March 3, 2023

ANNUAL REVIEW WORKSHOP OF THE RIGHT TO HEALTH CLUSTER - IMPROVING THE REALISATION OF THE RIGHT TO HEALTH

OUTCOME STATEMENT

1. INTRODUCTION

The Annual Review Workshop of the Right to Health Cluster was convened by Centre for Social Justice (CSJ) with the support of the Strengthening Civic Advocacy and Local Engagement (SCALE) programme of USAID. Participation was drawn from federal and state level demand and supply side stakeholders vis, representatives of the Federal Ministry of Health, Budget Office of the Federation, National Primary Health Care Development Agency, Commissioners of the Ministries of Health from Adamawa, Bauchi, Ekiti, Imo, Nasarawa, Rivers and Sokoto states. Others were the chief executive officers and representatives of the Health Insurance/Contributory Health Management Agencies of Adamawa, Bauchi, Ekiti, Imo, Nasarawa, Rivers and Sokoto states as well as Pro Health HMO, representing Health Maintenance Organisations and the Private Sector. The Cluster members in attendance were Centre for Peoples Health, Peace and Progress; Women and Youth Empowerment for Advancement and Health Initiative; Centre for Citizens Rights; People Rights Organization; Clarmar Development Foundation; New Initiative for Social Development; and Journalists for Public Health and Development from Sokoto, Adamawa, Nasarawa, Imo, Rivers, Ekiti and Bauchi States respectively *("the focal states*"). The media was represented by key print and electronic media institutions.

The Annual Review was convened to review the outgone year's activities, draw lessons on what worked, what did not work and the underlying reasons for year 1 results as well as plan for the incoming year. It focused on a review of the critical deliverables to be achieved to make the project a success. These deliverables include activation of the compulsory and universal health insurance regime leading to increased uptake of health insurance; new and alternative funding mechanisms for health; improved budgetary outlays for health (more public money for health); enhanced value for money (improved health services delivered from existing resources); and increased awareness of rights and duties of respective stakeholders in the health sector leading to improvements in holding duty bearers to account. This

is expected to result in improvements in health indicators in primary health care, maternal new born and child health, etc.

2. PRESENTATIONS

The following presentations were made:

- Improving the realization of the right to health in Nigeria: Project background, goal, objectives, activities and the Journey so far by CSJ.

- Budgeting for the Right to Health at the federal level - issues, successes, challenges and opportunities by Budget Office of the Federation.

- Implementing health policies, standards and budgets – issues and challenges by the Federal Ministry of Health.

- Basic Health Care Provision Fund, overview and Implementation Status of the NPHCDA Gateway by the National Primary Health Care Development Agency.

- Adamawa State Contributory Health Management Agency Overview.

- Nasarawa State Health Insurance Agency Score Card.

- Bauchi State Health Contributory Management Agency (BASHCMA) - Status of Implementation.

- Imo State Health Insurance Agency: Situation Report.

- Ekiti State Health Insurance Scheme: Covering Vulnerable Populations - Issues, Successes, Challenges and Opportunities.

- Overview of the Sokoto State Contributory Health Care Scheme.

- Rivers State Health Care Financing for Universal Health Coverage.

- Expanding Health Insurance Coverage in Nigeria by Pro Health HMO.

These presentations were followed by plenary discussions and detailed review of activities of the Cluster in Year One.

3. RESULTS EMERGING FROM YEAR ONE ACTIVITIES

Our capacity building, advocacy, research and awareness creation activities has contributed to the following results.

a. The Basic Health Care Provision Fund (BHCPF) has been properly positoned as a statutory transfer, implying that it enjoys priority as first line charge on the Consolidated Revenue Fund of the Federal Government.

b. Increased federal and state level appropriation for the realisation of the right to health between 2022 and 2023 budgets:

Federal	*2022 Health vote as a Percentage of Overall Budget*	*2023 Health vote as a Percentage of Overall Budget*
Federal	4.86	5.27
Bauchi	11.13	15.01
Ekiti	6.30	6.90
Nasarawa	10.73	12.46
Sokoto	9.56	13.53

c. The Constituency Project Year of Health and Improving Health Insurance Coverage letter to federal and state legislators led to a federal legislator in Adamawa

State enrolling 1000 constituents into the Adamawa State Health Insurance programme.

d. Joint advocacy with the Sokoto State Contributory Health Management Scheme Agency Law (SOCHEMA Law) has led to increments in enrolment from 43,943 at the commencement of the project to 54,637 enrolees/beneficiaries of health insurance and the accreditation of additional 141 PHCs for the health insurance scheme.

e. In accordance with S.19 (2) (k) of the SOCHEMA Law, advocacy contributed to the activation of the 1% levy of State and Local Government capital projects in Sokoto State.

f. Contributed to the development of the Work Plan and Operational Guidelines of the Adamawa State Contributory Health Management Scheme.

g. Increased sensitisation and awareness creation through multi-media platforms vis print and electronic media, social media including Facebook, Twitter and WhatsApp. Reached over 100million persons through our engagement.

h. Capacity building for 30 CSOs and representatives of MDAs on the strategies for the realisation of the right to health as well as improvements in budgeting for the highest attainable standard of physical and mental health.

4. CHALLENGES

- Low level of public awareness and understanding of the nature and benefits of health insurance.

- Low level of public awareness that health insurance is compulsory as well as rights and duties of demand and supply side stakeholders in the health scetor.

- Political will to drive health reforms at the highest level is low.

- Opaque public health finance systems.

- Paucity of resources for the Cluster to engage the executive budget of all the seven focal states.

- Limited disposable income of the population and increase in multi-dimensional poverty.

- Rivers State Law provides for a voluntary health insurance scheme as against the federal compulsory health insurance scheme.

5. LESSONS LEARNT

- Projects of this nature (that are not service delivery projects) that are focused on law and policy implementation and attitudinal change are not sprint runs but a marathon that requires time (beyond a year) to achieve proposed goals and results. This requires familiarization and full understanding of the ecosystem, work culture and ethics of both supply and demand side actors.
- High level political leadership commitment is key and underscores any meaningful achievement. Obtain clear commitments to performance data collection and reporting at the onset of the programme with measurable milestones and indicators.

- Alliance building with relevant stakeholders and duty bearers is a pre-condition for the achievement of results. This will require greater collaboration and synergy with other demand and supply side stakeholders.
- It is imperative that the project focuses on nudging public agencies charged with the critical task of driving health reforms to actually take ownership and drive the reforms. They are both the legal and legitimate institutions to drive reforms as civil society's duty is to meddle and push the public agencies on the road to reforms.
- Sustained exposure to peer learning, exchange, and adaptation among key state actors are essential. Encourage peer learning platforms across states as key drivers of innovation and development.

- Partnering with the media in a multi-media approach is imperative for sensitization and awareness creation. Citizens only access services and

opportunities they know about and a rights-conscious public is more likely to seek access. Generating feedbacks from the public is necessary to deepen engagement and course correction.

- The engagement with community and religious leaders who are the custodians of the people's religion and culture easily promotes project acceptance and buyin by the populace. Cultural and religion play prominent roles in the acceptability of new policies by citizens.

6. OPPORTUNITIES

- Federal and state level laws (with the exception of Rivers State) that have made health insurance compulsory and universal.

- Establishment of federal and state level agencies/institutions to regulate the sector, drive enrolment and improvement of services.

- Existing but un-activated mechanisms including statutory provisions for percentages of state and local government consolidated revenue funds for health financing to improve healthcare delivery coverage to vulnerable groups.

- Stakeholders can be organised and mobilised under coordination platforms. Stakeholder organisations can demonstrate ownership by driving their role and activities for enhanced enrolment in health insurance and greater demand for accountability and value for money.

- Available state level health indicators, poverty studies and surveys as evidence to drive health service delivery and reforms; ability and willingness of sections of the population to pay for services including health insurance, etc.

- Association of State Health Insurance Schemes can be used for benchmarking, for learning and adoption of best practices based on best in class performance.

- Change of government after elections may usher in new officials with the political will to implement reforms.

7. STATE LEVEL CHALLENGES, OPPORTUNITIES AND COMMITMENTS ON HEALTH INSURANCE

State	Challenges	Opportunities	Commitments
Adamawa State	*a.* Low awareness of health insurance *b.* High out of pocket expenditure *c.* Quality Issues *d.* Poor referral services *e.* Weak capacity of agency/ healthcare staff	*a.* Development of communication and marketing strategy to boost/create demand for enrolment. *b.* Part commencement of the formal sector scheme is a plus. It is the only state among the focal states to have commenced its public sector scheme	*a.* To increase enrolment through the implementation of a communication and marketing strategy; get Local Government workers on board. *b.* To engage in joint advocacy for increased enrolment with CSJ. *c.* To support advocacy for Health Development Bank
Bauchi State	*a.* Political support not so strong to drive aggressive reforms *b.* Low awareness *c.* Human resource for health constraint *d.* Challenge of deduction and remittance *e.* Poor release of equity funds *f.* Lack of operational vehicles *g.* Public sector health insurance scheme is yet to commence	*a.* Presence of international development partners. *b.* Concluded negotiations with Organised Labour to start the formal sector scheme	*a.* To operationalise the formal sector scheme within two months. *b.* To engage in joint advocacy for increased enrolment with CSJ. *c.* To support advocacy for Health Development Bank

Ekiti State	*a.* Low operational capacity of the Agency to manage a State-wide programme *b.* Low engagement of stakeholders for formal and informal health plan *c.* Low awareness of the Scheme *d.* Public sector health insurance scheme is yet to commence	*a.* State governments financial commitment *b.* Dedicated EKHIS staff who are ready to work is an opportunity for partners to implement programs and support technically *c.* Existence of partners and CSOs in the state is a good avenue for technical and financial support	*a.* To operationalise the formal sector scheme *b.* To engage in joint advocacy for increased enrolment with CSJ. *c.* To support advocacy for Health Development Bank
Imo State	*a.* Frequent change in state leadership has stalled the progress and results in constant change in policy direction	*a.* The newly created Ministry of Health Insurance in the state provides a viable opportunity for the	*a.* To commence and operationalise the formal sector scheme within one month.
	b. Weak political will *c.* Public sector health insurance scheme is yet to commence *d.* Unutilized tranches of BHCPF collected	effectiveness of the scheme in the state. *b.* Concluded negotiations with Organised Labour to start the formal sector scheme	*b.* To engage in joint advocacy for increased enrolment with CSJ. *c.* To support advocacy for Health Development Bank
Nasarawa State	*a.* Low revenue profile of the state resulting in low equity funds *b.* Inadequate human resources *c.* Absence of trust on the part of civil servants for the public sector scheme *d.* Public sector health insurance scheme is yet to commence	*a.* Payment of the new minimum wage to government employee will serve as boost to enrolment.	**a.** To support advocacy for Health Development Bank

Rivers State	*a.* Absence of political will for commencement of scheme *b.* Unutilized trenches of BHCPF collected. *c.* The law in the state is inconsistent with the NHIA. *d.* Leadership and management of the Scheme has not been constituted.	*a.* The current transition period provides opportunity for advocacy for the state's adoption of the compulsory health insurance scheme. *b.* Existence of a health financing technical working group in the State.	
Sokoto State	*a.* Poor perception of the scheme by the populace *b.* Low awareness about the scheme *c.* Non-release of the equity fund for the vulnerable people in the state *d.* Implementation of the formal sector insurance in the state is yet to commence despite signing MOU with Organized Labour Union since September 2021. *e.* Lack of confidence in Government policies (trust issues)	*a.* Presence of International Partners in the State supporting in capacity building of the staff and sensitization of the public. *b.* Existence of Associations with large number of members to enrol into the informal segment of the scheme. *c.* Commencement of 10% of remuneration deduction from legislators. *d.* Resource mobilization opportunities in the law establishing SOCHEMA	*a.* To commence and operationalise the formal sector scheme within one month. *b.* To ensure that 10% of salary deductions from elected and appointed officers of the Sokoto state Government are remitted to the Agency. *c.* To engage in joint advocacy for increased enrolment with CSJ.
			d. To support advocacy for Health Development Bank

8. IDENTIFICATION OF STAKEHOLDERS

The success of the project will depend on the identification and engagement of all relevant stakeholders in a whole of society and whole of government approach to reforms. These stakeholders include public, private and civil society actors.

Public Sector	Civil Society/Professional Groups	Private Sector
a. Ministry of Health at federal and state levels	*a.* Non-governmental organisations	*a.* Health Maintenance Organisations.
b. National Primary Health Care Development Agency	*b.* Organised labour – apex unions and health sector specific unions	*b.* Health Care Providers.
c. State Primary Health Care Development Agencies	*c.* The Media	*c.* Pharmaceutical companies
d. National Health Insurance Authority	*d.* Nigeria Medical Association; Association of Nurses and Midwifes; Pharmacists and other relevant professional groups.	
e. State level Health Insurance Agencies	*e.* Traditional institutions	
f. Federal and State level Ministries of Finance/Budget Office	*f.* Religious institutions	
g. Relevant Committees of the National Assembly	*g.* Women's groups	
h. Relevant Committees of State Houses of Assembly in	*h.* Youth groups	

the Focal States *i.* Nigeria Governor's Forum *j.* Focal State Governors	*i.* Traders Associations *j.* Associations of Artisans *k.* People living with Disabilities and other Vulnerable Groups	

9. OBSERVATIONS

The Workshop Made the Following Observations

a. The challenge of inadequate budgetary/fiscal resources constrains the implementation of the right to the highest attainable standard of physical and mental health at the federal and state levels. Federal and state governments hardly meet the 15% appropriation to health benchmark of the Abuja Declaration.

b. In many states of the federation, the sums budgeted for the right to health are not always fully released. There is always a difference between appropriated and released votes.

c. Increased transparency and accountability in the management of public health funds will increase stakeholders' confidence and trust in public health service delivery.

d. At the federal level, emerging evidence shows that the Federal Ministry of Health is not fully utilising the sums of money appropriated and released for the implementation of its activities and programmes.

e. S.11 of the National Health Act (NHA) which establishes the Basic Health Care Provision Fund demands a contribution of not less than 1% of the consolidated revenue fund of the Federal Government. Despite states being the primary beneficiaries of the Fund, they have no obligation to contribute to the Fund. The requirement of counterpart funding provided in the same section has not been activated. There is no charge on the Federation Account to support the realisation of the right to health.

f. State Health Insurance and Contributory Health Management Laws in the focal states provide for the contribution of between 1% to 2% of the consolidated revenue fund of the State to the Equity Funds of health insurance/contributory health management agencies for the benefit of indigent and vulnerable persons in the respective states. However, these laws have been obeyed in the breach.

g. Innovative, sustainable and revolving health financing arrangements founded in law and policy have not been put in place for improved health financing at the federal level and in the focal states.

h. There has been no budgetary provision for the Special Intervention Fund required for the activation of the Vulnerable Group Fund established in S.25 of the National Health Insurance Authority Act (NHIAA).

i. With the exception of Adamawa State, no other focal state has activated the public sector health insurance/contributory scheme involving contributions by the state government being the employer and deductions from employees' salary after agreement signed with the respective mother labour unions. However, primary school

teachers and local government employees in Adamawa State are not yet enrolled in the scheme as is the case in other focal states.

j. Increased political will for the attainment of UHC at the state level will improve funding, value for money and health indicators.

k. Public awareness on the benefits and compulsory nature of health insurance under Nigerian law is very low.

10. RESOLUTIONS

Based On The Foregoing Observations, The Workshop Resolved As Follows:

a. The Federal and State Governments should take steps to dedicate not less than 15% of the budget to the health sector in accordance with the Abuja Declaration.

b. Federal and State Governments should ensure that their yearly income and expenditure proposals are realistic and evidence based. To a reasonable extent, this will guarantee the full release of sums budgeted for the right to health. Furthermore, they should consider ringfencing funds dedicated to the health sector.

c. Federal and State Governments should enhance transparency and accountability in the management of public health funds. This will include the full publication, (deploying a multi-media framework) of the funds released to states by the BHCPF under the various windows, the health institutions at the state level where services funded by the BHCPF are available, etc. Furthermore, in accordance with S.2 (2) (d) of the NHA, the federal and states ministries of health should prepare and present the annual state of health reports.

d. The Federal Ministry of Health should consider early and proactive procurement steps to select vendors, contractors, consultants, etc., early enough to ensure full utilisation of appropriated and released funds for the implementation of its activities and programmes.

e. The Federal Government should initiate dialogue and consensus building with state governors for the amendment of relevant laws including S.11 of the NHA which establishes the BHCPF so that the BHCPF will be funded by a contribution of not less than 1% of the Federation Account. This will increase the pool of resources available to the Fund.

f. State Governments are enjoined to implement the provisions of Health Insurance and Contributory Health Management Laws providing for the contribution of between 1% - 2% of the consolidated revenue fund of the State/Local Governments to the Equity Funds of health insurance/contributory health management agencies for the benefit of indigent and vulnerable persons in the respective states.

g. FGN should establish a Health Development Bank of Nigeria specifically focused on funding interventions in the health sector. It should be the equivalent of the Bank of Industry charging single digit interest on its loans over a relatively long amortization period. It should support world class health facilities and infrastructure, health technology, development of highly skilled human resources, etc.

h. FGN should make provisions for the Special Intervention Fund required for the activation of the Vulnerable Group Fund established in S.25 of the National Health Insurance Authority Act (NHIAA). This can come by way of a supplementary budget when a new administration takes office in June 2023.

i. State Health Insurance Agencies/Health Contributory Management Agencies should take urgent and targeted steps towards kickstarting the public sector health insurance/contributory schemes involving contributions by the state government being the employer and deductions from employees' salary. This should cover all civil servants, teachers and all employees of state and local governments in the state.

j. Stakeholders including Health Insurance Agencies/Health Contributory Management Agencies, HMOs, Organised Labour, Civil Society, etc should collaborate in advocacy campaigns to the Nigerian Governors Forum and at the state level towards convincing state governors to prioritise health expenditure, improving value for money and health indicators.

k. Stakeholders listed in paragraph j above should collaborate in awareness campaigns, sensitisation and education on the benefits and compulsory nature of health insurance under Nigerian law.

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