GOVERNANCE AND POLITICAL AGENDA

FOR HEALTH

(Mainstreaming Social Justice In Public Life)

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By

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ACRONYMS

ANC	Ante Natal Care
BHCPF	Basic Health Care Provision Fund
CHEWs	Community Health Extension Workers
CHOs	Community Health Officers
CRD	Chronic Respiratory Disease
CVD	Cardio Vascular Diseases
ERGP	Economic Reform ad Growth Plan
FGN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
GDP	Gross Domestic Product
GMP	Good Manufacturing Practices
GSM	Global system for Mobile Communications
HIS	Health Insurance Scheme
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IDSR	Integrated Disease Surveillance and Response
JCHEWs	Junior Community Health Extension Workers
LGA	Local Government Area
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn and Child Health
NAFDAC	National Agency for Food, Drug Administration and Control
NCD	Non Communicable Disease
NHA	National Health Act
NHP	National Health Policy
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
PHC	Primary Health Care
PLHIV	People Living with HIV
PPP	Public Private Partnership
RH	Reproductive Health

SMART	Simple, Measurable, Achievable, Realistic, Timely
THE	Total Health Expenditure
UBEC	Universal Basic Education Commission
UHC	Universal Health Coverage
CESR	Covenant on Economic, Social and Cultural Rights
UNCESCR	United Nations Committee on Economic, Social and Cultural Rights
USD	United States Dollar
WDC	Ward Development Committee
WHO	World Health Organization

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INTRODUCTION

The theme of the National Health Policy 2016 is; “promoting the health of all Nigerians to accelerate socio-economic development”. The theme recognises the fact that health is central to the life of the population and the nation. There is no Nigeria without Nigerians and if Nigerians have to enjoy the constitutional right to life, their access to the best attainable standard of physical and mental health must be guaranteed.

Politics is the art of managing and allocating resources to competing needs. It is all pervasive and encompassing. It determines the standard of health care we receive, the availability and quality of food we eat and even the quality of the air we breathe, because decisions about the foregoing are guided by laws and policies which are the products of political contestation. The implementation of these laws and policies also depend on the political will of individuals and political parties at the helm of affairs.

Considering the poor state of health care in Nigeria, there are several questions begging for answers. What did the political parties and candidates promise in their manifestoes in previous election cycles? Were the promises in manifestoes implemented or implementable? Were the promises:

- Specific through targeting specific health challenges and indicators for improvement;
- Measurable through being quantifiable and stating indicators for progress;
- Attainable by not being pipe dreams, through being feasible and realistic and assignable to key stakeholders who are in a position to implement them: Did the promises take into consideration the social and economic context of the country?;
- Realistic through being feasible, considering available resources or new resources that could be generated from an optimally operated system;
- Timely, raises the question whether the promises were achievable within the timeframe of the life of the administration or extended versions of the promised timeframe.

Nigeria’s current health indicators clearly show that previous health promises by political parties were not SMART and even the components that were actionable, were not implemented. We had a situation where a political party promised to increase the number of physicians by 150% in four years- an impossible task considering the number of years it takes to train a physician. Promises of free health care were made without an iota of thinking through the cost. Thus, previous political manifestoes on health were simply a wish list, without a clear intent that the promises will be implemented.

A summary of Nigeria’s health statistics is detailed below.

Table 1: Summary of Nigeria's Health Indicators

INDICATOR	
Life Expectancy at Birth (Male)	54.7
Life Expectancy at Birth (Female)	55.7
Life Expectancy at Birth (Both Sexes)	55.2
Maternal mortality ratio (per 100,000 live births)	814
Proportion of births attended by skilled health personnel (%)	43
Under-five mortality rate (per 1000 live births)	104.3
Neonatal mortality rate (per 1000 live births)	34.1
Tuberculosis incidence (per 100,000 population)	219
Malaria incidence (per 1000 population at risk)	349.6
Reported number of people requiring interventions against NTDs (Neglected Tropical Diseases)	128, 936, 746
Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70 (%)	22.5
Suicide mortality rate (per 100 000 population)	9.5
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)	26.3
Adolescent birth rate (per 1000 women aged 15–19 years)	145.0
UHC service coverage index	39
Density of physicians (per 1000 population)	0.4
Density of nursing and midwifery personnel (per 1000 population)	1.5
Density of dentistry personnel (per 1000 population)	0.0
Density of pharmaceutical personnel (per 1000 population)	0.1
Prevalence of stunting in children under 5 (%)	43.6

Source: World Health Statistics 2018, World Health Organization

The foregoing indicators show that Nigeria has not been respecting its obligations of conduct and obligations of result in health care; neither has it been respecting the obligations to respect, protect and fulfill the right to health. A change in direction is needed and change needs to guarantee an appropriate governance and political agenda for the health sector.

This handbook seeks to provide direction for the context of the change as it sets a governance and political agenda for the health sector. It reviews the building blocks of health and asks leading questions with a boxed-in context to help political parties,

presidential aspirants and candidates to focus on key issues in their policies and manifestoes. The purpose is to mainstream health issues in governance and political discourse so that it will be a national priority in political debates. It provides a checklist which political parties can use to benchmark their manifestoes without having to go through bulky legal and policy frameworks. It can be used to engage political and governance discourse at both the federal and state levels.

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Lead Director

GOVERNANCE AND STEWARDSHIP FOR HEALTH

1.1 Legal and Policy Frameworks: Nigeria has operated two comprehensive national health policies (1988 and 2004) and a National Strategic Health Development Plan (NSHDP) 2010-2015. The Second NSHDP 2018-2022 is reported to have been developed. A third health policy, the 2016 National Health Policy (NHP) has been adopted by the National Council on Health. What would the party do to strengthen legal and policy frameworks?

The NHP 2016 at page 13 States that: "*Nigeria is governed by the provisions of the 1999 Constitution. Unfortunately, it does not lay emphasis on health and fails to state the roles and responsibilities of the 3-tiers of Government in health systems management and delivery. The National Health Act 2014 is the first legislative framework for the health system. The country has several sub-sectoral policies and plans including the reproductive health policy, national Human Resources for Health (HRH) policy and plan, national health promotion policy, health financing policy, amongst others".* In 2014, the Constitution Amendment exercise provided for maternal and child health as justiciable Fundamental Rights in Chapter 4 of the Constitution. However, the amendment did not scale through after approval by 24 states of the Federation because the President refused to give assent to the Bill due to legislative executive feud which had nothing to do with the amendment. The Constitution is the *grundnorm* and ranks highest in the hierarchy of laws. As such, it needs definitive statements on the right to health. There was a three year hiatus between the expiry, by effluxion of time, of the First NSHDP and the Second NSHDP. Many of the policies are old and need to be updated to take into consideration developments in demographics, modern technology, social developments, etc.

1.2 Coordination and Oversight: The National Health System suffers from poor oversight and coordination. What would the party do to entrench effective coordination and oversight?

The NHP at page 13 states: "*There is an existing framework for oversight of programme implementation, starting with the National Council on Health at the highest level. There are various national coordination platforms including the Health Partners Coordinating Committee chaired by the Minister of Health, the Development Partners Group for health, and different Thematic Technical Groups and Task Teams. There is however poor coordination and harmonization of these groups, leading to duplication of functions and waste of scarce resources*". The NHP further states that there is ineffective coordination among the three levels of government and between the private and public sectors. However, the National Health Act makes detailed provisions for the governance of the National Health System. It is generally accepted that Primary Health Care (PHC) is reserved for states and local governments but many federal constituency projects focus on the capital components of PHC facilities. Many completed federal constituency project PHC facilities are not operational after completion where states and LGAs did not buy into the projects. Thus, available resources were wasted.

1.3 Executive Legislative Collaboration for Health: Collaboration between the Executive and Legislature is imperative in ensuring good health care for the population.

How would the party manage Executive Legislative relationships to generate a good partnership for health?

The Legislature is the arm of government charged with making laws for the peace, order and good government of the Federation and the States while the Executive executes laws and policies. In presidential democracies, there is an inbuilt tension in the relationship between the Executive and the Legislature, with obvious checks and balances. The general position is the Executive originates and prepares budgets while the Legislature approves and exercises oversight over the management and use of public resources. Good working relationship between the Executive and Legislature is imperative for improved allocations to health, value for money and improvements on health delivery.

1.4 Benchmarking and Positive Competition: Benchmarking is the practice of evaluating something by comparing it with a standard. States and components of the National Health System can be peer reviewed; be evaluated against best, fit for purpose and good practices with a view to peer learning and learning from the best in class. Will the party consider this a good practice and how would the party implement this?

Nigeria in 2005, during the implementation of the National Economic Empowerment and Development Strategy of the Obasanjo administration, undertook a benchmarking exercise for State Economic Empowerment and Development Strategies. The benchmarking was divided into various components. The report encouraged states to improve their public finance management system, reduce poverty, enhance policy formulation and implementation, etc. This can be replicated in the health sector. Benchmarking exercises can be tied to a challenge fund, an incentive to encourage the best performers and some form of naming and shaming of laggards who have failed to take steps to improve the health system of their states and agencies. Benchmarking should be collaborative between the government, donors and civil society. In two benchmarking exercises undertaken by Centre for Social Justice at the federal level, notably, the Fiscal Responsibility Index and the Budget Inequality Index[1], the Ministry of Health performed poorly among the benchmarked Ministries. This shows a weak capacity to deliver on its vision, mission and overall national health goals.

1.5 Accountability, Transparency and Civil Society Partnership: Accountability and transparency are two sides of the same coin and they are qualities of a functional, efficient and effective health system. They build confidence in the system and guarantee that all partners have the opportunity to contribute to the development of the sector. Extant government civil society collaboration is perfunctory. How will the party guarantee accountability and transparency in the health sector?

[1] The Fiscal Responsibility Index looked at the key parametres of fiscal responsibility including transparency, accountability and value for money while the Budget Inequality Index considered how policies, plans and programmes of Ministries contributed to the reduction of inequality.

The NHP states that there is a lack of transparency in the budgetary process. While the federal budget appropriation is published, information on state budget appropriations is not usually publicly available. In addition, budget execution reports are not made public. There is high level of corruption and fraud; inadequate level of accountability and transparency; lack of effective mechanisms for engaging consumers in policy and plan development and implementation. Civil society is considered a meddlesome interloper by government, and as such, there is hardly a meaningful engagement between government and civil society.

1.6 Standards: The standard of health services delivered in Nigeria's health institutions need to be improved. The services do not represent the best that the country can deliver. What will the party do to improve standards?

The National Health Act in sections 13 and 14 states as follows: "*13. (1) Without being in possession of a Certificate of Standards, a person, entity, government or organization shall not :- (a) establish, construct, modify or acquire a health establishment, health agency or health technology; (b) increase the number of beds in, or acquire prescribed health technology at a health establishment or health agency; (c) provide prescribed health services; or (d) continue to operate a health establishment, health agency or health technology after the expiration of 24 months from the date this Bill took effect. (2) The Certificate of Standards referred to in subsection (1) of this section may be obtained by application in prescribed manner from the appropriate body of government where the facility is located. In the case of tertiary institutions, the appropriate authority shall be the National Tertiary Health Institutions Standards Committee, acting through the Federal Ministry of Health. 14. Any person, entity, government or organisation who performs any act stated under section 13 (1) without a Certificate of Standards required by that section is guilty of an offence and shall be liable on conviction to a fine of not less than N500,000.00 or in the case of an individuals to imprisonment for a period not exceeding two years or both".*

1.7 Monitoring and Evaluation: Instituting a comprehensive accountability framework that promotes effective monitoring and evaluation of health sector performance, system audit, feedback system, due process in procurement and independent verification is imperative for the improvement of healthcare delivery[2]. What will the party do to improve monitoring and evaluation in the health sector?

"Monitoring and Evaluation (M&E) is a process that helps improve performance and achieve results. Its goal is to improve current and future management of outputs, outcomes and impact. It is mainly used to assess the performance of projects, institutions and programmes. It establishes links between the past, present and future action"[3]. Health M&E is *"about collecting, storing, analyzing and finally transforming data into strategic information so it can be used to make informed decisions for programme management and improvement, policy formulation, and advocacy"- https://www.globalhealthlearning.org/program/monitoring-and-evaluation.*

[2] See page 26 of the National Health Policy.
[3] https://en.wikipedia.org/wiki/Monitoring_and_evaluation.

2. HEALTH FINANCING

2.1 15% Budget Benchmark: The 2001 Abuja Declaration of African Heads of State recommends 15% of a country's annual budget to be dedicated to health care. Considering the demands of other sectors, including the poor infrastructure and educational outcomes, what percentage of the budget will the party dedicate to the health sector?

Government takes the lead in health financing and the budget is a clear indicator of the level of commitment of a government to sectoral financing. Section 1(c) and (e) of the National Health Act provides for the state obligation to provide for persons living in Nigeria the best possible health services within the limits of available resources; and to protect, promote and fulfill the right of the people of Nigeria to have access to health care services. Other less endowed and resource poor countries in Africa have dedicated larger percentages to healthcare: Algeria (10.67%), Botswana (8.82%), The Gambia (10.62%), Ghana (7.08%), Guinea Bissau (9.51%), Madagascar (15.61%), Malawi (10.77%), Sierra Leone, (7.86%), South Africa (14.06%), Tunisia (13.57%), etc.[4]

Table 2: Government Health Expenditures as % of Total Health Expenditures in Africa (2015)

Countries	**Government Health Expenditure (as % of Total Health Expenditure)**
Namibia	62.98
South Africa	53.55
Kenya	44.86
Ghana	34.95
Egypt	30.08
Ethiopia	26.87
Cote d'Ivoire	21.83
Rwanda	21.37
Niger	21.02
Nigeria	16.53

Source: World *Bank* (2018), World Development Indicators 2018

2.2 Appropriation, Releases and Utilization: In funding in the last 9 years - the average funding at the federal level has averaged 4.99% of the overall budget as indicated in Table 3. Compared to the demands of the Abuja Declaration, this has left a funding gap of N5.124 trillion in the nine years. Table 4 shows the real picture in terms of budgeted sums, released sums and utilised sums. How will the party address the variance between budgeted, released and utilised sums to ensure that the full budgeted sums get to the Federal Ministry of Health (FMoH) and is utilised for the appropriated purposes?

[4] This is statistics for the year 2015: Source: https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS.

According to the Fiscal Responsibility Act[5], the sums appropriated for a specific purpose shall be used solely for the purpose specified in the Appropriation Act. The Ministry of Finance rationalizes expenditure in the event budgeted revenue is not realized and this process is also a determination of governmental priorities. Ring-fencing the budget of critical sectors may be considered an innovation to ensure that targets and goals are realised.

Table 3: Shortfall in the 15% Benchmark to Health Sector

Year	Total Budget (N' Billion/Trillion)	Health Allocation (N' Billion)	As % of Total Budget	As 15% of Total (N' Billion)	Variance from 15% Benchmark (N' Billion)
2010	**4,427,184,596,534**	**164,914,939,155**	**3.73**	**664,077,689,480**	**499,162,750,325**
2011	**4,484,736,648,992**	**257,870,810,310**	**5.75**	**672,710,497,349**	**414,839,687,039**
2012	**4,648,849,156,932**	**284,967,358,038**	**6.13**	**697,327,373,540**	**412,360,015,502**
2013	**4,987,220,425,601**	**282,501,464,455**	**5.66**	**748,083,063,840**	**465,581,599,385**
2014	**4,695,190,000,000**	**264,461,210,950**	**5.63**	**704,278,500,000**	**439,817,289,050**
2015	**4,493,363,957,158**	**259,751,742,847**	**5.78**	**674,004,593,574**	**414,252,850,727**
2016	**6,060,677,358,227**	**250,062,891,075**	**4.13**	**909,101,603,734**	**659,038,712,659**
2017	**7,441,175,486,758**	**308,464,276,782**	**4.15**	**1,116,176,323,014**	**807,712,046,232**
2018	**9,120,334,988,225**	**356,450,966,085**	**3.91**	**1,368,050,248,234**	**1,011,599,282,149**
Totals		**2,429,445,659,697**		**7,553,809,892,765**	**5,124,364,233,068**

Source: Approved Budgets 2010-2019: Budget Office of the Federation

Table 4: NSHDP, Health Capital Budget Allocation, Releases, Cash Backed and Utilisation

Year	FG Projected Contribution to the NHSDP (N'bn)	Approved Capital Health Budget (N'bn)	Released Health Capital Budget (N'bn)	Cash Backed Health Capital Budget (N'bn)	Utilised Sum of the Health Capital Budget (N'bn)	Utilised as a Percentage of Approved Budget	Utilised as a Percentage of Cash Backed Sum
2010	189,244.09	53,066	33,570	33,562	17,745	33.44	52.87
2011	189,244.09	55,415	38,785	38,716	32,165	58.04	83.08
2012	189,244.09	60,920	45,001	37,171	33,682	55.29	90.61
2013	189,244.09	60,047	28,838	28,838	19,109	31.82	66.26
2014	189,244.09	49,517	20,472	20,472	18,688	37.74	91.28
2015	189,244.09	22,676	16,445	16,445	12,214	53.86	74.27
2016	189,244.09	28,650	28,593	28,593	27,810	97.07	97.26
Total	**1,324,708.63**	**330,291**	**211,704**	**203,797**	**161,413**	**Average for 7 years: 52.47**	**Average for 6 years: 79.38**

Source: Budget Implementation Reports - Budget Office of the Federation

- NOTE: In 2017, out of NGN 55,609,880,120 Capital Budget for Health, only NGN N13,488,516,307 was released and NGN 13,488,516,307 was cash backed as at the third quarter of 2017.

2.3 Retaining the Status Quo? Will the party retain the status quo in official health financing or will it increase or reduce the health budget? What reasons could possibly

[5] Section 27 (1) of the Fiscal Responsibility Act.

inform an increase or reduction of the health budget? Total expenditure on health as a percentage of Gross Domestic Product (GDP) is 3.7%[6]. Thus, Nigeria spends less than 5% of its (GDP) on health, and annual per capita health spending is less than what is required to meet Universal Health Coverage. How will the party improve best value for money in the health sector?

Retaining the status quo will imply that extant health indicators are satisfactory and we are happy with them. Increase in financing may or may not translate into improved services, if value for money is not mainstreamed. Value for money comes with its three cardinal parametres of economy, efficiency and effectiveness. Economy - the practice by management of thrift and good housekeeping, acquiring human and materials resources in appropriate quantity and quality at the lowest possible cost. Efficiency - ensuring that the maximum useful output is gained from the resources devoted to each activity, or alternatively that only the minimum level of resources is devoted to achieving a given level of output, reducing waste in the system. Effectiveness is about ensuring a focus on policy outcomes, improving health[7] indicators and realization of policy objectives. Paragraph 32 of the General Comment on the Right to Health states: *"As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberate retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided in the Covenant in the context of the full use of the State party's maximum available resources".* Essentially, the commitment on the right to health is a forward ever obligation.

2.4 Incrementalism or Quantum Leap? Will the party adopt incrementalism in health financing or will it adopt the quantum leap approach or leap frogging in a way and manner that delivers practical and realistic change - moving human and materials resources into the system at once.

Incrementalism is a method of working by adding to a project using many small incremental changes instead of a few (extensively planned) large jumps. Logical *incrementalism* implies that the steps in the process are sensible[8]. It implies change by degrees or gradualism. Quantum leap is about abrupt change, sudden increase, or dramatic advance[9].

2.5 Basic Health Care Provision Fund: What is the position of the party on the Basic Health Care Provision Fund (BHCPF) as provided for in section 11 of the National Health Act (NHA)? What percentage of the Consolidated Revenue Fund will the party commit to the BHCPF? Any plans for the expansion of funds available under the BHCPF and what strategies would the party use in the expansion?

[6] This is the percentage as at 2014; see http://www.who.int/countries/nga/en/.
[7] The Pursuit of Value for Money by Samuel O. Afemikhe at pages 4-5.
[8] https://en.wikipedia.org/wiki/Incrementalism
[9] *https://www.merriam-webster.com/dictionary/quantum%20leap*

Section 11 of the National Health Act provides for a BHCPF as follows: *(1) There is hereby established a Basic Health Care Provision Fund (in this Act referred to as "the Fund). (2) The Basic Health Care Provision Fund shall be financed from - (a) Federal Government annual grant of not less than one percent of its Consolidated Revenue Fund (b) grants by international development partners; and (c) funds from any other source.* The stated percentage of the Federal Government grant is the minimum and not the maximum, meaning that it can be increased. What other sources as stated in subsection (c) can the party exploit in increasing funding for the BHCPF?

2.6 Access to the BHCPF: Considering the experience of states in accessing the Universal Basic Education Fund, how would the party ensure operationalization and improved access to the BHCPF? The UBEC funds are available but states, due to a number of reasons are not accessing the idle funds.

The National Health Act in section 11 states: *"(5) For any State or Local Government to qualify for a block grant pursuant to subsection (1) of this section, such State or Local Government shall contribute (a) in the case of a State, not less than 25% of the total cost of the project; (b) in the case of a Local Government, not less than 25% of the total cost of the project as their commitment in the execution of such project. (6) The National Primary Health Care Development Agency shall not disburse money to any (a) Local Government Health Authority if it is not satisfied that the money earlier disbursed was applied in accordance with the provisions of this Act (b) State or Local Government that fails to contribute its counterpart funding and (c) States and Local Governments that fail to implement the National Health Policy, norms, standards and guidelines prescribed by the National Council on Health".*

2.7 Prioritisation in Health Care: Which aspect of health care – preventive, promotive and curative; primary, secondary and tertiary will the party dedicate the most attention to? What reasons will inform the prioritization of investments and public attention?

Identifying the core state obligations in health is imperative. The Committee on Economic, Social and Cultural Rights affirmed the following as being part of the minimum core obligations of the state in health: reproductive, maternal (prenatal as well as post natal) and child health care; immunization against the major infectious diseases occurring in the community; prevention, treatment and control of epidemic and endemic diseases; provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them and provision of appropriate training for health personnel including education on health and human rights[10]. "*A State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care...is prima facie failing to discharge its obligations under the Covenant*"[11].

[10] Paragraph 44 of General Comment on the Right to Health of the Committee on Economic, Social and Cultural Rights.
[11] Paragraph 12 of Committee on Economic, Social and Cultural Rights' General Comment No.3 on the nature of State party's obligations under the Covenant (article 2, paragraph 1 of the Covenant).

2.8 Economic Accessibility (Affordability): How will the party increase economic accessibility (affordability) of health care? Considering that budgetary resources for health may never be enough to adequately fund health care services, how else will the party improve financing for health? Nigeria's out- of-pocket health expenditure is about 72% of total health expenditure (THE) while the country has the largest population of the poor in the world.

"Health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households"[12]. "*The Committee recalls General Comment No.3 paragraph 12 which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low cost targeted programmes"*[13]. The UBEC example provides a special fund for basic education; SIN taxes could discourage unhealthy lifestyles while providing more resources for funding healthcare, while minimal surcharges on imports and other economic activities could be considered. Incentive based reordering of taxation could make donations to government for health care delivery tax deductible up to a certain limit of taxable income. The idea of a Health Bank of Nigeria could be explored to deepen health financing and to provide funds for the health sector beyond budgetary allocations and money from the National Health Insurance Scheme. The Bank is to focus on funding for the development of hospitals and other health institutions; human resources for health in terms of giving out student loans for the acquisition of rare and advanced competencies in the medical sciences; health infrastructure funding and for research on key tropical diseases and medical conditions prevalent in epidemiological analysis. The Bank will also be involved in loans to drugs and health hardware and software manufacturing institutions and service providers. Essentially, the Health Bank will be set up to respect, protect, promote and fulfill the enjoyment of the right to health.

The Bank will give out single digit interest loans or loans at rates below that which is available in money deposit banks. The loans will be long term in nature, with a long period of amortization. The Bank will not essentially be set up for profit but for the furtherance of the right to health. However, it is not expected to be loss making. It should be self-sustaining and earn income and profits at a rate below the prevailing market rate. The initial capital will be subscribed to by the Federal Government through the Central Bank and Ministry of Finance. Regional and international development banks such as the African Development Bank and World Bank, etc. can also be called upon to subscribe.

[12] Paragraph 12 of the General Comment on the Right to Health of the Committee on Economic, Social and Cultural Rights.
[13] Paragraph 18 of the General Comment on the Right to Health of the Committee on Economic, Social and Cultural Rights.

2.9 Health Insurance (Private and Social): Would the party introduce universal and compulsory prepaid health insurance schemes?

Health insurance and prepaid health care penetration is available to less than 5% of the population. It pools resources from a large number of insured for the treatment of persons who need the services; it facilitates access to health care and reduces the burden of out-of pocket-expenditure. For health insurance to be effective, it has to be universal and compulsory while the state intervenes to provide resources for the poorest of the poor who cannot afford to pay the premiums. The objectives of the extant National Health Insurance Scheme are as follows: ensure that every Nigerian has access to good health care services; protect families from the financial hardship of huge medical bills; limit the rise in the cost of health care services; ensure equitable distribution of health care costs among different income groups; and maintain high standard of health care delivery services within the Scheme. Other objectives are; ensure efficiency in health care services; improve and harness private sector participation in the provision of health care services; ensure adequate distribution of health facilities within the Federation; ensure equitable patronage of all levels of health care; and ensure the availability of funds to the health sector for improved services[14].

2.10 Recurrent Versus Capital Expenditure: The allocations to capital expenditure have been very low over the years as shown in Table 5 below. How would the party manage the interface between recurrent and capital expenditure?

Table 5: Recurrent Versus Capital Expenditure 2011-2018

Year	Overall Health Sector Allocation	Health Capital Expenditure Allocation	% of Capital to Overall Allocation
2011	257,870,810,310	38,785,000,000	15.04
2012	284,967,358,038	60,920,219,702	21.38
2013	282,501,464,455	60,047,469,275	21.26
2014	264,461,210,950	49,517,380,725	18.72
2015	259,751,742,847	22,676,000,000	8.73
2016	250,062,891,075	28,650,342,987	11.46
2017	308,464,276,782	55,609.880,120	18.03
2018	356,450,966,085	86,485,848,198	24.26

Source: Budget Office of the Federation

There has been a mismatch between the recurrent and capital funding of the Health Sector over the years. The average allocation to capital expenditure for the six years is 17.36%. With the lack of equipment and facilities in health establishments, there is evidence from Table 5 that the capital component of the health budget has been poorly funded. The right mix of capital and recurrent spending is required for optimum delivery of health services.

[14] See section 5 of the National Health Insurance Scheme Act, Laws of the Federation 2004.

2.11: Borrowing for Health Care: Nigeria has been borrowing to fund health care. How would the party respond to this development? Would the party continue to borrow for health care?

Nigeria is heavily indebted and its revenue to debt ratio is about 40%. FGN has been borrowing money from the World Bank to finance Health Sector activities. Examples include the borrowing of USD200million to fund vaccines procurement in 2015 and the USD 500million loan being used for Saving One Million Lives Program-for-Results (SOMLPforR). Although the health programmes are laudable, borrowing for health care financing is not sustainable; FGN should implement innovative local resource mobilization mechanisms to fund the health sector sustainably. This will include expansion of non-oil revenue. Creation of the enabling environment for the organized private sector and small businesses to thrive may help to improve the revenue profile of the country and improve quality of life.

3. HUMAN RESOURCES FOR HEALTH

3.1 Increasing the Number of Physicians and other Health Workers: How will the party increase the number of physicians, pharmacists and other health workers in Nigeria to match the national health priorities? The extant number of health personnel is not sufficient to meet the demands of healthcare in Nigeria.

Table 6 tells the story.

Table 6:.Nigeria's Human Resources for Health

Registered Health Worker Cadre	Number	Population Ratio per 100,000	Sub-Saharan African Population Ratio per 100,000[15]
Medical Doctors	65,759	38.9	15
Nurses and Midwives	249,566	148	72
Pharmacists	16,979	10	-
Community Health Officers (CHOs)	5,986	3.5	-
Community Health Extension Worker (CHEWs)	42,938	25.3	-
Junior Community Health Extension Workers (JCHEWs)	28,458	16.8	-
Radiographers	1,286	0.76	-
Medical Laboratory Scientists	19,225	11.3	-
Physiotherapists	2,818	1.7	-

Source: National HRH Profile 2013 cited in the NHP 2016

The availability of trained medical and health professionals and personnel receiving domestically competitive salaries is one the indicators of availability of functional public health and health care facilities and services[16]. Health facilities need adequate personnel to deliver effective service. The Basic Health Care Provision Fund established by section 11 of the National Health Act sets aside 10% of the Fund for the development of human resources for PHC. Section 41 of the Act is on the development and provision of human resources in the National Health System. It states: "*(1) The National Council shall develop policy and guidelines for, and monitor the provision, distribution, development, management and utilisation of human resources within the national health system. (2) The policy and guidelines stated in subsection (1) of this section shall amongst other things, facilitate and advance: (a) the adequate distribution of human resources; (b) the provision of appropriately trained staff at all levels of the National Health System to meet the population's health care needs; and (c) the effective and efficient utilisation, functioning, management and support of human resources within the National Health System".* It further provides in section 43 (d): *"The Minister shall make*

[15] WHO 2006
[16] Paragraph 12 (a) of General Comment No.12 of the UNCESCR on the Right to highest attainable standard of Health

regulations with regard to human resources management within the National Health System in order to: identify shortages of key skills, expertise and competence within the National Health System, and prescribe strategies which are not in conflict with any other existing legislation, for the education and training of health care providers or health workers in the Federation, to make up for any shortfall in respect of any skill; expertise and competence.

3.2 Inequitable Geographic Distribution of Health Personnel: The available health personnel are not equitably distributed across the Federation. They are concentrated in the urban areas and there is a wide disparity between the North and South of Nigeria and across geopolitical zones. How will the party achieve equitable spread across the federation? Table 7 shows the distribution and spread.

Table 7: Disparity in the Distribution of Various Cadres Health Workers Among Geopolitical Zones

Health Workers	Total Number	North Central %	North East%	North West%	South East%	South South%	South West%
Doctors	52, 408	9.73	4.06	8.35	19.59	14.37	43.9
Nurses	128,918	16.4	11.65	13.52	15.29	27.75	15.35
Radiographers	840	14.3	3.66	5.97	15.0	18.3	43
Pharmacists	13,199	19.94	3.8	7.79	11.74	12.39	44
Physiotherapists	1,473	10.8	2.73	8.32	8.58	7.93	62
Medical Lab Scientist	12,703	6.82	1.72	3.6	35.26	23.89	29
Environmental & Pub HW	4,280	9.39	11.27	18.94	12.36	15.69	32.08
Health Records Officers	1,187	13.34	4.85	11.6	14.64	29.9	26
Dental Technologists	505	14.08	5.92	5.92	12.96	16.62	44.5
Dental Therapists	1,102	13.19	10.29	21.86	10.19	12.99	31.5
Pharmacy Technicians	5,483	6.17	9.12	18	8.58	11.8	46

Source: Professional Regulatory Agencies 2008

Would the party consider incentives for health personnel to work in the rural areas and certain disadvantaged parts of the country? Incidentally, the areas that attract the least health personnel seem to need them the more. Section 42 of the Act states as follows: "*The Minister, with the concurrence of the National Council, shall determine guidelines that will enable the State Ministries and Local Governments to implement programmes for the appropriate distribution of health care providers and health workers".*

3.3 Retention of Health Personnel and Brain Drain: Nigeria has one of the highest rates of highly trained medical personnel leaving the country to work for greener pastures overseas. While the country is yet to meet international standards in doctor/pharmacist/nurse patient ratio, the best available are lost to brain drain. What would be the party's strategy to stop the migration?

NOIPolls reports that the "*continuous migration of trained medical personnel had further worsened the physician-patient ratio in Nigeria from 1: 4,000 to 1: 5,000, contrary to the World Health Organisation's (WHO) recommended 1: 600. According to NOIPolls, this means Nigeria needs 303, 000 medical doctors currently, and at least 10, 605 new doctors annually to cover the gaping physician-patient ratio. The country has about 72,000 medical doctors registered with the Medical and Dental Council of Nigeria, with only approximately 35,000 practicing in Nigeria. Reasons for the continuous brain drain have been cited as high taxes and deduction from salary (98 percent), low work satisfaction (92 percent), poor salaries and emoluments (91 percent) and the knowledge gap existing in the medical practice abroad (47 percent)".*[17]

3.4 Taming Industrial Disputes in the Health Sector: The frequency of strikes and industrial actions in the health sector has been high in the last four years[18]. The industrial actions have arisen over remuneration, poor working environment, professional rivalry, etc. What action will the political party take to stem the tide of industrial disputes?

The National Health Act in section 45 states as follows: *(1) Without prejudice to the right of all cadres and all groups of health professionals to demand for better conditions of service, health services shall be classified as Essential Service, and subject to the provisions of the relevant law. (2) Pursuant to subsection (1) of this section, industrial disputes in the public sector of health shall be treated seriously and shall, on no account, cause the total disruption of health services delivery in public institutions of health in the Federation or in any part thereof. (3) Where the disruption of health services has occurred in any sector of National Health System, the Minister shall apply all reasonable measures to ensure a return to normalcy of any such disruption within 14 days of the occurrence thereof.* Despite this provision, strikes have been the norm in the sector.

[17] See Emeka Okonkwo in https://allafrica.com/stories/201807040702.html

[18] Joint Health Sector Unions (JOHESU): Failure to meet their 15 point demand; January 22, 2014 (3 day warning strike); June 15, 2015 – June, 21 2015; November 2014 – 3rd Feb 2015. Nigerian Medical Association (NMA): Commenced July 1, 2014. A 24 point demand titled "Facing the challenges in the health sector" was made. University College Teaching Hospital Ibadan. – April 2015 (108 days). Psychiatric Hospital in Yaba – Commenced May 2015; Ladoke Akintola University of Technology (LAUTECH): February – June 2015; Federal Medical Center Owerri: May 2015 (Lasted for 12 weeks); Joint Health Sector Unions (JOHESU) and Assembly of Health Care Professional Association (AHPA): May 31 – June 7 2016. Health workers in Federal Government hospitals embarked on a 7-day nationwide warning strike. – June 22; JOHESU/National Association of Nigeria Nurses and Midwives (NANNM): Sept 20 – October 1 2017 - prolonged delay by the Federal Government in meeting their demands dating back to 2012. JOHESU/Assembly of Health Care Professional Association/Federal Medical Centre (FMC)/ Lagos University Teaching Hospital (LUTH), Idi-Araba, Lagos: April 17, 2018; University Teaching Hospital, ABSUTH, Aba : April 2015 - September 7, 2015 (5 months) in protest over non-payment of arrears of salary.

3.5 Reducing Medical Treatment Abroad: It is estimated that Nigeria spends over $1billion abroad every year on medical tourism[19]. What will the party do to stop this waste of scarce resources?

Public confidence in the Nigerian Health System is low. Many rich Nigerians and even Nigerians in the middle and low income groups spend huge resources to travel abroad for medical treatment. The reasons for medical tourism include ill-equipped hospitals and facilities and absence of requisite skills and competencies for the treatment of some health conditions. Even public servants travel abroad at the public expense for medical treatment. However the NHA states in section 46 that: "*Without prejudice to the right of any Nigerian to seek medical check-up, investigation or treatment anywhere within and outside Nigeria, no public officer of the Government of the Federation or any part thereof shall be sponsored for medical check-up, investigation or treatment abroad at public expense except in exceptional cases on the recommendation and referral by the medical board and which recommendation or referral shall be duly approved by the Minister or the Commissioner as the case may be*".

[19] https://www.vanguardngr.com/2017/08/nigeria-loses-1bn-annually-medical-tourism-omatseye/

4. MEDICINES, VACCINES, HEALTH TECHNOLOGIES AND RESEARCH

4.1 Fake and Substandard Drugs: Fake and substandard drugs are still available in the Nigerian pharmaceutical industry. What will the party do to stem this tide?

The NHP 2016 (page 13) states that: "*The National Agency for Food, Drug Administration and Control (NAFDAC) is the regulatory body responsible for ensuring the quality of food, drugs and other regulated products which are manufactured, exported, imported, advertised and used. While NAFDAC has made efforts to check the prevalence of fake and substandard medicines and products, the challenge still exists. To strengthen the regulatory capacity of NAFDAC, its drug quality control laboratory is being upgraded to achieve WHO pre-qualification.* Also, paragraph 12 (d) of General Comment No.14 of the UNCESR requires health facilities goods and services to be of good quality, scientifically approved and persons to be treated with unexpired drugs. Again, the NHA makes it the duty of the Federal Ministry of Health in section 2 (l) and (m) to promote the availability of good quality, safe and affordable essential drugs, medical commodities, hygienic food and water; and issue guidelines and ensure the continuous monitoring, analysis and good use of drugs and poisons including medicines and medical devices.

4.2 Local Manufacture of Medicines and Health Commodities: Nigeria spends a lot of scarce foreign exchange for the importation of medicines and health commodities. What steps will the party take to improve local content and manufacture of medicines and health commodities?

The NHP states that: "*Nigeria has made progress in improving capacity for local manufacturing of medicines and health commodities with four pharmaceutical companies receiving WHO certification for Good Manufacturing Practices (GMP). However, this is still inadequate considering the need and there is still a high dependence on importation. In addition, the country is unable to make progress in the local production of active pharmaceutical ingredients. There are no locally manufactured products that are WHO prequalified yet*". The state obligation to use the maximum of available resources for the progressive realization of the right to health demands prudence and best value for money. Thus, importing medicines that can be produced locally will not produce optimum results and will not be sustainable in the long run. Further, based on the indivisibility, inseparability and interconnectedness of all human rights and fundamental freedoms, local production of medicines and health commodities will create jobs, earn more tax for government, develop technology and improve the GDP. Essentially, it is a win-win scenario for all. Nigeria's Vision 20:2020 recommends that Nigeria increases its capacity to manufacture essential drugs, vaccines and consumables from 40% to 80% of national need.

4.3 Supportive Technologies for Health: The capacity to maintain and service medical equipment is mostly lacking in the Nigerian Health System leading to health technologies not being deployed for their optimum whole life cycle. What steps will the party take to remedy this?

The NHP states that: *"There is shortage of biomedical engineers and poor institutional capacity for maintenance of equipment and medical devices. Maintenance agreements are often not included or not followed up in the procurement contracts. There are no comprehensive maintenance standards and plans as well as spare parts and operational cost".*

4.4 New Information Technologies and Health: New information and communications technologies have emerged to bridge time and space and to ease communications. Most parts of Nigeria have access to GSM services and internet penetration is gradually growing. How would the party use these technologies to improve health care?

"Telemedicine is the use of telecommunication and information technology to provide clinical health care from a distance. It has been used to overcome distance barriers and to improve access to medical services that would often not be consistently available in distant rural communities. It is also used to save lives in critical care and emergency situations. Although there were distant precursors to telemedicine, it is essentially a product of 20th century telecommunication and information technologies. These technologies permit communications between patient and medical staff with both convenience and fidelity, as well as the transmission of medical, imaging and health informatics data from one site to another. Early forms of telemedicine achieved with telephone and radio have been supplemented with videotelephony, advanced diagnostic methods supported by distributed client/server applications, and additionally with telemedical devices to support in-home care" - https://en.wikipedia.org/wiki/Telemedicine

4.5 Health Research: Research is essential for the development of drugs and cures for various ailments. Particularly, it is imperative for finding solutions to disease conditions most frequently found in epidemiological analysis in the country. How would the party encourage effective health research? How would the party determine research priorities?

The NHP states that: "*There is a National Health Research Policy and Priorities that has been developed by the FMOH in 2014. There are in existence research structures such as Research Institutes (Nigeria Institute of Medical Research and National Institute for Pharmaceutical Research and Development) and training institutions supporting learning and dissemination of research products. However, research is still underfunded in most institutions. Currently, the various research institutions and health programmes are left to develop their research priorities. There is a paucity of targeted research studies that address the country's policy needs. There is limited, collation, dissemination and use of available evidence from research for decision-making. The capacity of FMoH and the State Ministries of Health to promote and lead health research activities is very weak".* A competitive research funding scheme where institutes no longer get funds/grants as a matter of right and course but through the success of their research efforts, will create the right enabling environment for targeted and goal based medical research.

4.6 Private Sector Participation in Research: In consideration of the paucity of public resources, the participation of the private sector is key to research efforts to encourage local development of medicines and health goods. However, private sector operatives

complain of being unduly taxed. What policies will the party put in place to encourage private sector participation in research and development?

The private sector should lead the way in research considering that research products and outcomes can be patented and commercialised for profit. But the public sector is obliged to provide fiscal and other incentives for the research to proceed.

5. HEALTH MANAGEMENT INFORMATION SYSTEM

5.1 Health Governance Information: Information at the federal and state level on the state of health care and sector is important to inform the government and citizens on developments in health. How will the party handle the gathering and public access to health information?

Section 35 (1) and (2) of the NHA provides as follows: "*(1) The Federal Ministry of Health shall facilitate and co-ordinate the establishment, implementation and maintenance by State Ministries, Local Government Health Authorities and the private health sector of the health information systems at national, state and local government levels in order to create a comprehensive National Health Management Information System. (2) The Minister may, for the purpose of creating, maintaining or adapting databases within the national health information system desired in subsection (1), of this section prescribe categories or kinds of data for submission and collection and the manner and format in which and by whom the data is to be compiled or collated and shall be submitted to the Federal Ministry of Health*. Further, the NHA in section 2 (d) requires the Federal Ministry of Health to: *"ensure the preparation and presentation of an annual report of the state of health of Nigerians and the National Health System to the President and the National Assembly"*. Again in section 35 (3) of the NHA, it is provided that: "*The Minister and Commissioners shall publish annual reports on the state of health of the citizenry and the health system of Nigeria including the states thereof".* However, these provisions seem to have been honoured in the breach.

5.2 Health Statistics and Data: Compilation of health statistics in Nigeria has always been late and not timely. Routine analysis of data is inadequate and linking data to policy making is deficient. What will the party do to plug these lapses?

The NHP states at page 14: "*Nigeria developed its National Health Information Policy and Strategy in 2014 and has a roadmap to strengthen the routine health information system across the country. There is fragmentation in the data systems due to the emergence of vertical programmes and their parallel systems. The FMoH has established its national health management information software (DHIS 2) for routine health information. However, progress in integrating the various versions of the software by disease programmes and partners is slow. The review and harmonization of the data reporting tools was carried out in 2013; but compliance and implementation is still low with reporting rates varying across states. Overall completion rate in the national DHIS 2 database is just over 60%. The Integrated Disease Surveillance and Response (IDSR) system has been successful in detecting outbreaks, but the response capacity is still inadequate. There are still challenges with the quality of data, with various values for selected indicators. Routine analysis of data with provision of timely feedback is inadequate. As a result, efforts in data use for policy making are deficient. There is often more success in translating the results of surveys to policy. The quality of data is still sub-optimal, and data quality assessments are not regularly and consistently conducted. There is often large variation in the values of indicators from different data sources. Other challenges related to health information system include very weak capacity for HIS at sub-state level e.g. LGA, facilities, untimely production/reporting of routine data, inadequate use of available data for planning and decision making, limited information from the private sector and little or no operational research activities. Fund allocation by government to the health information system is inadequate and unable to meet the needs. This has made the Government unable to take the lead in directing partners on the landscape, causing more fragmentation.*

5.3 Information about Existing Facilities and Competencies: There is no up to date compendium of available health facilities and competencies in Nigeria. This has partly contributed to overseas medical tourism and suboptimal patronage of existing facilities. What steps will the party take to remedy this?

So many resources have been spent in equipping teaching hospitals and some states have also invested in "world class hospitals". The information about available equipment, facilities and competencies need to be publicly available so that they can be optimally utilized for the benefit of the population.

5.4 Information Accessibility: Information is a critical resource for the management of the health system. The rights to seek, receive and impart information and ideas concerning health issues should be optimally utilized for the promotion of health care, especially for preventive health services. How will the party use the mass media for promotion of health?

Public health challenges especially those related to the environment, sanitation, housing[20] and diseases that can be prevented through lifestyle change, early detection and vaccination, etc., can be reduced through availability of information in public health institutions, mass media - including print, electronic, digital and social media. Thus, it will be more of preventive approach to health challenges rather than waiting for curative medicine. This will ultimately reduce the cost of health services.

[20] It is pertinent to recall the Health Principles of Housing prepared by WHO which views housing as the environmental factor most frequently associated with conditions for diseases in epidemiological analysis; - See UNCESCR General Comment No. 4 on the Right to Adequate Housing at paragraph 8 (d).

6. HEALTH PROMOTION, COMMUNITY OWNERSHIP AND PARTNERSHIPS FOR HEALTH

6.1 Community Participation: The participation of the society, communities and their ownership of the health system is imperative for health promotion. A framework for engaging community structures exists. How would the party activate such a framework?

The NHP provides at page 15 that: "*There are Health Promotion Units at the Federal and State levels. However, there is often a lack of leadership needed for health promotion. According to the National Health Promotion Policy 2006, there is little understanding of concepts of health promotion, consumer rights, the need for multi-sectoral action and the promotion of supportive environment for health behaviour change. In addition, there is lack of frameworks and guidelines that ensure systematic planning and management of health education interventions*[21]*. There is a framework for the development of, and engagement with, community structures such as Ward Development Committees, Village Development Committees and Health Facility Committees. These committees are responsible for demand creation, monitoring of health services, community mobilization, and participation in programme implementation, among others. However, they are often not empowered and are unable to carry out their mandate within the community. Despite the existence of these structures, communities are not adequately involved in the design and planning of interventions and often are not in a position to hold the government and service providers accountable. However, where the committees are supported, they have proven to be instrumental in increasing demand for services*"[22].

6.2 Public Private Partnerships: These partnerships are essential to harness the resources and energy of all stakeholders towards the goal of universal health coverage. How would the party activate PPPs for improvement of health care in Nigeria?

The NHP states at page 15*: "Nigeria signed up to the global compact of the International Health Partnerships and related initiatives in 2008, and signed a country compact with its development partners in 2010. Nigeria developed a Public-Private-Partnership Policy for Health in 2005. It was designed to promote and sustain equity, efficiency, accessibility and quality in health care provision through the collaborative relationship between the public and private sectors. The policy is currently under review. Despite this, private sector engagement remains weak. There are only few incentives for private sector engagement in health services delivery. However, there are new developments to improve public-private partnerships, including the provisions of the National Health Act 2014 and the Infrastructure Concession Regulatory Commission. Although platforms for partner coordination exist, there is still laxity in ensuring donor alignment to national priorities and programmes. In recent years, there has been an increased effort to include other stakeholders like the private sector, and civil society in policy and planning processes. There has been progress in multi-sectoral collaboration as exemplified by the comprehensive response to epidemics and disasters and HIV programme in Nigeria. However, effort is needed to strengthen this intersectoral collaboration, considering that many of the determinants of health outcomes are outside the health sector".*

[21] National Health Promotion Policy 2006; Federal Ministry of Health.
[22] NPHCDA Assessment of WDCs.

7. SERVICE DELIVERY

7.1 Maternal and Child Health: Nigeria's maternal and child health indicators are scandalous and demand special attention to remove our country from the list of infamy. Table 8 shows the status. What would the party do to redress this scandal?

Table 8: MNCH Statistics in Nigeria

INDICATOR	
Maternal mortality ratio (per 100 000 live births)	814
Proportion of married or in-union women of Reproductive age who have their need for family Planning satisfied with modern methods (%)	26.3
Proportion of births attended by skilled health personnel (%)	43
Under-five mortality rate (per 1000 live births)	104.3
Neonatal mortality rate (per 1000 live births)	34.1
Life Expectancy at Birth (Female)	55.7

Source: World Health Statistics 2018, World Health Organization

Nigeria is ranked 137 out of 140 countries in infant mortality; proportion of infant mortality and maternal death attributable to malnutrition is 53%; while the proportion of children who are under the age of 5 who are underweight is 24%[23].

7.2 Maternal and Child Health - Regional Peculiarities: The overall picture in Table 8 above masks geo-political peculiarities. Thus, the needs and efforts required in the geo-political zones are not the same. Table 9 shows the picture. What will the party do to address this geo-political variance?

Table 9: Maternal and Newborn Health Statistics Disaggregated into Geopolitical Zones

	North Central	North East	North West	South East	South South	South West
Percentage of women without Ante Natal Care (ANC)	26.0	40.8	55.4	4.2	20.6	5.7
Percentage delivered in a health facility	45.7	19.5	11.5	78.1	50.1	75.0
Percentage with no postnatal checkup	49.6	65.7	81.7	37.4	36.0	23.9
Percentage of babies less than 2.5 kg at birth	7.5	13.6	27.2	4.3	11.6	3.4
Percentage of children	26.9	14.2	9.6	51.7	52.0	40.9

[23] Page 84 of the Economic Reform and Growth Programme.

receiving all basic vaccinations						
Median age of women at first marriage	18.9	16.3	15.3	22.7	21.5	21.8
Median age of women at first birth	20.6	18.8	17.9	23.7	21.8	22.7
Percentage of women age 15-19 who have begun childbearing	18.8	32.1	35.7	8.2	12.3	8.2
Percentage of children whose births are registered	27.8	20.4	19.5	51.8	37.3	51.2

Source: Nigeria Demographic and Health Survey, 2013

7.3 Immunisation Coverage: Many of the diseases that kill little children are vaccine-preventable diseases. Table 10 below shows the immunization coverage in Nigeria. However, this pan Nigerian picture masks the rural urban divide, regional and state disparities in terms of coverage. What steps would the party take to increase immunization coverage?

Table 10: Immunization Coverage in Nigeria and the Globe

	HepB3 (One-Year Old)		DPT (12-23 Months)		Measles (12-23 Months	
	2010	***2016***	***2010***	***2016***	***2010***	***2016***
Nigeria	49%	49%	54%	49%	56%	51%
SSA	70.9%	73.6%	72.0%	73.6%	72.6%	71.7%
Global	75.7%	85.3%	85.0%	85.8%	84.8%	84.9%

Source: World Bank World Development Indicators, 2018

7.4 Obstacles to MNCH Coverage: Religion and culture have been pleaded as obstacles to women accessing ante and post natal care in some regions of the country. The states in these regions have MNCH indicators way below the national average. How would the party address this challenge?

"For instance, 11% of births to uneducated mothers occur in health facilities while 91% of births in mothers with more than secondary education occurs in health facilities; 86% of mothers in urban areas receive ANC from skilled providers compared to only 48% of mothers in rural areas; while ANC coverage in the North West is 41% compared to 91% in the South East" – NHP

7.5 Harmful Traditional Practices and Discrimination against Women: These have prevented women's full access to health care and enjoyment of the right to health. They include early/child marriage, female genital mutilation, etc. What steps would the party take to eliminate these harmful and discriminatory practices?

Paragraphs 20 and 21 of the General Comment on the Right to Health states as follows (20): "*The Committee recommends that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and sociocultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health". (21). "To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights".*

7.6 Disability: The National Health Policy states its goal on disabilities as: "*To ensure the attainment of well-being that would enable people living with disabilities (PLWDs) achieve economically productive lives*". What would the party do to attain this goal?

"A disability is an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. It substantially affects a person's life activities and may be present from birth or occur during a person's lifetime". "*Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives"* - World Health Organization[24].

7.7 Malaria: Malaria is endemic in Nigeria. How would the party respond to the malaria challenge?

According to the NHP: "*Malaria remains an important cause of morbidity and mortality in Nigeria and it accounted for 32 percent of the global estimate of 655,000 malaria deaths in 2010 (World Health Organization, 2012). An estimated 97 percent of the country's approximate population of 160 million residents is at risk of malaria. Children under age 5 and pregnant women are the groups most vulnerable to illness and death from malaria infection in Nigeria*[25]". As at 2016, malaria incidence was still as high as 349.6 per 1,000 population in Nigeria. The 2016 malaria incidence rate in Nigeria represents an improvement of 3.05% from the 2010 malaria incidence rate of 360.6 per 1,000 population in Nigeria.

[24] Taken from *https://en.wikipedia.org/wiki/Disability*
[25] NHP 2016 at page 6.

7.8 Neglected Tropical Diseases: The neglected tropical diseases include filariasis, onchocerciasis, trachoma, worm infestation, schistosomiasis, leprosy etc. They constitute a major public health challenge. What will the party do to address the challenge?

7.9 The HIV/AIDS Pandemic: Nigeria has large numbers of her citizens infected with and affected by HIV. How would the party address the HIV pandemic?

Current HIV prevalence among women attending ANC in Nigeria is 3.0% (ANC, 2014). In Nigeria, 58% of the estimated 3,037,364 PLHIV in 2015 were females. (Nigeria Spectrum Estimates, 2016). Estimated number of new HIV infections in Nigeria dropped from 130,295 in 2010 to 104,388, with 55% (104,388) of the new infections found among females[26].

7.10 Vesico Vaginal Fistula: Nigeria contributes a great percentage of the world VVF patients - 800,000 patients out of the 2million estimate. This is 40% of the world total. How would the party address this health challenge?

The endemic states are Sokoto, Kebbi, Borno, Kano, Katsina, Plateau, Ebonyi and Akwa Ibom. The patients virtually lose their human dignity through a substandard life lived in isolation and most times are subjected to inhuman and degrading treatment. Again, their right to life is under serious threat as they are abandoned and neglected. Treating each patient at a cost N100,000 for surgery, remediation and rehabilitation will cost a total of N80 billion. Provisions for treating VVF should be phased over a period of six years at N15 billion per year. Preventive measures should be mainstreamed in VVF management and control.

7.11 Non Communicable Diseases: The NHP states that there is the need to significantly reduce the burden of non-communicable diseases in Nigeria in line with the targets of the third Sustainable Development Goal. What will the party do to achieve this goal?

The World Health Organisation states that: "*Non-communicable - or chronic - diseases are diseases of long duration and generally slow progression. The four main types of non-communicable diseases are cardiovascular diseases (like heart attacks and stroke), cancer, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. Non-communicable diseases, or NCDs, are by far the leading cause of death in the world, representing 63% of all annual deaths. Non-communicable diseases (NCDs) kill more than 36 million people each year. Some 80% of all NCD deaths occur in low- and middle-income countries"*[27]. According to Wikipedia: *"A non-communicable disease (NCD) is a medical condition or disease that is not caused by infectious agents (non-infectious or non-transmissible). NCDs can refer to chronic diseases which last for long periods of time and progress slowly"*[28].

[26] https://naca.gov.ng/fact-sheet-hiv-prevention-program/
[27] http://www.who.int/features/factfiles/noncommunicable_diseases/en/
[28] https://en.wikipedia.org/wiki/Non-communicable_disease

7.12 Family Planning: Nigeria's population is growing at the rate of 3.2% per annum while its economy is growing at the suboptimal level of less than 2%. "*UN projections estimate that at the current rate of population growth, Nigeria will be among the four most populous countries in the world with an estimated population of well over 289 million in 2050*"[29]. What is the party planning for population control and family planning?

Achieving Nigeria's family planning goals was estimated to cost N190bn (USD 603 million) between 2013 and 2018[30]. At the London FP 2020 Summit in 2012, FGN made a commitment to allocate USD 3 million annually for FP commodities and USD 8.35 million annually for RH commodities. Between 2012 and 2016, FGN met just 11 per cent of these funding commitments[31]. At same summit in 2017, the Minster of Health – Prof. Isaac Adewole announced an increase in the annual budgetary allocation for FP commodities to USD4 million. He also committed to ensure a total disbursement of USD56 million to the states through the GFF[32].

7.13 Patients' Bill of Rights: The Consumer Protection Council has introduced the Patients' Bill of Right (PBOR) to set acceptable standards for health services delivery. How will the party implement this Bill?

The Bill consists of the following: *Right to relevant information:* This is to ensure that you understand any diagnosis, treatments and other procedures and outcomes you may encounter. *Right to timely access to medical records:* This confirms that you should have access to your own accurate medical records in a timely manner. *Right to transparent billing:* This right validates that you are entitled to a clear and full breakdown of the bills for your treatment plans. *Right to privacy:* This affirms your right to confidentiality and privacy. *Right to clean healthcare environment:* This emphasizes that you have a right to a safe and secure environment to get treatment and other healthcare services. *Right to be treated with respect:* This right applies to everyone without bias to gender, ethnicity, religion, disability, allegations of crime or economic circumstances. *Right to receive urgent care:* This reaffirms patients' rights to receive immediate and sufficient care when it is an emergency. *Right to reasonable visitation*: This declares visitation, within reasonable rules and regulations, as an entitlement. *Right to decline care:* This confirms that patients have a right to decline treatments as long as they are aware of the consequences of that decision and it is legal to do so. *Right to decline or accept to participate in medical research:* Everyone has the right to decline being a part of any medical research and also to accept to participate in any such research. *Right to quality care:* The care you receive must be of a sufficient quality and meet standards required and *Right to express dissatisfaction regarding services received.* These are not new rights but are derivable from national and international human rights standards applicable in Nigeria and many of the rights are codified in sections 20-30 of the NHA.

[29] ERGP at page 84.
[30] Nigeria Family Planning Blueprint: Scale-Up Plan (September 2014)
[31] HP+ Policy Brief (March 2017)
[32] Daily Trust news report "P2020: Nigeria hikes family planning pledge to $4m" - https://www.dailytrust.com.ng/news/health/fp2020-nigeria-hikes-family-planning-pledge-to-4m/205132.html

7.14 Emergency Care: Health emergencies which raise issues of life and death are common place in Nigeria. How will the party respond to the provision of emergency health care?

With the bulk of the population not under a prepaid health care scheme, such emergencies pose serious challenges. Again, hospitals request for police report before treating persons with gunshot wounds. In all these cases, the difference between life and death may be immediate access to care, which if not forthcoming, will lead to death. The NHA states that 5% of the Basic Health Care Provision Fund shall be used for Emergency Medical Treatment to be administered by a Committee appointed by the National Council on Health. Again, by section 20 of the NHA: "*(1) A health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason whatsoever. (2) Any person who contravenes this section is guilty of an offence and is liable on conviction to a fine of ₦100, 000.00 (one hundred thousand naira) or to imprisonment for a period not exceeding six months or to both".*

7.15 Environmental Health: A healthy and livable environment is one of the underlying determinants of health. How will the party promote a healthy environment for the good health of the populace?

There are three obligations of State on the right to health - to respect, protect and fulfil. Adapted to the right to a healthy environment: the obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health through acts and omissions that pollute the environment. The obligation to *protect* requires States to take measures that prevent third parties from interfering with healthy environments - to pollute them, for instance, through unregulated mineral extraction activities. And the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the remediation of unhealthy environments. The dominant black soot in Port Harcourt, Rivers State, arising from gas flaring which is causing respiratory and other health challenges is a case that needs governmental action.