HEALTH SECTOR MEDIUM TERM SECTOR STRATEGIES (MTSS) 2018-2020

A Memorandum from Civil Society Organisations (CSOs) Working in the Health Sector

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BCG	Bacille Calmette Guerin
CMYP	Comprehensive EPI Multi-Year Plan
CPR	Contraceptive Prevalence Rate
CRA	Child Rights Act
CRF	Consolidated Revenue Fund
CSJ	Centre for Social Justice
CSOs	Civil Society Organisations
ERGP	Economic Recovery and Growth Plan
EXCoF	Executive Council of the Federation
FGN	Federal Government of Nigeria
FMB&NP	Federal Ministry of Budget and National Planning
FMoH	Federal Ministry of Health
FP	Family Planning
FRA	Fiscal Responsibility Act
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GFF	Global Financing Facility
GoN	Government of Nigeria
HIV	Human Immunodeficiency Virus
HMO	Health Management Organization
HPV	Human Papilloma Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDPs	Internally Displaced Persons
IGR	Internally Generated Revenue
IPV	Inactivated Polio Vaccine
ITN	Insecticide-Treated Net
LGAs	Local Government Areas
MDAs	Ministries, Departments and Agencies of Government
MDGs	Millennium Development Goals
MNCH	Maternal, New Born and Child Health
MSS	Midwives Service Scheme
MTEF	Medium Term Expenditure Framework
MTSS	Medium Term Sector Strategies
NASS	National Assembly
NCDC	National Centre for Disease Control
NCDs	Non Communicable Diseases
NGO	Non-Governmental Organisation

NHA	National Health Act
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NPP	National Population Policy
NSHDP	National Strategic Health Development Plan
OOPS	Out-Of-Pocket Spending
OPV	Oral Polio Vaccine
PCV	Packed Cell Volume
PHC	Primary Health Care/Primary Health Centre
PHCUOR	Primary Health Care Under One Roof
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private OR Public – Public Partnership
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RI	Routine Immunisation
SDGs	Sustainable Development Goals
SMART	Specific, Measurable, Achievable, Realistic and Time-bound
SOMLPforR	Saving One Million Lives Program-for-Results
SURE-P	Subsidy Reinvestment and Empowerment Programme
TBD	To Be Determined
TFR	Total Fertility Rate
THE	Total Health Expenditures
UHC	Universal Health Coverage
USD	United State Dollar
VPDs	Vaccine Preventable Disease
VVF	Vesico-Vaginal Fistula
WHO	World Health Organisation

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EXECUTIVE SUMMARY

The Medium Term Expenditure Framework (MTEF) for the period 2018 - 2020 is being developed and when finalized and endorsed by the Executive Council of the Federation, it will be transmitted to the National Assembly for its approval in compliance with Section 14 of the Fiscal Responsibility Act (FRA). The Health Medium Term Sector Strategy (MTSS), which will guide the provisions of the MTEF is expected to articulate a medium-term (three years) goals and objectives against the background of the overall goals of high level national health policies, international health standards and the attainment of the Sustainable Development Goals (SDGs). The MTSS will identify and document key programmes that will be embarked upon by the government to improve the quality of health of the Nigerian people.

The MTSS/MTEF 2018-2020 would be expected to help actualize the goals and objectives of the Economic Recovery and Growth Plan, National Health Policy 2016 (NHP), National Health Act (NHA) 2014, National Strategic Health Development Plan (NSHDP), and many other national and international commitments. In particular, it should help to improve our national health indices which, is among the worst globally. Although the improvement in the macroeconomic situation of the country has been minimal, increased investment in health is highly recommended as doing otherwise may further worsen the national health and economic indices.

Current health indices in Nigeria should be the basis of a robust investment plan in the MTSS anchored on the macroeconomic realities of the country. Today, life expectancy in Nigeria is among the lowest in the world at 53 years for males and 56 years for females. Government's investments in health fall well below regional and global standards and much of Nigeria's public health sector financing is donor-dependent[1] – many of which is expected to decline substantially in the next five years due to dwindling resources and donor fatigue. Health sector funding has also failed to translate to the desired outcomes: healthy mothers, thriving children, and a stronger workforce; largely due to inefficiency in the management of available resources.

Based on a critical review of the health sector, the current statutory obligations of the Government of Nigeria and in line with a sector strategy that considers the critical investments that must be made in the medium term, Civil Society Organizations working in the Health Sector call on the Government of Nigeria to honor its commitments to Nigerian people and hereby make the following recommendations:

[1] Health Sector MTSS 2017-2019 – A Memo from CSOs working in the Health Sector; published by CSJ

Memorandum makes the following policy recommendations:

1. FUNDING

i) Allocate 15% of the total annual national budget to the health sector in compliance with the Abuja Declaration of 2001. Where not possible, start with a minimum of 7.5% (being 50% of the Abuja Declaration) allocation in 2018 and progressively increase by 1.5% until the 15% is attained by 2023.

ii) The bulk of the new resources should go to capital expenditure to enhance access to equipment and health supporting infrastructure. At least, not less than 40% of the allocation should go to capital expenditure in 2018 and progressively increasing in subsequent years.

iii) As stipulated in the National Health Act 2014; in particular, allocate not less than 1 percent of the Consolidated Revenue Fund to the Basic Health Care Provision Fund in the 2018 budget and beyond.

iv) To generate more funding for the Health Sector, amend the National Health Insurance Scheme Act to make health insurance compulsory and universal. Consider new sources for health insurance funding to include a 2% surcharge on all imports, a special sin tax on alcohol and tobacco and minimal tariffs on telecommunications services to be borne by the consumer.

v) Consider the establishment of a Health Bank to provide single digit long term loans for the development of health institutions, health infrastructure, research and human resources for health. The initial capital is to be subscribed by the FGN with an invitation to regional and international development institutions to subscribe to the authorized capital. The establishment should be done after thorough studies confirming its viability.

vi) Whilst taking steps to establish the Health Bank, consider a special window of funding for the Health Sector. This should be established through administrative action by institutions such as the Central Bank of Nigeria which has provided similar long term and bailout funds in the past.

2. CONSTITUTIONAL, LEGAL AND POLICY GUARANTEE

i) Elevate the right to Primary Health Care and Maternal, New Born and Child Health to a Fundamental Right under Chapter Four of the Constitution of the Federal Republic of Nigeria, 1999 (as amended).

ii) Female child marriage should be prohibited across the Federation of Nigeria and the prohibition should be duly enforced.

iii) FGN should strengthen and sustain ongoing efforts towards a policy and legal framework for local vaccine production and sustainable immunization financing.

3. FUNDING SPECIFICS

i) Consider bi-annual funding of the procurement of vaccines to avoid delays and bottlenecks associated with public procurement, management, release, cash backing and utilization of public funds.

ii) Specific provisions in (collaboration with State Governments) should be made for the healthcare of IDPs in the North East Region ravaged by insurgency.

iii) Specific provisions should be made for the care and rehabilitation of VVF patients. A phased provision of N15billion per annum over 6 years will take of the backlog of patents who need care.

iv) Consider a moratorium on brand new capital projects not associated or linked with existing ones unless the project is of utmost priority. This will avoid the thin spread of available resources which produces no results. Money should be spent on completing, equipping and making functional the existing projects.

v) PHC revitalization should be done with the strong collaboration and commitment of States and LGCs. It should focus on funding and equipping functional PHCs run by States and Local Governments. The collaboration trough an MoU is imperative for the sustainability of the intervention based on previous experience. A clear SMART tool for functionality assessment should be developed by FMoH and the NPHCDA to determine the PHCs that qualify for funding.

vi) Capital votes should be managed by the agencies and parastatals that need them. There is no need to sequestrate the bulk of capital votes at the headquarters of the Ministry.

vii) Provide funding and other resources in the medium term for energy sustainability through renewable energy and energy efficient lighting and equipment. This will reduce the cost of energy in health institutions.

4. REVENUE GENERATION AND OTHER FUNDING

i) The reform of the Internal Revenue Generation system of Public Health Institutions is long overdue. The systems need reform through a multiplicity of practices including the

deployment of robust information technology that delivers real time interaction between payments, the establishment and the supervising authorities. Also, public private partnerships in IGR management should be considered.

ii) Consider Public Public Partnership and Public Private Partnerships models of funding the acquisition of capital equipment and facilities. However, necessary caution must be applied in adopting the public-private partnership model of health funding in order not to price public health facilities beyond the reach of the low income earners.

5. FULL IMPLMENTATION OF THE NATIONAL HEALTH ACT

i) The definition of the meaning of the minimum package of health services should be articulated. The Minister of Health and FMoH should articulate the definition of basic minimum package of health services required by the NHA and this should include MNCH and the minimum core obligations of the state in healthcare.

ii) The FMoH should set machinery in motion for the issuance of certificates of standards to deserving health institutions in accordance with sections 13 and 14 of the NHA.

iii) The Minister of Health should prepare and present an Annual State of Health of Nigerians and National Health System Report to the President and the National Assembly in 2017 and thereafter prepare and present same every year.

iv) Other duties stated in the NHA including the classification of health establishments and technologies; duty to disseminate information, etc. should be performed by the FMOH, the Minister of Health and other specified authorities.

6. TRANSPARENCY AND ACCOUNTABILITY

i) The specific annual contributions of Donors and Development Partners should be identified and captured in the budget to ensure transparency, accountability and prevent double budgeting and duplication of efforts.

ii) Increase the efficiency of health sector spending through greater value for money strategies. Ensure strict and efficient utilisation of the resources allocated to the health sector by implementing open contracting standards as part of an open government strategy.

iii) The Minister of Finance should prepare and publish a disbursement schedule within 30 days of the enactment of the Appropriation Act as stipulated by Section 26 of FRA and ensure full and timely release of the capital budget of the Federal Ministry of Health every financial year.

iv) The Budget Office of the Federation should resume the publication of Quarterly Budget Implementation reports on its website and in national dailies. The MDAs should likewise publish details of budget releases and expenditure on quarterly basis. This will help to promote transparency and accountability.

v) The FMoH should embrace the civil society as a critical partner in achieving greater value for money in a bid to improve national health outcomes. Future preparation of the MTSS should rely on a full Sector Team including the civil society and other relevant stakeholders. The FMoH should engage CSOs for budget monitoring and tracking expenditure borrowed sums in the sector.

The Table below details recommendations for critical health sector interventions for the period 2018-2020 at the federal level based on a Medium Term Sector Strategy.

Table 1: Critical Funding Recommendations 2018-2020

HEALTH SUB-SECTORS – HEADINGS	2017 PROVISIONS	PROPOSAL FOR 2018	PROPOSAL FOR 2019	PROPOSAL FOR 2020	JUSTIFICATION/COMMITMENTS
Total Health Budget	**N308.5bn** (only 4.15 per cent of overall budget – 18% is for capital expenditure)	At least 7.5% of total budget	At least 9% of total budget	AT least 10.5% of total budget	Ideally, it should be absolutely based on 15% of the Total Budget as agreed in Abuja Declaration (2001). The Uyo Recommendation 2016 (of NASS, FMOH and CSOs) should be implemented as it has considered current economic realities.
- **Basic Health Care Provision Fund (At least 1% of CRF)**	No fund allocated. **N47.6bn** should have been budgeted	At least 1% of CRF of FGN	At least 1% of CRF of FGN	At least 1% of CRF of FGN	Statutory Transfers to be implemented in accordance with the tenor of NHA.
Immunization	N12.51bn for vaccine procurement	Total = $751 million Secured = 274 **Funding Gap = $477million**	Total = $668 million Secured = $55 million **Funding Gap = $613 million**	$619 million Secured = $57 million **Funding Gap = $561 million**	Based on the Revised cMYP (2016-2020) projections, a total of **$2.038bn** is required to fund immunization programme in Nigeria between 2018 and 2020. Of this amount, only **$386 million** has been secured leaving a funding gap of **$1.65bn**. FGN plans to introduce three new

					vaccines namely - Men A vaccine in 2017, Rotavirus vaccine in 2018 and HPV vaccine in 2019. All the new vaccines will be financed with GAVI support, and co-financing from the Government of Nigeria[2]. With the impending withdrawal of GAVI support in 2021, FGN must establish a sustainable financing mechanism. NB: Because of the lead-time in vaccine procurement, we strongly recommend a biennial appropriation for the procurement of vaccines.
Family Planning	N970 million	Funding gap = N4.4bn[3]	**N58.6bn** Counterpart fund for the procurement and national distribution of contraceptive commodities based on 2016 forecast	TBD	Achieving Nigeria's family planning goals was estimated to cost N190bn (USD 603 million) between 2013 and 2018[4]. 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[5]. At same summit in 2017, the Minster of Health – Prof. Isaac Adewole announced an increase in the annual budgetary allocation for FP commodities to **USD4 million**. He also committed to ensure a total disbursement of **USD56 million** to the states through the GFF[6].
Nutrition All Nutrition Related	N1.2bn	N131.5bn	N144.65bn	N159.12bn	The total cost required to operationalise the Strategic Plan of Action from 2014-2019 USD 2.16

[2] Comprehensive EPI Multi-Year Plan 2016-2020
[3] Fact Sheet: Financing for Family Planning in Nigeria by HP+ (June 2017)
[4] Nigeria Family Planning Blueprint: Scale-Up Plan (September 2014)
[5] HP+ Policy Brief (March 2017)
[6] 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

projects/policy development					billion and the average annual cost is **USD 431 million (NGN 131.5bn). N1.2bn** was appropriated in 2017 as counterpart funding to UNICEF for the procurement of RUTF. But the extant projection assumes Nigeria bears the burden and a 10% yearly increase. Any donation from UNICEF will be factored in, in due course.
Midwives Service Scheme (MSS)	N400 million	N1.28 bn	N1.41bn	N1.551bn	Based on projected increase of functional PHCs country wide with at least 10 percent increase annually. A total of N400 million was allocated for the scheme in 2017 as against N700 proposed. The empirical need was N1.06bn. States and LGAs should be encouraged to play their part in sustaining this scheme.
NHIS	N129.7 million	All NHIS operational budget	All NHIS operational budget	All NHIS operational budget	N129.7 million was allocated as capital expenditure for NHIS in 2017 budget. The operational budget of the agency is not detailed in the budget despite recommendations and advocacy by CSOs in this regard. Providing the recurrent budget of NHIS in the budget will help to promote transparency and accountability. It is expected that when the Bill currently before NASS is passed into law making health insurance compulsory, the resources available will increase.
NACA Capital Projects on HIV Response					
SUPPLY OF RAPID TEST KITS AND CONSUMABLES TO STATES	-	N80bn	N80bn	N80bn	Testing 20m persons yearly at N4000 each over the medium term.

ART for 1,000,000 PLHIV in 36 States and FCT	-	N50.212bn	N55.234	N60.757bn	At prevailing cost of treatment based on earlier budgetary projections. 10% increase is projected for 2019 and 2020 based on the progressive realisation obligation of the state. The national treatment gap is however stated to be 2,350,000 PLHIV.
VVF		N15billion	N15billion	N15billion	For remediation, rehabilitation and treatment of VVF Patients
Health Bank of Nigeria		N2billion	N300billion		For 2018, the N2billion is for preliminary and feasibility studies; this should come from the budget. For 2019, the sum of N300billion is to be funded by the CBN as the authorized capital to attract other investors.

PART ONE: FOR 2018 AND THE MTSS/MTEF

1. INTRODUCTION

1.1 Background

The Medium Term Expenditure Framework (MTEF) for the period 2018 - 2020 is in the process of preparation by the Federal Ministry of Budget and National Planning (FMB&NP). When finalized, considered and endorsed by the Executive Council of the Federation (EXCoF), it will be transmitted to the National Assembly (NASS) for approval[7].

The Health Medium Term Sector Strategy (MTSS) which should inform the health component of the MTEF including its focus on primary health care is expected to:

- Articulate medium-term (three years) health goals and objectives against the background of the overall goals of high level national health policies, international health standards and the attainment of the Sustainable Development Goals (SDGs);
- Identify and document the key programmes and projects the government plans to embark upon to achieve the national health goals and objectives;
- Cost the identified key initiatives in a clear and transparent manner;
- Phase implementation of the identified initiatives over the medium-term;
- Define the expected outcomes of the identified initiatives in clear measurable terms; and
- Link expected outcomes to the objectives and goals.

1.2 Rationale for the Exercise

Official preparation of the Health Sector MTSS by the Federal Ministry of Health (FMoH) provides CSOs working in the Health Sector an opportunity to present memorandum articulating key inputs into the MTSS and 2018 federal health budget. The memorandum is to focus on the needs and rights of Nigerians and makes appropriate recommendations for the promotion of the right to health including Maternal, New Born and Child Health (MNCH). It is therefore imperative that CSO stakeholders deliberate and consolidate their inputs into a policy paper framework that will be submitted to the Federal Ministry of Budget and National Planning, the Federal Ministry of Health, the National Assembly and other stakeholders.

[7] As required by section 14 of the Fiscal Responsibility Act, 2007.

By this memorandum, CSO stakeholders seek to articulate medium-term (three years) health goals and objectives against the background of the overall goals of high level national health policies, international health standards and the attainment of the SDs; identify and document the key initiatives that will be embarked upon to achieve these goals and objectives. It also provides the opportunity to provide insights on how to cost the identified key initiatives in a clear and transparent manner; phase implementation of the identified initiatives over the medium-term; define the expected outcomes of the identified initiatives in clear measurable terms; and link expected outcomes to the overall sectoral health goals and objectives.

1.3 Outlining Linkages Between MTSS and Annual Budget[8]

Section 18 of the Fiscal Responsibility Act (FRA) stipulates that annual budgets are to be derived from MTEF. It further provides that notwithstanding anything to the contrary contained in the FRA or any law, the MTEF shall:

1) *Be the basis for the preparation of the estimates of revenue and expenditure required to be prepared and laid before the National Assembly under section 81 (1) of Constitution.*

2) *The sectoral and compositional distribution of the estimates of the expenditure referred to in subsection (1) of this section shall be consistent with the Medium Term Developmental Priorities set out in the Medium Term Expenditure Framework.*

CSOs therefore seek to make inputs into the Medium Term Developmental Priorities of the Federal Government in the Health Sector considering that this will form the basis for the preparation of the 2018 federal Health budget.

1.4 Identifying High Level National and International Policies and Standards

Nigeria has multiple national laws and policies guiding the right to health. These include but are not limited to the National Health Act 2014 (NHA), National Health Policy 2016, health component of Vision 20:2020, and the recently unveiled Economic Recovery and Growth Plan (2017-2020), etc. These policies stated the goals of the sector within the context of overall national goals. More so, Nigeria is a member of the United Nations and signatory to a plethora of international standards that mandate States Parties to be more responsive to the bundle of rights encapsulated in health and MNCH[9]. The SDGs

[8] See Health Sector MTSS 2017-2019 – *A Memo from CSOs Working in the Health Sector*; published by CSJ.

[9] These include article 25 of the Universal Declaration of Human Rights; article 12 of the International Covenant on Economic, Social and Cultural Rights; article 16 of the African Charter on Human and Peoples Rights; article 24 of the Convention on the Rights of the Child; article 14 of the African Charter on

1-3 all support the protection of the right to health. SDG 3 is specifically on ensuring healthy lives and promoting well-being for all at all ages[10].

The Constitution of the Federal Republic of Nigeria1999 (as amended), which is the supreme law, protects the right to life in section 33 and the right to life is inextricably linked to the right to health. The easiest way to deprive a person of her life is a denial of access to good quality health care service to the point of abrogation. Chapter 2 of the Constitution, under the Fundamental Objectives and Directive Principles of State Policy creates a state obligation; the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused. It also states that there should be adequate medical and health facilities for all persons[11].

Although the constitutional health provisions are non-justiciable, the NHA on the basis of that mandate gives specific rights and duties to right holders and duty bearers respectively, and this makes effective, the right to health or specific aspects of it including MNCH[12]. The NHA specifically empowers the Ministry of Health to prepare strategic medium term health and human resource plans annually for the exercise of its powers and the performance of its duties under the Act.[13]

The NHA further establishes a Basic Health Care Provision Fund with a government annual grant of not less than one percent of the Consolidated Revenue Fund which is to be used *inter alia*; 50 per cent for the provision of basic minimum package of health services to citizens in eligible primary or secondary health care facilities through the

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the Rights and Welfare of the Child; article 12 on the Convention on the Elimination of all Forms of Discrimination against Women, etc.

[10] Targets include: 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. They further include: 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: Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination, etc.

[11] 1999 Constitution of the Federal Republic of Nigeria: Section 17 (3) (c) and (d).

[12] Item 60 of the Second Schedule to the 1999 Constitution provides for the establishment and regulation of authorities for the Federation or any part thereof - (a) To promote and enforce the observance of the Fundamental Objectives and Directive Principles contained in this Constitution;

[13] See section 2 (2) of the Act.

National Health Insurance Scheme; 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. 5 per cent of the Fund shall be used for emergency medical treatment. It also makes provisions for grants to states and local government 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 Primary Health Care Development Agency over State and Local Government Health Authorities 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[14].

The Economic Recovery and Growth Plan (ERGP) which is the economic and growth plan of the Buhari Administration makes provisions for the revitalization of the health system.

The Child Rights Act (CRA) in section 13 subsection 1 to 3 stated as follows:

> *13.—(1) Every child is entitled to enjoy the best attainable state of physical, mental and spiritual health.*
>
> *(2) Every Government, parent, guardian, institution, service, agency, organisation or body responsible for the care of a child shall endeavour to provide for the child the best attainable state of health.*
>
> *(3) Every Government in Nigeria shall—*
>
> > *(a) endeavor to reduce infant and child mortality rate;*
> > *(b) ensure the provision of necessary medical assistance and health care services to all children with emphasis on the development of primary health care;*
> > *(c) ensure the provision of adequate nutrition and safe drinking water;*
> > *(d) ensure the provision of good hygiene and environmental sanitation;*
> > *(e) combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;*
> > *(f) ensure appropriate health care for expectant and nursing mothers; and*
> > *(g) support, through technical and financial means, the mobilisation of national and local community resources in the development of primary health care for children.*

A review of the above shows that the CRA has created positive obligations for the state to ensure the protection of the rights of the child to MNCH services.

[14] See section 11 (5), (6) and (7) of the National Health Act.

Nigeria is not short on policies dealing with health and MNCH. The First Pillar of Vision 20:2020 is "Guaranteeing the Productivity and Wellbeing of the People" and one of its strategic objectives is focused on health – "enhance access to quality and affordable healthcare". The First National Implementation Plan of Vision 20:2020 targets improvements in the health indicators to achieve a remarkable drop in MNCH and Under-5 mortality rates. The Vision targets further a reduction by half of the HIV prevalence rate of 4.4% by 2015 and increasing immunisation coverage from 27% at the base year (2009/10) to 95% in 2015. This is yet to be achieved as at 2017.

1.5 Structure of the Sector

The Health Care System in Nigeria is established by the National Health Act 2014. It is constituted by the public and private health care sectors. The levels of care provided in the care facilities are classified into primary, secondary or tertiary. The public health sector is owned and governed by the three tiers of government - the Federal, State and Local Governments. The Federal Government manages tertiary health care (federal university teaching hospitals, federal medical centers and federal specialists' hospitals)); the State is responsible for the tertiary and secondary healthcare (in state university teaching hospitals and general hospitals respectively) while the Local Governments manage the Primary Health Care (health care centres, health posts and dispensaries). On the other hand, the private sector which could be for-profit (owned by individuals or a consortium) or not-for-profit (missionary hospitals, NGO clinics) also provides health care at the three levels described above.

2. KEY CHALLENGES OF THE HEALTH SECTOR AND LAYING OUT GOALS, OBJECTIVES AND TARGETS BASED ON HIGH LEVEL NATIONAL AND INTERNATIONAL POLICIES AND STANDARDS

2.1 Challenges of the Nigeria Health Sector

The challenges of the Nigeria health sector is aptly described by a situation analysis in the NHP 2016[15] and reproduced here as follows;

> *"The situational analysis undertaken was based on examining the functioning of the Nigerian health system from the perspectives of the strategic thrusts of the NHSDP and the WHO health system building blocks. The analysis showed that the Nigerian health system is weak and, hence, underperforming across all building blocks. Health system governance is weak. There is an almost total absence of financial risk protection and the health system is largely unresponsive. There is inequity in access to services due to variations in socio-economic status and geographic location. For instance, 11% of births to uneducated mothers occur in health facilities while 91% of births to mothers with more than secondary education occurs in health facilities; 86% of mothers in urban areas*

[15] *See pages xiii and xiv of the National Health Policy 2016*

receive ANC from skilled providers, compared to only 48% of mothers in rural areas; and ANC coverage in the North West is 41% compared to 91% in the South East. Other problems related to health services include: curative-bias of health services delivered at all levels; inefficiencies in the production of services; unaffordability of services provided by the private sector to the poor; limited availability of some services, including VCT, PMTCT and ART; low confidence of consumers in the services provided, especially in public health facilities; absence of a minimum package of health services; lack of proper coordination between the public and private sectors; and poor referral systems".

The Economic Recovery and Growth Plan (ERGP), which is the economic and growth plan of the Buhari Administration states as follows of the Nigerian Health System:

"Nigeria's health system does not provide the level of service required to meet the needs of its population. At 52 years, the average life expectancy in Nigeria is lower than that of its peer African countries, e.g. Ghana (61 years) and South Africa (57 years). The prevalence of infectious diseases remains high. Nigeria ranks poorly on incidence of tuberculosis (128 out of 138 countries) and prevalence of HIV (123 out of 138 countries). On under-five child mortality, there are 89 deaths per 1000 live births, a level far above the target of 64 deaths per 100 live births set in the UN Sustainable Development Goals[16]".

The challenges undergirding the poor performance include insufficient financing, inadequate and inequitable access, weak supply chain management, limited human resource capacities and insufficient coordination, cohesion and accountability[17].

2.2 Sectoral Goals, Objectives, Targets and Strategies

The national key policy document Vision 20:2020 has robust health goals and objectives[18].

The ERGP states its policy objectives as follows[19]:

- Improve the availability, accessibility, affordability and quality of health services;

[16] See page 85 of the ERGP
[17] ERGP, supra.
[18] To provide equitable, efficient, high quality but affordable health services based on the primary health care approach, appropriately updated to improve the knowledge, attitude, practice and the adoption of healthy lifestyles by the people: Reduction in maternal and childhood morbidity and mortality and the burden of other priority endemic diseases and: Improvement of basic sanitation and water supply. Increase Nigeria's capacity to manufacture essential drugs, vaccines and consumables from 40% to 80% of national need. Others are expansion of secondary and tertiary health care coverage: Improvement of health data base and promotion of research: Strengthen referral linkages among the various levels of health care – the primary, secondary and tertiary health care facilities; and Enhance and strengthen the availability and management of health resources (financial, human and infrastructural).
[19] Pages 85-86 of the ERGP.

- Expand health coverage to all Local Governments.
- Provide sustainable financing for the health care sector.
- Reduce infant and maternal mortality rates.

The ERGP presents its strategies as follows in Table 2.

Table 2: ERGP Strategies in the Health Sector

Programme		Health	
No.	Strategy	Key activities	Lead
31	Revitalize the primary healthcare system	■ Revitalize 10,000 primary health care centres and establish at least one functional primary health centre (PHC) in each ward to improve access to health care ■ Fully implement the primary health care refinancing programme to mobilize domestic resources ■ Drive progress to meet UN SDG health targets	Ministry of Health Sustainable Development Goals' Office
32	Roll out universal health coverage (NHIS)	■ Expand the NHIS towards universal health care coverage ■ Enforce the Tertiary Institutions Social Health Insurance Programme for students in tertiary institutions ■ Pilot the Public Primary Pupils Social Health Insurance Programme to provide quality health services to pupils in middle- and lower-income socio-economic levels who are less likely to have insurance	Ministry of Health Ministry of Education
33	Strengthen delivery beyond the primary health care system	■ Provide anti-retroviral medication to people living with HIV/AIDS ■ Ramp up projects to eradicate polio, measles and yellow fever ■ Make strategic investment in tertiary health care institutions in collaboration with the National Sovereign Investment Authority and other relevant stakeholders, e.g., establish diagnostic centres in all States ■ Develop and adopt an e-health scheme to connect	Ministry of Health Ministry of Science and Technology
34	Partner with the private sector to construct model mega-health	■ Partner with the private sector to develop at least one mega-health centre in each State to provide high-quality preventive and curative healthcare	Ministry of Health

35	Build the capacity of health care personnel to improve service delivery	■ Provide a rural service allowance and basic amenities to health workers in rural areas to retain qualified personnel ■ Identify and fill gaps to optimize the health worker-to- population ratio by recruiting and training more health workers and attracting talent from abroad ■ Develop the Diaspora Medical Assistance Programme to attract and encourage Nigerian medical professionals abroad to provide volunteer	Ministry of Health

Source: Pages 86-87 of the ERGP

The National Health Policy 2016 was developed to reflect new realities and trends, including the unfinished agenda of the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs), emerging health issues (especially epidemics), the provisions of the NHA, the new PHC governance reform of bringing PHC Under One Roof (PHCUOR), and Nigeria's renewed commitment to universal health coverage[20]. It outlined the following as its vision, mission and goals;

- Vision, Mission and Policy Goal
- *Vision*: Universal Health Coverage (UHC) for all Nigerians
- *Mission*: To provide stakeholders in health with a comprehensive framework for harnessing all resources for health development towards the achievement of Universal Health Coverage as encapsulated in the National Health Act 2014, in tandem with the Sustainable Development Goals (SDGs)
- *Overall Policy Goal:* 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.

The ten (10) policy thrusts of the policy, derived from the NSHDP thrusts and the WHO health systems building blocks 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[21].

2.3 National Targets on Key Disease Intervention Areas

Nigeria still has a high prevalence of communicable diseases and an increasing burden of non-communicable diseases. Communicable diseases account for 66% of the total burden of morbidity. These diseases include malaria, acute respiratory infections (ARI), measles, diarrhoea, tuberculosis, HIV/AIDs and neglected tropical diseases (filariasis, onchocerciasis, trachoma, worm infestation, schistosomiasis, leprosy etc.). Although the

[20] See page xiii of the National Health Policy 2016.
[21] See page xv of the National Health Policy 2016.

incidence of HIV/AIDs is currently on the decline, the absolute number of affected persons still places a huge morbidity burden on Nigeria's resources[22].

The Federal Government through various national policy documents and strategic plans have set targets on reducing diseases of high burden in the country and other MNCH interventions. They are summarised in the sub-sections below;

2.3.1: Immunization Coverage and Funding Targets: The national immunization priorities as outlined in the cMYP 2016-2020[23] are:

- Increase and sustain routine immunization coverage for all antigens; and reduce morbidity and mortality from VPDs.
- Reach the hard-to- reach LGAs/communities.
- Sustain availability of bundled vaccines at service delivery sites.
- Introduce new and underutilized vaccines (PCV, Rotavirus, HPV and IPV) into the country's immunization schedule.

The national immunization coverage targets for the antigens on the routine immunization programme are summarized in Table 3 below.

Table 3: Targets for Routine Immunisation

Indicator	2013	2020
Penta-3	59.7%	95%
BCG	80%	94%
OPV0	55%	95%
IPV	n/a	95%
PCV-13	n/a	95%
Rota	n/a	95%
Measles-1	58.8%	95%
Tetanus Toxoid	50%	100%
Fully Immunized Children	51%	80%
Dropout Rate	18.6%	10%

Table 2: National Immunization Coverage Targets by antigens
Credit: cMYP, 2016-2020

To achieve these targets by 2020, large sums of money will need to be mobilized. The projected cost is summarized in Table 4 below.

[22] See page 10 of the National Health Policy 2016.
[23] See page 2 of the Comprehensive EPI Multi-Year Plan 2016-2020 (Revised in January 2017)

Table 4: Resources Required to Meet Immunisation Targets

	2018	2019	2020	Total
Total Resources Required (US$ millions)	751	668	619	2,038
Total Secure Financing (US$ millions)	274	55	57	386
Funding Gap (with secure) (US$ millions)	477	613	561	1,651
Total Secured and probable financing (US million)	549	384	347	1,280
Gap (with secure + probable) (US$ millions)	202	284	272	758
% of total needs	27%	43%	44%	38%

Table 3: Immunization Financing Projections. Data Source: cMYP 2016-2020 (revised in Jan 2017)

2.3.2 Family Planning Targets: At the London FP 2020 Summit that held on July 11, 2017, Nigeria made a commitment to increase usage of modern contraceptive methods from the current 17% to 27% by 2020[24]. This is a downward review of the target of 36% by 2018 as committed at the London FP 2020 in 2012 and also contained in the *National Family Planning Scale-Up Plan 2014*[25]. Nigeria has also committed to increase the number of family planning service outlets from the current 10,000 to 20,000 by 2020.

Other family planning targets include;

- Reduce the annual national population growth rate to 2% or lower (currently 3.2%).[26]
- Reduce the total fertility rate (TFR) by at least 0.6 children every five years (between 2008 and 2013, TFR declined from 5.7 to 5.5). [27]
- Increase the modern contraceptive prevalence rate (CPR) by at least 2 percentage points each year (currently 9.8%, an increase of 0.1 percentage points from 2008).

Achieving the above targets is key to achieving the national development goals as outlined in the National Population Policy (NPP) which include:

- Achieve and sustain economic growth, eradicate poverty, protect the environment and provide high quality social services.

[24] Nigeria's FP 2020 Commitment made in July 2017 by the Minister of Health, Prof. Isaac Adewole - https://www.youtube.com/watch?v=ydow2gxTfYg. Watched on 16/07/2017.
[25] See page vii of the National Family Planning Scale-Up Plan 2014.
[26] National Population Commission. 2009. "Population Figures and Growth Rate based on 2006 Population and Housing Census, Federal Republic of Nigeria Gazette 96, February 2009.
[27] National Population Commission of Nigeria (NpopC) and ICF International. 2014. NDHS 2013. 2009. "Population Figures and Growth Rate based on 2006 Population and Housing Census, Federal Republic of Nigeria Gazette 96, February 2009.

- Achieve balance between population growth rate and available resources.
- Improve the reproductive health of all Nigerians.

2.3.3 Malaria Prevention & Control Targets: Malaria is endemic in Nigeria with all year transmission and 97 percent of the population at risk. *Plasmodium falciparum* is the predominant parasite species, mainly transmitted by *Anopheles gambiae S.S., An. funestus* and *An. arabiensis*[28]. The current national malaria prevalence is 45 percent by RDT and 27 percent by microscopy[29]. FGN envisions a malaria-free Nigeria and has set a goal to reduce malaria burden to pre-elimination levels (prevalence of less than 5%) and bring malaria-related mortality to zero by 2020[30].

In order to achieve the malaria elimination goal by 2020, FGN outlined the following objectives/targets:

- Ensure at least 80% of targeted population utilizes appropriate preventive measures by 2020.
- Test all care-seeking persons with suspected malaria using RDT or microscopy.
- To treat all individuals with confirmed malaria seen in private or public facilities with effective anti-malarial drug by 2020.
- Provide adequate information to all Nigerians such that at least 80% of the populace habitually takes appropriate malaria preventive and treatment measures as necessary by 2020.
- Ensure the timely availability of appropriate antimalarial medicines and commodities required for prevention and treatment of malaria in Nigeria wherever they are needed by 2018.
- At least, 80% of health facilities in all LGAs report routinely on malaria by 2020.
- To strengthen governance and coordination of all stakeholders for effective program implementation towards an “A” rating by 2018 on a standardized scorecard.

2.3.4 HIV/AIDS Prevention and Response Targets: Nigeria has the second highest burden of HIV globally. In 2012, Nigeria fell within the category of countries classified as

[28] National Malaria Strategic Plan 2014-2020 (page xiv).
[29] National Malaria Indicators Survey (NMIS) 2015.
[30] National Malaria Strategic Plan 2014-2020 (page xv).

having a stable change in the incidence rate of HIV infection among adults 15–49 years old, 2001–2011[31]. Multiple objectives and targets were set by FGN in various national policy documents including the *National HIV/AIDS Strategic Plan 2010-2015*, *National HIV/AIDS Prevention Plan (2014-2015)* and the *President's Comprehensive Response Plan for HIV/AIDS in Nigeria (2013-2015).* Most of the targets have not been achieved in 2017. Currently, FGN is working to achieve the following targets[32]:

- Provide universal access to comprehensive and quality HIV prevention, treatment, care and support services through a multi-sectoral approach.
- Facilitate multi-sectoral interventions that will ensure an end to AIDS by 2030.
- Support effective measures that will ensure that 90% of all people living with HIV infection will know their status, 90% of all people diagnosed with HIV infection will receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy will have viral suppression[33].

2.3.5 Tuberculosis Prevention and Control Targets: Nigeria wants to control tuberculosis and leprosy by achieving the following objectives[34]:

- Implement comprehensive strategies for case notification, management and control of tuberculosis and leprosy in the general population in line with the global road map.
- Increase access to high-quality integrated services for all people co-infected with tuberculosis and HIV.
- Improve access to diagnosis and treatment of multi-drug resistant tuberculosis.
- Improve access to diagnosis and treatment of paucibacillary and multibacillary leprosy.

2.3.6: Non-Communicable Diseases Prevention and Control Targets: The Federal Government wants to significantly reduce the burden of non-communicable diseases in Nigeria in line with the targets of the SDG 3[35]. The objectives of the National Health Policy on NCDs are:

[31] Global AIDS reports 2012.
[32] As outlined in the National Health Policy 2016 (page 30).
[33] UNAIDS Target 90:90:90.
[34] National Health Policy 2016 (page 31).
[35] SDG Targets on Non-Communicable Diseases: Target 3**.**4 **-** By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. Target 3.5**:** Strengthen the prevention and treatment of substance abuse, including

- To integrate the prevention and control of non-communicable diseases into the national strategic health development plan and into relevant policies across all tiers of government.
- To ensure the acquisition of up-to-date evidence on non-communicable diseases in Nigeria.
- To reduce the burden of NCDs by engaging agencies and stakeholders that provide services impacting on the social determinants of health.
- To provide an appropriate framework for research on the prevention and control of NCDs.
- To strengthen partnerships with stakeholders and development partners.
- To monitor and evaluate the progress made at all levels of NCDs prevention and control.

2.3.7 Prevention and Control Targets for other Health Conditions: The NHP 2016 also outlined the national objectives and targets for other health conditions including mental health, oral health, eye health, public health emergencies and response, disability; and health-related problems and issues including nutrition, food safety, health promotion, water and sanitation, gender and medical tourism[36].

3. SITUATION ANALYSIS OF HEALTHCARE FINANCING IN NIGERIA

The two most critical challenges being faced by the Nigerian Health Sector (in our opinion) are inadequate funding and inefficient utilization of available resources. Apart from the ownership of public health assets and payment of the health workforce, Government of Nigeria at all levels has not shown the desired political will in funding the health sector over the years. This has contributed significantly to the low quality of health care and the abysmally poor health indices. In 2001, African Heads of States met in Abuja and made a commitment to allocate a minimum of 15% of their total annual budgets to the provision of best possible quality of care to its citizens. While only a few countries have achieved this target within the past 16 years, Nigeria is yet to hit 50% of the target. Chart 1 below compares Nigeria's percentage allocation to health with other African countries.

narcotic drug abuse and harmful use of alcohol. Target 3.6**:** By 2020, halve the number of global deaths and injuries from road traffic accidents.

[36] See page 34-42 of the National Health Policy 2016.

Chart 1: How Nigeria Compares with other African Countries

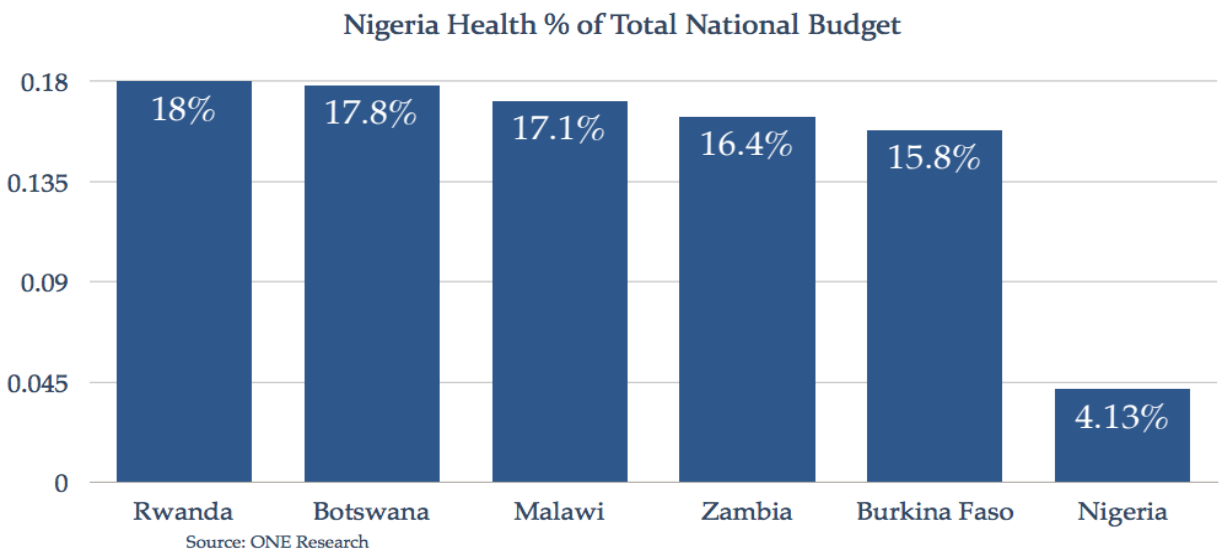
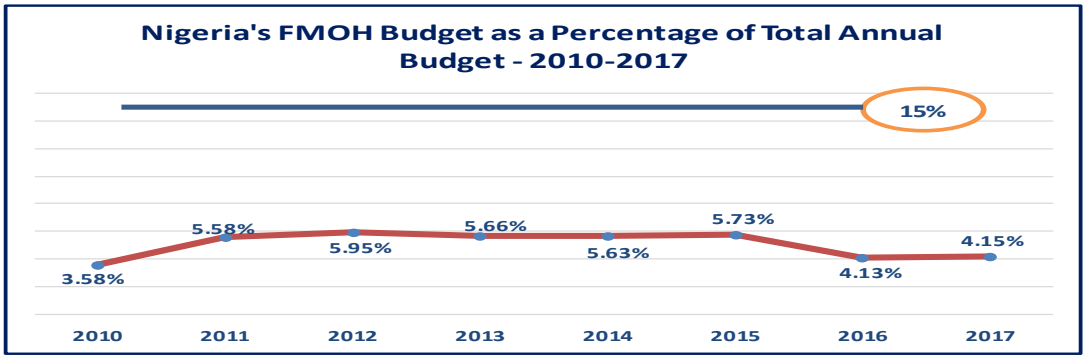


Chart 1: Credit: Pharm. Remi Adeseun. PowerPoint presentation on Status of RMNCAH funding at the Uyo Legislative Retreat, November 2016

Nigeria's highest health budgetary allocation as a proportion of the total annual federal budget was 5.98% achieved in 2012. Since then, a downward trend has persisted despite intensive advocacy by CSOs and other key stakeholders. Chart 2 below shows a trend analysis of the proportion of the FGN budget allocated to FMOH between 2010 and 2017.

Chart 2: Percentage Allocations to the Health Sector in Nigeria



Data Source: Budget Office

Improving the functioning of health systems and achieving equitable access and affordability of healthcare services to all is encapsulated in current efforts to achieve universal health coverage (UHC) (Onwujekwe, 2013). The World Health Organization (2010) proposed five target indicators for countries to use to progress in achieving

universal coverage and these are: Total health expenditure should be at least 4% - 5% of the gross domestic product: Out-of-pocket spending should not exceed 30-40% of total health expenditure and: Over 90% of the population is covered by pre-payment and risk pooling schemes. Others are close to 100% coverage of population with social assistance and safety-net programmes and 80% of access to services by the 40% poorest in the population.

Table 5 below provides details and trends of key indicators of health financing in Nigeria.

Table 5: Trend of Key Indicators of Health Financing in Nigeria

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
1. THE, % GDP	4	4	7	5	6	3	4	3	4	2
2. GGHE, % THE	31	30	25	37	36	26	31	31	24	27
3. Private HE, % of THE	69	70	75	63	64	74	69	69	76	73
4. GGHE, % govt expenditure	4	4	7	6	5	6	7	7	6	7
5. External, % of THE	5	6	2	5	5	8	5	6	5	6
6. Social security expenditure, % GGHE	0	0	0	0	0	-	-	-	-	0
7. OOP, % Private HE	90.4	90.4	95.9	95.4	95.3%	96	96	96	96	96
8. Social Security expenditure, % THE	0	0	0	0	0	0	0	0	0	0
9. OOP % THE	62.4	63.5	71.6	60.3	65.7	71	66	66	73	75
10. THE per capita US$	27	33	74	73	69	81	93	90	109	94
11. THE Per capita PPP int. $	45	59	131	113	136	175	193	178	207	
12. Total Federal HE as % of Federal budget					5.4%	4.0%	4.1%	5.95%	5.7%	5.63%

Source: Authors calculations of Trends of Health Financing Indicators in Nigeria[37]

Public expenditures in Nigeria account for 20-30% of Total Health Expenditures (THE), whilst private expenditures accounts for 70-80% of the expenditures. The dominant

[37] Source 1: World Health Statistics 2005-2011. http://apps.who.int/ghodata/?vid=15000&theme=country#
Source 2. http://www.fmf.gov.ng/Budget2009Info/2009FBudgetHealth.pdf
http://www.who.int/whr/2000/en/whr00_en.pdf
Source 3: Nigerian National Health Accounts

private expenditure in Nigeria is out-of-pocket spending (OOPS), accounting for more than 65% of THE in the country[38].

The indices in Table 5 above depict the low funding of the health sector by Governments across the Federation, which also accounts for the low insurance coverage. The percentage of Nigerians covered by any form of pre-payment insurance scheme is less than 2% of the population[39]. Those covered are mostly civil servants and the formal private sector, leaving out the more vulnerable segments of the population who have higher disease burdens, lower incomes and are in most need of protection[40].

4. REVIEW OF EXISTING BUDGET COMMITMENTS (2013-2017): KEY ISSUES

4.1: Low Budgetary Allocation

A review of the budgetary allocation to the Federal Ministry of Health between 2013 and 2017 will reveal the commitment of FGN to the health sector. If FGN had implemented the 15% Abuja Declaration benchmark, the national health indices would have probably been better. Table 6 shows the state of allocations.

Table 6: The FGN Health Budget and Variance from 15% Abuja Declaration

Year	Total Budget (N' Billion/Trillion)	Health Allocation (N' Billion)	As % of Total Budget	As 15% of Total (N' Billion)	Variance from 15% Benchmark (N' Billion)
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	1,116,176,323,013.70	807,712,046,231.70

Data Source: Budget Office of the Federation

Table 7 shows the allocation to the health sector at the federal level for 2015 -2017 and its real value in Naira and United States Dollars.

Table 7: Health Vote as a Percent of Overall Budget 2015-2017 and its Real Value

Year	Health Budget	National Budget	Percentage Health	Exchange Rate	USD Value
2015	259,751,742,847	4,493,363,967,157	5.78	@1USD=N190	$1,367,114,436
2016	250,062,891,075	6,060,677,358,227	4.13	@1USD=N197	$1,269,354,777
2017	304,190,961,402	7,298,507,709,937	4.15	@1USD=N305	$997,347,414

Source: Budget Office of the Federation and Authors Calculations

[38] See page 14 of the Draft National Health Financing Policy; referencing National Health Accounts 2010.
[39] According to the remarks made by the Executive Secretary of NHIS – Prof. Usman Yusuf during the Nigeria Health Watch Forum (April 2017).
[40] Draft National Health Financing Policy .

From Table 7, it is clear that in Naira terms, the health vote of 2015 was higher than the vote of 2016 and the vote marginally appreciated in 2017. On average, this is less than a third of the 15% of the overall budget requirement in the Abuja Declaration. However, in terms of its real value in USD terms which takes cognizance of the inflation rate, cost of living and other macroeconomic variables, the allocation to health has been on the decrease over the three year timeframe.

4.2 Capital Versus Recurrent Funding of the Health Sector

There has been a mismatch between the recurrent and capital funding of the Health Sector over the years. Table 8 shows the picture.

Table 8: Recurrent versus Capital Expenditure 20111-2017

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

Source: Budget Office of the Federation

The average allocation to capital expenditure for the six years is 19.10%. With the lack of equipment and facilities in health establishments, there is evidence from Table 8 that the capital component of the health budget has been poorly funded and this is compounded by poor releases, cash-backing and utilization.

4.3 Late and Partial Release of Appropriated Funds

Due to the persisting late passage and assent to the Appropriation Act, health budgets are usually released late. Budget Implementation Reports by the Budget Office of the Federation showed partial release of allocated funds; partial cash-backing of released funds while utilization has been low due to late disbursements and poor absorptive capacity. This has to improve in the medium term and beyond. For the years 2011, 2012, 2013, 2014, 2015 and 2016, the percentage of appropriated health expenditure utilized has been 68.83%, 55.29%, 55.56%, 37.74 %, 53.86% and 97% respectively. Thus, the only good performance has been in the year 2016. Cumulatively, over the years, the average percentage performance has been 61.38%. This does not show

sufficient commitment to funding the capital component of the health budget. Chart 3 shows the utilization of capital allocation to health for the years 2011-2015[41].

Chart 3: Health Capital Budget – Released - Cash Backed and Utilised; 2011-2015

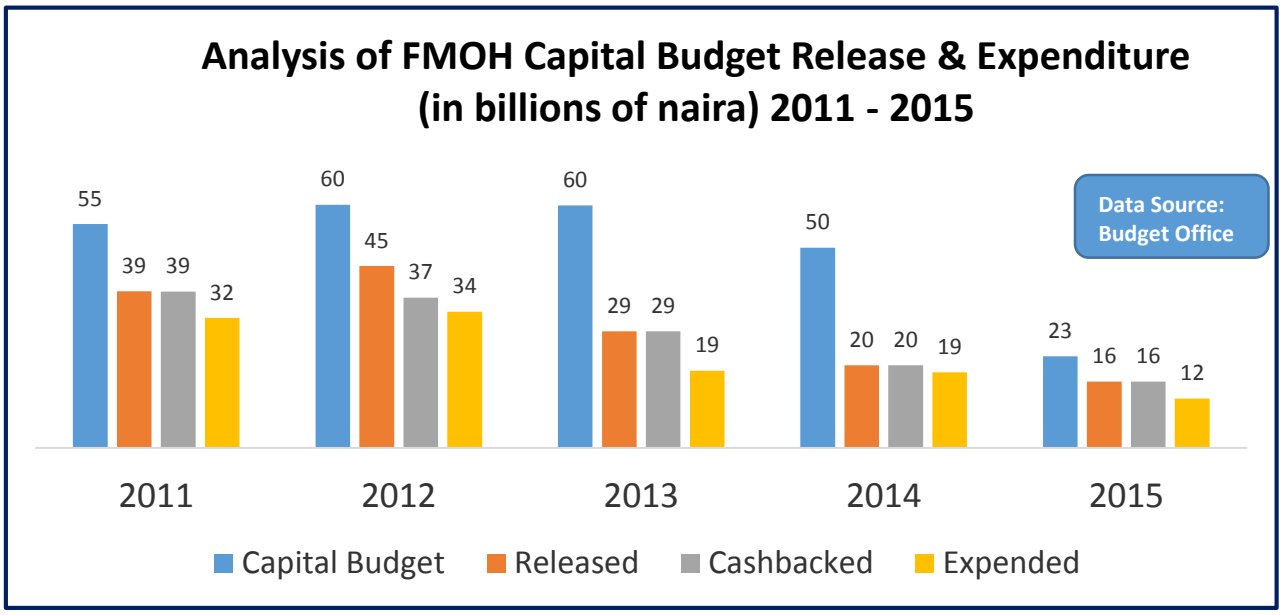


Chart 3: Analysis of Capital Budget Release and Utilization 2011-2015.

4.4 No Appropriation for Basic Health Care Provision Fund

Since the enactment of the NHA in 2014, no appropriation of at least 1% of Consolidated Revenue Fund (CRF) of the FGN has been made for the Basic Health Care Provision Fund as provided in Section 11 of the Act. This has reduced funding that should have been made available for primary health care, MNCH and health insurance coverage. How much is 1% CRF? Chart 4 provides a summary.

Chart 4: 1% of CRF for the Years 2015, 2016 and 2017

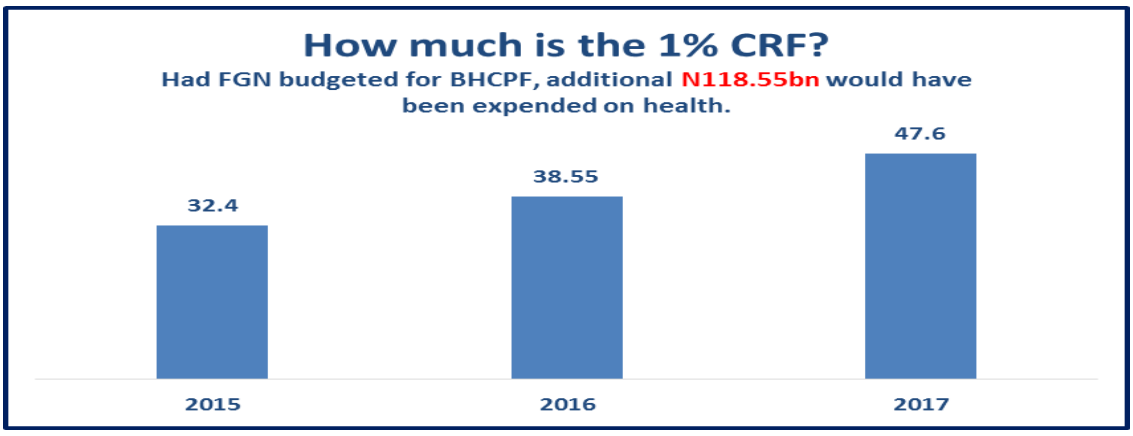


Chart 4: Data Source: Budget Office

[41] Source: Budget Implementation Reports - Budget Office of the Federation.

Thus, a total of N118.5billion has been lost by the Health Sector to the refusal and neglect of the FGN to provide for the Basic Health Care Provision Fund.

4.5 Debt Financing for Health is not Sustainable

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 programs 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.

5. KEY HEALTH SECTOR ACHIEVEMENTS IN THE PAST DECADE

1. Eradication of Guinea Worms
2. Control of Ebola Disease outbreak in 2014
3. No report of vaccines stock-out since 2014. Note that it was donor funds (loan from the World Bank) and Nigeria counterpart funds that have been in use since 2014.
4. Interruption of the wild polio virus for two years (July 2014 – July 2016)
5. Reduction of HIV incidence rate
6. Reduction of malaria prevalence rate and related deaths.

6: MDAS HEALTH PROJECTS/ACTIVITIES THAT SHOULD BE SUSTAINED

6.1 PHC Revitalization Initiative

Although the proposal to revitalize Primary Health Care Centres is a welcome development for the improvement of primary health care, it should be noted that this is not a function reserved for the Federal Government. This is within the remit of Local Governments with the assistance of States. FGN at best contributes to the capital components of established PHCs but the recurrent component will not be borne by FGN. Thus, the revitalisation needs to be done with the strong collaboration, dedication and commitment of States and Local Governments who will eventually run these PHCs and bear the recurrent costs. Thus, funding and capital equipment should only be made available to extant and functional PHCs run by States and Local Governments. The collaboration (through a Memorandum of Understanding) is imperative for the sustainability of the intervention based on previous experience from programmes like the MSS of the SURE-P. A clear SMART tool for functionality assessment should be

developed by FMoH and the NPHCDA to determine the PHCs that qualify for funding. FGN should provide resources in form of grants to States and LGAs given that it takes more than half of the Federation Account funds. Strong accountability frameworks and practices must be put in place to ensure efficient utilization of approved funds. FG should focus more on development of national health policies and ensure all the existing ones are implemented.

6.2 Activities Towards Local Vaccine Production

The MoU signed by FMOH and May & Baker Pharmaceutical Company should be implemented successfully and more PPP arrangements brought on board. The obligation to use the maximum of available resources for the progressive realization of the right to health imports the notion of prudence and best value for money. Thus, importing vaccines (when the capacity to produce them locally can be developed) may not produce optimum results and will not be sustainable in the long run. The Vaccine Production Laboratory in Yaba Lagos which has been left to rot away will now be put into use. Further, based on the indivisibility, inseparability and interconnectedness of all human rights and fundamental freedoms, local production of vaccines will create jobs, earn more tax for government, develop technology and improve the GDP. Essentially, it is a win-win scenario for all. With the economy in recession and the scarcity of foreign exchange, it makes no sense to continue importation of vaccines.

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 and in response to this, FGN took steps to inaugurate a committee on local vaccine production which was constituted in 2016. However, funding should be made available for the preparation of a National Vaccine Policy. Further partnership with the private sector should be done through open competitive bidding.

6.3 Others

Other programmes and activities that need to be continued include the Midwives Service Scheme; Primary Health Care Under One Roof and improved surveillance and regular information and epidemiology data updates on websites of the MDAs especially the NCDC and NPHCDA.

7. MDAS PROJECTS/PROGRAMMES PERFORMING POORLY

- No National Health Policy between 2007-2016 (although, a new health policy has been approved)
- No existing NSHDP (NSHDP 2010-2015 was extended to 2016)
- Poor implementation of MSS.
- Worsening maternal health indices (Maternal Mortality increased from 545 to 576 per 100,000 live births between 2008 & 2013)

- No appropriation for Basic Health Care Provision Funds as required by NHA 2014.
- Low insurance coverage (less than 2% - according to the NHIS Executive Secretary)
- Misappropriation of government and donor funds (Global Fund, GAVI, etc)

8. OTHER HEALTH SECTOR CHALLENGES

8.1 Timeline for Vaccine Procurement

Vaccines for immunisation are not available for purchase across the counter. They need a lead time to order, procure and deliver and as such, should not be programmed for annual funding if the FMoH is to meet timelines. Annual provisions in the budget will mean that the drugs will arrive at a time that targets will be missed. Thus, vaccines need to be available when they are needed. It is therefore imperative to consider bi-annual funding of the procurement of vaccines to avoid delays and bottlenecks associated with public procurement, management, release, cash backing, and utilisation of public funds.

8.2 VVF Cases and the Right to Human Dignity

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. The endemic states are Sokoto, Kebbi, Borno, Kano, Katsina, Plateau, Ebonyi and Akwa Ibom states. The patients virtually lose their human dignity through a substandard life lived in isolation and most times are subjected to inhuman and degrading treatment. Again, their right to life is under serious threat as they are abandoned and neglected. Treating each patient at a cost N100,000 for surgery, remediation and rehabilitation will cost a total of N80 billion. Provisions for treating VVF should be phased over a period of six years at N15billion per year.

8.3 New Capital Projects

Resources are so thinly spread in the sector across so many uncompleted projects that were due for completion so many years ago. Many existing projects are begging for maintenance and equipment to make them functional. This has not guaranteed value for money and improvement of health care services. A moratorium on brand new capital projects, not related to existing projects has become necessary unless the new project is of utmost priority. Otherwise, money should be spent on completing, equipping and making functional the existing projects.

8.4 Health Sector Provisions for the North East

The North East of Nigeria has been ravaged by the Boko Haram insurgency leading to loss of lives and property and displacement of whole populations. There are critical health challenges arising from the displacements and the terrorist action especially for

women and children. These challenges need lots of resource to engage. Although there is a Presidential Initiative for the North East and some resources had been set aside for the region under Service Wide Votes in previous budgets, clear interventions are needed from the vote of the FMoH to supplement other provisions.

There is a minimum core obligation on the state to provide for these IDPs, who due to circumstances beyond their control cannot provide the basics of life for themselves. It is an obligation to facilitate the satisfaction of the minimum essential levels of existential rights[42]. The state must be seen to be dedicating the maximum of its available resources to address the humanitarian crisis within the context of satisfying other equally important and pressing needs. Humanitarian assistance is a continuum from relief, rehabilitation, and resettlement to development. It should be rendered in a way that takes cognisance of the inherent dignity and worth of the human person and facilitates a return to normal human life.

It is recommended for provisions to be made for health interventions in camps for internally displaced persons and for persons who are returning to their places of abode from IDP camps.

8.5 Sequestration of Capital Votes at the Headquarters

Out of a capital vote of N51.315 billion in 2017, the head office of the FMoH has a vote of N25.891 billion which is 50.46% of the overall capital vote. This concentration of votes at the head office is uncalled for. It is simply an allocation of funds to where it is not needed, instead of allocation to the units that need them. This is merely a struggle by the head office to be in charge of procurement awards for purposes that are not clearly defined. With only N5.926 billion being 2.34% of the recurrent vote (personnel and overheads) of the Ministry situated in the headquarters, it is unexplainable why the headquarters is proposing to spend over 50% of the capital vote. The FMoH should critically review the capital votes at the headquarters and retain only those necessary for headquarters operations. The remaining should be reallocated to agencies and parastatals that show credible evidence of being the ones in need of procuring the goods and services for which the budget has made provisions.

PART TWO: FOR ACTION IN THE MEDIUM TERM

Part Two is dedicated to action needed to improve budgeting for the right to health after the passage of the 2018 budget vis - in the medium term, before the end of the tenure of the current Executive and National Assembly. Action (in terms of bills, motions and

[42] See General Comment No.3 (Fifth Session) 19990 of the UN CESCR on the nature of state parties obligations under the ICESCR.

oversight activities) is expected from the legislature and a multiplicity of other stakeholders. Other key actions are expected from the FMoH.

9.1 Elevate Primary and Maternal Health Care to a Justiciable Right

It is urgent to guarantee primary health care and Maternal, New Born and Child Healthcare as a fundamental human right in Chapter Four of the Constitution of the Federal Republic of Nigeria, 1999 as amended. The last proposal for amendment by the Seventh National Assembly of section 45 (b) stated that: *every citizen of Nigeria is entitled to free primary and maternal health care services".* This should be considered[43]. The implication of this is that funding for these items will enjoy a first line charge as a statutory transfer. The ongoing constitution amendment process provides a window of opportunity. In doing this, we will be adopting a rights based framework for the realisation of MNCH instead of the current basic needs approach. This will involve a clear definition of PHC and MNCH services as entitlements of persons in need of them; definition of rights holders and duty bearers. This will be in tandem with Nigeria's obligation to fulfill the right to health under the ICESCR and section 1 of the National Health Act.

9.2 New Sources of Funding Health Care

FGN should explore new sources of funding healthcare and by extension PHC and MNCH to include universal, compulsory and contributory health insurance, and new incentive based taxes and levies. The National Health Insurance Act should be amended to make public or private health insurance compulsory. If motor vehicle insurance is compulsory, do we value our health less than vehicles? Health insurance will help to pool large funds that can be used to subsidise services for indigent, poor and vulnerable persons. New sources of funding could come from minimal tariffs on telecommunications services to be borne by the consumer[44], surcharge on all imports into the country[45] and a special sin tax[46]. Incentive based reordering of taxation could make donations to government for health care delivery tax deductible up to a certain limit of taxable income. Again, the foregoing will be in tandem with Nigeria's obligation to fulfill the right to health under the ICESCR and section 1 of the National Health Act.

Also, the acquisition and maintenance of high cost equipment could be done under two types of partnerships; the Public Private Partnership and the Public Public Partnership.

[43] The entire constitutional amendment was stuck in the Presidency-National Assembly rivalry and did not sail through.
[44] Considering that corporate organisations already claim they are overtaxed and we need to be conscious of the need to attract and keep investors in the country. But it should be fixed at a level that will not inconvenience the majority of Nigerians - it should be a progressive tariff that increases with more call hours.
[45] A 2% surcharge may be considered.
[46] Sin Tax can be levied on alcohol, tobacco and gambling, etc.

In the second model, public establishments such as the Central Bank of Nigeria, Nigeria National Petroleum Corporation, the Pension Fund etc. can invest in healthcare establishments. Staff can also invest and share in the profits of such PPP equipment. This will increase staff motivation and as such, the efficiency of healthcare service delivery. The first PPP model involves the private sector in collaboration with the public sector.

9.3 Review the Operations of the National Health Insurance Scheme (NHIS)

The NHIS was set up for the purpose of providing health insurance which shall entitle insured persons and their dependents the benefit of prescribed good quality and cost-effective health services. As a follow up to the House of Representatives Resolution 241/2016 detailing the poor performance of the NHIS and the inhumane treatment of enrollees by Health Maintenance Organisations and Health Care Providers, and the subsequent public hearings, it has become necessary for the executive and legislature to take steps to reposition the Scheme to make it more effective and result oriented.

9.4 Special Window for Health Care Financing

The legislature in collaboration with the executive should consider the establishment of a special window, a low single digit interest fund dedicated to the procurement of medical and health equipment. The need for this is premised on the fact that private health care providers cannot be expected to source funds for procuring capital and recurrent costs at the double digit interest rate without out-rightly commercialising health services. Health care institutions should be able to cover costs and generate some returns but not purely on the commercial level that shoots the cost of services beyond the ordinary. The window can be established by law or through administrative action by such institutions like the Central Bank of Nigeria.

9.5 Consider the Establishment of a Health Bank of Nigeria Incorporated

The idea of a Health Bank is 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.

It 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.

9.6 Prohibition of Female Child Marriage

Female child marriage should be prohibited by law with strong penalties for male offenders. This will take care of and reduce some MNCH challenges including VVF. The prohibition is in recognition of the state's obligation to protect the female child from third party violation(s) of her right to life and health. VVF caused by obstructed labour and birth canals that are not ready and good enough to deliver has wrecked damage on the lives of women. In consideration of great damage to lives caused by VVF, special funding should be made available for prosecution of offenders.

9.7 Definition of Basic Minimum Package of Health Services

Section 3 (1) of the NHA entitles all Nigerians to a basic minimum package of health services. The definition of the meaning of this basic package has been left unarticulated. The Minister and FMoH should articulate the definition of basic minimum package of health services required by the NHA and this should include MNCH. The minimum package should reflect Nigeria's minimum core obligations in health care, constitutional rights to life and human dignity. The definition is important for costing and funding the minimum package. The legislature is invited to use the power of oversight to nudge the Minister of Health to facilitate the definition of this package.

9.8 The Continuum: Budget and Policy Alignment

Previous and current experience in the implementation of national plans reveals a lot of disarticulations. From Vision 20:2020, National Economic Empowerment and Development Strategy, Seven Point Agenda, Transformation Agenda to the current Economic Recovery and Growth Plan; projections were more than appropriations; appropriations more than releases; cash backed sums are less than releases and actual expenditures are less than cash backed sums. Expenditures are therefore far less than projections thereby making the planning exercise an exercise in futility. It is recommended that health budgets should be backed by a clear Medium Term Sector Strategy which is linked to high level national and international standards; fully costed and progressively allocates more resources to health based on increased availability of resources. There should be an inseparable link between policy, planning, budgeting,

performance, monitoring and evaluation continuum. This continuum should be reflected in a health sector specific budget template to be devised by collaboration between the executive and legislature. The legislature should insist on the establishment of the link between policies and appropriation during the consideration of the budget. Clarity of the budget template will dictate that projects are clearly and properly described in the budget and repetition of budget heads and items should be avoided.

9.9 Formation of Sector Teams for Future Budget Planning

The executive is enjoined to collaborate with the stakeholders in civil society, professional associations, organized labour, the academia, etc. to ensure that the preparation of Health Medium Term Sector Strategies is done by a team that represents all stakeholders including the MDA and its parastatals. This will guarantee comprehensiveness of future budgets and the fact the budget votes will target programme results and goals of the sector.

9.10 Reform of Internally Generated Revenue Practices

There is some irrefutable evidence than many health MDAs generate a lot of IGR which is not properly documented and remitted to treasury. This denies government of revenue and facilitates the running down of the facilities when resources are not available to continuously equip and maintain them. The IGR system in public health establishments therefore needs reform through a multiplicity of practices including public private partnerships, robust information technology platforms that deliver real time interaction between payments, the establishments and the supervising authorities. Collaboration between the legislature and executive can deliver the needed change to stop the leakages. But the executive should initiate the dialogue leading to this reform.

9.11 Adopt Best Practices in Public Procurement

Good and fit procurement practices should be adopted by FMoH and NPHCDA; with a standard price database to remove price differentials for the same projects, programmes and activities and to enhance value for money in MNCH operations. Adoption of open procurement and contracting should be encouraged through legislative oversight.

9.12 Certificate of Standards for Health Establishments

The NHA states in sections 13 and 14 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 Act 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.

(3) 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 individual, to imprisonment for a period not exceeding two years or both.

Unfortunately, the FMoH has not set machinery in motion for the issuance of certificate of standards more than 24 months after the coming into force of the Act. In essence, the implication of the foregoing is that all health care establishments in Nigeria are operating in violation of the law. The certification process should include documentation of all health facilities in terms of type and services delivered. It is recommended that NASS should initiate dialogue with the FMoH and nudge the Minister through a resolution to make provisions for the implementation of the NHA on certificate of standards.

9.13 Implementation of the Full Gamut of the National Health Act

There are other provisions of the NHA which have been more obeyed in the breach. These include the failure of the Minister to prepare and present an Annual State of Health of Nigerians and National Health System Report to the President and the National Assembly; classification of health establishments and technologies; duty to disseminate information, etc. The civil society through different advocacy platforms; the National Assembly, through motions and oversight activities, should remind the executive of the need to fully implement these provisions.

9.14: Renewable Energy and Health Establishment Energy Costs

The cost of energy, especially electricity is one of the highest recurrent costs of medical establishments. Considering this high costs, it is imperative for health establishments to begin the transition to renewable energy and energy efficiency. It is admitted that the

initial sunk in cost of renewables is high. But a phased transition over the medium term (defined as three to five years) to renewable energy and energy efficient lighting and other equipment is imperative. In the long term, this will reduce the cost of providing electricity.

10. SUMMARY OF POLICY RECOMMENDATIONS

The Memorandum makes the following policy recommendations:

FUNDING

- Allocate 15% of the total annual national budget to the health sector in compliance with the Abuja Declaration of 2001. Where not possible, start with a minimum of 7.5% (being 50% of the Abuja Declaration) allocation in 2018 and progressively increase by 1.5% until the 15% is attained by 2023.

- The bulk of the new resources should go to capital expenditure to enhance access to equipment and health supporting infrastructure. At least, not less than 40% of the allocation should go to capital expenditure in 2018 and progressively increasing in subsequent years.

- As stipulated in the National Health Act 2014; in particular, allocate not less than 1 percent of the Consolidated Revenue Fund to the Basic Health Care Provision Fund in the 2018 budget and beyond.

- To generate more funding for the Health Sector, amend the National Health Insurance Scheme Act to make health insurance compulsory and universal. Consider new sources for health insurance funding to include a 2% surcharge on all imports, a special sin tax on alcohol and tobacco and minimal tariffs on telecommunications services to be borne by the consumer.

- Consider the establishment of a Health Bank to provide single digit long term loans for the development of health institutions, health infrastructure, research and human resources for health. The initial capital is to be subscribed by the FGN with an invitation to regional and international development institutions to subscribe to the authorized capital. The establishment should be done after thorough studies confirming its viability.

- Whilst taking steps to establish the Health Bank, consider a special window of funding for the Health Sector. This should be established through administrative action by institutions such as the Central Bank of Nigeria which has provided similar long term and bailout funds in the past.

CONSTITUTIONAL, LEGAL AND POLICY GUARANTEE

- Elevate the right to Primary Health Care and Maternal, New Born and Child Health to a Fundamental Right under Chapter Four of the Constitution of the Federal Republic of Nigeria, 1999 (as amended).

- Female child marriage should be prohibited across the Federation of Nigeria and the prohibition should be duly enforced.

- FGN should strengthen and sustain ongoing efforts towards a policy and legal framework for local vaccine production and sustainable immunization financing.

FUNDING SPECIFICS

- Consider bi-annual funding of the procurement of vaccines to avoid delays and bottlenecks associated with public procurement, management, release, cash backing and utilization of public funds.

- Specific provisions in (collaboration with State Governments) should be made for the healthcare of IDPs in the North East Region ravaged by insurgency.

- Specific provisions should be made for the care and rehabilitation of VVF patients. A phased provision of N15billion per annum over 6 years will take of the backlog of patents who need care.

- Consider a moratorium on brand new capital projects not associated or linked with existing ones unless the project is of utmost priority. This will avoid the thin spread of available resources which produces no results. Money should be spent on completing, equipping and making functional the existing projects.

- PHC revitalization should be done with the strong collaboration and commitment of States and LGCs. It should focus on funding and equipping functional PHCs run by States and Local Governments. The collaboration trough an MoU is imperative for the sustainability of the intervention based on previous experience. A clear SMART tool for functionality assessment should be developed by FMoH and the NPHCDA to determine the PHCs that qualify for funding.

- Capital votes should be managed by the agencies and parastatals that need them. There is no need to sequestrate the bulk of capital votes at the headquarters of the Ministry.

- Provide funding and other resources in the medium term for energy sustainability through renewable energy and energy efficient lighting and equipment. This will reduce the cost of energy in health institutions.

REVENUE GENERATION AND OTHER FUNDING

- The reform of the Internal Revenue Generation system of Public Health Institutions is long overdue. The systems need reform through a multiplicity of practices including the deployment of robust information technology that delivers real time interaction between payments, the establishment and the supervising authorities. Also, public private partnerships in IGR management should be considered.

- Consider Public Public Partnership and Public Private Partnerships models of funding the acquisition of capital equipment and facilities. However, necessary caution must be applied in adopting the public-private partnership model of health funding in order not to price public health facilities beyond the reach of the low income earners.

FULL IMPLMENTATION OF THE NATIONAL HEALTH ACT

- The definition of the meaning of the minimum package of health services should be articulated. The Minister of Health and FMoH should articulate the definition of basic minimum package of health services required by the NHA and this should include MNCH and the minimum core obligations of the state in healthcare.

- The FMoH should set machinery in motion for the issuance of certificates of standards to deserving health institutions in accordance with sections 13 and 14 of the NHA.

- The Minister of Health should prepare and present an Annual State of Health of Nigerians and National Health System Report to the President and the National Assembly in 2017 and thereafter prepare and present same every year.

- Other duties stated in the NHA including the classification of health establishments and technologies; duty to disseminate information, etc. should be performed by the FMOH, the Minister of Health and other specified authorities.

TRANSPARENCY AND ACCOUNTABILITY

- The specific annual contributions of Donors and Development Partners should be identified and captured in the budget to ensure transparency, accountability and prevent double budgeting and duplication of efforts.

- Increase the efficiency of health sector spending through greater value for money strategies. Ensure strict and efficient utilisation of the resources allocated to the health sector by implementing open contracting standards as part of an open government strategy.

- The Minister of Finance should prepare and publish a disbursement schedule within 30 days of the enactment of the Appropriation Act as stipulated by Section 26 of FRA and ensure full and timely release of the capital budget of the Federal Ministry of Health every financial year.

- The Budget Office of the Federation should resume the publication of Quarterly Budget Implementation reports on its website and in national dailies. The MDAs should likewise publish details of budget releases and expenditure on quarterly basis. This will help to promote transparency and accountability.

- The FMoH should embrace the civil society as a critical partner in achieving greater value for money in a bid to improve national health outcomes. Future preparation of the MTSS should rely on a full Sector Team including the civil society and other relevant stakeholders. The FMoH should engage CSOs for budget monitoring and tracking expenditure borrowed sums in the sector.

THIS MEMORANDUM WAS ADOPTED BY THE FOLLOWING ORGANISATIONS

1. Centre for Social Justice (CSJ)
2. Health Reform Foundation of Nigeria (HERFON)
3. The ONE Campaign
4. Nigeria Medical Association
5. Evidence for Action (Mamaye)
6. Save the Children
7. Women Advocates for Vaccine Access (WAVA)
8. West African Academy of Public Health (WAPH)
9. White Ribbon Alliance Nigeria (WRAN)
10. Nigeria Health Watch
11. Center for the Right to Health (CRH)
12. Education as a Vaccine (EVA)
13. Rotary International District 9125 Nigeria
14. Sustainable Healthcare International
15. Silver Lining for the Needy Initiative (SLNI)
16. International Federation of Women Lawyers, Nigeria(FIDA)
17. Ummah Support Initiatives (USI)
18. Strengthening Advocacy and Civic Engagement
19. Public Health Foundation of Nigeria (PHFN)

20. Association for the Advancement of Family Planning
21. Civil Society Scaling-Up Nutrition in Nigeria
22. Health Policy Research Group
23. Nigeria Health Economics Association
24. Wellbeing Foundation Africa (WBFA)
25. Glamorous Mothers Development
26. Women Advocates Research and Documentation Centre
27. Pan-African Community Initiative in Education and Health (PACIEH)
28. Positive Action for Treatment Access (PATA)
29. Health, Work, Education & Shelter (HEWS) Foundation
30. Connected Development
31. Citizens Wealth Platform
32. New Nigeria Youth Organisation
33. NIWAAFA
34. CHRCR
35. GIFSEF (African Green Movement)
36. VTF
37. NIWA
38. Community Centre For Development
39. Development Communication Network
40. Peoples Empowerment Forum
41. Disability Rights Advocacy
42. Centre for Peoples Health, Peace and Progress
43. African Network for Environment and Economic Justice
44. Women Advocacy, Research and Documentation Centre
45. CBM
46. Alpha Health Alert and Human Development Organisation
47. Four Aces Consulting Ltd
48. YPD
49. Labour, Health and Human Rights Development
50. Michael Adedotun Oke Foundation
51. Gender Care Initiative
52. Green Transact
53. GSHAAL
54. ECOWATCH
55. Centre for Research , Advocacy, Women and Youth Development
56. SOGON
57. Good Governance Team
58. Save and Serve Human Initiative
59. International Centre for Development and Budget Advocacy
60. CLIMATTERS
61. CCIDESOR
62. Society for Family Health

63. Public and Private Development Centre (PPDC)
64. CRAWYD
65. Nigerian Urban Reproductive Health Initiative (JHPHINI/NURHI)
66. African Youth Initiative on Population, Health and Development (AfrYPoD)
67. Association for Social Reform and Awareness Network Katsina
68. Catholic Secretariat
69. Human Development Initiative
70. Afrihealth Optometrics Association
71. Leads Nigeria Kaduna
72. CSACEFA
73. Islamic Youth League
74. GHON
75. CHEDEM
76. Track Health
77. CHEDI
78. ARC
79. National Hospital
80. NIFT
81. UNDC
82. DCS
83. Vaccines Network for Disease Control
84. Advocacy for Change Initiative
85. International Peace and Civic Responsibility Centre
86. Women and Youth Empowerment for Advancement and Health Initiative
87. Lexville Foundation
88. Federal for Muslim Women Association
89. Center for Citizens with Disability