release, May 16, 2018, available at <http://ingoforum.ng/nigeria-ingo-forum-public-statement-on-relocation-of-idps-to-bama/>.

actors on the ground.

The fact that the government is engaged in armed conflict with Boko Haram, a designated terrorist group, further complicates the work of humanitarian actors and challenges humanitarian principles. One interviewee mentioned that their organization's staff was threatened with arrest and prosecution under Nigeria's counterterrorism laws, as the government wrongly suspects it has ties with Boko Haram.⁴³ In December 2018, the government went as far as briefly suspending UNICEF's operations in Nigeria, accusing the organization of spying for Boko Haram and claiming that there was "credible information" that foreign aid agencies and NGOs were training and deploying spies for Boko Haram.⁴⁴

Donor agencies have also imposed constraints on humanitarian actors. USAID contracts contain a broad counterterrorism clause prohibiting implementing partners from providing material assistance to people affiliated with designated terrorist groups and reportedly placing onerous requirements to clear individuals prior to providing them with assistance. UNICEF has refused to sign the USAID contract containing this clause, but other organizations have. This has yet to have a big impact given the current lack of access to Boko Haram-controlled areas. However, it will likely become an issue if and when those areas become accessible, as aid organizations would inevitably be in closer contact with Boko Haram.

Although not conflict-related, numerous interviewees noted that there are sociocultural barriers to providing health services to certain populations. In particular for sexual and reproductive health services, shame and stigma prevent many women, especially younger women, from accessing care. Practices such as early marriage are also a huge barrier to sexual and reproductive health and can have long-term negative health implications. Cultural beliefs around the need to increase the population make family planning initiatives challenging. There is also a need to allay people's fears that vaccines are a population-reduction tool and to explain healthy practices and

how to take some medications. These challenges are exacerbated by language barriers in many areas of the northeast.

International Health Policy and Its Implementation in Nigeria

The UN and its members states, as well as key international health organizations, have developed a number of policies to enable affected populations to access adequate and appropriate health services. While most of the above challenges are out of the hands of health actors on the ground, the proper implementation of these policies can make a big difference. This section assesses how the humanitarian health response in Nigeria fares in terms of coordination, the prioritization of health services, its sustainability and the transition to development work, and accountability for health services provided.

A SLOWLY IMPROVING COORDINATION

Although coordination among humanitarian actors has significantly improved in Nigeria, interviewees highlighted this as an ongoing challenge and an area with room for improvement. The health sector working group was widely acknowledged to be one of the better functioning and better attended sector working groups, meeting once a month in Abuja and twice a month in Maiduguri. Some attributed this to the stronger presence of government representatives in the working group, although there was a general feeling that further leadership and ownership by the Ministry of Health would be beneficial. The response to the 2017 cholera outbreak, which was controlled within five months, was highlighted as a success for the health sector working group.⁴⁵

Duplication of activities and unmet needs nonetheless remain, creating feelings of disenfranchisement among the local population. Some interviewees described organizations beginning to implement projects in health facilities before realizing other organizations were already working

43 Interview with humanitarian expert, Maiduguri, September 2018.

44 "Why Did Nigeria Ban UNICEF?," *The Economist*, December 18, 2018.

45 See also, "Nigeria: Cholera Outbreak in Restive Borno State Successfully Contained, Says UN Health Agency," *UN News*, December 24, 2017.

there. The health sector working group has reportedly helped resolve some of these issues, but several factors continue to hamper efforts. These include differences in mandate and modus operandi among various organizations, turf battles and competition, and donor constraints and earmarked funding. One interviewee described it as “coordination within the scope of each organization’s interest.”⁴⁶ The sheer number of organizations present in Maiduguri is also a challenge for coordination.

At the level of local government areas, coordination mechanisms have been put in place in some areas, but need to be strengthened. The move to local-level coordination—perceived as key for better provision of health services—has been slow. Given the lack of experienced staff on the ground at the field level in Borno State, coordination efforts, as well as the transfer of information back to Maiduguri, are weak. Several interviewees also voiced concern about the UN coordination mechanism’s burdensome processes and the resulting delays.

OPPORTUNITIES FOR MAKING GLOBAL AND HUMANITARIAN HEALTH ACTIVITIES MORE COMPLEMENTARY

The epidemic response in the northeast is relatively well coordinated between humanitarian health and global health actors. The Nigeria Centre for Disease Control, supported by WHO, coordinates surveillance and alerts for the country, and state primary healthcare development agencies coordinate immunization at the state level. A number of humanitarian health actors work on case management and collect surveillance information. They transmit this information to the government, which then reports on the epidemiological situation in health sector coordination meetings. Organizations like Gavi (the Vaccine Alliance), the Global Fund, and the Bill and Melinda Gates Foundation provide grants and vaccines to the Ministry of Health, through which all vaccine orders must go.

However, most global health programs are national, and prevention plans developed by the Ministry of Health and WHO are considered unrealistic for the conflict-affected states. Indeed, the state of health in the northeast would seem to require context-specific strategies and methods. Finally, global health actors have committed a large amount of funding to the polio response. The extensive polio infrastructure put in place has been used to respond to other disease outbreaks such as cholera and Lassa fever.⁴⁷ Polio response teams have also reportedly been able to operate in areas of the northeast outside of government control where humanitarian health actors have been unable to go. So far, however, no other health activities have been linked to these polio immunization campaigns. For some interviewees, this seemed like a missed opportunity.

GAPS IN MENTAL HEALTH, SEXUAL AND REPRODUCTIVE HEALTH, AND SECONDARY HEALTH SERVICES

There is a number of key health issues appear to have been under-prioritized in the current response. One of these is mental health. The high mental health needs of the population in the northeast were highlighted in the UN’s 2018 humanitarian needs overview, and the 2018 humanitarian response plan includes mental health and psychosocial support in its health priorities. There is a UN mental health sub-working group, and the WHO has worked with the Borno health commissioner to develop a Borno State Strategic Framework for Mental Health (2018–2021). WHO has also started a Mental Health Gap Action Programme, which has included hiring and training ten mental health specialists,⁴⁸ and a number of organizations provide psychosocial support.⁴⁹

Overall, however, there seemed to be a general consensus on the need for more mental health and psychosocial support programs. Among the obstacles and challenges highlighted by actors on the ground are health workers’ lack of the requisite

46 Interview with humanitarian expert, Maiduguri, September 2018.

47 WHO, “Polio Infrastructure Remains Crucial for Mounting Initial Response to Disease Outbreaks in Nigeria,” August 23, 2018, available at <https://afro.who.int/news/polio-infrastructure-remains-crucial-mounting-initial-response-disease-outbreaks-nigeria>.

48 WHO and Government of Nigeria, “Nigeria: Northeast Response—Health Sector Bulletin No. 10,” October 2018.

49 For example, IOM provides direct psychosocial support and services to affected populations in Borno, Adamawa, and Yobe. WHO and Government of Nigeria, “Nigeria: Northeast Response—Health Sector Bulletin No. 8,” August 2018.

skills and training, the challenge of funding such activities given the ethical requirement of longer-term engagement, and the cultural stigma around mental health issues. Furthermore, the Nigerian government has reportedly pushed back against mental health and psychosocial support interventions and closely scrutinized psychosocial support activities that have been undertaken.⁵⁰ Noncommunicable diseases more generally are also considered a health priority in the 2018 humanitarian response plan but have reportedly been seriously neglected both in discussions and in the implementation of programs.

Sexual and reproductive health services are being implemented through the Minimum Initial Service Package, the international framework for responding to sexual and reproductive health needs in humanitarian crisis settings. The UN sexual and reproductive health sub-working group has grown from four to twenty-two partners over the last two years, and organizations are increasingly looking to provide comprehensive sexual and reproductive health services in the clinics they support, including medical responses to gender-based violence. There do appear to be some positive trends, but important gaps remain. Very few health workers are adequately trained to provide holistic and comprehensive sexual and reproductive healthcare. Given the level of need, the response is still insufficient.

Interviewees also mentioned the huge gap in secondary healthcare. While most humanitarian health organizations in the northeast focus on primary healthcare, there is no comprehensive secondary care in most local government areas in Borno. Most interviewees also stressed the lack of a proper referral system, though efforts are underway to improve and strengthen this. Finally, although the issue was not necessarily seen as being under-prioritized, there remains a strong need for maternal and child health services given the scope of the crisis.

LIMITED ENGAGEMENT WITH LOCAL HEALTH ORGANIZATIONS

The 2018 humanitarian response plan commits to promoting the localization of the humanitarian response in the northeast, but engagement of local

partners by international humanitarian actors appears limited in the health sector. For example, the voices of local NGOs are reportedly insufficiently present in the health sector working group. Many of the big donor agencies do not work directly with local partners, and some are legally restricted from funding local organizations.

However, donor agency representatives stressed that they encourage their implementing partners to work with local organizations. Some donors also contribute to the Nigeria Humanitarian Fund, which provides funds to local partners. Several interviewees pointed to the fact that there was little local humanitarian expertise and capacity in Nigeria when the humanitarian response started and that local capacity was only slowly building. Nonetheless, most humanitarian health actors work through and train community-based health workers, who are often the only people available on the ground.

THE STRUGGLE TO PROVIDE SUSTAINABLE HEALTH SERVICES

Ensuring the sustainability of health services remains a key challenge for international actors in northeastern Nigeria. This is particularly challenging in Borno State, in large part because of the Ministry of Health's absence from most local government areas. Humanitarian health actors, where possible, work through existing health facilities, and many have signed memoranda of understanding with the Ministry of Health. In most areas, however, they are close to substituting for government health services, with no real hope of handing over to the government, whose capacity, funding, and human resources for health remain insufficient.

Furthermore, the involvement of UN agencies and international NGOs poses challenges for hand-over and hence sustainability. They have tended to provide free health services in Ministry of Health facilities, depriving them of revenue and thus threatening their survival. Many skilled health workers have left government employment to work for UN agencies or international NGOs, which they perceive as providing better opportunities. Some international NGOs have also hired third-party contractors to provide health services in areas

⁵⁰ Interview with humanitarian expert, Maiduguri, September 2018.

where there are no Ministry of Health staff or volunteers.

Nonetheless, there are many efforts to strengthen the public healthcare system, notably by supporting primary healthcare facilities and Ministry of Health staff where they are present, in particular through training. Donor agencies are reportedly increasingly requesting implementing partners to engage in such activities.

A NASCENT IMPLEMENTATION OF THE HUMANITARIAN-DEVELOPMENT NEXUS

Questions around sustainability tie directly into the conversation around the implementation of the humanitarian-development nexus in Nigeria. This is a central issue due to the protracted nature of the crisis and is one of the priorities identified in the 2018 humanitarian response plan. Moreover, Nigeria is a pilot country for the UN's New Way of Working, and the resident/humanitarian coordinator has published a strategic vision to support a platform to coordinate humanitarian and development assistance.⁵¹ The UN has also recently set up a humanitarian-development nexus taskforce in Abuja to develop collective outcomes for the humanitarian and development sectors for the next three to five years, and WHO is creating a humanitarian-development nexus working group for health in Maiduguri. The government has clearly been pushing for a transition to development through its Presidential Committee for the North East Initiative, aimed at coordinating recovery efforts, and the so-called "Bama Initiative," an effort to rehabilitate local government areas to support the return of displaced persons. Two international conferences, one in Oslo in 2017⁵² and one in Berlin in 2018,⁵³ brought international attention to the crises in the Lake Chad region, and

the need to support humanitarian, development, and peacebuilding activities in Niger, Chad, Nigeria, and Cameroon.

Donor agencies have also focused on the humanitarian-development nexus. The European Union is piloting its implementation in the Lake Chad region and has developed a package aimed at restoring basic services in Borno State that covers both humanitarian and development activities. It is also developing one for Yobe State. The UK's Department for International Development is about to launch a new eight-year health program in five northern states, including Yobe and Borno, through which it will work with both development and humanitarian actors. The World Bank has developed a multi-sectoral crisis recovery project for northeastern Nigeria,⁵⁴ and its national Saving One Million Lives project and performance-based financing initiative include some funds for the northeast. Events and workshops are being held for donors to get behind one approach for both addressing drivers of conflict and providing relief.

However, despite international focus on the humanitarian-development nexus in theory and policy, its implementation has been limited. Organizations are making individual and sporadic attempts to tie humanitarian, recovery, and development efforts and actors together, but they are not guided by an overarching goal or framework. Proper implementation of the nexus also requires better coordination between humanitarian and development actors, as well as among development actors.

In the health sector, development-oriented activities remain limited in the northeast. There has been some work to strengthen health systems, but these have been mainly implemented by humanitarian actors with funding for early recovery

51 Edward M. Kallon, "Strategic Vision to Support a Coordinated Platform for the Delivery of Humanitarian and Development Assistance in Nigeria," UN Office of the Resident and Humanitarian Coordinator Nigeria, August 2017. Other UN documents relevant to the humanitarian-development nexus include UNDP and UNHCR, *Strategy on Protection, Return and Recovery for the North-East Nigeria*, February 2017; and UNDP and OCHA, *Resilience for Sustainable Development in the Lake Chad Basin*, August 2018. The UNDP administrator and the emergency relief coordinator recently went on a joint visit to Nigeria and "called on national and international partners to reinforce joint efforts to address dire humanitarian needs in the conflict-affected northeastern Nigerian states of Borno, Adamawa and Yobe, while at the same time speed up the recovery of livelihoods." UNDP and OCHA, "United Nations Humanitarian and Development Chiefs Join Forces to Support Crisis-Affected People in North-East Nigeria," October 2018.

52 The Oslo Humanitarian Conference on Nigeria and the Lake Chad Region raised \$672 million. UN OCHA, "Oslo Humanitarian Conference for Nigeria and the Lake Chad Region Raises \$672 million to Help People in Need," February 24, 2017, available at <https://reliefweb.int/report/nigeria/oslo-humanitarian-conference-nigeria-and-lake-chad-region-raises-672-million-help>.

53 The High-Level Conference on the Lake Chad Region raised \$2.17 billion in grants and \$467 million in concessional loans. German Federal Foreign Office, "High-Level Conference on the Lake Chad Basin, Outcome Statement by the Co-hosts," September 2-4, 2018, available at <https://lakechadberlin.de/wp-content/uploads/2018/09/ENG-001-CO-HOSTS-OUTCOME-STATEMENT-FINAL-2.pdf>.

54 The World Bank conducted a recovery and peacebuilding assessment in northeastern Nigeria that looked at health issues and the need to reconstruct or repair health facilities and increase the availability of health services. See: *North-East Nigeria: Recovery and Peace Building Assessment—Synthesis Report*, June 2017; World Bank, *Project Appraisal Document: Multi-Sectoral Crisis Recovery Project for Northeastern Nigeria*, March 2017.

through humanitarian channels. This has included, for example, the rehabilitation of health structures and the implementation of the recovery and development parts of the Minimum Initial Service Package in more stable areas. One interviewee raised concerns about some development-oriented projects, describing one that interrupted ongoing health services without providing interim solutions and others that were being undertaken without prior needs assessments.⁵⁵

One key question is where it is appropriate and feasible to implement the humanitarian-development nexus in northeastern Nigeria. All interviewees agreed that such activities would be more appropriate in Adamawa and Yobe States, which are more stable and have a stronger government presence. Many interviewees questioned the relevance and feasibility of nexus activities in much of Borno State, where communities have been destroyed, attacks and displacement continue, and military escorts are required outside of the cities. Existing services are provided by humanitarian actors; no government or civilian structures are present. In many accessible areas, even the humanitarian response is poor quality. This is due in part to insufficient presence on the ground, which also makes it difficult to envision more risk-averse development actors working there.

Nonetheless, development actors have been increasingly focused on Borno State. Although there may be opportunities in some parts of the state, and focusing on development in these areas could help push the government to expand its civilian presence, the security situation remains concerning. Some interviewees expressed concern about the impact of focusing on development in areas where there are still clear humanitarian needs, stressing that development needs to complement—not replace—humanitarian action.

INSUFFICIENT ACCOUNTABILITY FOR HEALTH SERVICES PROVIDED

One of the key gaps of the humanitarian response—in all sectors—is its quality. This was largely attributed to insufficient accountability. Given the insecurity and challenges in access, most

organizations are unable to adequately monitor and supervise their activities. Indeed, few organizations have senior staff on the ground, and most monitor activities by conducting infrequent, short visits from Maiduguri. Several interviewees mentioned their organization's efforts to strengthen internal monitoring, and some reported working on setting up third-party monitoring mechanisms. The inter-sector coordination group does produce a periodic monitoring report every six months, but it only covers quantitative indicators.⁵⁶

The humanitarian response in northeastern Nigeria also lacks systematic efforts to promote accountability to affected populations. OCHA chairs a working group on accountability to affected populations/community engagement, and there are discussions about developing an accountability-to-affected-populations action plan, but many interviewees felt that not enough was being done. Some interviewees questioned the added value of such initiatives, pointing out that with so few health actors and services in many areas, people would not dare complain about the only actor operating in their area or would ask for more services rather than improved quality.

Some humanitarian health organizations have set up suggestion boxes, but given language barriers and low literacy rates, these have reportedly not been very effective. Others have created free phone call systems, with varying reports as to their functionality. The UN is rolling out a new project in the northeast, U-Report, which will enable the conduct of monthly surveys that can be targeted geographically. However, this system works through text messaging, and many areas, especially in Borno State, are cut off from the phone network. Additionally, the most excluded populations may not own mobile phones. One of the key ways humanitarian health actors have engaged with communities is by supporting community committees. They have used these structures to inform and engage with communities, and some interviewees stressed that this is one way they have been able to obtain qualitative community feedback on their programs.

55 Interview with humanitarian expert, Maiduguri, September 2018.

56 Inter-Sector Coordination Group, "Periodic Monitoring Report, January to June, 2018," available at https://reliefweb.int/sites/reliefweb.int/files/resources/28092018_nga_pmr_january_june_2018.pdf.

Conclusion

Humanitarian and health actors in northeastern Nigeria face numerous challenges to providing adequate services to those who need them. The volatile security situation, in particular in Borno State, is a key challenge for all actors operating there. Related restrictions to accessing populations in areas outside of government control are also a major concern, as over 800,000 people remain completely out of reach for aid organizations. These government-imposed restrictions, as well as the fact that the government is engaged in an armed conflict with a designated terrorist group, challenge organizations' ability to conduct principled humanitarian action. These challenges affect the ability of humanitarian health actors to coordinate the health services they provide, ensure these services are sustainable and consider the need for longer-term recovery and development, and monitor implementation. In spite of the complex political and security situation, there are a number of ways these actors can improve delivery of health services in northeastern Nigeria:

- **Humanitarian health actors should improve coordination both with each other and with global health actors working in northeastern Nigeria.** They should particularly strengthen coordination at the level of local government areas. This requires building the capacity of staff at the more local level. Humanitarian and global health actors should also explore how infrastructure such as that set up for the polio response could be used to provide other types of health services, in particular in areas that are hard for humanitarian organizations to reach.
- **Relevant UN agencies, local and international health organizations, donor agencies, and the Ministry of Health should scale up the response to under-prioritized health services.** In particular, they should strengthen efforts to make mental health services more widely available. Given widespread sexual and gender-based violence, clinical responses to sexual and reproductive health issues also need to be scaled up. Finally, more organizations need to strengthen their capacity to provide secondary healthcare services.
- **Humanitarian and development actors, donor agencies, and the Ministry of Health should focus efforts to implement the humanitarian-development nexus for health services on areas where it is relevant and feasible.** Given the security situation in Nigeria's Borno State, emphasis should be put on Adamawa and Yobe States, where greater stability makes recovery- and development-oriented solutions more promising.
- **Humanitarian health actors should improve their accountability for the health services they provide.** This could be done, for example, by ensuring the presence of more senior staff at the field level and conducting more regular and longer monitoring and evaluation visits. Organizations should also strengthen their accountability to affected populations and build the capacity of communities to engage with the activities or mechanisms they put in place.
- **Humanitarian donor agencies need to ensure that counterterrorism clauses in their funding contracts are not overbroad and do not impede the ability of humanitarian actors to provide neutral, independent, and impartial aid.** They should acknowledge the complexity of the work of humanitarian actors in northeastern Nigeria and explore frameworks to ensure humanitarian actors are not shouldering the bulk of the risks.

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