RIGHT TO HEALTH MANUAL

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SCALE
STRENGTHENING
CIVIC ADVOCACY AND
LOCAL ENGAGEMENT

CENTRE FOR SOCIAL JUSTICE

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By

Centre for Social Justice

Plot 836, Block 1, Emmanuel Aguna Crescent, Off Idris Ibrahim Crescent, Off Obafemi Awolowo Way, Jabi
P.O. Box 11418 Garki, Abuja.
Website: www.csj-ng.org
Blog: csj-blog.org
Twitter: @censoj
Facebook: Centre for Social Justice, Nigeria
Email-censoj@gmail.com

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ABBREVIATION

ACHPR	African Charter on Human and Peoples Rights
BHCPF	Basic Health Care Provision Fund
CBHIS	Community Based Social Health Insurance Scheme
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEDAW	Discrimination against Women
CHEWs	Community Health Extension Worker
CHOs	Community Health Officers
CRF	Consolidated Revenue Funds
CSJ	Centre for Social Justice
NHIS	National Health Management Information System
ECOSOC	Economic and Social Council
FEC	Federal Executive Council
FGN	Federal Government of Nigeria
FMC	Federal Medical Centre
FMOH	Federal Ministry of Health
FRA	Fiscal Responsibility Act
GDP	Gross Domestic Product
GIS	Geographical Information System
GMP	Good Manufacturing Practices
HCPs	Health Care Providers
HIS	Health Information System
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HMOs	Health Maintenance Organisations
HRH	Human Resources for Health
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDSR	Integrated Disease Surveillance and Response
IDSR	Integrated Disease Surveillance and Response

INTOSAI	International Organisation of Supreme Audit Institutions
JCHEWs	Junior Community Health Extension Workers
JMP	Joint Monitoring Programme
JOHESU	Joint Health Sector Unions
LAUTECH	Ladoke Akintola University of Technology
LGAs	Local Government Areas
LUTH	Lagos University Teaching Hospital
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MNCH	Maternal, New Born and Child Health
MSP	Minimum Service Package
MTEF	Medium Term Expenditure Framework
MTSS	Medium Term Sector Strategies
NAFDAC	National Agency for Food and Drug Administration and Control
NCDs	Non-communicable diseases
NGOs	Non-Governmental Organisations
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NHREC	National Health Research Ethics Committee
NIMR	Nigeria Institute of Medical Research
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
PBOR	Patients' Bill of Right
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PLWDs	People Living With Disabilities
SDGs	Sustainable Development Goals
SOMLPforR	Saving One Million Lives Program-for-Results
SPT	Sector Planning Teams
THE	Total Health Expenditure
UBEC	Universal Basic Education Commission
UDHR	Universal Declaration on Human Rights

UHC	Universal Health Coverage
UN	United Nation
UNICEF	United Nations Children Fund
USD	United State Dollar
WHO	World Health Organisation

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Section One

INTRODUCTION

1.3 OBJECTIVES

To equip participants with:

- a full understanding of the normative content of the right to health in Nigeria;
- strategies and methodologies for enforcing and realizing the right to health;
- ideas for collaboration between stakeholders for realising the right to health.

1.2 BACKGROUND

The right to health is an empowering right that greatly facilitates the realisation and enjoyment of other human rights and fundamental freedoms. It is a part of the most fundamental of the fundamental human rights which is the right to life as it supports the fulcrum upon which other rights rotate.

Nigeria is bound by national and international standards on the right to health and these include, at the international level, the standard setting Universal Declaration on Human Rights (UDHR),[1] the International Covenant on Economic, Social and Cultural Rights (ICESCR),[2] Convention on the Elimination of All forms of Discrimination against Women (CEDAW)[3], Goal 3 of the Sustainable Development Goals (SDGs) and the regional African Charter on Human and Peoples Rights (ACHPR).[4] Others include the Alma-Ata Declaration[5] on Primary Health Care clarified in the Declaration of Asanta.[6] The states and local governments, being parts of the Federal Republic of Nigeria are bound by these standards.

At the national level, there is the constitutional obligation under the Fundamental Objectives and Directive Principles of State Policy on adequate medical and health facilities for all persons;[7] National Health Act of 2014, National Primary Health Care Development Agency Act,[8] National Health Insurance Scheme Act,[9] National Health Policy of 2016 and the National Strategic Health Development Plan (NSHDP) 2018-2022.

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[1] Article 25 of the UDHR.
[2] Article 12 of the ICESCR.
[3] Article 12 of CEDAW
[4] Article 16 of the ACHPR
[5] International Conference on Primary Health Care, Alma –Ata, Union of Soviet Socialist Republics, 6-12 September 1978.
[6] Global Conference on Primary Health Care Asanta Kazakhstan, 25-26 October 2018.
[7] S.16 (3) (d) of the Constitution of the Federal Republic of Nigeria 1999 as amended.
[8] Cap N69, Laws of the Federation of Nigeria 2004.
[9] Cap N.42, Laws of the Federation of Nigeria 2004.

Health is not mentioned on Nigeria's Constitutional Schedules as the federal, state and local governments all have a role to play. This is not to deny the overall policy and leading role of the Federal Government of Nigeria (FGN) through the Federal Ministry of Health (FMoH) and relevant agencies and institutions in taking the lead in efforts to realise the right to health of Nigerians.

It is pertinent at the outset to analyse key terms and policy contexts that will be found in many parts of this Manual. The first is Universal Health Coverage (UHC).

1.2.2 Universal Health Coverage: UHC connotes a scenario where all persons have access to the health services they require, at the necessary time and where they are needed without financial hardship. The services being referred to include essential health services ranging from health promotion to prevention, treatment, rehabilitation and palliative care.[10] As part of SDG 3, UHC includes financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. An appropriate articulation of UHC must essentially include the cardinal parametres of the right to health vis, availability, accessibility (non-discrimination, physical, economic and information accessibility), acceptability, quality as well as cultural acceptability.[11] UHC requires competent human resources for health operating under an enabling and adequately resourced environment that understands the inseparability, indivisibility and interrelatedness of the right to health and other human rights and fundamental freedoms.

UHC envisions a ***whole-of-government, health-in-all policies and whole-of-society approach*** towards the realisation of the right to the highest attainable state of physical and mental health. The whole of government approach is an understanding that securing the health of the population cannot be achieved by the Ministry of Health and its departments and agencies alone. It requires inter-ministerial/agency collaboration and mainstreaming health in other sectors. Health is made an explicit objective of every policy decision.[12]

Health in all policies approach is a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people.[13] The first two approaches (whole-of-government, health-in-all policies) are interrelated and involve governance and policy making. On the other hand, the whole-of-society approach involves the engagement of all relevant stakeholders in

[10] See https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
[11] See General Comment No.14 (2000) on the Right to Health of the United Nations Committee on Economic, Social and Cultural Rights.
[12] A whole-government approach to improving health. See https://www.health.org.uk/ publications/ reports/a-whole-government-approach-to-improving-health.
[13] https://www.google.com/search?client=firefox-b-d&q=health+in+all+policies+approach- Health in all policies approach.

society to address socio-economic and livelihood issues including public health, education, food security, agriculture, power and energy, communications, environment, employment, industry, and social and economic development.[14] It seeks to move away from the medicalisation of health to a more well-nuanced understanding of the various factors affecting the health of the population and the stakeholders who can contribute to more positive health outcomes.

Health care is usually classified into primary, secondary and tertiary cares. A review of the three tiers of care is imperative.

1.2.1 Primary Health Care (PHC) and UHC: PHC is seen as an entry point for improving UHC. PHC is part of the tripod that includes secondary and tertiary health care. These two terms, UHC and PHC are part of the right to the highest attainable standard of physical and mental health which accrues to all individuals without discrimination on the grounds of sex, religion, political opinion, place of birth, orientation, etc.

UHC is not limited to PHC but includes interventions at the secondary and tertiary levels of care. However, PHC is the foundation for UHC. PHC as defined by World Health Organisation (WHO) and the United Nations Children Fund (UNICEF) is:

> *"A whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment".*[15]

WHO and UNICEF further articulated three interrelated and synergistic components of PHC as follows:[16]

> *"Meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services;"*

> *"Systematically addressing the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors; and"*

[14] www.whole+of+society+approach+to+ health&cvid=b2f643e9af8a437abde88f1f74cb4715&aqs=edge. 0.69i59j69i60 .7526j0j1&pglt=43&FORM=ANNTA1&PC=U531
[15] See World Health Organization (WHO) and UNICEF- A Vision for Primary Health Care in the 21st Century: Towards UHC and SDGs at page 2.
[16] WHO and UNICEF, supra.

"Empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers".

PHC is the first level of contact for citizens and the community with the national (and state) healthcare system. It focuses on the primary health problems in the community, providing preventive, curative, rehabilitative and promotional health services. It engages the broad determinants of health through a multi sector/stakeholder approach anchored on the understanding of the complex interplay of factors that lead to improved health. Essentially, PHC would include issues related to nutrition, supply of safe water, sanitation, maternal, new born and child health, immunization and family planning. Others include health education and community mobilisation and control of communicable diseases, etc.

The task of the National Primary Health Care Development Agency (NPHCDA) provides further insight on the constituents of PHC. NPHCDA states that it controls preventable diseases, improves quality of care, engages the community, develops a high-performing and empowered workforce, improves access to basic health care services, strengthens institutions and partnerships.[17] Primary health care is defined in the NPHCDA Act as including:

> "*care designed to prevent disease and promote health and out-patient care, including general medical care, maternal and child health care, domicilliary health care and rehabilitation and nursing care, including home visits."*[18]

In Nigeria, PHC is funded from the government budget and through other funding sources including aid and grants from international and other development partners. Ideally, it should be operated by the third tier of government, being the local government councils. Effective PHC systems ought to be inclusive ensuring that no one is left behind, equitable, efficient and cost-effective in order to enhance people's physical and mental health, as well as social well-being. It builds resilience, engages the upstream determinants of health, while attacking factors (beyond health) most frequently associated with disease conditions in epidemiological analysis.[19]

PHC is critical for realizing UHC because:[20]

> *"PHC plays a key role in reducing household expenditure on health by addressing the underlying determinants of health and by emphasizing population-level services that prevent*

[17] https://nphcdang.com/
[18] See the interpretative S.14 of the NPHCDA Act.
[19] See Nigeria's One Health Strategic Plan 2019-2023. See also the National Action Plan for Health Security: 2018-2022.
[20] WHO and UNICEF, supra at page 6.

illness and promote well-being. This both reduces the need for individual care and can avoid the escalation of health issues to more complex and costly conditions. Empowered people and communities are key advocates for increasing financial protection for health services".

"PHC is a cost-effective way of delivering services, so focusing on PHC is the best-value way for countries to move towards universal access. The involvement of empowered people and communities as co-developers of services improves cultural sensitivity and increases patient satisfaction, ultimately increasing use and improving health outcomes. In addition, there is considerable evidence that health systems based on primary care services that are first-contact, continuous, comprehensive, coordinated, and people-centred have better health outcomes".

"In many countries, the majority of people who do not currently have access to care are disadvantaged. PHC is optimally placed to address this, because of its emphasis on tackling the determinants of health, which underpin vulnerability. Additionally, in most countries, the PHC focus on community-based services is the only way to reach remote and disadvantaged populations".

1.2.2 Secondary Health Care: Secondary health care refers to:[21]

> *"Hospitals and outpatient specialist clinics to which people go, after referral from primary health care services. These services are generally more specialized and further from where people live. They often include a greater range of diagnostic services such as X-ray and pathological laboratory services; they may also include specialized treatment, such as operating theaters, radiotherapy, and certain drug therapies not normally available in primary care. The principal difference between primary and secondary services is in the range and specialization of the staff available".*

Ideally, secondary health care should get patients from PHC referrals. However, the lines between the different levels of care have been blurred in Nigeria based on systemic challenges with the entire healthcare system.

1.2.3 Tertiary Health Care: Tertiary health care refers to:[22]

> *"Specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital. Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions".*

Ideally, tertiary health care should be accessed through referrals from secondary health care facilities. But the line has also been blurred in Nigeria considering that tertiary health

[21] See Palipedia, the Free Online Palliative Care Dictionary; https://pallipedia.org/secondary-health-care/
[22] See https://en.wikipedia.org/wiki/Health_care

institutions now treat common illness like malaria as a first point of contact and not on referral from secondary institutions.

1.2.4 Plan, Policy, Budget Continuum: The plan, policy and budget continuum ensures that plans and policies are implemented through the annual budget. Plans and policies provide the legal and policy framework for sectoral governance and service delivery while budgets activate plans and policies through providing resources for their implementation. The disconnect between plans, policies and budgeting has been largely responsible for poor health outcomes at the federal level and in most states of Nigeria. Funding for the provision of basic PHC has partly been met through the tool of budget. Nigeria's out of pocket health expenditure is one of the highest in the world and has been stated by the World Bank at 70.52 percent. This is in contrast to the Sub-Saharan Africa average of 29.98 percent. [23]

For the budget to adequately address health concerns, there is the need for stakeholders' engagement on the continuum-of-budget approach which follows through the various stages of the budgeting process (formulation, approval, implementation, monitoring, evaluation, reporting and audit) to ensure that adequate and specific interventions crucial to meeting the health needs of the population are formulated, implemented, monitored, evaluated and reported upon. The Medium Term Expenditure Framework (MTEF) provides the opportunity to operationalise the whole-of-government, and health-in-all policies approach. The MTEF, among other things, provides the projections for the annual budget as it relates to all sectors, including health care. As such, the importance of stakeholders' engagement at this stage of budgeting for sufficient provision for health funding/resources cannot be overemphasized. On the other hand, the Medium Term Sector Strategies (MTSS) provides the sectoral priorities for allocation of budgetary resources for the incoming year in the health sector.

Furthermore, the current Nigerian and indeed global economic environment provides a new dimension and challenge. Budgeting for health in a time of constrained fiscal resources poses a major challenge which requires innovation and all hands-on deck approach to meet policy goals and objectives. With shrinking public resources, the need to make critical choices on where available resources could be deployed for optimum results becomes ever pressing. It is within this context that this Right to Health Programme was designed for structural and purposive engagement of the federal, state and local government level health systems as well as information dissemination and advocacy for reforms.

[23] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG, 2019.

Section Two

REVIEW OF INTERNATIONAL AND NATIONAL STANDARDS

2.1 INTRODUCTION

Law governs virtually all aspects of public and private life and budgeting for PHC as a component of public finance management is no exception. The applicable standards are national and international in tenor. While some are in the realm of hard law that can be pleaded before the courts, others are guides, standards of achievement recognised by a super majority of civilized humanity. This Section reviews the guiding laws, policies and standards as a basis for the review of relevant data and statistics, public expenditure systems, etc., in the latter Sections of this Manual.

Health is understood as a basic human right which is inextricably linked to the realisation of other human rights. Its obvious link to the right to life, which is the fulcrum upon which other rights rotate implies that the right to life could be violated through the denial of health supporting conditions to the point of abrogation.

2.2 INTERNATIONAL STANDARDS

Nigeria is a state party and has ratified a multiplicity of international standards on the right to health. It has also been part of international conferences where declarations and protocols have been concluded. These standards include the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights, Convention for the Elimination of all forms of Discrimination against Women, African Charter on Human and Peoples Rights, etc. The Sustainable Development Goals (SDGs) and various declarations on PHC further provide a guide on the right to health.

2.2.1 Universal Declaration of Human Rights (UDHR):[24] The UDHR which is a standard setting instrument in article 25, the UDHR states:

> *(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*

The UDHR obligates States to provide a standard of living adequate for the health and well-being of every citizen. The reference here is that everyone ought to be guaranteed

[24] The Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 (General Assembly resolution 217 A)

adequate health services and this is linked to other determinants of well-being including food, housing, clothing, etc.

2.2.2 International Covenant on Economic, Social and Cultural Rights (ICESCR):[25] The ICESCR and its delineations appears to be the most comprehensive provision on the right to health. It states in article 12 that:

> *"1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
>
> *2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:*
>
> > *(a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child;*
> >
> > *(b) The improvement of all aspects of environmental and industrial hygiene;*
> >
> > *(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
> >
> > *(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."*

It is imperative to note that paragraphs (a) to (d) above encompass various aspects of PHC, secondary and tertiary health care. The Committee on Economic, Social and Cultural Rights (CESCR) has defined the cardinal parametres of the right to health as follows.[26]

> ***(a) Availability**: Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.*
>
> ***(b) Accessibility**: Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:*

[25] General Assembly Resolution 2200A (XXI) of December 16 1966; Entry into force: 3 January 1976, in accordance with article 27.

[26] The CESCR was charged with receiving and reviewing State Party's reports and overseeing the full implementation of the ICESCR.

Non-discrimination: *Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds;*

Physical accessibility: *Health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;*

Economic accessibility (affordability): *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;*

Information accessibility: *Accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality;*

(c) Acceptability: *All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e., respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;*

(d) Quality: *As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.*

In delineating the nature of state obligations on the right to health, resort has to be made to article (2) 1 of the ICESCR which states that:

Each State Party to the Present Covenant undertakes to take steps individually and collectively and through international assistance and cooperation especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means including particularly the adoption of legislative measures.

An examination of the operative phrases in this article will follow.

A. To the Maximum of Available Resources: The phrase "maximum of available resources" recognizes the difference in wealth and resources available to the different countries in the world who are State Parties to the ICESCR. In accordance with the Limburg Principles,[27] states are obligated regardless of economic development, to ensure respect for minimum subsistence rights for all. Resources include what can be sourced locally and from aid and general international cooperation. Resources could be classified into different categories - human, technological, information, natural and financial resources [28]. For a state party failing to meet its obligations on the right to health to rely on lack of resources, it must show that every effort has been made to use all the resources at its disposal to satisfy the minimum core obligation[29]. In times of grave economic crisis, vulnerable groups are still entitled to subsistence rights by the states adoption of low cost measures. The question of prioritizing the expenditure of the state becomes relevant here. It has been noted that corruption absorbs a lot of resources that could have been invested in health, etc. In the circumstances, it would be problematic for Nigeria to plead the unavailability of resources as a reason for low quality health indictors while refusing to plug the leaking pipes of corruption.

B. To Achieve Progressively the full Realization of ESC Rights: The progressive realization phrase is not to be interpreted to mean an indefinite postponement of action to realize the right to health. Rather it obliges states parties to move immediately and as expeditiously as possible towards the realization of the right. The obligation exists independently of increase in resources; requiring effective use of available resources and developing societal resources for the realization of the right to health[30]. The concept of progressive realization is a recognition of the fact that full realization of the right to health will generally not be achieved in a short time[31]. However, issues around non discrimination, access to information, equity and equality do not require progressive realization but are capable of immediate implementation[32].

C. To Take Steps… By all Appropriate Means including particularly the Adoption of Legislative Measures: The phrase recognises the need for the state to take deliberate, concrete and targeted steps which are as clear as possible towards meeting the obligation

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[27] The Limburg Principles on the Implementation of ICESCR, UN Document E/CN 4/1987/17

[28] See Roberts E. Robertson *"Measuring State Compliance with the Obligation to Devote the Maximum of Available Resources to Realising Economic, Social and Cultural Rights* (1994) 16 HUM RTS.Q 693, 695-697.

[29] See General Comment No. 3 of the UN Committee on ESCR, adopted at the Fifth Session of the ESCR Committee in 1990, UN Doc E/199/123, Annex 111, para 10.

[30] See Principles 21-24 of the Limburg Principles.

[31] See para 9 of General Comment No. 3 of the UN Committee on ESCR.

[32] Para 10 of General Comment No.9 of the ESCR Committee on the Domestic Application of the ICESCR adopted December 3 1998; UN document E/C.12/1998/24.

to protect the right to health.[33] It acknowledges legislation as an important step while not limiting the steps to be taken by states parties to legislation alone. It is expected that state parties before ratification or immediately after ratification of the ICESCR should bring their domestic law in conformity with the requirement of the Covenant. Other means to be adopted by the state may include administrative, judicial, economic, social and educational measures consistent with the nature of the right to health[34]. The State is also under an obligation to provide an effective remedy to persons whose right to health have been violated and this may include judicial remedies. States enjoy a margin of discretion in the selection of the means and methods for implementing obligations on the right to health under the ICESCR. This is also the case for many civil and political rights[35].

While the most appropriate means of achieving the full realization of the right to health will inevitably vary significantly from one state party to another, the ICESCR clearly requires that each state party take whatever steps that are necessary for that purpose.

It is imperative to point out that violations of the right to health whether directly perpetuated by the state (action) or by private entities which could have been prevented by the state (omission) engages the states responsibility. The state is obligated to prevent, investigate and punish any human rights violation carried out in its territory not only by the acts of public officers but also directly resulting from acts not directly imputable to officers of the state. This has been aptly captured in the following words[36]:

> *..to take reasonable steps to prevent human rights violations and to use the means at its disposal to carry out investigations of violations committed within its jurisdiction, to identify those responsible, to impose the appropriate punishment and to ensure the victims adequate compensation.*

In accordance with Maastricht Guidelines, there are three layers of obligations in matters of ESC rights including the right to health.[37] They are the obligations to respect, protect and fulfill. Failure to perform any one of the three obligations constitutes a violation of

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[33] General Comment No. 3 of the UN ESC Rights Committee (Supra).
[34] Principle 17 of the Limburg Principles.
[35] Guideline 8 of the Maastricht Guidelines on Violations of ESCR developed by the Experts Meeting held from January 22-26 1997 at the instance of the International Commission of Jurists (Geneva, Switzerland), the Urban Morgan Institute of Human Rights (Cincinnati Ohio, USA) and the Centre for Human Rights of the Faculty of Law of the Maastricht University (The Netherlands).
[36] ***Velasques Rodrigues*** case- Inter American Court of Human Rights of July 29 1988, 1 ACHR series C, Decisions and Judgements No.4, paras 174-175 or (OAS/ser.l/V111 19, doc 13 1998, para 174. The position in this case can be rightly asserted to be *jus cogens.*
[37] The Maastricht Guidelines 1997 on Violations of Economic, Social and Cultural Rights. The Guidelines were adopted by a group of over thirty experts who convened from 22–26 January 1997 in Maastricht on the occasion of the Limburg Principles' 10th anniversary. See UN document E/C.12/2000/13 by the Committee on Economic, Social and Cultural Rights (CESCR).

such rights. The obligation to respect requires states not to interfere with the enjoyment of the right to health. Thus, they are to refrain from denying or limiting equal access for all persons, including women, children, vulnerable groups, detainees, minorities etc., to preventive, curative and palliative health services; abstaining from enforcing discriminatory state practices as state policy and abstain from imposing discriminatory practices relating to women's health and status.

The obligation to protect stresses on the need to ensure that third parties (non-State actors) do not infringe upon the enjoyment of the right to health. In essence, this is about the state's obligation to adopt legislation and policies; ensure that third parties do not violate people's right to health or exploit them through abuse of market processes, to maintain health ethics and standards, abolition of harmful traditional practices and gender-based violence, control pollution and environmental degradation, etc. Ensuring transparency and accountability through increased access to health-related public finance information will facilitate the implementation of the obligation to protect the right to health.

The obligation to fulfill requires states to take positive steps to realize the right to health. It is expected of states to take positive measures including appropriate budgeting through dedicating the maximum of available resources, implementation of plans and policies; promotion of health fostering factors for example through WASH; disseminating appropriate nutrition and lifestyle information, and supporting people, to make informed choices about their health, etc.

Lack of access to resources has been touted as one of the main reasons for the non-implementation of the right to health. Although this argument to a great extent lacks merit since no human rights is cost free, it is pertinent to point out that the duties to respect and protect the right to health can be implemented without expending too much resources. The obligation to respect is a negative duty (freedom from discrimination for instance, requires no resources) while the obligation to protect imposes no greater burden than that incurred through the normal law enforcement mechanism. It is only fulfillment bound obligations that directly require resources to implement. In a state like Nigeria, proper management of financial and other resources and mobilization of available human resources (including reduction of brain drain and loss of critical personnel to foreign countries) can go a long way in addressing the problems raised by lack of resources.

D. The Minimum Core Content of the Right to Health: There is a duty to satisfy what the CESCR has identified as the minimum core obligation/content of the Covenant's articles to wit; a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights[38]. The Committee went ahead to state that if the ICESCR were to be read in such a way as not to establish such a minimum core

[38] See General Comment No. 3 (supra).

obligation, it would be largely deprived of its raison d'etre. Thus, the minimum core obligation is the threshold below which no state will be allowed to descend. It is an obligation which must be met regardless of resources available to the state. PHC has been identified as part of the minimum core obligation of the right to health. Other health determining and supporting factors identified as part of the minimum core obligation of the right to health include essential foodstuffs (nutrition), basic shelter, basic education.[39]

If the state adopts the whole-of-government, health-in-all policies and whole-of-society approach to health, it would have taken a giant step towards fulfilling its obligations and at a minimum, to meet its minimum state obligations that will implement the minimum core content of the right.

In accordance with the Maastricht Guidelines, there is a distinction in the minimum state obligations in obligations of conduct and obligations of result:

> *"The obligation of conduct requires action reasonably calculated to realize the enjoyment of a particular right. In the case of the right to health for example, the obligation of conduct could involve the adoption and implementation of a plan of action to reduce maternal mortality. The obligation of result requires states to achieve specific targets to achieve a detailed substantive standard. With respect to the right to health, for example, the obligation of conduct requires the reduction of maternal mortality to levels agreed at the 1994 Cairo International Conference on Population and Development and the 1995 Beijing Fourth World Conference on Women"*.

2.2.3 Convention on the Elimination of All Forms of Discrimination against Women:
CEDAW[40] provides in article 12 as follows:

> *"1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning".*
>
> *"2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".*

CEDAW calls for affirmative action and concrete steps to ensure that in law and in fact, women do not suffer discrimination in the field of health. This provision is based on the understanding of the life cycle approach to health which recognizes the peculiar needs of women and the fact that health outcomes at an early stage of life would contribute to the determination of outcomes at later stages of life.

[39] General Comment No.3 (supra), Paragraph 10.
[40] Adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979; entry into force 3 September 1981, in accordance with article 27(1).

2.2.4 Convention on the Rights of the Child:[41] The Convention in article 24 made detailed provisions on the rights of the child to health.

> *"1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."*
>
> *"2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:*
>
> > *(a) To diminish infant and child mortality;*
> >
> > *(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;*
> >
> > *(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;*
> >
> > *(d) To ensure appropriate pre-natal and post-natal health care for mothers;*
> >
> > *(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;*
> >
> > *(f) To develop preventive health care, guidance for parents and family planning education and services."*
>
> *"3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children'.*
>
> *"4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries".*

This provision is detailed and covers aspects of PHC, secondary and tertiary care and the determining factors affecting the enjoyment of the right to the highest attainable

[41] Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49

standard of physical and mental health. In matters concerning children, the best interest of the child is always the overriding guiding principle.[42]

2.2.5 The African Charter on Human and Peoples' Rights (ACHPR): The ACHPR states in article 16:

> *"(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health".*
>
> *"(2) State Parties to the present Charter shall take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick".*

Earlier in article 1 of the Charter, it is stated that:

> *"The Member States of the Organization of African Unity parties to the Charter shall recognize the rights, duties and freedoms enshrined in this Charter and shall undertake to adopt legislative or other measures to give effect to them."*

The ACHPR has been domesticated as part of Nigerian law.[43] It is enforceable before Nigerian courts.

2.2.6 Sustainable Development Goals (SDGs): Goal 3 of the SDGs focuses on ensuring healthy lives and promoting well-being at all ages. The targets are detailed below.

- *By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.*
- *By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.*
- *By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.*
- *By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.*
- *Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.*
- *By 2020, halve the number of global deaths and injuries from road traffic accidents to 3.7.*
- *By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.*
- *Achieve universal health coverage*, including financial risk protection, *access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.*

[42] Article 3 of the Convention on the Rights of the Child.
[43] Cap A9, Laws of the Federation of Nigeria 2004.

- *By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.*
- *Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.*
- *Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.*
- *Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.*
- *Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.*

SDG 3 is comprehensive and includes issues of PHC, UHC, preventive and curative health as well as health through the secondary and tertiary health care systems.

Alma Ata Declaration[44] **and Declaration of Astana:**[45] The Alma Ata Declaration sought to articulate the contours of PHC as follows:

> *Primary health care:*
>
> *1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;*
>
> *2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;*
>
> *3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;*
>
> *4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry,*

[44] Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

[45] Global Conference on Primary Health Care Asanta Kazakhstan, 25-26 October 2018.

education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

States, members of WHO under the Declaration of Astana in consolidating the gains of the Alma Ata Declaration asserted:

"PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions. We will prioritize disease prevention and health promotion and will aim to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care. PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of noncommunicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health. PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive. We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. We will benefit from sustainable PHC that enhances health systems' resilience to prevent, detect and respond to infectious diseases and outbreaks."

2.3 NATIONAL AND SUBNATIONAL STANDARDS

This part of the Manual would review national and subnational standards starting from the Constitution of the Federal Republic of Nigeria 1999 which is the supreme law of the land.

2.3.1 Constitution of the Federal Republic of Nigeria 1999: It provides in Chapter 2 under the Fundamental Objectives and Directive Principles of State Policy - section 17 (3) (c) and (d), that:

"The State shall direct its policy towards ensuring that-

(c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;

(d) there are adequate medical and health facilities for all persons;"

However, these provisions are under the non-justiciable Chapter 2 of the Constitution which appears like constitutional ropes of sand. They are more honoured in breach. But the state can enact a law which gives specific rights and duties to right holders and duty bearers respectively, and this will make effective, the right to health or specific aspects of it including UHC. This is the context that gave rise to the National Health Act of 2014. This position has been very well captured by the Supreme Court as follows[46]:

> *"The Constitution itself has placed the entire Chapter 11 under the Exclusive Legislative List. By this, it simply means that all Directive Principles need not remain mere or pious declarations. It is for the Executive and the National Assembly, working together, to give expression to anyone of them through appropriate enactment as occasion may demand."*

2.3.2 National Health Act 2014: The National Health Act was made as an Act to provide a framework for the regulation, development and management of the National Health System and set standards for rendering health services in the Federation and for related matters. The Act made a number of provisions which potentially will improve health care delivery. These include the mandate of the Federal Ministry of Health to prepare strategic medium-term health and human resources plans annually for the exercise of its powers and the performance of its duties under the Act.[47] The Ministry is to ensure that the national health plan forms the basis for budget preparation and other government planning exercise as may be required by law[48]. The National Council on Health established by the Act has a mandate inter alia to ensure that children between the ages of zero and five years and pregnant women are immunized with vaccines against infectious diseases.

The Act establishes a Basic Health Care Provision Fund with a government annual grant of not less than one percent of the Consolidated Revenue Fund[49] which is to be used inter alia; 20 per cent for essential drugs, vaccines, and consumables for eligible primary health care facilities; 15 per cent for the provision and maintenance of facilities, equipment and transport for eligible primary health care facilities whilst 10 per cent is to be used for the development of human resources for primary health care. It also makes provisions for grants to states and local governments who will be required to provide counterpart funding of 25 per cent of the total cost of the project. It strengthens the authority of the National

[46] Per Uwaifo J.S.C. in Attorney General Ondo State v Attorney General Federation (2002) 9 N.W.L.R. (Pt.772) 222 at 391.
[47] See section 2 (2) of the Act
[48] Supra
[49] In addition to the 1% of CRF, there are other funding sources provided in the ACT such as grants from international donor partners and funds from any other source.

Primary Health Care Development Agency over Local Government Health Authority as it can withhold funds due to the later, if it is not satisfied that the money earlier disbursed was applied in accordance with the provisions of the Act. The Act demands that health institutions including PHC centres operate and are duly licensed with a certificate of standards.[50]

2.3.3 National Health Policy (NHP): The *v*ision of the NHP is UHC for all Nigerians. The mission is t*o* provide stakeholders in health with a comprehensive framework for harnessing all resources for health development towards the achievement of UHC as encapsulated in the National Health Act in tandem with the SDGs. The overall policy goal is to strengthen Nigeria's health system, particularly the primary health care sub-system, to deliver effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians. There are ten policy thrusts in the NHP. They are: Governance; Health Service Delivery; Health Financing; Human Resources for Health; Medicines, Vaccines, Commodities and Health Technologies; Health Infrastructure; Health Information System; Health Research and Development; Community Ownership/ Participation; and Partnerships for Health. All these policy thrusts cut across the three tiers of primary, secondary and tertiary healthcare.

By the identification of 52 stakeholders including government agencies, private sector and civil society, the NHP adopts the whole-of-government, health-in-all policies and whole-of-society approach. Furthermore, the NHP identifies the primacy of PHC.

2.2.4 National Primary Health Care Development Agency: By the NHP, State Primary Health Care Development Agencies are supposed to mirror the NPHCDA. By S.3 of the NPHCDA Act, the functions of the Agency include:

> *(a) to provide support to the National Health Policy by-*
>
> *(i) reviewing existing health policies particularly as to their relevance to the development of primary health care and to the integrated development of health services and health manpower and propose changes when necessary;*
>
> *(ii) preparing alternative proposals for decision makers at all levels based on scientific analysis, including proposals for health legislation; and*
>
> *(iii) assisting the translation of policies into relevant and feasible strategies, based on research evidence, wherever appropriate;*
>
> *(b) to provide technical support to the planning, management and implementation of primary health care by-*
>
> *(i) stimulating and assisting States and Local Government Areas to initiate or accelerate primary health care development where none is taking place or is at very slow pace, and*

[50] S.13 of the Act.

specifically, by supporting the development of capabilities at Local Government Area level in the planning, reviewing and replanning of their health programmes;

(ii) promoting the participation of women at all levels of primary health care planning, management and implementation particularly at the Local Government Area level;

(iii) conducting studies on health plans for primary health care at various levels to see whether they are relevant to the National Health Policy, feasible and multi-sectoral;

(iv) promoting the monitoring of plan implementation at various levels;

(v) stimulating the technical development of primary health care on an equitable basis in all Local Government Areas; and

(vi) providing strategic technical support to the implementation of selected primary health care components as may be required to enhance orderly development and improve upon or introduce new skills required for health services or to integrate new components into them;

Other functions include mobilization of resources, nationally and internationally, for the development of primary health care in support of the programmes of the Agency and to conduct or commission studies on resource mobilisation for health and on issues of cost and financing on equitable basis; to provide support to the monitoring and evaluation of the National Health Policy; to promote health manpower development; to provide support to the village health system; to promote health systems research,; to promote technical cooperation and to promote primary health care.

NPHCDA has developed Minimum Standards for Primary Health Care in Nigeria (PHC Minimum Standards) applicable across the Federation.[51] The PHC Minimum Standards defines the standards required in health infrastructure, human resources for health and service provision. Furthermore, FGN and the states have been operating the policy of Primary Health Care Under One Roof (PHCUOR). It has nine pillars vis, governance and ownership, legislation, minimum service package (MSP), repositioning, PHC systems development, operational guidelines, human resources, funding structure and sources of funds, and infrastructure establishment.

2.2.5 Patients' Bill of Rights: The Consumer Protection Council has introduced the Patients' Bill of Right (PBOR) to set acceptable standards for health services delivery. The rights are:

(1) Right to relevant information

[51] It was for the period 2007-2012. Even though it has not been revised and updated, the standards still speak to PHC needs of today.

This is to ensure that you understand any diagnosis, treatment and other procedures and outcomes you may encounter.

(2) Right to timely access to medical records

This confirms that you should have access to your own accurate medical records in a timely manner.

(3) *Right to transparent billing*

This right validates that you are entitled to a clear and full breakdown of the bills for your treatment plans.

(4) *Right to privacy*

This affirms your right to confidentiality and privacy.

(5) Right to clean healthcare environment

This emphasises that you have a right to a safe and secure environment to get treatment and other healthcare services.

(6) Right to be treated with respect

This right applies to everyone without bias to gender, ethnicity, religion, disability allegations of crime or economic circumstances.

(7) Right to receive urgent care

This reaffirms patients' rights to receive immediate and sufficient care when it is an emergency.

(8) Right to reasonable visitation

This declares visitation, within reasonable rules and regulations, as an entitlement.

(9) Right to decline care

This confirms that patients have a right to decline treatment as long as they are aware of the consequences of that decision and it is legal to do so.

(10) *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 medical research.

(11) Right to quality care

The care you receive must be of a sufficient quality and meet standards required.

(12) Right to express dissatisfaction regarding services received

Section Three

COMMENTARY ON THE NATIONAL HEALTH POLICY 2016

The policy framework governing the operations of the health sector in Nigeria is the National Health Policy 2016 developed by the Federal Ministry of Health. Based on the provisions of the National Health Policy 2016, the health system in Nigeria is divided into ten (10) key areas namely:

1. Governance and stewardship
2. Health service delivery
3. Health financing
4. Human resources for health
5. Medicines, vaccines, other health technologies
6. Health infrastructure
7. Health information system
8. Health research and development
9. Health promotion, community participation and ownership
10. Partnership for health

1. GOVERNANCE AND STEWARDSHIP

Goal: To provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality health care and development in the National Health System.

Objectives: To effectively use the platform in the health sector for the provision of strategic governance and oversight.

 To provide clear policy orientation for health development.

 To facilitate the implementation of legislative and regulatory frameworks for health development, including the National Health Act 2014.

 To strengthen accountability, transparency and responsiveness of the national health system.

Comment: Nigeria is governed by the provisions of the 1999 Constitution. Unfortunately, it does not lay emphasis on health and fails to clearly indicate the roles and responsibilities of the three tiers of Government in health systems management and delivery. The National Health Act 2014 is the first legislative framework for the health system, though it has not properly addressed the gaps in the Constitution.

There is an existing framework for the oversight of programme implementation, including the National Council on Health, Health Partners Coordinating Committee (chaired by the Minister of Health), Development Partners Group for Health, etc. However, poor coordination and harmonization of these groups leads to duplication of functions and waste of scarce resources. There is lack of transparency in the budgetary process. There is usually insufficient public information on budget implementation. There is inadequate political will and commitment to health, as evidenced by low budgetary allocation to health. Corruption and fraud are also an issue. There is ineffective coordination among the three levels of government, as well as between the private and public sectors. There is lack of effective mechanisms for engaging consumers in policy and plan development and implementation, and weak donor coordination and harmonization of donor aid.

2. HEALTH SERVICE DELIVERY

Goal: Provide and ensure access to, and use of, high quality and equitable health care services, especially at the primary health care level, by all Nigerians.

Objectives: To provide a minimum health care service package for all Nigerians at all levels.

 To strengthen governance and accountability of service delivery units to improve the management of health facilities.

 To enhance demand-creation for health care services and health system responsiveness to client needs.

 To strengthen referral systems.

 To ensure the provision of adequate and safe blood for appropriate treatment of patients at all times.

 To strengthen traditional medicines/care as a component of the national health system and improve partnership with traditional medicine practitioners in health care delivery.

 To ensure timely, accessible, affordable, and reliable laboratory and radiological investigations for enhancing accurate diagnosis.

 To improve the quality of health services and ensure patient safety at all levels of the health system.

Comment: In Nigeria, health services are delivered through primary, secondary and tertiary health facilities by both the public and private sectors. Although primary health care is the fulcrum of the Nigerian health system, the provision, financing and management of primary health care services, as well as secondary health care services, leaves much to be desired. The availability of health facilities does not translate into the

availability of quality healthcare services. Certain services are not generally available to a large percentage of the population. There is consistent disruption of health care services, due to incessant industrial action by all cadres of health care providers in public facilities. Even though the private sector has played a vital role in making health services available, there is still poor integration of the private sector in the Nigerian health system.

Many health facilities are situated far away from the people, especially in rural and hard-to-reach areas. The most common barriers to accessing health services by the population are the cost of services, distance to the health facility, and the attitude of health workers. The quality of health services is generally poor and does not instill confidence in the people. This has led to some people seeking care outside the country, or bypassing the primary and secondary health facilities to seek health care at tertiary health institutions. Competence in the diagnosis and management of clinical illnesses is disproportionate, while adherence to clinical guidelines is low. Even where quality may be high, the perception of service users may not correlate with the actual quality of care delivered. These may be due to the poor attitude of health workers, lack of clarity of standards and protocols, as well as inadequate implementation of these guidelines and other regulations. There is no institutional framework for regulating quality and standards. While the National Health Act 2014 provides that health facilities are required to obtain a certificate of standards, the requirements for this certificate are not specified in the Act. Regulations that would provide these requirements have also not yet been enacted.

3. HEALTH FINANCING

Goal: Ensure adequate and sustainable funding that will be efficiently and equitably used to provide quality health services and ensure financial risk protection in access to health services for all Nigerians, particularly the poor and most vulnerable.

Objectives: To strengthen the institutional environment for sustainable financing and ensure accountability in the health sector.

 To guarantee financial access to a minimum package of health services through mandatory health insurance for all Nigerians.

 To strengthen domestic mobilization of adequate resources to sustain funding for health.

 To ensure value for money in purchasing cost-effective services essential for achieving the health-related SDGs and national priorities.

 To bolster health investments for economic growth and development.

COMMENT: Health financing challenges include inadequate public health funding, incomplete and unreliable data on health financing, allocative and technical inefficiencies

in health spending, very limited coverage with risk pooling mechanisms, and poor private sector investments in health.

Table 1 below shows the allocation to the Federal Ministry of Health over the years expressed as a percentage of the total federal budget.

Table 1: Allocation to Health as a Percentage of the Total Federal Budget

Years	Recurrent Budget for Health	Capital Budget for Health	Total Health Budget	Health Budget as a % of Total Budget
2016	221,412,548,087	28,650,342,987	250,062,891,074	4.13%
2017	252,854,396,662	55,609,880,120	308,464,276,782	4.15%
2018	269,965,117,887	86,485,848,198	356,450,966,085	3.91%
2019	315,617,344,056	50,146,387,170	365,763,731,226	4.14%
2020	336,597,463,881	59,909,430,837	396,506,894,718	3.74%
2021	415,234,696,058	134,591,025,027	549,825,721,085	4.05%

Source: Budget Office of the Federation and Authors Calculations

Tabe 2 shows the out-of-pocket health expenditure between the years 2000 and 2019.

Table 2: Out-of-Pocket Health Expenditure in Nigeria

Year	Out-of-Pocket Expenditure (% of Current Health Expenditure)
2019	70.524
2018	75.946
2017	77.27
2016	75.187
2015	71.89
2014	71.854
2013	70.927
2012	72.844
2011	74.725
2010	76.877
2009	74.475
2008	72.757
2007	70.938
2006	70.459
2005	65.971
2004	64.548
2003	72.814
2002	65.049

2001	60.748
2000	60.162

Source: Global Health Expenditure Database, The World Bank 2019.

From Table 1, the health budget as a percentage of the total federal budget is still below acceptable standards for a country that intends to transform its health sector. Furthermore, less than 5% of the population is currently covered by any form of prepayment schemes, such as health insurance. At the current level and trends of health financing, Nigeria will not achieve universal health coverage. Tabe 2 shows unduly high out of pocket expenditure which is far higher than the Sub-Saharan average.

4. HUMAN RESOURCES FOR HEALTH

The Goal: To provide appropriate and adequate human resources for healthcare at all levels of the health system.

Objectives: To strengthen the institutional framework for human resources planning, production, recruitment, distribution, management and practices in the health sector.

 To ensure clarity in the roles and responsibilities of actors at all levels on human resources for health planning, production and management.

Comment: The Federal Ministry of Health has established a national health workforce registry, although it is not yet fully functional and the registry's data are not regularly updated. Currently, the regulatory bodies maintain records of the health workers in their jurisdiction, but the records are also often not up to date and are, thus, inadequate for planning.

Some of the other major challenges of human resources for health include: poor management of human resources for health (including retention, remuneration, supervisory and logistics support); a poor working environment; limited opportunities for continuing education; migration to "greener pastures"; professional rivalry; divided/ conflict of interests of health staff; and frequent strike actions.

Table 3: Nigeria's Human Resources for Health

Health Indicator	
Density of Medical doctors (per 10 000 population)	3.8
Density of nursing and midwifery personnel (per 10 000 population)	15.0
Density of dentists (per 10,000 population)	0.2
Density of Pharmacists (per 10 000 population)	1.2

Source: World Health Statistics 2021, World Health Organization

5. MEDICINES, VACCINES, OTHER HEALTH TECHNOLOGIES

Goal: To ensure that quality medicines, vaccines, commodities and other technologies are available, affordable and accessible to all Nigerians.

Objectives: To build and maintain an integrated and effective system at all levels that ensures availability of good quality medicines, vaccines, health commodities and other technologies at all times in accordance with international standards.

 To establish effective structures that ensure accessibility of medicines, vaccines, commodities and other technologies at all levels and at all times.

 To create an enabling environment that ensure affordability of medicines, vaccines, commodities and other technologies at all times.

 To create appropriate mechanisms/structures that will enable proper regulation, management and administration of medicines, vaccines, commodities and other technologies.

 To develop and facilitate the use of Traditional Medicine in Nigeria in the official healthcare system; and also harness its economic benefits.

Comment: Nigeria has made appreciable progress in improving her capacity for local manufacturing of medicines and health commodities as some Nigerian pharmaceutical companies have received 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. The National Agency for Food and 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 in Nigeria. While NAFDAC has made significant efforts to check the prevalence of fake and substandard medicines and products, the challenge still exists.

There are fragmented systems and inefficient processes for the procurement, storage and distribution of medicines, vaccines, health commodities and technologies, including a reliable “cold chain” for the vaccines. Other challenges include poor implementation of guidelines, few training opportunities, and a poor pool of necessary skills for supply-chain management, among providers. These deficiencies often lead to drugs and other health commodities being frequently out of stock. It is expected that the provision of 20% of the Basic Health Care Provision Fund for essential drugs will address this gap.

There is shortage of biomedical engineers and poor institutional capacity for the maintenance of equipment and medical devices. Maintenance specifications 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 maintenance funds. Other problems related to medicines, vaccines include low spending on pharmaceuticals, vaccines and proportion of health expenditure, high prices of medicines, and irrational use of medicines.

6. HEALTH INFRASTRUCTURE

Goal: To have an adequate and a well distributed network of health care infrastructure that meets quality and safety standards.

Objectives: To improve availability and distribution of functional health facilities across the country to ensure equitable access to health services, especially in underserved areas.

 To ensure compliance with quality standards and requirements for facilities and biomedical equipment.

 To ensure effective maintenance of health equipment and infrastructure at all levels.

Comment: Physical structures, such as buildings and other physical facilities, such as pipe borne water, good access roads, electricity and transportation are deficient in most locations. Also, technological equipment meant for hospital use, such as surgical equipment, computers, power generating plants, and consumables are inadequate. Poor location of healthcare facilities leads to under-utilization of healthcare services.

There is a poor facility management and maintenance culture and a lack of standardization for health infrastructure. Although there is GIS system on health facilities in Nigeria. However, there is urgent need for its standardization and harmonization.

In order to ensure an optimum quality health infrastructure for primary health care, the National Health Act has specified 15% of the Basic Health Care Provision Fund to make available predictable financing obligations for the provision and maintenance of health facilities, equipment and transport. However, this provision is yet to make a critical impact in the sector.

7. HEALTH INFORMATION SYSTEM

Goal: To institutionalize an integrated and sustainable health information system for decision-making at all levels in Nigeria.

Objectives: To provide timely reliable and accurate data that will inform policy making, evidence-based decisions and resource allocation for improved health care at all levels.

 To develop and strengthen the national e-health system.

Comment: Nigeria developed its National Health Information Policy and Strategy in 2014 and has a roadmap to strengthen the 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 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 is being carried out, but the level of compliance and implementation is still low with varying reporting rates across the states. The overall completion rate of the national database is still below expectation.

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 the use of various values for selected indicators.

Routine analysis of data and the provision of a timely feedback mechanism are inadequate. As a result, efforts in data use for policy making are deficient although there has been more success in translating the results of surveys into policy. The quality of data is still sub-optimal, and data quality assessments are neither regularly nor consistently conducted. There are often large variations in the values of indicators from different data sources.

Other challenges related to the Health Information System (HIS) include: a very weak capacity for the HIS at the sub-state level in regard to its operation at the LGAs, the provision of 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. Funds allocation by Federal and State Governments to the health information system is inadequate and unable to meet the needs. This has made Federal Government unable to take the lead in directing partners on the landscape, causing more fragmentation.

8. HEALTH RESEARCH AND DEVELOPMENT

Goal: To have robust research and development systems at all levels that generate reliable health data that is responsive to the decision-making needs of the health system.

Objectives: To provide a coordination and regulatory framework for health research and development by all relevant stakeholders, in line with the National Health Act 2014.

 To advocate and solicit for mobilization of adequate funding for health research and development, including the establishment of a National Health Research and Innovation Fund.

Comment: There is a National Health Research Policy and Priorities that has been developed by the FMoH since 2014. There are research structures, such as research institutes (the Nigeria Institute of Medical Research and the National Institute for Pharmaceutical Research and Development), as well as training institutions supporting learning and dissemination of research products in health. 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 paucity of targeted research studies that address the country's health policy needs. There is limited collation, dissemination and use of available evidence from research for decision-making. The capacity of the FMoH and the State Ministries of Health to promote and lead health research activities is very weak.

There is a mechanism for the regulation of research whereby NAFDAC regulates clinical trials, in line with the principles of Good Clinical Practice. The National Health Research Ethics Committee (NHREC), along with identical Committees at state and institutional levels, provide ethical oversight for all health research studies. The collaboration between NAFDAC and the national NHREC has been successful, so far. The collaboration has however been through informal mechanisms, which need to be formalised. Furthermore, the NHREC has not been able to monitor and provide adequate guidelines to the state and institutional HRECs, due to underfunding and challenges with its operational structure, especially in regard to the provision of dedicated professional staff, a formal office space for its operations, and a dedicated budget line.

9. HEALTH PROMOTION, COMMUNITY PARTICIPATION AND OWNERSHIP

Goal: To strengthen and sustain active community participation and ownership in health planning, implementation, monitoring and evaluation.

Objectives: To empower communities for active participation in planning, monitoring and evaluation and decision making for effective implementation of the health policy.

 To strengthen communities on the use of monitoring and evaluation (M&E) reports for resource mobilization and utilization for improved health outcomes.

 To strengthen effective community systems on the use of M&E to reflect gender and cultural issues for improved health outcomes.

Comment: There are various health promotion units at both federal and state levels. However, they often lack effective leadership for health promotion. According to the National Health Promotion Policy 2006, there is little understanding of the concepts of health promotion, consumer rights, the need for multi-sectoral action, and the promotion of a supportive environment for behavioural changes in health care. In addition, there are few frameworks and guidelines for systematic planning and management of health

education interventions. There is a framework for the development of, and engagement with, community structures, such as Ward Development Committees, the 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 functions. However, they are often not empowered and are, therefore, 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 health interventions and are often not in a position to hold government and service providers accountable.

However, where the committees are supported, they have proved to be instrumental in increasing demand for services.

10. PARTNERSHIPS FOR HEALTH

Goal: To promote effective partnerships among the public, and private sectors and other stakeholders for optimum resource mobilization and use towards universal health coverage for all Nigerians.

Objectives: To identify areas of need for collaboration and partnerships among actors in the health system.

 To promote partnerships for the purpose of supporting capacity building, innovation and sustainability in health financing, provisioning, utilization and quality assurance and improvement.

 To ensure that formal, systematic and innovative mechanisms are developed and used, involving all public and non-state actors in the development and sustenance of the health sector.

 To promote both inter and intra-sectoral collaboration in the health sector.

Comment: Nigeria signed up to the Global Compact of the International Health Partnerships and related initiatives in 2008, and signed up to a complementary 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 a collaborative relationship between the public and private sectors. Despite this, private sector engagement remains weak as there are very few incentives for private sector engagement in health services delivery.

Although platforms for partnership coordination exist, laxity persists in ensuring donor alignment to national priorities and programmes. In recent years, there has been an increased effort to include other stakeholders, such as the private sector and civil society

in policy and planning processes for health care delivery. There has been progress in multi-sectoral collaboration as exemplified by the comprehensive response to epidemics and disasters and the HIV programme in Nigeria. However, greater effort is needed to strengthen this inter-sectoral collaboration, considering that many of the determinants of health outcomes are outside the health sector.

Section Four

NIGERIA'S HEALTH INDICATORS

This Section reviews Nigeria's key health indicators especially in comparison to countries in World Health Organization (WHO) African region and the global membership of WHO. Health indicators are quantifiable characteristics of a population commonly used in public health analysis and by researchers as supporting evidence for describing the health of a population.[52] Indicators gives a summarized picture of the status of the realization of a specific aspect of the health of the population.

Table 4: Nigeria's Health Indicators versus WHO Africa and Global

Indicator	Nigeria	WHO African Region	WHO Global
Life expectancy at birth - male (years)	61.2	62.4	70.8
Life expectancy at birth – female (years)	64.1	66.6	75.9
Life expectancy at birth – both sexes (years)	62.6	64.5	73.3
Healthy life expectancy at birth – male (years)	53.9	55.0	62.5
Healthy life expectancy at birth – female (years)	54.9	57.1	64.9
Healthy life expectancy at birth – both sexes (years)	54.4	56.0	63.7
Maternal mortality ratio (per 100 000 live births)	917	525	211
Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70 (%)	16.9	20.8	17.8
Suicide mortality rate (per 100 000 population)	3.5	6.9	9.2
Under-five mortality rate (per 1000 live births)	117	74	38
Neonatal mortality rate (per 1000 live births)	36	27	17
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)	6.2	4.8	5.8
Road traffic mortality rate (per 100 000 population)	20.7	27.2	16.7
Proportion of women of reproductive age who have their	35.6	57.1	76.8

[52] https://en.wikipedia.org/wiki/Health_indicator.

need for family planning satisfied with modern methods (%)			
Adolescent birth rate (per 1000 women aged 15–19 years)	106.0	102.1	42.5
Population with household expenditures on health >10% of total household expenditure or income (%)	15.1	7.3	12.7
Population with household expenditures on health >25% of total household expenditure or income (%)	4.1	1.8	2.9
Age-standardized mortality rate attributed to Household and ambient air pollution (per 100 000 population)	307.4	180.9	114.1
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)	68.6	45.8	11.7
Mortality rate from unintentional poisoning (per 100 000 population)	3.3	2.5	1.1
Age-standardized prevalence of tobacco use among persons 15 years and older (%)	4.8	12.7	23.6
Diphtheria tetanus pertussis (DTP3) immunization coverage among 1-year-olds (%)	57	74	85
Measles containing vaccine second-dose (MCV2) Immunization coverage by the nationally recommended age (%)	9	33	71
Pneumococcal conjugate 3rd dose (PCV3) Immunization coverage among 1-year-olds (%)	57	70	48
Total net official development assistance to medical research and basic health sectors per capita (US$)	3.63	5.34	1.44
Density of Medical doctors (per 10 000 population)	3.8	2.8	17.5
Density of nursing and midwifery personnel (per 10 000 population)	15.0	10.3	39.0
Density of dentists (per 10 000 population)	0.2	---	---
Density of Pharmacists (per 10 000 population)	1.2	---	---
Domestic general government health expenditure	4.4	6.8	10.0

(GGHE-D) as percentage of general government expenditure (GGE), 2018 (%)			
Prevalence of stunting in children under 5 (%)	35.3	31.7	22.0
Prevalence of wasting in children under 5 (%)	6.5	5.8	6.7
Prevalence of overweight in children under 5 (%)	2.7	4.2	5.7
Proportion of population using safely managed drinking-water services (%)	20	29	71
Proportion of population using safely managed Sanitation services (%)	27	20	45
Proportion of population using a handwashing facility with soap and water (%)	42	28	60
Amount of water and sanitation related official Development assistance that is part of a government coordinated spending plan (current US$ millions)	193.93	2932.34	8846.42
Age standardized prevalence of raised blood pressure among persons aged 18+ years (SBP of >140 mmHg and/or DBP >90 mmHg)	23.9	27.4	22.1
Prevalence of obesity among children and adolescents (5–19 years) (%)	1.9	2.8	6.8
Age standardized prevalence of obesity among Adults (18+ years) (%)	8.9	10.6	13.1
Malaria incidence (per 1000 population at risk)	303.3	225.2	56.8
Unmet need for family planning – currently married women (%)	18.9		
Percentage receiving antenatal care from a skilled provider (%)	67.0		
Percentage of live births delivered by a skilled provider (%)	43.4	65	83
Percentage of live births delivered in a health facility (%)	39.4		
Out-of-pocket expenditure, 2019 (% of current health expenditure)	70.524		

Source: World Health Statistics 2021, World Health Organization; Nigeria Demographic and Health Survey 2018, National Planning Commission, Abuja; Global Health Expenditure Database, The World Bank.

Table 4 shows that Nigeria's health indicators are poor and for the greater part lower than WHO African region and the global membership of WHO. The indicators range from life expectancy, maternal, child health and mortality/morbidity indicators, family planning, household expenditure on health, WASH indicators, etc. It indicates that Nigeria's health system is in need of massive systemic and systematic reforms, increased value for money investments, more efficient deployment of existing resources and massive injection of new resources.

Out of pocket health expenditure is a reference to direct expenses on health care which is not covered by any prepayments for health services. It is paid from an individual's cash reserves. It forces people, especially the poor to make unnecessary choices between their health and expenditure on other basic rights such as food, housing and education. Table 5 shows the out-of-pocket health expenditure as a percentage of health expenditure.

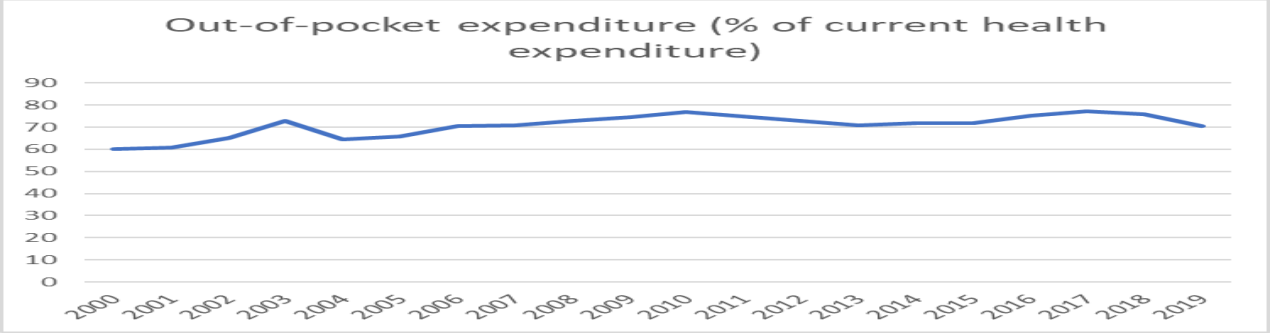
Table 5: Out-of-Pocket Expenditure (As a % of Current Health Expenditure) from 2000 – 2019

Year	Out-of-Pocket Expenditure (% of current health expenditure)		
2019	70.524	2009	74.475
2018	75.946	2008	72.757
2017	77.27	2007	70.938
2016	75.187	2006	70.459
2015	71.89	2005	65.971
2014	71.854	2004	64.548
2013	70.927	2003	72.814
2012	72.844	2002	65.049
2011	74.725	2001	60.748
2010	76.877	2000	60.162

Source: Global Health Expenditure Database, The World Bank.

Table 5 is illustrated in Chart 1.

Chart 1: Out-of-Pocket Expenditure (As a % of Current Health Expenditure) from 2000 – 2019



Source: Global Health Expenditure Database, The World Bank.

Table 5 and Chart 1 show that out of pocket health expenditure kept increasing from the year 2000 (60.1%) up to 2010 (76.8%) before it started a very marginal decline and peaked again in 2017 (77.2%) and marginally declined thereafter to the current 70.52%. The current Nigerian out of pocket health expenditure is compared in Table 6 with other African countries and country groupings.

Table 6: Nigeria's Out-of-Pocket Health Expenditure Compared to Other Countries

Country/Region	Out of Pocket Expenditure (% of Current Health Expenditure)
Nigeria	70.52
Angola	37.46
Benin	47.04
Burkina Faso	34.69
Cote d'ivoire	37.29
Gabon	23.09
Ghana	36.22
Kenya	24.30
Rwanda	11.67
Sub Saharan Africa	29.98
Low and Middle Income Countries	35.09
Low Income Countries	45.36

Source: World Health Organization Global Health Expenditure database, World Bank https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG,%202019

Angola, Benin, Burkina Faso, Cote D'Ivoire, Gabon, Kenya, Rwanda, all performed better and had lower out of pocket expenditure than Nigeria. The Sub Saharan Africa average is 29.98% as against Nigeria's 70.52%. Low and middle income countries recorded 35% while low income countries alone recorded 45.3%. Table 6 shows that Nigeria needs to improve and increase the coverage and penetration of its prepaid public and private health insurance schemes as well as improve public expenditure on health. A regime of compulsory and universal health insurance scheme in Nigeria is imperative while government makes special provisions for persons who are unemployed and unable to pay premiums through increased public expenditure on health.

Availability of safely managed sanitation services is a factor that determines and impacts on the health of a population. Poor sanitation is a factor that predisposes people to diseases causing pathogens. Table 7 and Chart 2 shows people using safely managed sanitation services a s a percentage of the population in Nigeria.

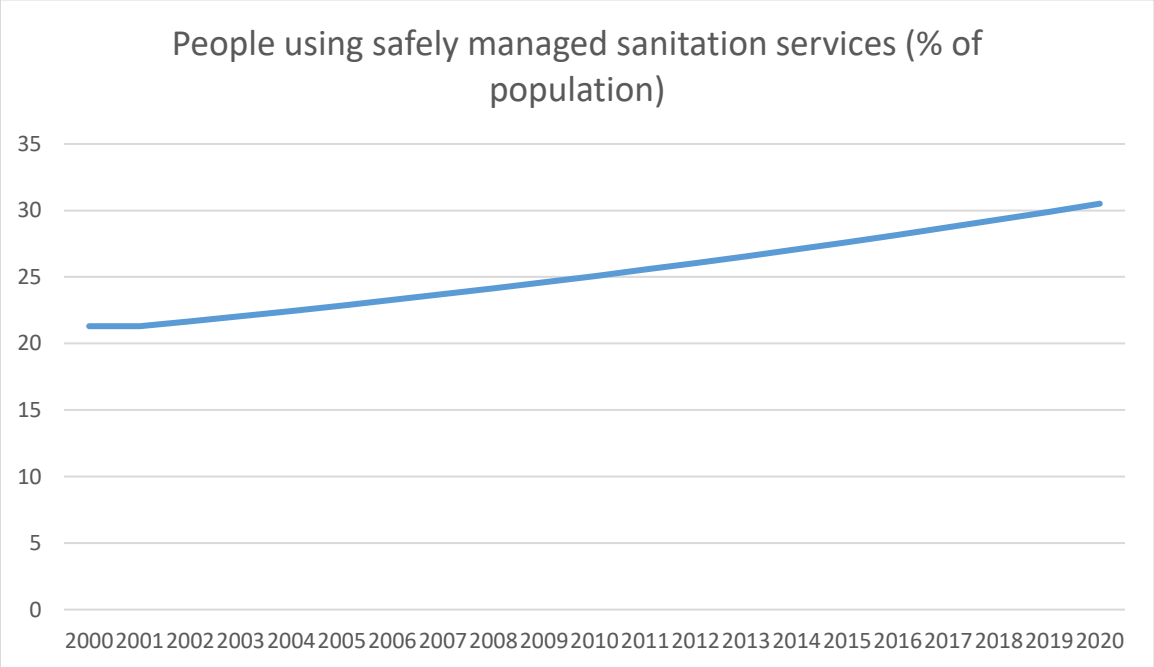
Table 7: Use of Safely Managed Sanitation Services (% of Population)

Year	People using Safely Managed Sanitation Services (% of Population)		
2020	30.509	2009	24.601
2019	29.905	2008	24.145
2018	29.313	2007	23.701
2017	28.735	2006	23.269
2016	28.171	2005	22.85
2015	27.621	2004	22.443
2014	27.084	2003	22.047
2013	26.561	2002	21.662
2012	26.051	2001	21.301
2011	25.554	2000	21.301
2010	25.071		

Source: Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene, The World Bank

Table 7 is illustrated in Chart 2.

Chart 2: People Using Safely Managed Sanitation Services (% of Population)



Source: Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene, The World Bank

Table 7 and Chart 2 displays a very poor performance. The slight improvement from 21.3% to 30.5% over a period of 21 years is an improvement of less than .5% every year.

Human, financial, information technology, etc. resources are required to improve this indicator.

Section Five

GENDER AND THE RIGHT TO HEALTH

GENERAL RECOMMENDATIONS ADOPTED BY THE COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN

Twentieth session (1999)

General recommendation No. 24: Article 12 of the Convention (women and health)

1. The Committee on the Elimination of Discrimination against Women, affirming that access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women, decided at its twentieth session, pursuant to article 21, to elaborate a general recommendation on article 12 of the Convention.

Background

2. States parties' compliance with article 12 of the Convention is central to the health and well-being of women. It requires States to eliminate discrimination against women in their access to health-care services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement and during the post-natal period. The examination of reports submitted by States parties pursuant to article 18 of the Convention demonstrates that women's health is an issue that is recognized as a central concern in promoting the health and well-being of women. For the benefit of States parties and those who have a particular interest in and concern with the issues surrounding women's health, the present general recommendation seeks to elaborate the Committee's understanding of article 12 and to address measures to eliminate discrimination in order to realize the right of women to the highest attainable standard of health.

3. Recent United Nations world conferences have also considered these objectives. In preparing this general recommendation, the Committee has taken into account relevant programmes of action adopted at United Nations world conferences and, in particular, those of the 1993 World Conference on Human Rights, the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women. The Committee has also noted the work of the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and other United Nations bodies. It has collaborated with a large number of non-governmental organizations with a special expertise in women's health in preparing this general recommendation.

4. The Committee notes the emphasis that other United Nations instruments place on the right to health and to the conditions that enable good health to be achieved. Among such instruments are the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Racial Discrimination.

5. The Committee refers also to its earlier general recommendations on female circumcision, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), disabled women, violence against women and equality in family relations, all of which refer to issues that are integral to full compliance with article 12 of the Convention.

6. While biological differences between women and men may lead to differences in health status, there are societal factors that are determinative of the health status of women and men and can vary among women themselves. For that reason, special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities.

7. The Committee notes that the full realization of women's right to health can be achieved only when States parties fulfil their obligation to respect, protect and promote women's fundamental human right to nutritional well-being throughout their lifespan by means of a food supply that is safe, nutritious and adapted to local conditions. To this end, States parties should take steps to facilitate physical and economic access to productive resources, especially for rural women, and to otherwise ensure that the special nutritional needs of all women within their jurisdiction are met.

Article 12

8. Article 12 reads as follows:

> "1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning.
> "2. Notwithstanding the provisions of paragraph 1 of this article, States parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

States parties are encouraged to address the issue of women's health throughout the woman's lifespan. For the purposes of the present general recommendation, therefore, "women" includes girls and adolescents. The general recommendation will set out the Committee's analysis of the key elements of article 12.

Key elements

Article 12 (1)

9. States parties are in the best position to report on the most critical health issues affecting women in that country. Therefore, in order to enable the Committee to evaluate whether measures to eliminate discrimination against women in the field of health care are appropriate, States parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures. Reports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture.
10. States parties are encouraged to include in their reports information on diseases, health conditions and conditions hazardous to health that affect women or certain groups of women differently from men, as well as information on possible intervention in this regard.

11. Measures to eliminate discrimination against women are considered to be inappropriate if a health-care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.

12. States parties should report on their understanding of how policies and measures on health care address the health rights of women from the perspective of women's needs and interests and how it addresses distinctive features and factors that differ for women in comparison to men, such as:

(a) Biological factors that differ for women in comparison with men, such as their menstrual cycle, their reproductive function and menopause. Another example is the higher risk of exposure to sexually transmitted diseases that women face;

(b) Socio-economic factors that vary for women in general and some groups of women in particular. For example, unequal power relationships between women and men in the home and workplace may negatively affect women's nutrition and health. They may also be exposed to different forms of violence which can affect their health. Girl children and adolescent girls are often vulnerable to sexual abuse by older men and family members, placing them at risk of physical and psychological harm and unwanted and early pregnancy. Some cultural or traditional practices such as female genital mutilation also carry a high risk of death and disability;

(c) Psychosocial factors that vary between women and men include depression in general and post-partum depression in particular as well as other psychological conditions, such as those that lead to eating disorders such as anorexia and bulimia;

(d) While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence.

13. The duty of States parties to ensure, on a basis of equality of men and women, access to health-care services, information and education implies an obligation to respect, protect and fulfil women's rights to health care. States parties have the responsibility to ensure that legislation and executive action and policy comply with these three obligations. They must also put in place a system that ensures effective judicial action. Failure to do so will constitute a violation of article 12.

14. The obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health-care providers meet their duties to respect women's rights to have access to health care. For example, States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women punish women who undergo those procedures.

15. The obligation to protect rights relating to women's health requires States parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations. Since gender-based

violence is a critical health issue for women, States parties should ensure:

(a) The enactment and effective enforcement of laws and the formulation of policies, including health-care protocols and hospital procedures to address violence against women and sexual abuse of girl children and the provision of appropriate health services;

(b) Gender-sensitive training to enable health-care workers to detect and manage the health consequences of gender-based violence;

(c) Fair and protective procedures for hearing complaints and imposing appropriate sanctions on health-care professionals guilty of sexual abuse of women patients;

(d) The enactment and effective enforcement of laws that prohibit female genital mutilation and marriage of girl children.

16. States parties should ensure that adequate protection and health services, including trauma treatment and counselling, are provided for women in especially difficult circumstances, such as those trapped in situations of armed conflict and women refugees.

17. The duty to fulfil rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care. Studies such as those that emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care. The Committee asks States parties to report on what they have done to address the magnitude of women's ill-health, in particular when it arises from preventable conditions, such as tuberculosis and HIV/AIDS. The Committee is concerned about the evidence that States are relinquishing these obligations as they transfer State health functions to private agencies. States and parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. States parties should therefore report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women's health. They should include information on positive measures taken to curb violations of women's rights by third parties and to protect their health and the measures they have taken to ensure the provision of such services.

18. The issues of HIV/AIDS and other sexually transmitted diseases are central to the

rights of women and adolescent girls to sexual health. Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health. As a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices. Harmful traditional practices, such as female genital mutilation, polygamy, as well as marital rape, may also expose girls and women to the risk of contracting HIV/AIDS and other sexually transmitted diseases. Women in prostitution are also particularly vulnerable to these diseases. States parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country. In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality.

19. In their reports, States parties should identify the test by which they assess whether women have access to health care on a basis of equality of men and women in order to demonstrate compliance with article 12. In applying these tests, States parties should bear in mind the provisions of article 1 of the Convention. Reports should therefore include comments on the impact that health policies, procedures, laws and protocols have on women when compared with men.

20. Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives.

21. States parties should report on measures taken to eliminate barriers that women face in access to health-care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women's access, such as high fees for health-care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and the absence of convenient and affordable public transport.

22. States parties should also report on measures taken to ensure access to quality health-care services, for example, by making them acceptable to women. Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory

testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women's rights to informed consent and dignity.

23. In their reports, States parties should state what measures they have taken to ensure timely access to the range of services that are related to family planning, in particular, and to sexual and reproductive health in general. Particular attention should be paid to the health education of adolescents, including information and counselling on all methods of family planning.

24. The Committee is concerned about the conditions of health-care services for older women, not only because women often live longer than men and are more likely than men to suffer from disabling and degenerative chronic diseases, such as osteoporosis and dementia, but because they often have the responsibility for their ageing spouses. Therefore, States parties should take appropriate measures to ensure the access of older women to health services that address the handicaps and disabilities associated with ageing.

25. Women with disabilities, of all ages, often have difficulty with physical access to health services. Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation. States parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity.

Article 12 (2)

26. Reports should also include what measures States parties have taken to ensure women appropriate services in connection with pregnancy, confinement and the post-natal period. Information on the rates at which these measures have reduced maternal mortality and morbidity in their countries, in general, and in vulnerable groups, regions and communities, in particular, should also be included.

27. States parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services. The Committee notes that it is the duty of States parties to ensure women's right to safe motherhood and

emergency obstetric services and they should allocate to these services the maximum extent of available resources.

Other relevant articles in the Convention

28. When reporting on measures taken to comply with article 12, States parties are urged to recognize its interconnection with other articles in the Convention that have a bearing on women's health. Those articles include article 5 (b), which requires States parties to ensure that family education includes a proper understanding of maternity as a social function; article 10, which requires States parties to ensure equal access to education, thus enabling women to access health care more readily and reducing female student drop-out rates, which are often a result of premature pregnancy; article 10 (h), which requires that States parties provide to women and girls access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning; article 11, which is concerned, in part, with the protection of women's health and safety in working conditions, including the safeguarding of the reproductive function, special protection from harmful types of work during pregnancy and with the provision of paid maternity leave; article 14, paragraph 2 (b), which requires States parties to ensure access for rural women to adequate health-care facilities, including information, counselling and services in family planning, and (h), which obliges States parties to take all appropriate measures to ensure adequate living conditions, particularly housing, sanitation, electricity and water supply, transport and communications, all of which are critical for the prevention of disease and the promotion of good health care; and article 16, paragraph 1 (e), which requires States parties to ensure that women have the same rights as men to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise those rights. Article 16, paragraph 2, proscribes the betrothal and marriage of children, an important factor in preventing the physical and emotional harm which arise from early childbirth.

Recommendations for government action

29. States parties should implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services.

30. States parties should allocate adequate budgetary, human and administrative

resources to ensure that women's health receives a share of the overall health budget comparable with that for men's health, taking into account their different health needs.

31. States parties should also, in particular:

(a) Place a gender perspective at the centre of all policies and programmes affecting women's health and should involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women;

(b) Ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS;

(c) Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion;

(d) Monitor the provision of health services to women by public, non-governmental and private organizations, to ensure equal access and quality of care;

(e) Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;

(f) Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence.

Chapter Six
IMPROVING THE EFFICIENCY AND EFFECTIVENESS OF HEALTH CARE DELIVERY UNDER THE NATIONAL HEALTH INSURANCE SCHEME

6.1 INTRODUCTION

The long title to the National Health Insurance Scheme Act ("the Act") describes it as an Act to establish the National Health Insurance Scheme ("NHIS" or "Scheme") with the objectives of ensuring access to good health care services to every Nigerian and protecting Nigerian families from financial hardship of huge medical bills; and for matters connected therewith[53].

S.1 (1) of the Act provides that the Scheme is for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost-effective health services as set out in the Act. In carrying out these noble goals, a stakeholder process is unleashed between the NHIS being the regulator, Health Maintenance Organisations ("HMOs"), Health Care Providers ("HCPs") and contributors and their dependents who are the beneficiaries of the Scheme.

In improving the efficiency and effectiveness of health care delivery under the NHIS, it will be imperative to assess the performance of HMOs and HCPs who are key stakeholders. Also, a review of the objectives of the Scheme as stated in S.5 of the Act is imperative. The objectives are to:

- *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;*
- *maintain high standard of health care delivery services within the Scheme*
- *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;*
- *ensure the availability of funds to the health sector for improved services.*

Further, it is pertinent to review the functions of HMOs and HCPs as stated in the Act. HCPs by S.18 (1) of the Act are under a definite obligation:

53. See Cap N42, Laws of the Federation of Nigeria, 2004.

A health care provider registered under the Scheme shall, in consideration for a capitation payment in respect of each insured person registered with it, or for payment of approved fees for services rendered and to that extent and in the manner prescribed by this Act, provide -

- *defined elements of curative care;*
- *prescribed drugs and diagnostic tests;*
- *maternity care for up to four live births for every insured person[54];*
- *preventive care, including immunization, family planning, ante natal and post-natal care;*
- *consultation with defined range of specialists;*
- *hospital care in a public or private hospital in a standard ward during a stated duration of stay for physical or mental disorders;*
- *eye examination and care, excluding test and the actual provision of spectacles; and*
- *a range of prosthesis and dental care as defined.*

For HMOs, S. 20 of the Act assigns the following functions:

- *the collection of contributions from eligible employers and employees under this Act;*
- *the collection of contributions from voluntary contributors under subsection (3) of section 17 of this Act;*
- *the payment of capitation fees for services rendered by health care providers registered under the Scheme;*
- *rendering to the Scheme returns on its activities as may be required by the Council;*
- *contracting only with the health care providers approved by the Scheme for the purpose of rendering health care services under this Act;*
- *ensuring that contributions are kept in accordance with guidelines issued by the Council and in banks approved by the Council; and*
- *establishing a quality assurance system to ensure that qualitative care is given by the health care providers*.

Thus, the Act expects collaboration between NHIS as regulator through HMOs as purchasers of service to actual service providers in health care providers to render quality and efficient service to the contributors and their dependents. So, where is the challenge coming from which limits efficiency and effectiveness? Centre for Social Justice (CSJ) prepared this memorandum drawing from interviews with selected beneficiaries, former staff of HMOs, health professionals and through literature review and interactions with the

54. Covering four live births makes eminent sense. However, we are living in a country where families give birth to more than four children. The Guidelines also define family in terms of a monogamous union whilst polygamous unions are also recognized by law. So, there is a lacuna that needs to be filled through the interrogation and re-definition of basic concepts.

regulator.

The memorandum and the recommendations are drawn up against the background of the health duties of state under national and international standards and jurisprudence and these are the obligations to respect, protect and fulfill the right to health. The obligation to respect requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect mandates states to take measures that prevent third parties from interfering with the right whilst the obligation to fulfill requires states to take appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health[55].

6.4 KEY CHALLENGES AND ACTION POINTS

A. Inflation of Number of Enrollees and Capitation

Analysis: The HMOs are known to inflate the number of registered enrollees under their care and at the end of the day, make false claims for payment of capitation which is borne by the NHIS. The Executive Secretary, NHIS, Usman Yusuf, disclosed that the Scheme had removed about 23,000 ghost enrollees[56]. One can imagine the billions of naira that had been stolen from the system through this kind of false claims and inflation. This will definitely be at the expense of real-life enrollees. Those who enrolled the ghosts were third parties who sought to interfere with the enjoyment of the right to health of the enrollees and as such, the protection duty of the state was right to fish them out.

On the flip side of it, HMOs report that they have enrolled only 450,000 Nigerians under private insurance schemes since inception. This figure is too low and seems to be underestimated. There is a perverse incentive to under report the numbers enrolled considering that they are required to pay a certain percentage of the premium to NHIS. This is most likely the case considering that before the advent of health insurance in Nigeria, many blue-chip companies, individuals and organisations were running retainerships with private health service providers and majority of the retainers were converted to private insurance schemes[57]. This is validated by the submission of a HMO, AXA Mansard Health that total premium size in the private sector health insurance scheme in the form of employer sponsored insurance is about N50 billion covering 2.5 million lives[58].

55 See the Maastricht Guidelines on Violation of Economic, Social and Cultural Rights adopted on the occasion of the 10th anniversary of the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights.

56 https://www.nhis.gov.ng/nhis-fishes-out-23%2C000-ghost-enrollees/

57 See *Relationship Management between HMOs and Service providers: Matters Arising* by Dr. Olanike Adeniba, former President, Health Care Providers Association of Nigeria.

58 Memorandum submitted to the Deputy Clerk, House of Representatives Committee on Health Care Services in June, 2017.

Action Point: To prevent the repetition of padding and under reporting in the future requires strong deterrence through criminal prosecution and stronger penalties in the Act. It is recommended that registration with the Scheme or private health insurance should be linked with Bank Verification Numbers and the National Identity Card Scheme. Those responsible should not simply be slapped on the wrist but made to pay a heavy price to deter others in future. Beyond this, those involved should be named and shamed and possibly blacklisted.

B. HMOs Withholding Funds Due to HCPs

Analysis: The Scheme is stated to be paying HMOs three months capitation upfront to enable them provide timely, standard and qualitative healthcare services to the enrollees through timely and regular payments to HCPs; but the HCPs are not paid timely and are owed a lot after rendering services[59].

Action Point: Reports from HCPs should be sent to the regulator which should investigate and if found to be true, follow up with administrative and punitive sanctions to deter future offence. The penalties in the Act should be applied but the Act should be amended for stiffer penalties.

C. Shortchanging Health Benefit Package of Enrollees

Analysis: The HMOs mostly do not offer their enrollees the list of health benefit packages known to be approved by the NHIS. Enrollees have been denied basic treatment packages by various HCPs. The HCPs only respond to the enrollees based on the type of agreement signed with the HMOs. In most reported cases where enrollees are denied some health benefits that is supposed to be in their package, the HCPs confirmed that such benefits were not in the agreement between them and their HMOs. This goes against one of the functional parametres of the right to health which is availability of services to attend to those in need of curative care.

Action Point: Full blown sensitization of enrollees on their rights and entitlements under the Scheme as stated in the enrollee bill of rights on the website of the Scheme. The sensitization should be the duty of the Scheme, HMOs, professional associations in the health sector, and health related civil society organisations. This will ensure information accessibility as a component of the right to health. Again, penalties should be stated in the law and by administrative action of the regulator to whip into line recalcitrant HMOs

[59] See the House of Representatives Motion of December 8, 2016.

and HCPs. The rights are stated to be:

- *Right of access to medical treatment as covered by the benefit package under the Scheme.*
- *Right to choose a provider of his/her choice as long as such a provider is accredited by the Scheme.*
- *Right to be issued with an NHIS identity card after being registered with the Scheme.*
- *Right to change Primary Healthcare Provider after three (3) months of initial access.*
- *Right to immediately change his/her provider if the facility is closed, relocated or the employee is on transfer to another town.*
- *Right to complain to the HMO about any act of negligence on the part of the Healthcare provider.*
- *Right to access medical care for spouse and four (4) biological children.*
- *Right to give constructive criticism of the operational methods of the Scheme.*
- *Right to be referred for specialised investigations or care. Referral means sending a patient for a range of specialized investigations or care through the recognized three levels of services:*
    - *Referrals made by primary healthcare provider to the secondary provider.*
    - *Referrals made by the secondary provider to tertiary provider,*
    - *Lateral referral from one specialist to another within the same level.*

D. Enrollees are Restricted to Substandard Drug List

Analysis: The HMOs offer only generic drugs, to their enrollees instead of branded drugs. There is an approved drug list in the National Health Insurance Scheme. However, the NHIS drug list does not provide for some certain level of quality required by the enrollees. This needs to be reviewed to meet up with health quality standards. It is the duty of the HMOs to recommend standard drugs for their enrollees, though this might attract some extra cost. HCPs are under obligation to provide prescribed drugs and diagnostic tests. For healthcare to meet the adequacy criteria, health facilities, goods and services must be scientifically and medically appropriate and of good quality.

Action: The Scheme should review the drug list to infuse greater quality in the dispensation of drugs.

E. Poor Quality Assurance to Enrollees

Analysis: The HMOs are supposed to provide proper oversight and quality assurance system to ensure that qualitative care is given by HCPs to their enrollees. This entails that the HMOs resolve queries promptly and investigates cases of medical malpractices on their enrollees. However, due to the poor agreement between the HMOs and the HCPs, the HMOs have been derelict in this core duty of offering proper quality assurance

to their enrollees as expected under a managed health care scheme. This has led to loss of confidence in the Scheme. As a result, some enrollees prefer to pay out of their pocket to get quality treatment despite being registered under the Scheme. In most cases, because treatment of enrollees under the managed health care has been pre-paid, the HCPs concentrate their efforts in attending to private patients outside the health insurance scheme. This leads to discrimination between patients coming from the Scheme and those paying out of pocket with the latter being better treated.

The foregoing is also linked to the implementation of S. 13 of the National Health Act which mandates the issuance of a certificate of standards to all health establishments within 24 months of the coming into force of the National Health Act[60]. A certified health establishment should meet quality assurance standards and protocols.

Action Point: Enhanced oversight of HMOs and HCPs by the NHIS to ensure that they fulfill their obligation on quality assurance. The Federal Ministry of Health should set in motion the process of obtaining certificate of standards for all health establishments. Certification and accreditation should not be a one-off event but should be reviewed periodically.

E. Lack of Standardization of Services Rendered to Consumers

Analysis: Users across the country receive different levels/standards of service across hospitals depending on the facility, town or state one visits. This is the challenge of a national accreditation system that would independently assist and grade hospitals not being in place. If the reverse were the case, it would make it easier for HMOs to pay hospitals according to their 'rating'[61]. There is also the slow pace in the accreditation of healthcare facilities by NHIS.

Action Point: Using quality assurance, NHIS should standardize the care received by enrollees across the Federation and ensure high standard of healthcare delivery services as provided in the objectives of the Scheme.

F. Inequitable Distribution of Enrollees

Analysis: For the purpose of maximizing cost, the HMOs are known to push the majority of their enrollees under particular HCPs. This is done to facilitate easy cost agreement for capitation with the HCPs. The HCPs are known to sign off agreements with HMOs

[60] It is submitted that all health establishments in Nigeria are operating illegally in view of this section and the fact that not a single health institution has undergone the process of certification.

[61] See https://www.avonhealthcare.com/press/guardian-12-may-2016-how-to-improve-health-insurance- coverage-in-nigeria-by-ukiri/

where they are given large number of enrollees. The effect of this lopsidedness stretches the use of facilities and personnel in the HCPs. This results to poor treatment and attendance of enrollees by the HCPs.

The inequitable distribution affects the referral system in Nigeria as an expert has noted that:

> *"A situation where the tertiary health institutions in the form of teaching hospitals and federal medical centres have over 70% of the enrollees domiciled in them is an aberration, an abuse of operational framework and a precipice for predictable failure. The teaching hospitals should have nothing to do with primary healthcare. They should stay back and await referrals from the primary/secondary care units as propagated by the private investors*"[62].

The foregoing does not guarantee appropriate patronage of all levels of healthcare as contemplated in section 5 of the Act on objectives of the Scheme. Again, the low capitation demands large volumes of enrollees to incentivize HCPs and for them to break even financially. The break-even or sustainability point is defined as 5000 lives. This is not available to many HCPs. Finally, enrollees seem to be denied of their right to choose a doctor or HCP of their choice. They are rather posted to HCPs by HMOs.

Action Point: The Regulator and HMOs should ensure the equitable distribution of enrollees to encourage HCPs to render effective services. Subject to enrollee choice, NHIS should consider placing a moratorium on HCPs that have what may be termed excess enrollees whilst redistributing to others with sufficient capacity to absorb new ones. Enrollees should, *ceteris paribus*, be concentrated at primary health care providers while secondary and tertiary providers receive referrals.

G. Inequitable Spread/Distribution of HMOs

Analysis: Most HMOs are concentrated in big cities such as Lagos and Abuja to the neglect of smaller cities and the rural areas. This leaves so many parts of the country and the population un-serviced and un-reached. This runs against the grain of one of the objectives of the Scheme which is to ensure equitable distribution of healthcare services within the federation[63].

Action Point: There should some form of decentralization where there could be regional HMOs licensed to operate within specific geopolitical zones of the country.

62 Health Insurance and Managed Healthcare Financing: the Nigerian Experience *by Dr. Iyke U. Udoh, Medical Director Meridian Hospitals.*
63 See section 5 (h) of the Act detailing the objectives of the Scheme.

H. Access to Services during Crisis Periods

Analysis: Coordination during crisis periods to guarantee enrollees access to services is very poor. This is usually the case during periods of strike by public sector medical professionals. The subsistence of a valid insurance contract based on the payment of premium is most times not respected during the crisis.

Action Point: Alternative arrangements should be worked out between the Scheme and HMOs for enrollees to get access to quality health care services even during periods of emergency and crisis.

I. **Low Capitation and Fees**

Analysis: HCPs have raised complaints about the low level of capitation currently standing at N750 and fees of N112.50. They complain that this cannot allow a diligent service provider to break even and continue in the meaningful business of saving lives. However, capitation is paid whether the insured uses the service or not. But the capitation covers not just the doctor's consultation alone but a wide range of prescribed drugs, diagnostic tests, hospital care in a ward for 15 days, services, etc. And this is further tied to the inequitable distribution of enrollees and subsequent low enrollee numbers in some HCPs. There are also complaints about fees being too low.

Action Point: It has become imperative for the Scheme to review the capitation and fees taking cognizance of extant macroeconomic realities in terms of the value of the naira, inflation, purchasing power, etc. The review should also be done on an annual or other periodical basis and after shifts in macroeconomic fundamentals. The review should be take cognizance of inputs from stakeholders including HMOs, HCP, the monetary and fiscal authorities in the Finance Ministry and Central Bank of Nigeria, organized labour, etc. Capitation should not punish through underlining a financial loss, but encourage a diligent service provider to recover his costs with a little margin to continue the service. Fees should be reflective of actual cost of services delivered by a diligent and reasonable physician/service provider.

J. Waiting Period for New Enrollees

Analysis: According to the Operational Guidelines, there is *a processing/waiting period of ninety (90) days before a participant can access healthcare services*. This is something that takes less than a month for private health insurance. This bureaucracy is not necessary.

Action Point: Cut the red tape and bureaucracy and reduce the waiting period to one month.

K. Outright Fraud

Analysis: Sometimes, hospitals present forms for services rendered to enrollees to sign without crossing out the other unpopulated spaces and when the enrollee signs, they go and populate the forms for services not rendered and claim the money.

Action Point: This speaks to the need for HMOs to put proper checks and balances in place to prevent operators from cheating the system.

L. Penalties in the Law

Analysis: The penalties in the extant law are too liberal for offenders and encourage impunity. The major penalty is S. 28 of the Act which states that:

> *(I) Any person who -*
>
> *(a) fails to pay into the account of an organisation and within the specified period any contribution liable to be paid under this Act; or*
>
> *(b) deducts the contribution from the employee's wages and withholds the contribution or refuses or neglects to remit the contribution to the organisations concerned within the specified time, commits an offence.*
>
> *(2) A person guilty of an offence under subsection (1) of this section is liable on conviction-*
>
> *(a) in the case of a first offence, to a fine of Nl00,000 or 500 per centum of the amount of the contribution involved, together with accrued interest on the contribution, whichever is higher, or imprisonment for a term not exceeding two years or less than one year or to both such fine and imprisonment; and*
>
> *(b) in the case of a second or subsequent offence, to a fine of N200,000 or 1,000 per centum of the amount of the contribution involved together with accrued interest on the contribution, whichever is higher, or imprisonment for a term not exceeding five years or less than two years or to both such fine and imprisonment.*

Action Point: More offences should be created and stiffer fines of a minimum of 1000 percent of the withheld sum and four to five years jail terms prescribed. In terms of more offences, the provision of the 2017 Senate Bill to repeal the NHIS Act is instructive.

> *57. (1) Any person who -*
>
> *(a) fails to pay into the account of the Commission and or a health insurance fund or HMO and within the specified period any contribution liable to be paid under this Bill; or*

(b) deducts the contribution from the employee's wages and withholds the contribution or refuses or neglects to remit the contribution to the appropriate Health Insurance Fund or an Organization concerned within the specified time; or

(c) fails to remit capitation to Healthcare Providers after receiving such from the Health Insurance Fund within the specified period indicated in the Operational Guidelines; or

(d) fails to settle fee-for-service or other claims from the Healthcare Providers after receipt and verification within the stipulated time allowed in the Operational Guidelines; or

(e) deliberately manipulates the enrollee register for the benefit of other parties before or after the release of the register by the Health Insurance Schemes;

(f) deliberately refuses to provide care to a duly registered enrollee after receiving payments from the relevant organization on behalf of such enrollee; or

(g) deliberately issues dud cheques

shall be guilty of an offence.

5.3 CONCLUSIONS AND OTHER RECOMMENDATIONS

A. Effective Regulation: Effective oversight by the regulator is needed to drive the Scheme while re-commitment by HMOs and HCPs to the original vision of the Scheme is needed. It is a fundamental aphorism that a Scheme that was set up to be managed by a Policy Governing Council cannot fulfill its mission in the absence of the Council. The establishment of the Governing Council is therefore long overdue.

An oversight structure that includes civil society (NGOs, professionals, etc.) is imperative for the Scheme. The Scheme should be energised through a complaints mechanism for enrollees to seek redress through state and zonal forums. Compensation mechanism for service failure is also needed. Effective regulation will include the development of robust online Information Technology Platform that monitors in real time, payments and activities of HMOs and HCPs. Already, funds have accrued for this purpose through the deductions volunteered by HMOs. Opening NHIS dedicated accounts by HMOs and HCPs will facilitate the electronic tracking process. Also, good and fit regulatory practices include periodic training and retraining of both HMOs and HCPs on the existing and new guidelines to bring them up to date with regulations. Enrollees should be free to choose their HMO from the list accredited by NHIS and subject to change periodically (not exceeding one year).

Name and shame defaulting HMOs and HCPs to ensure that stakeholders respect the

rules. Posting NHIS desk officers in all the HCPs which is about 8000 will involve the recruitment of 8000 staff and increasing the bureaucracy. This administrative part is better left to well-managed, regulated, supervised and resourced HMOs. The Scheme should share data with the Federal and State Ministries of Health for effective planning of health interventions across the Federation.

B. Beneficial Ownership and Improved Transparency: Nigerians need to know the beneficial owners of these HMOs so as to know who to hold responsible in the event of a breach of rules and regulations beyond the "bad guys" hiding behind the veil of incorporation of a company.

C. *Compulsory and Universal Health Insurance:* For the realization of universal health coverage, any proposed review of the law should make health insurance compulsory and universal for all Nigerians. If government has made vehicle insurance compulsory, then health insurance cannot be optional unless we value cars more than humans. Extant coverage is less than 5 percent of Nigerians. We can target 70 percent coverage in ten years. The proposal is as follows:

> *Subject to the provisions of this Act, any person -*
> *(a) who is ordinarily resident in Nigeria;*
> *(b) who has attained the age of 18 years;*
> *(c) whose total income whether derived from salaried or self-employment is not less than the minimum wage*
>
> *shall be liable to contribute to the Scheme, at such rate and in such a manner as may be determined from time to time, by the Council provided however that persons contributing under State and Private Health Insurance Schemes are not liable to double contribution.*

Furthermore, there should be a social and minimum core state obligation clause which mandates the state to pay premiums through the budget for persons who are unemployed and cannot afford premiums.

D. Make Disbursements and Service Provision under the Basic Health Care Provision Fund Transparent: The National Health Act's provided for the BHCPF to be funded by not less than 1 percent of the Consolidated Revenue Fund. 50% of it is by law to be routed to the Scheme which will use same to provide for vulnerable Nigerians and funding of MNCH. This should be a challenge for the executive and legislature to ensure that the disbursement and service provision under the BHCPF is made manifestly transparent. This is to be achieved through the publication in a portal and in the print and electronic media of disbursements to states, local governments and specific primary health care centres and other health establishments.

According to the NHA in S.12 (3) - (4):

(3) Money from the fund shall be used to finance the following:-

> *(a) 50% of the fund shall be used for the provision of basic minimum package of health services to citizens, in eligible primary/or secondary health care facilities through the National Health Insurance Scheme (NHIS);*
> *(b) 20 percent of the fund shall be used to provide essential drugs, vaccines and consumables for eligible primary health care facilities;*
> *(c) 15 per cent of the fund shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities; and*
> *(d) 10 per cent of the fund shall be used for the development of Human Resources for Primary Health Care;*
> *(e) 5 percent of the fund shall be used for Emergency Medical Treatment to be administered by a Committee appointed by the National Council on Health.*

(4) The National Primary Health Care Development Agency shall disburse the funds for subsection 3(b), (c) and (d) of this section through State and Federal Capital Territory Primary Health Care Boards for distribution to Local Government and Area Council Health Authorities.

E. Energise Community Based Health Insurance: The Community Based Social Health Insurance Scheme (CBHIS) is a non-profit health insurance programme for a cohesive group of households/individuals or occupation-based groups, formed on the basis of the ethics of mutual aid and the collective pooling of health risks, in which members take part in its management. The Scheme should put more efforts to organize this community scheme. NHIS should collaborate with the states and local governments nationwide to set up the CBHIS. The Scheme, states and local government should embark on community mobilization and sensitization on benefits of the CBHIP to members of the community and set up low-cost premiums that are affordable and renewable annually. The funding of CBHIS should be subsidized by the larger pool of NHIS funds.

F. Bigger Pool of Funds Needed Including Special Dedicated Public Funds: Nigeria needs a bigger pool of resources running into trillions to move the right to health to the next level. Beyond premiums, specific national revenues should be set aside for health including receipts from a special tax on sugar and carbonated drinks under the 2021 Finance Act, import duties, Value Added Tax, tariffs on the use telecommunication services to be borne by the consumer, etc. The bigger pool of funds will be used for vulnerable groups and for MNCH to the poor.

G. HMOs are still Needed: We do not need to throw the baby away with the bath water. Reforms are needed to make HMOs play their designated roles in the public sector. But their focus while taking cognizance of the profit motive must shift progressively to health as a right facilitated by a business run for a profit. One of the objectives of the Scheme in section 5 of the Act is to improve and harness private sector participation in the provision of healthcare services. Laws and regulations need to be enforced and lacunas plugged

by the legislature. Some HMOs are still rendering good service in the private sector and can do same in the public sector[64]. But the administrative cost accruable to HMOs should be reduced from the current 10% to not more than 7.5%.

H. Special Intervention Funds and Incentives: To compliment the NHIS financing which is mainly for curative care, FGN should consider the establishment of a Health Bank to offer long term single digit interest loans for capital and recurrent costs of health establishments. Considering health as business to compete with other sectors in need of funding in the traditional banking system is to deny the rights nature of healthcare. Nigeria has doled out various intervention and bailout funds which did not benefit the health sector. Special Health Intervention Funds are needed for long term single digit financing. Finally, if power, agriculture, mining, etc. can get import duty waivers, health is more than over qualified for import duty waivers.

64 Out of 67 accredited HMOs, 27 do not cover federal government lives and only collect premiums from the private sector.

Section 7
GOVERNANCE AND POLITICAL AGENDA FOR HEALTH

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 has 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[65], 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.

[65] 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.

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?

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[66]. 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"[67]. 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. 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 as shown in Table 8.

Table 8: Government Health Expenditures as % of Total Health Expenditures in Africa)

Countries	**Domestic General Government Health Expenditure (% of current health expenditure)**
Namibia	46.90
South Africa	58.76
Kenya	45.98
Ghana	40.24
Egypt	27.78
Ethiopia	22.70
Cote d'Ivoire	29.08
Rwanda	39.95

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

Niger	35.69
Nigeria	15.95

Source: World Bank 2022, World Health Organization Global Health Expenditure Database

Table 9: Trend of FGN Allocations to Health and Variance from the 15% Benchmark

The trend of FG Allocation to Health Sector as % of FG Total Budget					
Year	**Total Budget (N' Billion/Trillion)**	**Health Allocation (N' Billion)**	**As % of Total Budget**	**As 15% of the Total (N' Billion)**	**Variance from 15% Benchmark (N' Billion)**
2010	4,427,184,596,534	164,914,939,155	3.73	664,077,689,480.10	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
2019	8,826,636,578,915	372,702,999,290	4.22	1,323,995,486,837	951,292,487,547
2020	10,590,356,121,000	388,000,348,494	3.66	1,588,553,418,150	1,200,553,069,656
2021	13,588,027,886,175	546,977,207,109	4.03	2,038,204,182,926	1,491,226,975,817
Total	**83,363,753,204,517**	**3,737,126,214,590**	**## 4.73%**	**12,504,562,980,678**	**8,767,436,766,088**

Source: Budget Office of the Federation

This is the average over the 12 years.

Out of a total budget of N83.363 trillion, health got overall allocation of N3.737trillion while the 15% of the allocations should have been N12.504trillion. Therefore, this left a variance of N8.767trillion over the 12 years. Allocations to health averaged 4.73% over the 12 years.

2.2 Appropriation, Releases and Utilization: In funding in the last 11 years - Table 10 shows the real picture in terms of budgeted sums, released sums and utilised sums. Only 57% of the approved budget was actually utilized. 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?

According to the Fiscal Responsibility Act[68], 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

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

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 10: FGN Health Budget 2010-2021, Approved, Released, Cash Backed and Utilised

Health Capital Budget Allocation, Releases, Cash Backed, and Utilization							
				Utilization			
Year	Approved Capital Health Budget (N'mn)	Released Health Capital Budget (N'mn)	Cash Backed Health Capital Budget (N'mn)	Utilization (N'mn)	As a % of Approved Budget	As a % of Cash Backed Sum	As a % of the Released Budget
2010	53,066	33,570	33,562	17,745	33.44	52.87	52.86
2011	38,785	38,785	38,716	32,165	82.93	83.08	82.93
2012	60,920	45,001	37,171	33,682	55.29	90.61	74.85
2013	60,047	28,838	28,838	19,109	31.82	66.26	66.26
2014	49,517	20,472	20,472	18,688	37.74	91.29	91.29
2015	22,676	16,445	16,445	12,214	53.86	74.27	74.27
2016	28,650	18,470	18,470	12,430	43.39	67.30	67.30
2017	55,610	52,656	52,656	48,849	87.84	92.77	92.77
2018	86,486	63,481	63,481	52,988	61.27	83.47	83.47
2019	57,090	32,310	32,310	30,890	54.11	95.61	95.61
2020	51,403	96,801	96,801	66,807	129.97	69.01	69.01
2021	131,742	75,692	75,692	17,534*	13.31	23.16	57.45
Total	**695,992**	**522,521**	**514,614**	**363,100**	**#57.08**	**#74.14**	**#75.67**
*Source: Budget Office of the Federation: # Average *As at the end of the second quarter*							

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 inform an increase or reduction of the health budget? Total expenditure on health as a percentage of Gross Domestic Product (GDP) is 3.03%[69]. 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

[69]This is the percentage as at 2019; see https://data.worldbank.org/ indicator/SH.XPD. CHEX.GD. ZS?locations=NG

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[70] 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[71]. It implies change by degrees or gradualism. Quantum leap is about abrupt change, sudden increase, or dramatic advance[72].

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?

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

[70] The Pursuit of Value for Money by Samuel O. Afemikhe at pages 4-5.
[71] https://en.wikipedia.org/wiki/Incrementalism
[72] *https://www.merriam-webster.com/dictionary/quantum%20leap*

increased. What other sources as stated in subsection (c) can the party exploit in increasing funding for the BHCPF?

Furthermore, considering that access to information on funds released to states and their utilization on the NHIS and NPHCDA windows is not available to the public, how do you intend to introduce transparency and accountability into the management of the BHCPF?

2.6 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[73]. "*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*"[74].

2.7 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 70.52% 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"[75]. "*The Committee recalls General Comment No.3 paragraph 12 which states that even in times of severe resource constraints, the vulnerable members of society*

[73] Paragraph 44 of General Comment on the Right to Health of the Committee on Economic, Social and Cultural Rights.
[74] 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).
[75] Paragraph 12 of the General Comment on the Right to Health of the Committee on Economic, Social and Cultural Rights.

must be protected by the adoption of relatively low-cost targeted programmes"[76]. 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.

2.8 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

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

Federation; ensure equitable patronage of all levels of health care; and ensure the availability of funds to the health sector for improved services[77].

2.9 Recurrent Versus Capital Expenditure: The allocations to capital expenditure have been very low over the years as shown in Table 11 below. How would the party manage the interface between recurrent and capital expenditure?

Table 11: Recurrent versus Capital Expenditure 2010-2021

Recurrent Versus Capital Expenditure 2010 - 2021			
Year	**Overall Health Sector Allocation**	**Health Capital Expenditure Allocation**	**% of Capital to Overall Allocation**
2010	164,915	53,066	32.18
2011	257,871	38,785	15.04
2012	284,967	60,920	21.38
2013	282,501	60,047	21.26
2014	264,461	49,517	18.72
2015	259,752	22,676	8.73
2016	250,063	28,650	11.46
2017	308,464	55,610	18.03
2018	356,451	86,486	24.26
2019	372,703	57,090	15.32
2020	388,000	51,403	13.25
2021	546,977	134,591	24.61
Total	**3,737,126**	**698,841**	##**18.69**

Source: Budget Office of the Federation

##: This for average over the 12 years.

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 twelve years is **17.36%.** With the lack of equipment and facilities in health establishments, there is evidence from Table 11 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.

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

2.10: 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 in excess of 90%. 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 12 tells the story.

Table 12: Nigeria's Human Resources for Health

Indicator	Nigeria	African Region	Global
Density of medical doctors (per 10 000 population)	3.8	2.8	17.5
Density of nursing and midwifery personnel (per 10 000 population)	15.0	10.3	39.0
Density of dentists (per 10 000 population)	0.2	---	---
Density of pharmacists (per 10 000 population)	1.2	---	---

Source: World Health Statistics 2021, World Health Organization

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[78]. 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 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 13 shows the distribution and spread.

Table 13: 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

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

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)".*[79]

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

Table 14: Trend in the Migration of Medical Doctors and Nurses from 2014 to 2018

Year	2014	2015	2016	2017	2018
No. of doctors	656	688	1018	1426	1551
No. of nurses/midwives who migrated outside the country	1325	1589	2005	2536	3561

Source: Nigeria Health Workforce Country Profile 2018.

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[80]. The industrial

[80] 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. **April 2018:** Health workers under the aegis of JOHESU embarked on a "mega strike", which lasted for 44 days, between **April 17 and May 31.** In May, state and local government health workers joined the strike. The industrial action was called off following an order from the National Industrial Court compelling the striking workers to resume. The strike paralysed activities at both state and federal health institutions and led to the death of many. Members of the union had been demanding an increase in pay and improved working conditions since 2014. **January 14, 2019:** The Joint Council of Medical and Health Workers Union of Nigeria (MHWUN) and the National Association of Nigeria Nurses and Midwives (NANNM), Kwara State Council, declared an indefinite strike. They said the strike was due to the state government's refusal to apply the 10 per cent CONHESS for state health workers at the local government level. **June 2020:** NARD members in state-run hospitals, with the exemption of COVID-19 treatment centres, stopped working to protest the inadequacy of personal protective equipment for doctors, the size of hazard allowance provided, illegal deductions, and budget funding for residency training. The strike lasted from June 15 to June 21. Prior to the industrial action, the association had given a two-week ultimatum to the federal and state governments. And as NARD was calling its members to work, JOHESU threatened to call out its members on strike over poor working conditions and unfulfilled promises by the government. **September 15, 2020:** The Joint Health Service Unions (JOHESU) - representing medical staff such as nurses, midwives and radiologists embarked on a strike demanding the payment of a hazard allowance for treating coronavirus patients. They said the strike would last for seven days. **April 8, 2021:** NARD embarked on a strike action for being owed six months' salary, government offer of N5,000 as hazard allowance to the doctors and a lack of life insurance coverage and demanding that the government reviews the law regulating Postgraduate Medical Training (PMT) in Nigeria, which was established in 1979 and has never been reviewed. **August 2021:** The Nigerian Association of Resident Doctors (NARD) began this industrial action on 2 August. The strike was caused by pay disputes between the union and the Federal government of Nigeria, with the union alleging that the government had reneged on an agreement that they had reached

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.

3.5 Reducing Medical Treatment Abroad: It is estimated that Nigeria spends over $1billion abroad every year on medical tourism[81]. 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".*

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*

following the end of the last strike in April. On 4 October 2021, the doctors in Nigeria's government hospitals called off its two-month-old strike

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

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 are 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 needs 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 right 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[82] 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.

6. HEALTH PROMOTION, COMMUNITY OWNERSHIP AND PARTNERSHIPS FOR HEALTH

[82] 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).

6.1 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*[83]*. 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"*[84].

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,*

[83] National Health Promotion Policy 2006; Federal Ministry of Health.
[84] NPHCDA Assessment of WDCs.

effort is needed to strengthen this intersectoral collaboration, considering that many of the determinants of health outcomes are outside the health sector".

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 15 shows the status of Nigeria. What would the party do to redress this scandal?

Table 15: MNCH Statistics in Nigeria

Indicator	Value
Maternal mortality ratio (per 100 000 live births)	917
Proportion of women of reproductive age who have their need for family planning satisfied with modern methods (%)	35.6
Percentage of live births delivered by a skilled provider (%)	43.4
Under-five mortality rate (per 1000 live births)	117
Neonatal mortality rate (per 1000 live births)	36
Healthy life expectancy at birth – female (years)	54.9

Source: World Health Statistics 2021, World Health Organization

Nigeria is ranked 193 out of 193 countries in infant mortality (72 per 1,000 live birth) https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=NG . The proportion of children who are under the age of 5 who are underweight is 18.4% https://data.worldbank.org/indicator/SH.STA.MALN.ZS.

7.2 Maternal and Child Health - Regional Peculiarities: The overall picture in Table 14 above masks geo-political peculiarities. Thus, the needs and efforts required in the geo-political zones are not the same. Table 16 shows the picture. What will the party do to address this geo-political variance?

Table 16: Maternal and Newborn Health Statistics Disaggregated into Geopolitical Zones

Indicator	North Central	North East	North West	South East	South South	South West
Percentage of women without Ante Natal Care (ANC)	35.7	31.4	44.0	7.3	13.1	6.3
Percentage delivered in a health facility	49.2	25.4	15.6	81.8	50.2	76.3
Percentage with no postnatal checkup	87.8	92.8	92.5	88.0	77.0	83.7

Percentage of babies less than 2.5 kg at birth	16.6	15.7	14.6	14.7	12.6	13.1
Percentage of children receiving all basic vaccinations	31.0	22.9	19.9	57.0	41.8	43.0
Percentage of women age 15-19 who have begun childbearing	16.3	24.5	28.5	8.8	10.6	5.5
Percentage of children whose births are registered	45.1	36.9	37.1	82.9	64.6	72.8

Source: Nigeria Demographic and Health Survey 2018; Multiple Indicator Cluster Survey 2016 – 17

7.3 Immunisation Coverage: Many of the diseases that kill little children are vaccine-preventable diseases. Table 17 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 17: Immunization Coverage in Nigeria, SSA and the Globe

	HepB3 (One-Year Old)			DPT (12-23 Months)			Measles (12-23 Months		
	2010	2016	2020	2010	2016	2020	2010	2016	2020
Nigeria	49%	49%	57%	54%	49%	57%	56%	51%	54%
SSA	70.9%	73.6%	--	72.0%	73.6%	--	72.6%	71.7%	--
Global	75.7%	85.3%	83%	85.0%	85.8%	83%	84.8%	84.9%	84%

https://data.worldbank.org/indicator/SH.IMM.MEAS, 2020

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 UNCESCR 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[85].

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*

[85] *Taken from https://en.wikipedia.org/wiki/Disability*

women are the groups most vulnerable to illness and death from malaria infection in Nigeria[86]". 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.

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[87].

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 N400,000 for surgery, remediation and rehabilitation will cost a total of N320 billion. Provisions for treating VVF should be phased over a period of six years at N53.33 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*

[86] NHP 2016 at page 6.
[87] https://naca.gov.ng/fact-sheet-hiv-prevention-program/

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"[88]. 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"*[89].

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"*[90]. 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[91]. 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[92]. At same summit in 2017, the former Minister 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[93].

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

[88] http://www.who.int/features/factfiles/noncommunicable_diseases/en/
[89] *https://en.wikipedia.org/wiki/Non-communicable_disease*
[90] ERGP at page 84.
[91] Nigeria Family Planning Blueprint: Scale-Up Plan (September 2014)
[92] HP+ Policy Brief (March 2017)
[93] 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

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.

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.

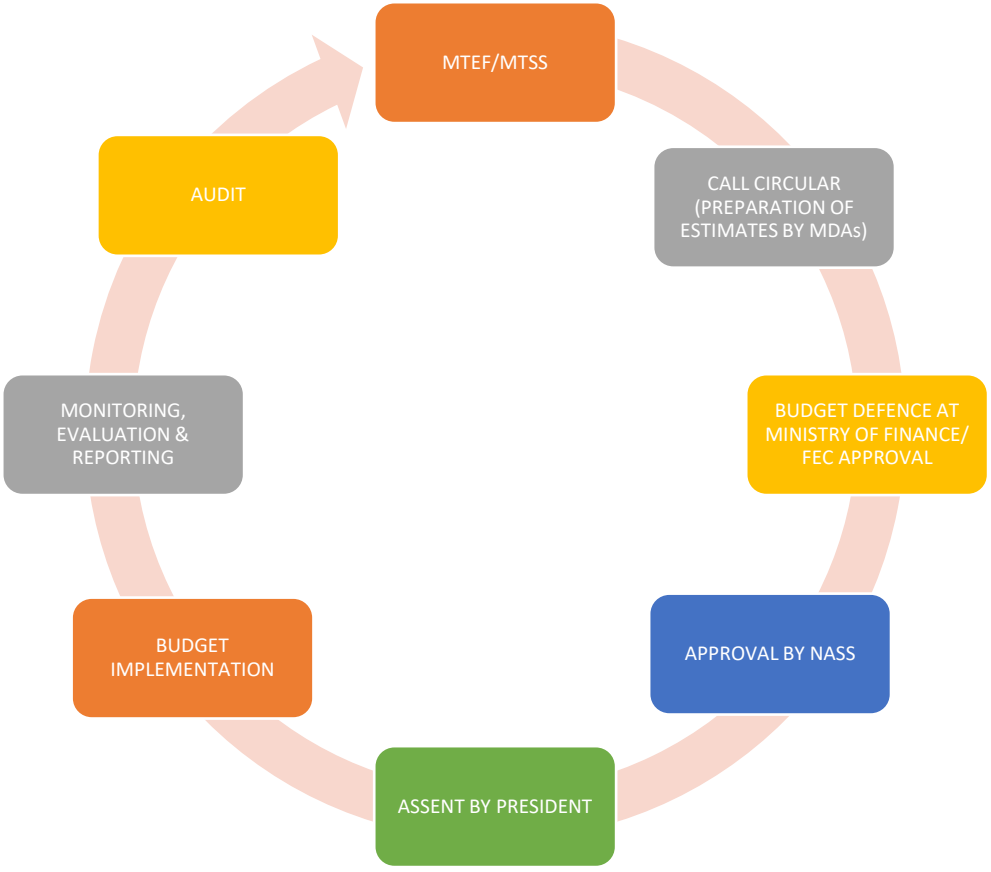
Section Eight

HEALTH AND THE BUDGET

8.1 THE BUDGET CYCLE

This Section reviews the various stages of the budget cycle and process and shows the interventions opportunities at each stage of the budgeting process. The plan, policy and budget continuum ensure that plans and policies are implemented through the annual budget. Plans and policies provide the legal and policy framework for sectoral governance and service delivery while budgets activate plans and policies through providing resources for their implementation. The disconnect between plans, policies and budgeting has been largely responsible for poor health outcomes at the federal level and in most states of Nigeria. The cycle is graphically presented in Chart 3.

Chart 3: Illustration of the Budget Cycle



Budgeting is a process. It is more appropriately called a cycle and it is continuous because fiscal governance is a continuum. When one budget cycle is winding down, another

begins. At the federal level, the cycle starts from the determination of priorities at the overall and sectoral levels through the medium term expenditure framework (MTEF) and the medium term sector strategies (MTSS).[94] It proceeds to sending out the budget call circular by the Ministry of Finance, preparation of sectoral budget proposals, technical support and budget bilateral discussions between ministries, departments and agencies of government (MDAs) and the Budget Office/Ministry of Finance and approval of the executive budget by the Federal Executive Council. Thereafter, the President submits the estimates to the National Assembly[95] who consider and approve of same. This is followed by presidential assent for the Appropriation Bill to become law. Implementation, monitoring, evaluation and reporting follows while audit[96] is the last stage of the cycle. The same process is repeated at the state level between the respective ministries in charge of budgeting, the governor, State House of Assembly and MDAs.

8.2 GENDER STATISTICS AND SEX DISAGGREGATED DATA

Sex disaggregated data and statistics is very relevant as the empirical basis for budgeting for the right to health.[97] Such data will provide information on the prevalence of particular types of diseases and disease burden in a state, community or overall national prevalence. Secondly, it will provide information that assesses the impact of previous budgetary expenditure for the realisation of the right to health as well as the challenges inherent in the system which demands budgetary attention. An effective monitoring and evaluation framework focused on health requires sex disaggregated data. Gender statistics will reveal differences and inequalities in access to and enjoyment of rights by women and men in the field of health. In providing evidence of gender inequalities, gender gaps and challenges in key areas of health, gender statistics helps to make gender inequalities visible, which in turn informs budgeting to address identified gender gaps.

[94] See S.11-14 of the FRA.
[95] S.80 (2), (3) and (4) as well as S.81 of the Constitution at the federal level and S.120 (2), (3) and (4) of the Constitution at the state level.
[96] S.85 of the Constitution.
[97] See Strategic Objective H.3 of the Beijing Declaration which provides inter alia a) Ensure that statistics related to individuals are collected, compiled, analysed and presented by sex and age and reflect problems, issues and questions related to women and men in society; (b) Collect, compile, analyse and present on a regular basis data disaggregated by age, sex, socio-economic and other relevant indicators, including number of dependants, for utilization in policy and programme planning and implementation; and (c) Involve centres for women's studies and research organizations in developing and testing appropriate indicators and research methodologies to strengthen gender analysis, as well as in monitoring and evaluating the implementation of the goals of the Platform for Action.

Sources of information and gender statistics would include the National Demographic and Health Survey,[98] and Multiple Indicators Cluster Survey.[99] Others are the data from the Ministry of Health and the Health Information Management System.

Gender statistics on health will facilitate the raising of posers and findings answers to them. Such posers will include:

- Did the budget address gender differentials in health risks, access to preventive, promotive, curative and remedial services?
- Did the budget perpetuate gender biases?
- Will the budget facilitate the reduction of inequalities in health for women and girls?

A proper deployment of gender statistics will lead to gender mainstreaming in budgeting for health. Gender mainstreaming has been articulated by the 1997 Agreed Conclusions of UN Economic and Social Council (ECOSOC) as:

> *"The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality."*

8.3 OPPORTUNITIES FOR INTERVENTION

The opportunities for intervention at each level of the cycle will now be discussed seriatim.

8.3.1 Medium Term Expenditure Framework: By S.18 of the Fiscal Responsibility Act (FRA), the MTEF is the basis for the preparation of the budget, being the estimates of revenue and expenditure required to be prepared and laid before the National Assembly under section 81(1) of the Constitution. The sectoral and compositional distribution of the estimates of expenditure (the budget) shall be consistent with the medium-term developmental priorities set out in the MTEF. The MTEF is made up of five parts. They

[98] NDHS is a national sample survey that provides up-to-date information on the background, characteristics of respondents on issues including domestic violence, FGM, HIV/AIDS, maternal and child health, mortality and morbidity, family planning and nutritional status, etc.
[99] MICS is an international household survey programme developed by UNICEF and the Nigerian version provides detailed information on children and women and measure key indicators that allows countries to monitor progress towards the SDGs.

are the macroeconomic framework,[100] a fiscal strategy paper[101] and a revenue and expenditure framework.[102] Other parts are a consolidated debt statement[103]and a statement on quasi fiscal activities of government, contingent liabilities and measures to prevent the crystallisation of such liabilities.[104]

The purpose of the MTEF is to:

- Achieve macroeconomic stability without compromising economic development.
- Direct the bulk of spending to the state's strategic priorities.
- Predictability of both policy and funding so that MDAs can plan ahead and programmes can be sustained.
- Financial discipline in line agencies as well as autonomy to increase incentives for efficient and effective use of public funds.

The MTEF is prepared by the executive and sent to the legislature for approval. It is a policy framework with details of aggregate expenditures and revenues and allocations to sectors. On a superficial review of the MTEF, it may seem that there are no opportunities for interventions related to health. However, the MTEF determines expenditure priorities and its projections of the goals of fiscal policy will relate to the decisions of policy makers to invest in sectors that are critical to the realization of the right to health. For instance, it could point in the direction as to whether there are

[100] A macro-economic Framework setting out the macro-economic projections, for the next three financial years, the underlying assumptions for those projections and an evaluation and analysis of the macroeconomic projections for the preceding three financial years.

[101] A Fiscal Strategy Paper setting out - the Federal Government's medium-term financial objectives; the policies of the Federal Government for the medium-term relating to taxation, recurrent (non-debt) expenditure, debt expenditure, capital expenditure, borrowings and other liabilities, lending and investment; the strategic, economic, social and developmental priorities of the Federal Government for the next three financial years; and an explanation of how the financial objectives, strategic, economic, social and developmental priorities and fiscal measures set out earlier relate to the economic objectives set out in section 16 of the Constitution.

[102] An expenditure and revenue framework setting out- estimates of aggregate revenues for the Federation for each financial year in the next three financial years, based on the predetermined Commodity Reference Price adopted and tax revenue projections; etc.

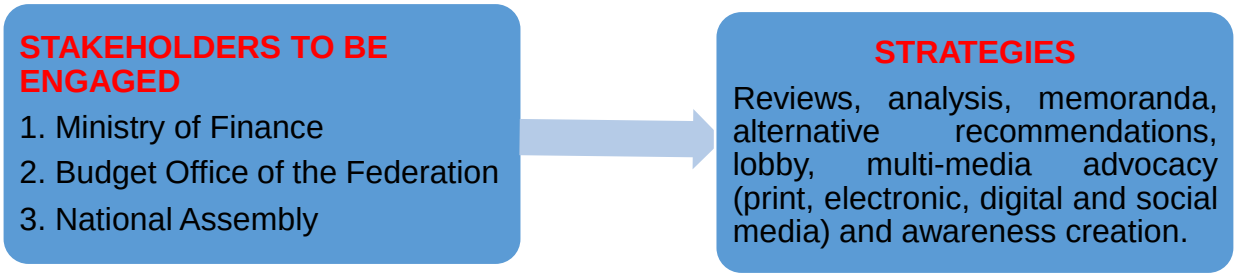
[103] A Consolidated Debt Statement setting out and describing the fiscal significance of the debt liability of the Federal Government and measures to reduce any such liability.

[104] A statement describing the nature and fiscal significance of contingent liabilities and quasi-fiscal activities and measures to offset the crystallization of such liabilities.

increases in provisions for key social investments such as the Basic Health Care Provision Fund of the National Health Act and any special funds for reducing the gender disparity in health. Fiscal policy will reveal issues related to taxation of goods, services and materials relevant for the protection of women and girls' enjoyment of the right to health or the general right to health of population. For instance, the recent taxation of carbonated drinks under the Finance Act 2022 emanated from the FSP. The MTEF from its envelope could also show the level and prioritisation of funding for key health agencies involved in the primary, secondary and tertiary care, the level of inter-agency collaboration in the whole-of-government and health-in-all policies approach.

Chart 4 shows the critical stakeholders and intervention strategies on MTEF.

Chart 4: Stakeholders and Strategies for MTEF Engagement



Intervention strategies for the executive and legislature include position papers and memorandum, alternative recommendations based on empirical evidence, awareness creation and sensitisation using a multi-media approach, lobby, etc.

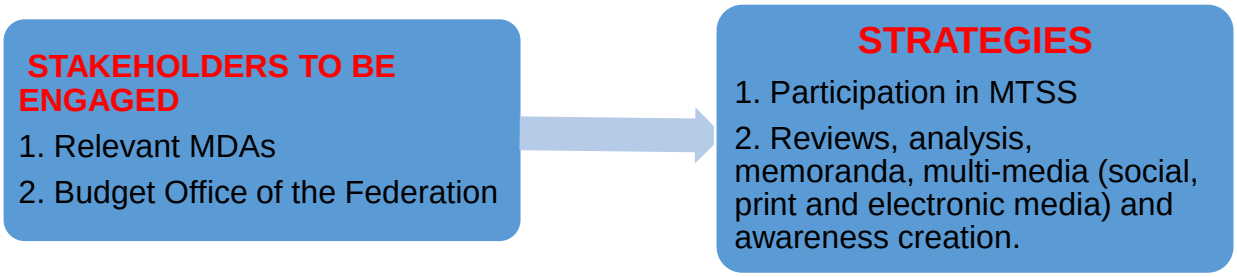
8.3.2 Medium Term Sector Strategies: The MTSS is the MDA/sectoral expenditure plan that has the following objectives:

- Articulates medium-term (three years) goals and objectives against the background of the overall goals of overarching high level policies, the attainment of the SDGs, etc.
- Identifies and documents the key initiatives (that is, projects and programmes) that will be embarked upon to achieve the goals and objectives.
- Costs the identified key initiatives in a clear and transparent manner.
- Phases implementation of the identified initiatives over the medium-term.
- Defines the expected outcomes of the identified initiatives in clear measurable terms; and

- Links expected outcomes to their objectives and goals.

The road map for the MTSS includes the formation and composition of Sector Planning Teams (SPT), followed by the identification and collation of high-level policy documents, a review of existing budgetary commitments will be followed by the top-down indicative envelope. The third stage is the Strategy Session where the SPT members review and agree on goals and objectives based on the review of high-level policy documents, agree on initiatives to deliver goals taking into account the review of existing budget commitments. The Strategy Session will develop broad based outputs and outcomes and prioritise the initiatives within the context of the goals. The documentation stage involves costing and phasing of the initiatives over the three-year horizon, fitting the initiatives into envelopes based on costing and prioritisation. It documents the log frame and finally generates the MTSS report.

Chart 5: Stakeholders and Strategies for MTSS Engagement



Civil society should intervene at key MDAs working on health. The MDAs would include the Ministries of Health and its agencies and in consideration of the whole of government approach to health, the Ministries of Women Affairs, Agriculture, Water Resources, Environment, Education, Information, etc. Representation by a knowledgeable civil society organization in the SPT will be an advantage that should be utilised to push for a transformative MTSS. The interventions would include evidence-based position papers and memorandum, lobby, etc.

8.3.3 Call Circular and Actual Budget Preparation: It is a circular defining guidelines and steps to be taken for the preparation of the estimates of revenue and expenditure at the level of respective MDAs and spending agencies. It sets out the requirements and instructions that must be satisfied and followed in the preparation of the budget estimates.[105] It has been more appropriately defined as:

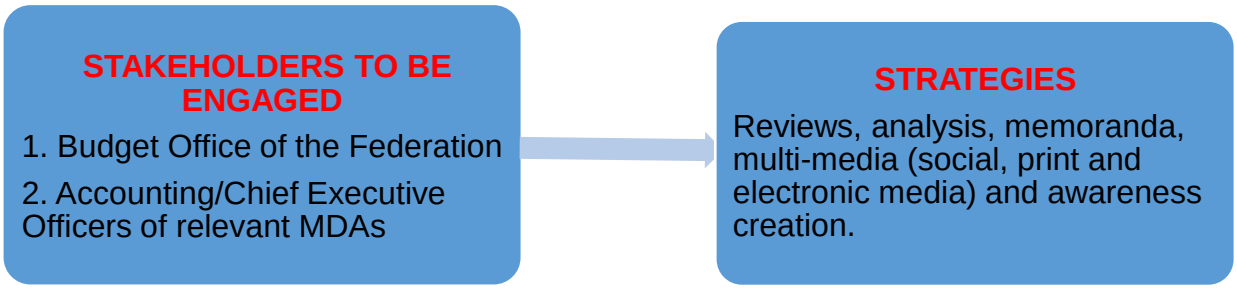
> **"***Budget Call Circular means a circular (i) requesting the submission in a prescribed form, of the revenue and expenditure estimates of Ministries, Extra-Ministerial Departments, and*

[105] See FGN Budget Call Circulars 2021 and 2022.

other executing Agencies of Government for the next financial year; and (ii) giving detailed guidelines and instruction on the preparation of the estimates and expenditure in a manner consistent with the medium term developmental priorities set out in the Medium Term Expenditure Frame Work".[106]

The contents of a Budget Call Circular could play a definitive and key role in the health responsiveness of a budget as it could set detailed guidelines on how to implement a health-in-all-policies and whole-of-government approach to health. Advocacy for ensuring that a Budget Call Circular takes specific cognisance of the right to health is imperative for the formulation of health responsive and transformative estimates.

Chart 6: Stakeholders and Strategies for Call Circular Engagement



Such advocacy could be extended to ensure that health is mainstreamed and the fuller details of a health responsive template is made part of the returns from MDAs.[107] The actual budget preparation at MDAs provides a critical opportunity for public officials to walk the health talk and incorporate the provisions of fundamental health policies into the estimates. Furthermore, a review of emerging estimates to determine whether they support or negate health commitments will be imperative. In targeting lobby and advocacy points, it is imperative to note that it is the duty of the Accounting Officer/Chief Executive to ensure that the stipulations of the Call Circular and other government policies and directives are complied with in the preparation of the estimates.

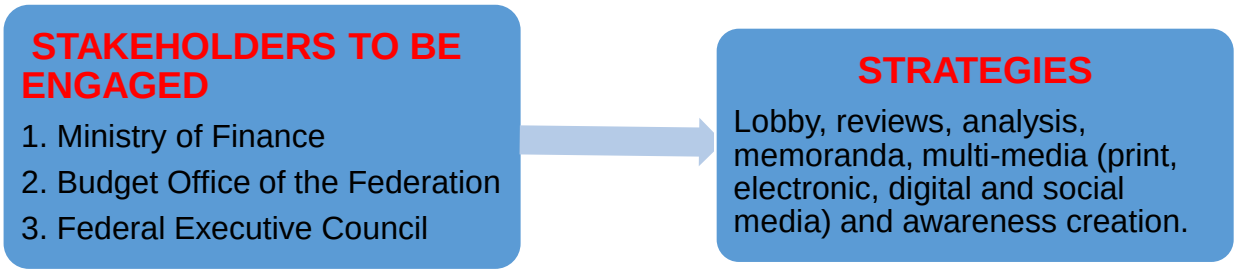
8.3.4 Budget Office/Ministry of Finance and National Executive Council: It is at this stage that MDAs go for bilateral discussions with Budget Office officials after using the

[106] https://www.lawinsider.com/dictionary/budget-call-circular

[107] The 2022 Federal Budget Call Circular states that: "MDAs should be further guided by the Federal Government's commitment in the Medium-Term National Development Plan MTNDP 2021-25, to protect the most vulnerable segments of our society. As a reminder, the MTNDP requires that all MDAs adopt the use of gender disaggregated data to show beneficiary distribution, and adopt strategies that target different social groups, especially women and children". Such a commitment can be extended to the right to health.

template provided in the Call Circular to prepare their estimates. The meetings are held to finalise the proposals and to ensure compliance with the Call Circular.

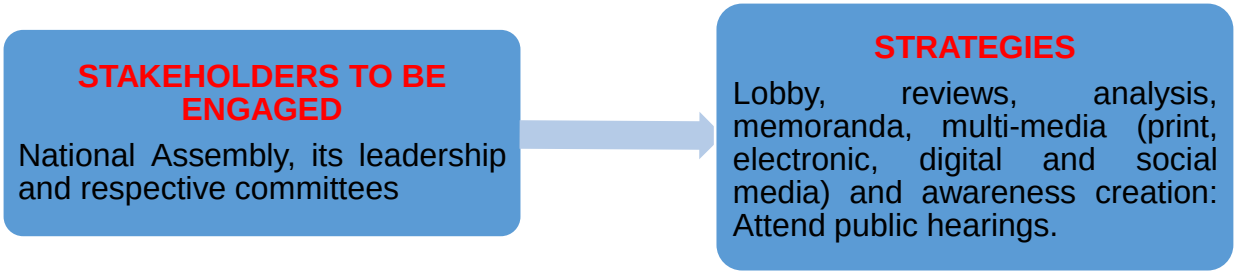
Chart 7: Stakeholders and Strategies for Budget Office and NEC Engagement



The finalised proposal is thereafter compiled and sent for approval to the Federal Executive Council. Thereafter, the FEC approved proposal is forwarded to the National Assembly by the President in accordance with S.81 of the Constitution.

8.3.5 Approval by National Assembly: Upon presentation by the President to the National Assembly, there is usually a debate on the general principles of the budget before the respective estimates of MDAs is committed to the committees exercising oversight over them.

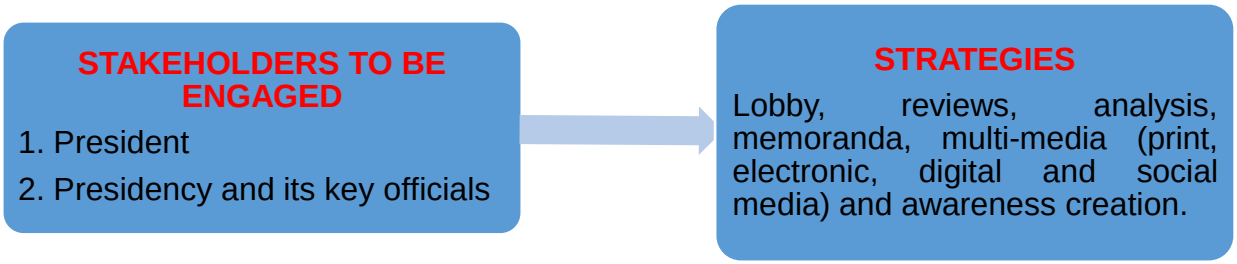
Chart 8: Stakeholders and Strategies for NASS Engagement



There are several opportunities for intervention before the legislature. The first would be interventions at the public hearing if a hearing is held. At the respective committees, there are opportunities to submit memoranda and position papers which may recommend realignment of specific estimates, increase or reduction in votes as well as weeding out frivolities, illegal and improper votes. Critical evidence-based information and recommendations from authoritative and knowledgeable stakeholders is required to move legislators to action. Lobbies at the committee stage, the coordinating Appropriation Committee and to the leadership of the legislature may be the critical action points.

8.3.6 Assent by the President: The Appropriation (Budget) Bill like other bills requires the assent of the President to become law after it has been approved by the legislature.

Chart 9: Stakeholders and Strategies for President's Engagement



The President under S.59 (4) of the Constitution has 30 days to signify or decline assent to the Appropriation Bill. S.59 (4) of the Constitution states that:

> *"Where the President, within thirty days after the presentation of the bill to him, fails to signify his assent or where he withholds assent, then the bill shall again be presented to the National Assembly sitting at a joint meeting, and if passed by two thirds majority of members of both houses at such joint meeting, the bill shall become law and the assent of the President shall not be required".*

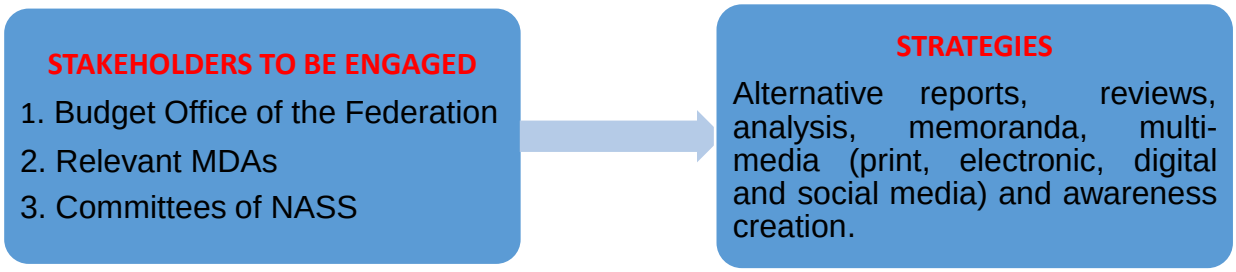
There is an opportunity to seek to influence estimates and budget policy at the stage of assent if there are proposals that retard the protection of the right to health. Advocacy encouraging the President to withhold assent to negative provisions or to fast-track assent to positive provisions can be deployed.

8.3.7 Budget Implementation, Monitoring and Reporting: Assent to the budget bill paves the way for the bill to become an Act of the National Assembly which will be implemented by MDAs through the facilitation of the Ministry of Finance and Budget Office. The Budget Office monitors and evaluates the implementation of the annual budget, assesses the attainment of fiscal targets and reports thereon on a quarterly basis to the National Assembly and Fiscal Responsibility Commission.[108]

The reports provide an opportunity for stakeholders to determine whether budget implementation is on course; whether money has been released and the extent of usage of released funds. There is also the opportunity for independent or alternative monitoring and reporting.

[108] S.30 (1) of the FRA.

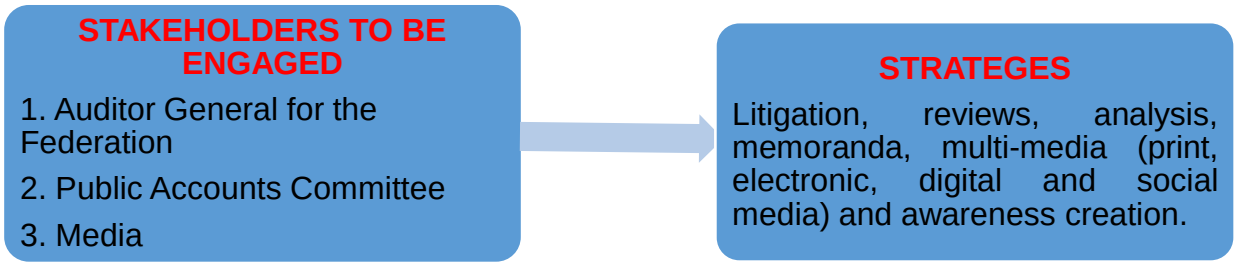
Chart 10: Stakeholders and Strategies for Budget Implementation, Monitoring and Reporting Engagement



The emerging report can be used to engage MDAs and legislative committees for course correction. It can also be used in the media for awareness raising and information dissemination.

8.3.8 Audit: The Lima Declaration of Guidelines on Auditing Precepts states that the concept and establishment of audit is inherent in public financial administration as the management of public funds represents a trust. Audit is not an end in itself but an indispensable part of a regulatory system whose aim is to reveal deviations from accepted standards and violations of the principles of legality, efficiency, effectiveness and economy of financial management early enough to make it possible to take corrective action in individual cases, to make those accountable to accept responsibility, to obtain compensation, or to take steps to prevent - or at least render more difficult such breaches.[109]

Chart 11: Stakeholders and Strategies for Audit Engagement



Audit, being a post mortem exercise provides the opportunity to review budget implementation with a view to providing information and knowledge that can be used for course correction in subsequent budget cycles. There are opportunities for intervention with MDAs and at the Public Accounts Committee of the legislature to ensure that there

[109] Adopted at the IX Congress of the International Organisation of Supreme Audit Institutions (INTOSAI).

is follow up on recommendations of the Auditor General and audit recommendations are implemented.

8.4 FGN BUDGET ANALYSIS AND TRENDS 2010-2021

8.4.1 Allocations and Variance from the Benchmark: The right to health demands finance and other resources for its implementation and realisation. The benchmark is the Abuja Declaration, being a commitment of African Heads of State and Government to dedicate at least 15% of their annual budgets to health expenditure. Table 17 below shows Federal budgets for health over the period 2010 to 2021.

Table 17: Trend of FGN Allocations to Health 2010-221 and Variance from the 15% Benchmark

The trend of FG Allocation to Health Sector as % of FG Total Budget					
Year	**Total Budget (N' Billion/Trillion)**	**Health Allocation (N' Billion)**	**As % of Total Budget**	**As 15% of the Total (N' Billion)**	**Variance from 15% Benchmark (N' Billion)**
2010	4,427,184,596,534	164,914,939,155	3.73	664,077,689,480.10	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
2019	8,826,636,578,915	372,702,999,290	4.22	1,323,995,486,837	951,292,487,547
2020	10,590,356,121,000	388,000,348,494	3.66	1,588,553,418,150	1,200,553,069,656
2021	13,588,027,886,175	546,977,207,109	4.03	2,038,204,182,926	1,491,226,975,817
Total	**83,363,753,204,517**	**3,737,126,214,590**	## **4.73%**	**12,504,562,980,678**	**8,767,436,766,088**

Source: Budget Office of the Federation

This is the average over the 12 years instead of being the total.

Table 17 shows that FGN did not meet the benchmark in any of the budgets in the 12 years under review. The highest percentage of 6.13% was in the year 2012, followed by 5.78% in 2015 and 5.75% in 2011 while the least percentage is 3.66% was recorded in 2020. However, the highest variance between the 15% benchmark and the appropriated sum was recorded in the year 2021 in the sum of N1.491trillion, followed by N1.2trillion and N1.011trillion in 2020 and 2018. These allocations depart from the principle of progressive realization of the right to health which is a forward ever, backward never principle. The allocations show an undulating framework instead of marginal increases as society and population grows and as resources increase.

Out of a total budget of N83.363 trillion, health got overall allocation of N3.737trillion while the 15% of the allocations should have been N12.504trillion. Therefore, this left a variance of N8.767trillionover the 12 years. Allocations to health averaged 4.73% over the 12 years.

Table 17 shows that the allocations to health have been nominally increasing in Naira terms over the years. If the allocations are converted into a more stable international currency vis, the United States Dollar, a different picture emerges. The conversion is done against the background of the fact that the Nigerian currency, the Naira has been depreciating over the years. Table 18 tells the story.

Table 18: FGN Allocations to Health In $USD

Conversion of Health Sector Budget Allocation to USD			
Year	**Health Allocation (NGN)**	**Rate**	**Health Allocation (USD)**
2010	164,914,939,155	149	1,109,268,441
2011	257,870,810,310	156	1,650,901,474
2012	284,967,358,038	155	1,835,302,106
2013	282,501,464,455	155	1,820,241,395
2014	264,461,210,950	168	1,578,872,901
2015	259,751,742,847	190	1,367,114,436
2016	250,062,891,075	197	1,269,354,777
2017	308,464,276,782	305	1,011,358,285
2018	356,450,966,085	305	1,168,691,692
2019	372,702,999,290	305	1,221,977,047
2020	388,000,348,494	360	1,077,778,746
2021	546,977,207,109	379	1,443,211,628

Source: Budget Office of the Federation

2012 still retained the highest allocation of $1.835billion, followed by 2013 ($1.820billion) and 2011 ($1.650billion). The least allocation was recorded in 2017 ($1.011bilion), followed by 2020 ($1.077billion) and 2010 ($1.109billion). Again, this is an undulating framework of a little progress followed by backward movement and stagnation.

8.4.2 Recurrent Versus Capital Expenditure: It is acknowledged that the health sector is labour intensive and requires a lot of recurrent costs in personnel and the associated overheads needed for treatment, rehabilitation and palliative care. However, the health sector requires capital equipment, machinery and goods for the effective discharge of its mandate. Table 19 shows the disaggregation between recurrent and capital expenditure in the sector over the 12 years.

Table 19: Recurrent versus Capital Expenditure 2010-2021

Recurrent Versus Capital Expenditure 2010 - 2021			
Year	**Overall Health Sector Allocation**	**Health Capital Expenditure Allocation**	**% of Capital to Overall Allocation**
2010	164,915	53,066	32.18
2011	257,871	38,785	15.04
2012	284,967	60,920	21.38
2013	282,501	60,047	21.26
2014	264,461	49,517	18.72
2015	259,752	22,676	8.73
2016	250,063	28,650	11.46
2017	308,464	55,610	18.03
2018	356,451	86,486	24.26
2019	372,703	57,090	15.32
2020	388,000	51,403	13.25
2021	546,977	134,591	24.61

Source: Budget Office of the Federation

Table 19 shows that the highest percentage of capital allocation of 32.18% was in 2010, followed by 24.61% in 2021 and 24.26% in 2018. This level of capital allocation is insufficient for a sector that is starved of critical investments. Capital allocation averaged 18.68% for the 12 years

8.4.3 Budget Credibility: FGN budgets suffer credibility challenges. Appropriated sums are not usually fully released and utilised. It is imperative to review the releases and utilised sums over the 12 year period to determine the credibility of the health allocations. Table 20 shows the trend.

Table 20: FGN Health Budget 2010-2021, Approved, Released, Cash Backed and Utilised

Health Capital Budget Allocation, Releases, Cash Backed, and Utilization							
				Utilization			
Year	**Approved Capital Health Budget (N'mn)**	**Released Health Capital Budget (N'mn)**	**Cash Backed Health Capital Budget (N'mn)**	**Utilization (N'mn)**	**As a % of Approved Budget**	**As a % of Cash Backed Sum**	**As a % of the Released Budget**
2010	53,066	33,570	33,562	17,745	33.44	52.87	52.86
2011	38,785	38,785	38,716	32,165	82.93	83.08	82.93
2012	60,920	45,001	37,171	33,682	55.29	90.61	74.85
2013	60,047	28,838	28,838	19,109	31.82	66.26	66.26
2014	49,517	20,472	20,472	18,688	37.74	91.29	91.29

2015	22,676	16,445	16,445	12,214	53.86	74.27	74.27
2016	28,650	18,470	18,470	12,430	43.39	67.30	67.30
2017	55,610	52,656	52,656	48,849	87.84	92.77	92.77
2018	86,486	63,481	63,481	52,988	61.27	83.47	83.47
2019	57,090	32,310	32,310	30,890	54.11	95.61	95.61
2020	51,403	96,801	96,801	66,807	129.97	69.01	69.01
2021	131,742	75,692	75,692	17,534	13.31	23.16	57.45
Total	**695,992**	**522,521**	**514,614**	**363,100**	**#57.08**	**#74.14**	**#75.67**
Source: Budget Office of the Federation							

Table 20 shows that only 57% of the approved budget was actually utilized over the 12 year period. This does not show that the budget for the right to health is credible.

8.4.4 Sample Agencies to Engage in Budgeting Beyond the Ministry of Health

Ministry of Agriculture →

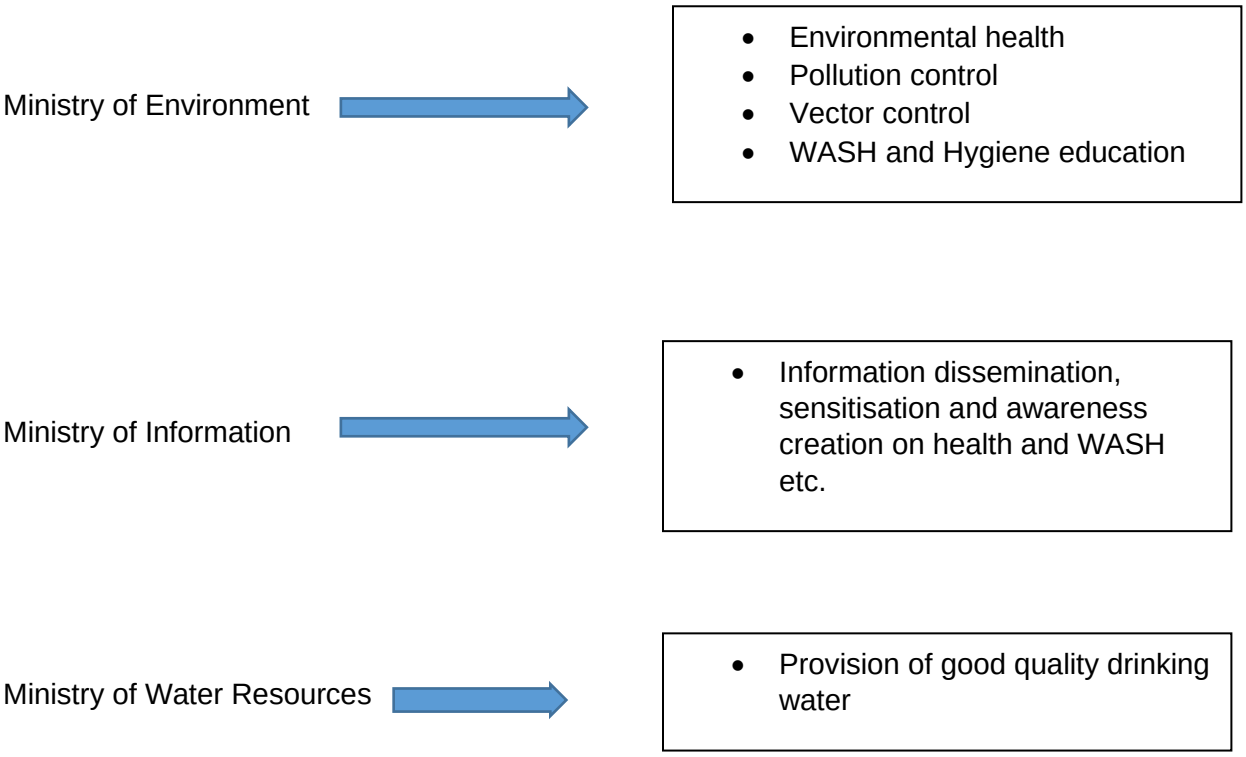
- Organic farming
- Proper management of crop, meat and dairy, etc.
- Food security and nutrition

Ministry of Education →

- Curriculum development, training of staff and teachers on key health subjects
- Reproductive and sexual rights education
- WASH education and empowerment

Ministry of Women Affairs →

- Reproductive and Sexual Rights
- Family Planning
- Economic empowerment and skills acquisition
- HIV prevention, treatment and management
- VVF Remediation



8.4.5 Basic Health Care Provision Fund: The National Health Act establishes the Basic Health Care Provision Fund. 50 percent of the Fund is dedicated to the provision of basic minimum package of health services to citizens in eligible primary or secondary health care facilities through the National Health Insurance Scheme (NHIS). 20 percent is to pass through the NPHCDA for essential drugs, vaccines and consumables for eligible primary health care facilities; 15 percent is for the provision and maintenance of facilities, equipment and transport for eligible primacy healthcare facilities; and a further 10 percent for the development of human resources for primary health care. The total for the NPHCDA window is 45 percent. Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Health Care Provision Fund has been developed. Under the NHA, states and local government are required to provide counterpart funding. PHC centres are required to be accredited to qualify as service centres under the Guidelines.