Quarterly Newsletter of the
Health Reform Foundation of Nigeria

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In this Issue

*In keeping with its advocacy mandate, the **Health Reform Foundation of Nigeria** in partnership with the **International Vaccine Access Centre (IVAC) of the Johns Hopkins University, USA** held an interactive session with the members of the Senate Committee on Health with a view to influencing parliamentarians on improved funding of immunization in Nigeria. The Senate Committee warmly received HERFON and promised as reported in this issue to become champions of immunization.*

*Furthermore, HERFON in conjunction with the **Centre for Social Justice** jointly commissioned two reports on the 2012 federal health budget and the right to health. The principal goal of the former was to ascertain whether there is convergence between budgetary allocations in the proposed 2012 federal health budget which was then under consideration by the Committee on Health in the National Assembly and what the government signed up to in its National Strategic Health Development Plan. The aim of the latter is to articulate our position on the right to health.*

This issue contains reports on these three Initiatives, - interactive session with the Senate Committee on Health, analysis of 2012 federal health budget, and the right to health.

The report on health budget was presented to the Federal Minister of Health, members of the Health Committee in the Federal Legislative and it was also circulated among key partners with a view to influencing the right decision on budgetary allocations most especially to MDGs 4 and 5 which are currently the primary focus of the Foundation. The right to health document is to be tabled before the newly constituted Constitution Review Drafting Committee of the Federal Government

Finally, this issue also contains a short piece on an important health sector reform initiative, namely, research ethics. Even though tons of health studies are conducted in Nigeria today, it is doubtful whether those that lead these studies recognize the need for ethical clearance. Yet, the country has put in place the structure and process for ethical review and clearance. Not only are proposals to be cleared by the ethics committee of their institution (viz., which in many instances do not exist or are not functioning as they ought to), proposals are expected to be processed through the National body set up by the Federal Government in the Federal Ministry of Health, Abuja to ensure that sacred ethical principles in research are not breached.

We invited the National Committee on Research Ethics led by Professor C.A. Adebamowo of the University of Ibadan and Aminu Yakubu the Desk officer at the Federal Ministry of Health to contribute a short piece on the structure and process for ethical review of research protocols in Nigeria to underscore this vital aspect of health sector reform.

HERFON Holds Interactive Session on Immunization with the Senate Committee on Health, May 2012

HERFON with the support of the International Vaccine Access Centre (IVAC) of the Johns Hopkins University, USA, organized an interactive session with the members of the Senate Committee on Health. The session was aimed at strengthening the role and oversight function of the Committee on improved funding of immunization in Nigeria. Nigerian Parliamentarians are in a unique position to effectively advocate cost-effective health interventions like immunization on behalf of the most vulnerable citizens in their constituency. This model of Parliamentarian advocates is similar to what has successfully been undertaken by the British Parliament.

In attendance were the following:

Senate Delegation:

- Senator Gyang Dalop Dantong (Chairman of Senate Committee on Health)
- Senator Chris N.Ngige
- Senor Sefiu Kaka
- Senator Danladi Sankara
- Senator Babajide C. Omoworare
- Senator Sahabi A. Yau
- Senator Paulinus Igwe
- Secretariat Staff

HERFON Delegation:

- Dr. Ben Anyene, Chairman, Board of Trustees
- Professor Lai Erinosho, Executive Secretary, HERFON
- Dr. Nkem Ene, Programme Manager
- Ms Theresa Kaka Effa, Senior Advocacy Officer
- Mr. Adewale Adeleye, Capacity Building Officer
- Mr. Ifeanyi Iloba, Logistics Officer
- Ms Kelechi Jumbo, Logistics Offices
- Dr. Emmanuel Sokpo, HERFON NAC Member

Others:

- Members of electronic and print media

There was a presentation which provided an overview of immunization programmes in Nigeria, followed by questions and answers on access to vaccines and financing of immunization in the country.

Proceedings of the Session

Declaring the interactive session open, the Senate Committee Chairman, Distinguished Senator (Dr.) Dantong congratulated HERFON for its strategic efforts to engage various stakeholders in health to ensure better health for all Nigerians especially in relation to the health of women and children.

The Executive Secretary, Professor Erinosho gave a short briefing on the HERFON and IVAC PAFIN project and what it seeks to achieve. Despite Nigeria's abundant resources, her health performance is very poor when compared to other African Countries like Ghana and South Africa. He called on the Senators to use their position to contribute to the improvement of the life of every Nigerian by accepting to be champions of immunization. The Senate Committee Members on Health should strengthen their oversight function to ensure that immunization coverage in Nigeria is expanded.

The opening remarks of the Executive Secretary was followed by an overview of the situation in Nigeria by Dr. Nkem Ene, the Programme Manager of HERFON who informed the Senators that it is tragic that Nigeria lags behind many countries. As example, a WHO report indicated that India had its first polio-free year in 2011 while Gabon and Congo have also been polio free in the last twelve months. Unfortunately, Nigeria is in the company of Pakistan and Afghanistan that are still facing the

problem of polio. The reasons for this are as follows:

- Inadequate Government commitment and under-funding of programmes (especially at State and LGA Levels).
- Delay in the release of the funds allocated to the procurement of vaccines, resulting in stock outs.
- Inadequate access and funding of routine services as vaccines and funds are diverted to support more of polio eradication campaign
- Poor supply chain and logistics management
- Socio- cultural and religious Issues

Dr. Ene argued further that Parliamentarians are better positioned to lead, and ensure vaccine access at all levels because they represent individuals, families, and community members in their wards and constituency. Key in their mandate is to promote the right to well-being through legislative oversight. They can also do so by ensuring that human and financial resources that are appropriated for immunisation are judiciously utilized. She enjoined them to accept the offer to be the champions of *better health for all Nigerians*.

Senator (Dr.) Dantong, the Chairman of the Committee thanked HERFON for doing a great work and said that the eradication of polio will have a multiplier effect on our economy, hence this HERFON's initiative is so important.

Dr. Ben Anyene, the Chairman of Board Trustees of HERFON underscored the issues raised by the National Programme Manager in her presentation on the low coverage of immunization. He attributed low coverage to policy issue, health system issue, and service issue. Nigeria has over the years been experiencing policy inconsistencies and lack of adequate logistics plan. Besides, the country has not been able to integrate MNCH services into PHCs. He further explained that about 80% of the population lives in the rural communities and can access the integrated services in Primary Health Care Centres in their locality but efforts are seriously not made to make these services available and affordable to the vulnerable group. He concluded by thanking the Committee for accepting to meet the HERFON delegation.

Senator Dantong wanted to know why Ghana is better off than Nigeria on immunization coverage to which the Executive Secretary responded by drawing their attention to factors like the strong political support and commitment of the authorities; consistency in public policies; ample funding; and community participation.

The Senate Chairman also sought clarification on why HERFON would like to propose that the budget allocation to immunization should be in recurrent rather than in the capital as is currently the case.

Responding, Dr. Emmanuel Sokpo informed them that drugs are not good to be under capital because the budgetary provisions under capital are often not released. He added that the substantial costs of vaccines are covered by international partners/donors while Nigeria hardly provides the expected contribution.

Another member of the Senate Committee called on HERFON to provide data which disaggregates the financial contributions of international partners/donors vis-à-vis the Nigerian Government to the procurement of vaccines and implementation of immunization programmes in the country. Such data will strengthen the work of the Committee and guide its members in their decision on budget allocation to programmes.

Senator Yau thanked HERFON for its advocacy efforts. He called on traditional and religious leaders to mobilize their communities to participate in immunization services, adding that community participation will create demand for quality health services in PHCs.

Senator Kaka noted that he is aware of the importance of immunization from his experience as a poultry farmer. His birds are likely to die if they are not vaccinated. Consequently, it is important to vaccinate people who are much more deserving than birds. He noted that he did not need to be persuaded to become a champion of immunization.

Finally, the Chairman of the Senate Committee congratulated HERFON and IVAC JHU for this initiative. He added that the Senators are the right people to be inducted champions of immunization since it is their responsibilities to appropriate funds

for improved health services. He therefore assured HERFON that they will do their best to make Nigeria a polio free nation.

Dr. Anyene presented plaques and HERFON chest tags to members of the Committee on behalf of the foundation.

In the closing remarks, Senator (Dr) Chris Ngige thanked HERFON for this laudable initiative and indicated that the Senate Committee can assist HERFON to get public-spirited Nigerians and the private sector on board on this laudable Initiative.

Next Step

- Continuous engagement with Senate Committee on Health
- Follow up with the Committee on Health to ensure that immunization funds are moved from capital to recurrent budget
- Replication of the interactive session with the House of Representatives Committee on Health
- Organization of study tours for parliamentarians for effective delivery of their mandate as the champions for immunization.
- Commission a report/paper on the financing of immunization programmes in Nigeria

Chairman Senate Committee on Health. Senator (Dr) Dangton (2nd left) with other members of his committee at the interactive session for improved financing of immunization in Nigeria

The Chairman Board of Trustee of HERFON, Dr Ben Anyene (right) presenting plaque to the Chairman Senate Committee on health as a Champion for immunization in Nigeria

The Chairman Board of Trustee of HERFON, Dr Ben Anyene (left) decorating Senator Dr. Chris Ngige as a Champion for immunization in Nigeria.

(L-R)The Chairman Board of Trustee of HERFON, Dr Ben Anyene, Programme Manager, Dr Nkem Ene, the Executive Secretary, Prof Lai Erinosho, the Senior Advocacy Officer, Ms Theresa Effa and Capacity building Officer, Mr Adewale Adeleye at the interactive session with the senate committee on health.

(L - R) Senator (Dr.) Dantong, Senator (Dr) Chris Ngige, Dr Ben Anyene decorating a member of Senate Committee on Health as Champion for Immunization at the interactive session

The Chairman Board of Trustees of HERFON, Dr Ben Anyene decorating a member of Senate Committee on Health as Champion for Immunization in Nigeria.

Members of Senate Committee on Health listening keenly as the Programme Manager of HERFON,
Dr Nkem Ene makes presentation at the interactive section.

(R-L) Ms Theresa Kaka Effa, Dr. Emmanuel Sokpo, Prof. Erinosho and Dr Nkem Ene at the interactive session with the Senate Committee on Health.

Analysis of the 2012 Federal Health Budget

Background

In accordance with section 18 of the Fiscal Responsibility Act, the Estimates (including the Health Estimate) should be derived from the Medium Term Expenditure Framework (MTEF) which in turn is informed by the Medium Term Sector Strategies (MTSS). The MTSS focuses on the achievement of the objectives of high level policy documents in the health sector.

The National Strategic Health Development Plan 2010-2015 (NSHDP) was developed by all stakeholders (government, development partners, civil society, and others) under the leadership of government as the overarching country health development plan. It took cognizance of all the high level policy documents in the health sector. Its development was approved by the National Council on Health (NCH) and Federal Executive Council (FEC) and involved enormous resources from both government and partners. As summarised by the Health Minister in the preface:

> The Plan is the overarching reference health development document for all actors towards delivery on a shared results framework, to which each and everyone will be held accountable for achieving the goals and targets as contained in the results framework. The Health Plan, which was also developed in tandem with the guidelines of the National Planning Commission – Vision 20:2020 process (including the NV20:2020 Implementation Plan), is the compass or reference for the health sector Medium Term Sector Strategy (MTSS) and annual operational plans and budgets at all levels[1].

The plan is further given strength by the presidential declaration on health, signed by the president, vice president and all the governors, which set the stage for its development[2] and the country compact (memorandum between development partners and government) signed by development partners to align their work with it. The federal component of the plan named the Federal Strategic Health Development Plan (FSHDP) has amongst its objectives, "*to form the basis for resource allocations to be deployed by the FMOH*".

Nigeria's statistics in the attainment of these two MDGs is frightening, - MDGs 4 and 5 seek to reduce child mortality and improve maternal health; Infant Mortality Rate of 75 per 1000 live births; Child Mortality Rate of 88 per 1000 live births; Under 5 Mortality Rate of 157 per 1000 live births and Maternal Mortality rate of 545 per 100,000 live births. Nigeria contributes 2.3% of the world's population but an alarming 10% of the global burden of Under 5 and Maternal Mortality. Improvement in MDGs 4 and 5 are tied to the protection of the fundamental right to life which is a core obligation of the state. Provision of adequate budgetary resources is a major step towards protecting the right to health.

The NSHDP and all its component plans including the FSHDP are expected to address

[1] National Strategic Health Development Plan (NSHDP) 2010 – 2015 pp 5

[2] National Strategic Health Development Plan (NSHDP) 2010 – 2015 pp1

the major challenge of the disconnection between stated policy goals and governmental spending.

With the existence and acceptance of this overarching health plan and the short time left before the deadline for MDGs, HERFON commissioned an analysis of the 2012 Federal Health Budget to see how well it is aligned towards meeting national health objectives.

The specific objectives of this analysis are to:

a. review alignment of the 2012 health budget with the Federal Strategic Health Development Plan 2010-2015 towards achieving the health related MDGs (MDG 4&5); and,
b. identify areas that can be improved to make better use of available resources.

Scope of analysis

Analysis was limited to overall budget, FMOH headquarters, and 12 agencies and teaching hospitals (attached as annex) with the highest budget estimates due to the size of the budget and the need to complete the exercise in time to contribute to ongoing budget review.

Findings

Alignment with FSHDP

Although the MTEF 2012-2015 provides estimates for health, unfortunately, there is no undergirding MTSS 2012-2014. The last MTSS exercise was for the years 2011-2013. There should have been a 2012-2014 MTSS based on the FSHDP and the budget derived from that. Even though every item in the budget can find a place in the FSHDP, a lot of important items in the FSHDP were not captured in the budget. Important priority areas in the FSHDP such as research basically got no push as their budget estimates were mostly personnel costs, and there was no clear budget for supporting public-private partnerships.

Figure 1: NIPRD 2012 Budget

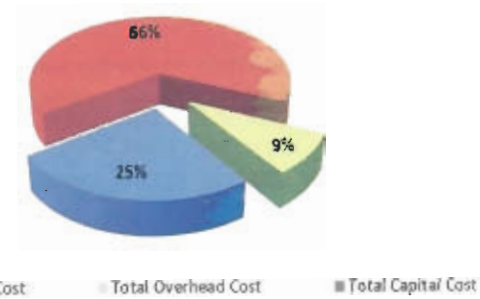
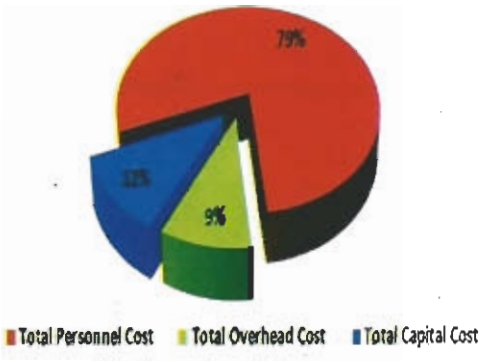


Figure 2: NIMR 2012 Budget

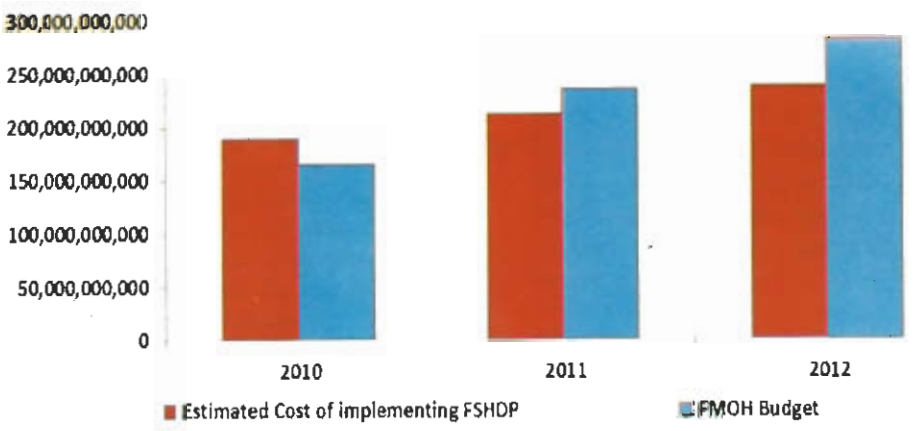


Comparing the health budget with cost of implementing the FSHDP towards achieving the MDGs

The 2012 federal health budget is 6% of the national budget, much lower than the 15% minimum allocation to health pledged by African Leaders in Abuja in 2001. It is important to note that all 6 African countries (Liberia, Malawi and Burkina Faso, Djibouti, Botswana and Rwanda) that had met or exceeded this target by 2010 are poorer than Nigeria.

However, when the total federal health budget is compared with the estimated cost of implementing the FSHDP, the budget looks adequate to deliver on the FSHDP targets and move us towards achieving the MDGs. The real issue is therefore not the total budget figure, but the gap between the capital and recurrent components of the budgets, wastes in the budget and non-implementation.

Figure 3: FSHDP budget vs FMOH budget



The First National Implementation Plan of Vision 20:20 require the FGN to invest a minimum of N148.4billion in capital expenditure on health in 2012, while the

capital component of 2012 health budget is a paltry 57.01billion, creating a deficit of N91 billion. Adding the Capital Vote proposed by the First National Implementation Plan to the 2012 Recurrent Estimates of 225.7billion would have produced a 2012 Health Estimate of about N374billion.

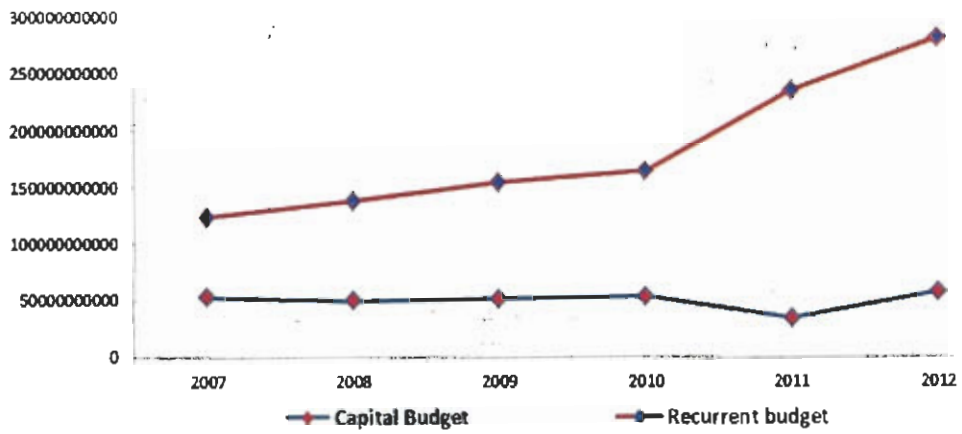
Unfortunately the health bill which would have made more resources available for health has not been signed by the President, despite being passed by the senate since last year.

Capital vs Recurrent Expenditures

Although there has been a significant increase in the total and recurrent allocation to the health sector since 2008, allocation to capital expenditure has on the average, remained static with a very steep decline in the 2011 budget (Figure 3).

It is also important to point out that the trend in the total health budget may be directly derived from that of the aggregate annual government spending which has also displayed an upward trend over same period. Additionally, the continued rise in the recurrent spending within the same period can also be associated with the increasing demand by health workers for increased pay. The static capital spending is grossly unacceptable considering the rate of growth of the nation's population and the ever growing pressure on the already over stretched health care facilities in the country.

Figure 4: Current vs Recurrent Budget 2007 - 2012



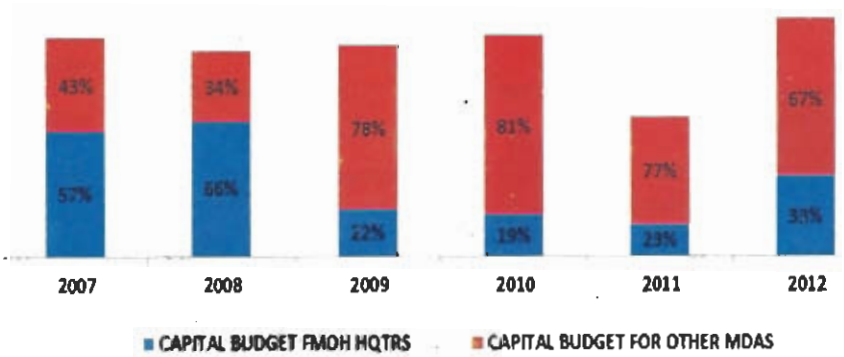
Given that growth in any sector is achieved and sustained with capital investment, it is doubtful that budget allocations within the past five years have addressed itself to growth and development in the sector. Statistics reveals that despite improvements in growth rate, the contribution of the health sector to the country's growth has remained very low. The country still suffers huge capital flight to other countries through medical tourism, as a result of the low quality services offered in the sector. Yet, the government spends the bulk of its budget maintaining the huge and often unbalanced personnel structure in the health sector. The picture becomes more disheartening when one realises that a substantial portion of the so called capital spending is purely for administrative purposes as against front line service delivery operations.

Improving budgeting and reducing wastage

FMOH HQTRS and the budget structure: understanding the political economy of the waste in the system: The FMOH is expected to drive health policy formulation, monitoring and evaluation of intervention measures in hospitals and agencies/extra ministerial departments. In doing this, the federal government often also retains considerable powers of oversight and regulation which are largely uneontested by the MDAs. More importantly, this power is greatly reflected in the headquarters' control of finance for the agencies within its purview. Such an arrangement creates a tension about where the balance of responsibility for the health system should lie. An important instance of this tension is found in the dichotomy between the responsibility of financing and that of implementation between the headquarters and the respective departments and agencies of the federal ministry of health.

Another reason for this tension is that the budget process within the federal ministry of health is substantially centralized. This allows a lot of room for manoeuvring within the headquarters. The incentive to concentrate funds at the centre has over the years been revealed in the headquarters' choice of controlling huge capital budget. Since its recurrent spending is minimal, the headquarters continues to allocate a large share of the capital budget to the centre. A lot of the waste and unnecessary expenditures noticed within the headquarters are located in the capital budget items as can be seen in Figure 5 below. It is clear that there is a strong link between the size of capital allocation to the headquarters and the size of waste in the ministry. Again, since some of the capital projects contained in the headquarters' budget are actually executed within the other MDAs that the headquarters should monitor or oversee, the position of the headquarters as a monitor might become compromised.

Figure 5: Comparison of Capital Budgets between FMOH HQTRs and all the other 84 MDAs put together



Reducing waste: Some examples from the FMOH HQTRs budget

a. The two different "Travel & Transport- General" and "Training-General" represent duplication of the

b. same activity. Again, the idea of "others" does not give any details. These items should be made to conform to the present administration's "cost cutting measures".

Budget Code	TRAVEL& TRANSPORT - GENERAL	Budget (NGN)
22020101	local travel & transport: training	76 536 091
22020102	local travel & transport: others	164 858 023
22020103	international travel & transport: training	62 150 809
22020104	international travel & transport: others	93 724 753

220205	TRAINING - GENERAL	Budget (NGN)
22020501	local training	18 110 307
22020502	international training	9 605 708

c. More details should be given about the line item below. The allocation to this item should also be reviewed in line with the current priorities of the ministry. Again, the item which is supposed to be a capital project simply does not look like one.

LINE ITEM	2011	2012
National health coordination, advocacy and public health enlightenment campaigns in liasing with state health ministries, partners and other NGOs.	245,690,870	138,157,567

e. Branding of ARV drugs and test kits will increase costs of HIV/AIDS commodities and services and reverse the achievements from use of generics. HIV/AIDS commodities are free in all HIV/AIDS service sites so the issue of selling the drugs in the open market does not arise. This idea should be discarded!

f.

MDG procurement and distribution of HIV/AIDS MDG branded ARV drugs and kits to designated treatment centres.	3 500 000 000

g. The allocation to the items below can be reviewed downwards based on proper estimation or use of previous consumption data, to reflect government's desire to cut down the cost of governance.

220203	MATERIALS & SUPPLIES - GENERAL	172 370 007
22020301	office stationeries / computer consumables	53,215,759

220203	MATERIALS & SUPPLIES - GENERAL	172 370 007
22020301	office stationeries / computer consumables	53,215,759
22020304	magazines & periodicals	83,311,531
22020307	drugs & medical supplies	35,842,717

h. Such a huge budget for activities that can be covered under several areas already budgeted for. No details/explanation for expenditure this huge!

MDG projects and programme coordination, tracking and assessments and special intervention on blindness prevention on oral health	1, 230, 000, 000

Examples of capital budget carried over from previous years

There are several capital items that are repeated over the last 3 years. Some items as "health management systems strengthening and advocacy" carry huge budgets without any breakdown to show what they mean and aim to achieve. There are also duplications and lumping together of activities that make it difficult to track whatever the money is meant for. The capital budget estimates need a thorough review and clean up. At a glance, a lot of savings can be made from removing duplications, throwing out activities with no clear alignment to national and international goals and investigating what happened to previous allocations for item that were budgeted for in previous years.

LINE ITEM	2009	2010	2011	2012
Health management systems strengthening			200,000,000	
MDG health management systems strengthening initiatives and support to non-communicable diseases in Nigeria				2,100, 000,000
Final payment for the on-shore component for10nos. CT scan machines (procuredin2010) appropriation by direct procurement, pre-installation assessment and completion of pre-installation works at some FMCs and installation of the10nos. CT Scan machines at Federal Medical Centres (FMCs) Yola, Gusau, Abakaliki, Owerri, Lokoja and Asaba; University of Nigeria Teaching Hospital, at University of Benin Teaching Hospital, National Orthopaedic Hospital Dala and Igbobi; payment for the completion of nurse tutors programme structure, Enugu.			200,789,565	182,771,314

Procurement and installation of CT Scans (procurement and installation of 10 other CT scans in batch b - FMCs - Birnin Kudu, Addo -Ekiti, , Keffi, Makurdi, Birnin Kebbi, Ebute Metta and Bida; Obafemi Awolowo University Teaching Hospital, University of Calabar Teaching Hospital, National Orthopaedic Hospital, Enugu. pre installation assessment and completion of pre installation works.		774,776,941	280,789,565	131,100, 851
Completion of pre-installation works for the establishment of 6 zonal dialysis centres and payment of off shore components for eighty (80) sets of dialysis machines with reverse osmosis equipment, including installation and training; including advocacy for oral health programmes in schools and human capacity development of staff.			200,690,870	130,604, 001
MDGs/DRG scale-up on HIV/AIDS: establish additional 200 comprehensive sites to expand access to treatment, care and support strengthen laboratory services, logistics support, training of different cadres of health workers, procurement of drugs, test kits and monitoring and evaluation of HIV/AIDS intervention across the country	150,000,000	3,000,000,000		
HIV/AIDS Control: expansion of access to treatment, care and support to PeopleLiving with AIDS (PLWHAs) through additional testing, counselling and treatment sites (100 sites nationwide); HIV test kits, etc.			102,361,248	139,310 935
MDG HIV/AIDS: Procurement and distribution of MDG branded HIV/AIDS drugs and test kits to designated treatment centres			2,620,000,000	3,500 000,000
TB: establish additional 580 AFB diagnostic centres; establish 2,322 additional DOTS treatment sites to improve treatment success rates and prevent the development of MDR strains	150,000,000			
Tuberculosis and leprosy control: establishment of 510 new dots centres and procurement of equipments and laboratory reagents and other consumables.			80,197,391	87,448,210
National tuberculosis/leprosy control: conduct national survey on TB prevalence in Nigeria; procure and distribute second-line MDR-TB control and treatment drugs for 560 patients nationwide			140,394,783	350,000,000
Construction of anti snake venom laboratory &		150,000,00		

clinic at Kaltungo (Echitab study)		0		
ECHITAB: Procurement of vials of anti-snake venom from ESG/UK; construction/equipping of anti-snake venom laboratory and clinic at Kaltungo, Gombe State and Zamko, Jos, Plateau State with laboratory materials			106,355,304	160 609 492

Conclusion

a. The current federal health budget, like the ones before it, falls short of the quantity of resources and allocation structure needed to implement the FSHDP and achieve the MDGs
b. The budget cannot be said to strictly align with the FSHDP as the 2012-2014 MTSS was not developed and some important capital expenditures from the FSHDP were not captured
c. Total health budget growth from previous years only reflects growth in recurrent costs and not the in capital needed to reform the sector. Personnel costs constitute 77% of the 2012 federal health budget.
d. The budgeting process for health is mostly centralised at the FMOH headquarters with the headquarters taking responsibility for capital projects that will be executed by front line MDAs. The involvement of the FMOH headquarters in procurements for the MDAs they supervise creates conflicts in responsibility which can compromise oversight
e. There are several areas of waste in the budget that can be cleaned and more resources made available for capital expenditures that can improve services to the people. Some overhead and capital costs are duplicated; others of low priority have huge budgets and several capital projects are carried over each year with increasing costs.

Recommendations to the FMOH and National Assembly on the 2012 Health Budget

a. Do a thorough line activity analysis of the entire budget and identify wasteful or low priority activities from where money can be moved to higher priority areas, especially those that contribute to achieving the MDGs e.g. public private partnerships, research, and insurance fund for the poor and vulnerable.
b. Review all capital expenditures carried over from previous years to determine what was allocated in those years, level of implementation and what is left to be budgeted for.
c. Allocation and disbursements to capital projects should be such that they are completed within agreed timelines.
d. Consider decentralising procurement of basic commodities such as drugs and health commodities and infrastructural projects to MDAs responsible for their use.

e. All MDAs should provide details of their overhead costs. Terms like "others" should be rejected in the budget.
f. Introduce budget implementation tracking activities into the budget.
g. The National Assembly should persuade the president to sign the health bill or in the alternative override him on it, to make more resources available for health.

Recommendations for future Health Budgets for FMOH

a. Initiate budget planning for 2013 early. Review implementation of the FSHDP, progress towards MDGs and use the gaps to develop the MTSS and next budget
b. The FMOH should conduct a human resource needs audit, develop a staff performance management system that ties staff to clear duties aligned with the ministry's objectives. The system should introduce incentive structures for performance and eliminate redundancy.
c. Train budget officers for MDAs on budget classification, costing and budgeting and institute process for holding them accountable for inflated or wasteful budgets.
d. Decentralise procurement of goods and services meant for non-headquarter MDAs to those MDAs. FMOH headquarters can negotiate for all MDAs on common items to get economies of scale but actual payments should come from those MDAs with the headquarters providing oversight.
e. Institute annual health budget expenditure analysis involving development partners, the private sector, and civil society.

MDAs Reviewed

S/N	MDAs	S/N	MDAs
1	FMOH Headquarters	8	University College Hospital Ibadan
2	National Health Insurance Scheme	9	Ahmadu Bello University Teaching Hospital
3	National Primary Health Care Development Agency	10	University of Nigeria Teaching Hospital Enugu
4	National Agency for Food and Drug Administration and control	11	University of Benin Teaching Hospital
5	National Post Graduate Medical College Of Nigeria	12	University of Ilorin Teaching Hospital
6	National Institute of Pharmaceutical Research and Development,	13	University of Maiduguri Teaching Hospital
7	Nigeria Institute of Medical Research, Yaba		

The Basis for the Inclusion of the Right to health as a Justiciable Right in the Constitution

Introduction

The right to health ("RtH") is a human right and belongs to the category of economic and social rights ("ESR"). The historical marginalisation of ESR has led in many quarters to doubts about their status as rights properly so called. The 1999 Constitution did not provide for claims and entitlements of citizens on the right to health in Chapter 4 containing the Bill of Rights. The provisions of Chapter 2 of the Constitution where a few sections mentioned health cannot be the basis to claim of rights. The realisation of the RtH may be pursued through numerous complementary approaches such as the: formulation of health policies, implementation of health programmes; or adoption of specific legal instruments[3]. However, providing for the right to health in a constitutional Bill of Rights sends a strong message of the commitment of the country to protect, promote, and facilitate the health of its citizens.

The Basis for the Inclusion of the Right to health as a Justiciable Right in the Constitution

Nigeria has been witnessing agitation of various component units of the Federation alleging marginalization and underdevelopment. What is at stake? – vital livelihood resources including health, access to communal and social infrastructure. There is the Boko Haram saga, the relatively abated Niger Delta crisis, the Eastern part of the country states that it is marginalized and the North is underdeveloped. Yet, Nigeria has been blessed with hundreds of billions of dollars realised from the sale of petroleum in the last 48 years. These problems would have abated if education, housing, health, and social security etc have been constitutionally guaranteed,.

Setting Constitutional Responsibilities and Giving Citizens a Voice in the Determination of Expenditure Priorities

Nigeria's health indicators particularly in MDGs 4 and 5 which seek to reduce child mortality and improve maternal health are frightening, - Infant Mortality Rate of 75 per 1000 live births; Child Mortality Rate of 88 per 1000 live births; Under 5 Mortality Rate of 157 per 1000 live births and a Maternal Mortality Rate of 545 per 100,000 live births. Nigeria contributes 10% to the global burden of Maternal and Under 5 mortality[4].

There are untapped resources lying idle at the various tiers of government. Even the decision on how to spend available resources is left to the whims and caprices of the executive (and may be the legislature). Empirical evidence has shown that uncontrolled power and unguided decision-making in the expenditure of public resources have led Nigeria to its present sorry state. There is therefore the need to set definite constitutional responsibilities for the legislature

[3] General Comment No.14 of the United Nations Committee on Economic, Social and Cultural Rights on the Right to the Highest Attainable Standard of Health (article 12 of the ICESCR).

[4] See FSHDP at page 20.

and the executive[5]. It is better for the commonwealth of Nigeria to decide priority areas than for its leaders to be left to imagine what our priorities are. It is the view of the Report of the National Political Reform Conference that the state and its agencies lack sufficient commitment to honour obligations and responsibilities to citizens[6] and this has led to human rights violations. It therefore recommended the merger of Chapters II and IV of the Constitution and its designation as a justiciable bill of rights[7].

Information emerging from the probes set up by the National Assembly, the cases filed by Economic and Financial Crimes Commission against former public office holders and the monies so far recovered by the EFCC and the ICPC show that resources that should have been constitutionally delimited have been frittered away. The Fiscal Responsibility Act grounds itself in the Fundamental Objectives and Directive Principles of State Policy. However, it is set to achieve fiscal prudence while there are few laws specifically enacted to achieve social responsibility as envisaged by the Fundamental Objectives.

Reflecting the Popular Will

The constitution of every nation is supposed to be the product of the popular will, reflecting the wishes and aspirations of the people, the notion of the people of the concept of a basic document to guide them and their government. In the words of a jurist, do the provisions of the 1999 Constitution on the RtH and ESR reflect the spirit of the nation on the subject?[8] If democracy is still guided by one person one vote, it is projected that if a poll were to be taken on the question of constitutional guarantee of RtH, it would surely be returned in the positive. The Constitution should be a social document that aims at satisfying social wants - the claims, demands and expectations involved in the existence of a civilized society, by giving effect to as many demands of the people as possible. The Constitution should re-order human and institutional conduct through politically organized society[9]. A constitution without a proper social engineering role is a worthless document.

Indivisibility, Interdependence and Inseparability of all Human Rights

Human rights are indivisible, interdependent and inseparable. You cannot separate the realisation of one right from the others. Separating Chapter 4 from the core provisions of Chapter 2 does not augur well for human development. The RtH is closely related to, and dependent upon the realisation of other human rights and fundamental freedoms including the rights to life, food, education, housing, human dignity, freedom from torture, etc. In protecting the right to life, Nigeria is under obligation to: adopt positive measures to reduce infant and adult mortality; increase life expectancy; eliminate malnutrition, and epidemics, etc[10].

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[5] A government with so much constitutional responsibilities would not indulge in such wasteful spending and monumental corruption as revealed in legislative probes since the return to civil rule in 1999.

[6] At page 70 of the Report.

[7] Ibid. at page 72 of the Report.

[8] Von Savigny - *On the Vocation of our Age for Legislation and Jurisprudence* (1831) Haywood Transl, p.27 of the historical school of jurisprudence.

[9] See Dean Roscoe Pound of the social engineering jurisprudence school of thought in the Philosophy of Law (1954) p, 47 See further Rudolf von Jhering who asserted that the state exists to achieve social purposes which cannot be achieved by the free interplay of individuals and groups in *Law as a Means to an End* (Transl by I Husik) 1924.

[10] See paragraph 5 of General Comment No.6 of the Human Rights Committee.

Owing to the pre-eminent role of health, good health for all people is a right and not a privilege. The right to life (already guaranteed in Chapter 4 of the Constitution) and the right to health cannot be separated. For without the enjoyment of the highest attainable standard of physical and mental health, life would be imperilled. If the right to health is not treated as part of the constitutional right to life, the easiest way of depriving a person of his life would be to deprive him of access to health supporting facilities to the point of abrogation[11]. Such a deprivation would make the right to life empty and hollow. Part of what living a life of dignity and freedom requires is the deference and assertion of the right to health for all people including the poorest of the poor.[12]

To implement Treaty Obligations

Nigeria has ratified a plethora of international treaties that contain provisions on the right to health. The treaties include the International Covenant on Economic, Social, and Cultural Rights ("ICESCR"), the Convention on the Elimination of all Forms of Discrimination against Women ("CEDAW"), Convention on the Rights of the Child ("CRC"), etc. It has also ratified the African Charter on Human and Peoples' Rights which it domesticated in Chapter A9 in the Laws of the Federation of Nigeria, 2004. Despite these ratifications, the provisions of the Fundamental Objectives and Directive Principles of State Policy which reflect the socio-economic aspirations of the Nigerian people including the RtH are by s.6(6) (c) of the 1999 constitution non justiciable and cannot find legal claims in law. This has constituted a stumbling block to the protection of the RtH in Nigeria. A State party to a treaty is barred from invoking its domestic law to defeat its international obligations in a treaty – Article 27 of the Vienna Convention on the Law of Treaties. If the rules were otherwise, the simplest way of avoiding treaty obligations is to enact domestic law which is inconsistent with the obligations, - exactly what Nigeria has done in her Constitution.

Nigeria is expected to bring its domestic law in conformity with her international obligations either shortly before or immediately after ratification of a treaty. It is also expected to take progressive legislative, administrative and policy actions to ensure the realization of the intentions of treaty obligations as against retrogressive measures of the type found in Chapter 2 of the Constitution. S.12 of the Constitution worsens matters by making cumbersome provisions for the implementation of treaties[13]. The failure of Nigeria to domesticate international treaties was noted as one of the challenges of human rights implementation by the National Political Reform Conference[14].

Nigeria is under obligation to modify her domestic law to give effect to treaty obligations and this chance has been offered by the constitution review process. It is against the principles of the common law doctrine of estoppel to approbate and reprobate at the same time - ratify treaties, domesticate same and make domestic laws that negate them.

Other African Countries Have Done It!

The following African Constitutions have made provisions on the right to health.

[11] This sentence is adopted from Justice Ghagwatti's postulations in **Olga Tellis v Bombay Municipal Corporation** (1986) AIR Sup. Ct 180.

[12] J. Achor in Immunisation Guide for the Family (1998) Shelter Rights Initiative, page 3.

[13] No treaty between the Federation and any other country shall have the force of law except to the extent to which any such treaty has been enacted into law by the National Assembly and it needs the ratification of a majority of state legislatures before it is presented for presidential assent.

[14] Main Report of the National Political Reform Conference at page 71.

Algeria: The constitutional bill of rights of Algeria provides the following in **Article 54**

> All citizens have the right to the protection of health. The state assures the prevention of and the fight against epidemic and endemic diseases.

Angola- Article 47

> (1) The State shall promote the measures needed to ensure the right of citizens to medical and health care, as well as child, maternity, disability and old age care, and care in any situation causing incapacity to work
>
> (2) Private and cooperative enterprises in health, social welfare and social security shall be exercised in accordance with the law.

Seychelles

29. Right to health care

> The State recognizes the right of every citizen to protection of health and to the enjoyment of the highest attainable standard of physical and mental health and with a view to ensuring the effective exercise of this right the State undertakes-
>
> (a) to take steps to provide for free primary health care in state institutions for all its citizens;
> (b) to take appropriate measures to prevent, treat and control epidemic, endemic and other diseases;
> (c) to take steps to reduce infant mortality and promote the healthy development of the child;
> (d) to promote individual responsibility in health matters;
> (e) to allow, subject to such supervision and conditions as are necessary in a democratic society, for the establishment of private medical services.

South Africa

The Constitution of South Africa makes provisions for the following the RtH.

Environment

Everyone has the right –

(a) to an environment that is not harmful to their health or well-being; and
(b) to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that –
(i) prevent pollution and ecological degradation;
(ii) promote conservation; and
(iii) secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.

26. Health care, food, water, and social security

(1) Everyone has the right to have access to:
(a) health care services, including reproductive health care;
(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
(3) No one may be refused emergency medical treatment.

Development of Jurisprudence

In matters of justiciability of RtH, it is imperative that the judiciary is allowed to develop jurisprudence which will ultimately improve the good governance and welfare of the people. The prevalent approach of shutting out violations of the RtH from judicial determination has obvious limitations and bottles up individual and social grievances.

There is nothing inherent in the nature of the RtH that makes it ineligible for constitutional protection as a right that can be enforced through the judicial process. Examples from the South African jurisdiction show this to be true. The respect and protection bound obligations of the RtH do not require progressive realization and can be made justiciable while the fulfillment bound obligations would require progressive realization and can also be justiciable. Statutory steps have already been taken for the fulfillment of some aspects of RtH; they need elevation to fundamental constitutional guarantees.

The Framework for the Inclusion of the Right to Health in the Constitution

In devising a framework for identifying aspects of the RtH that will be candidates for justiciable constitutional recognition, it is important to understand the concept of state duties in ESR particularly, the concept of the minimum core obligation which is in essence the basic nature and essence of the RtH - the essential elements without which the RtH loses its *righthood* and substantive significance. It is the floor below which conditions should not be permitted to fall. Below this floor, Nigeria will be deemed to be in violation of its RtH obligations.

The recommendation is that the minimum core state obligation which crystallises as the minimum core content of the RtH should be presented for constitutional recognition. This provision should be reconciled with the availability of resources based on a costing of what it would take to pay for the minimum content vis-à-vis the commitments of instruments such as Vision 2020 and the African Leaders 15% commitment. The available resources will also project the resources to be realised from new approaches such as compulsory health insurance for all citizens and 2% of the Consolidated Revenue Fund provided in the National Health Bill. The minimum core obligations should also be reconciled with the prevalent disease conditions as demonstrated by epidemiological data and health indicators in the Nigerian society. Within this context, primary health care, maternal and child health will be automatic candidates for constitutional recognition.

The state duties are to respect, protect, and fulfil the RtH and the ensuing obligations of conduct and obligations of result. The duty to respect enjoins states to refrain from interfering with the enjoyment of already entrenched rights. The obligation to protect requires States to prevent violations of such rights by third parties. The obligation to fulfil requires States to take appropriate legislative, administrative, budgetary, judicial, and other measures towards the full realization of the right. The above three obligations are further subdivided into obligations of conduct and obligations of result. Obligations of conduct require action reasonably calculated to realize the enjoyment of a particular right. In the case of the right to health for example, the obligation of conduct could involve the adoption and implementation of a plan of action to reduce maternal mortality. The obligation of result requires states to achieve specific targets to achieve a detailed substantive standard. With respect to the right to health, for example, the obligation of results requires the reduction of maternal mortality to levels agreed at the 1994 Cairo International Conference of Population and Development and the 1995 Beijing Fourth World Conference on Women[15].

The obligation to respect implies that the state should not interfere to destroy or impede access to already existing aspects of the RtH, for instance through pollution of air, water and soil which will deleteriously impact on health. The obligations to respect may not require the expenditure of resources and are negative

[15] See the Maastricht Guidelines.

obligations. As such, they can be categorized as part of the minimum state obligations. Both obligations of conduct and obligations of result related to the respect obligation are as such candidates for constitutional recognition. The duty to provide a judicial remedy in the event of a violation of entrenched RtH is apposite here.

Non discrimination has almost assumed the status of *jus cogens* as a peremptory norm of customary international law. Therefore, issues of non discrimination in access and enjoyment of government health facilities will also be part of the basic state obligations and deserve constitutional recognition.

The protection bound obligations are to an extent negative and may be notionally cost free - to prevent violations of the RtH by third parties. However, in most instances, states need to create a policy, legislative, regulatory, policing, judicial and enforcement mechanisms to ensure that third parties do not violate RtH. In the real world, these interventions cost money and other resources. But most of them form part of the core functions of government in the sense of maintaining law and order and securing lives and property. Thus creating standards, enforcing them and preventing third parties from violating the RtH and other protection bound obligations appear to be good candidates for constitutional recognition. Preventing harmful traditional practices such as female genital mutilation will be a candidate for recognition. Providing a judicial remedy in the event of violations by third parties is a basic component of this obligation. This is so both in terms of the ensuing obligations of conduct and obligations of result.

The fulfilment bound obligations appear more problematic because of the need for resources as they are seen as positive obligations. They require states to take appropriate legislative, administrative, budgetary, judicial and other measures towards the full realization of the rights. It has some semblance with the protection bound obligations in the sense of policy, legislative, regulatory, policing, judicial and the enforcement mechanisms needed for the fulfillment of rights. It is submitted that all fulfillment bound obligations that are part of the fundamental duties of government should be candidates for constitutional recognition. It is further submitted that from Nigeria's resource profile, aspects of the RtH demanding positive state intervention can be constitutionally protected. For instance, preventive and environmental health rights, essential primary health care including free consultation in government hospitals, emergency treatment, immunization for preventable diseases, free maternal and reproductive health care, etc. A framework law for the implementation of the RtH will also be obligatory on the state.

In selecting rights that will be candidates for constitutional recognition, it is imperative to include rights that the State has already set as

targets under the MDGs and other time bound targets, for instance in Vision 2020 and its First National Implementation Plan – health rights encapsulated in MDGs 4,5, and 6.

Resources for the fulfilment of the RthH need not come from existing government sources alone; new taxes can be raised, existing taxes

can be increased, for instance, increasing Value Added Tax from 5% to 10%, private sector actors may be under obligation to pay some costs, contributory schemes can be devised, etc. Budget leakages can be plugged and corruption minimized to free resources towards the fulfilment of these rights.

On a procedural issue, for the enforcement of the RtH, access to the courts should be liberalized

by the Constitution as against the present restrictive *locus standi* rules adopted by the courts. Finally, selected aspects of the RtH can be constitutionally protected, particularly those bordering on the minimum core obligations of the state and the obligations to respect and protect the RtH.

The Specific Recommendations

The following specific recommendations are made for the inclusion of the RtH into the justiciable Bill of Rights in Chapter 4 of the Constitution.

Proposed Right	Justification
Right to Health	
(1) Every person is entitled to the right to health and accordingly, the State shall provide:	
(a) free medical consultation in government medical institutions;	This can be provided within the context of available resources.
(b) free access to primary health care services including maternal and child health and reproductive health services;	This can also be provided within the context of available resources and to brighten our deplorable maternal and child health indicators.
(c) free medical care for children under the age of five and persons over sixty five years old;	This can also be provided within the context of available resources, taking cognizance of the rights of the child and of older persons.
(d) Free medical treatment for all persons in detention.	Linked to the right to life and the fact that detainees are not in a position to provide medical care for themselves.
(2) No person shall be denied emergency medical treatment in any medical institution.	This can be linked to the need to secure the right to life over and above financial and economic considerations.
(3) A person who by reason of sickness or any other cause is unable to give his consent shall not be deprived by any other person of medical treatment by reason only of religious or other beliefs.	This can be justified by the fact all other rights revolve around the right to life.
(4) Every person shall be entitled to full information about his medical condition and records.	Negative obligation and also linked with free medical consultation in government hospitals.
(5) The State shall take all appropriate steps, to the maximum of available resources with a view to achieving the progressive realization of the RtH including;	In accordance with our international obligations under the ICESCR.
(a) compulsory medical insurance for all citizens;	To be able to raise resources for the funding of the obligations.
	To limit the spread of diseases and thereby reduce the resource outlay on curative health services considering that the environment is an

(b) preventive and environmental health interventions; (c) enact a framework law for the progressive realisation of other aspects of the right to health not covered by these provisions.	influential factor in epidemiological analysis. This takes care of matters not covered by the Constitution and which need to be fleshed out to guarantee the RtH. For instance the National Health Bill which dedicates 2% of the Consolidated Revenue Fund for primary health care.

The Protection System of Human Research Participants under NHREC: An Important Health Sector Reform Initiative

Introduction

Attempts at health sector reform in Nigeria have been ongoing since the declaration of the alma ata in the late 70's[16], and the institutionalization of the Primary Health Care System as the basis for the Nigerian Health Care System by the late Prof. Olikoye Ransome Kuti. This was long before the concept of health sector reform became an area of focus in both policy and academic circles. Looking back however at this initiative, it is arguable a major reform initiative, in line with the definition of health sector reform proffered by Berman & Bossert (2000)[17] are several initiatives being implemented by policy makers within the health system. However, not all these qualify as reform initiatives. To qualify as a reform, an initiative should be significant, purposeful and a fundamental change in the processes and systems that
support service delivery and/health system strengthening.

Efforts at promoting institutional and policy changes in line with the health sector reform drive in the early 90's was driven by the fellows of the 'change agent' programme championed by Professor Eyitayo Lambo and largely supported by the UK Department For International Development (DFID)[18]. The pressure from these change agents and the publication of the WHO landmark report on

[16] WHO. 2007. Declaration of Alma-Ata, 1978. WHO Regional Office for Europe

[17] Berman P, Bossert TJ. A Decade of Health Sector Reform in Developing Countries: What Have We Learned?. DDM Symposium: "Appraising a Decade of Health Sector Reform in Developing Countries" Washington, D.C: 2000 March 15

[18] Oloriegbe I. The Nigeria Change Agent Programme: building capacity to catalyze changes. International consultation on strengthening health leadership and management in low income countries. Accra Ghana, WHO; 2007

Health Systems Strengthening in 2000[19], led to the first formal policy declaration for a health sector reform in 2003 - the Health Sector Reform Programme (HSRP)[20]; which also resulted in the revision of the 1988 National Health Policy in 2004[21]. The reform initiatives that were initiated as a result of these reform included both minor and major reform initiatives.

The development of various policies such as the Human Resource for Health, Health Care Financing, Health Promotion, Public Private Partnership in Health were all products of the HSRP. A major initiative was the establishment of the National Health Insurance Scheme, which aims at institutionalizing suitable risk pooling systems to guard Nigerians from the catastrophic health expenditures that tend to exacerbate the health-poverty vicious cycle, and more especially to improve the financial access of the poor to health care services.

Strengthening health research systems had been on the health reform agenda that was being implemented around this time. However, it was not generally given the desired attention by both government and non-government actors. This is seen for example in the fact that the development of the National Health Research Policy, which has been in the 'pipeline' since 2001, is yet to be finalized; while a National Health Research and Ethics Review Committee, which had been at least on the policy shelves in place since the 1980's, remained moribund until its revitalization in 2006[22]. The rest of this article will focus on this and how it has become an important policy reform that was necessary to ensure that Nigeria features prominently and contributes to research that improve health and health care services.

Why a functional Human Research Participant Protection System was necessary

Historically, a major challenge for the common man is not that scientists are conducting research, but rather the fear and potential that the scientists would use them as 'guinea pigs'; fostering their careers while these researches hold out nearly absolutely no value either to the participants or their communities. Examples of research studies where the fears of the common man had unfortunately become real abound in the literature include the Tuskegee Syphilis Study in Macon County Alabama, where about 400 Afro-Americans who had contacted syphilis were denied treatment because the researchers wanted to understand the natural history of the disease[23]. True that the understanding of the natural history of the disease could help in developing the cure for the disease, however, what was wrong was that these people were deceived into participating in the study; were not told they had syphilis; and when treatment became available, they were denied access to the treatment.

[19] WHR 2000. Health Systems: improving performance. WHO, Geneva; 2000

[20] Federal Ministry of Health. Health Sector Reform Programme 2003-2007. FMOH; 2003

[21] Federal Ministry of Health. Revised National Health Policy. FMOH; 2004

[22] Adebamowo CA, Mafe M, Yakubu AA, Adekeye JM, Jiya JY. Developing Ethical Oversight of Research in Developing Countries: Case Study of Nigeria. Harvard Health Policy Review 2007 Spring;8(1):96-106

[23] Brandt AM. Racism and Research: The Case of the Tuskegee Syphilis Study. Hastings Center Report 8, no. 6 (1978):21-29

In Nigeria, the Pfizer clinical trial of Trovafloxacin (Trovan) in Kano[24] is still fresh in our memories. All these however happened as a result of the absence of, or poor systems that ensure the protection of human research participants.

Thus, at various stages of the development of their health research systems, countries institutionalized suitable systems that will ensure that people that participate in research are protected against harm and that the research holds some social value for the participants directly, and/or their communities.

NHREC establishment process, mandate and expectations

While perhaps going at a snail's pace, efforts to strengthen the health research system started during the 2003-2007 reform initiatives. This was seen in the development of the 2nd draft version of the health research policy in 2006, which was not approved due to some bureaucratic bottlenecks, including change in administration. A high level ministerial forum for health research and development that was initiated by the Honourable Minister of Health at the time, - Professor Eyitayo Lambo and co-hosted by the Ghanaian Ministry of Health kick-stated it. The issue of strengthening system for protecting human research participants was given a major impetus by a Presidential Mandate from the Presidential Meeting on *Improving Life Expectancy of Nigerians* in mid 2006, by President Olusegun Obasanjo. The implementation of this mandate was given the momentum it required for speedy implementation by the technical support from the West African Bioethics Training Program (WABTP), an NGO, funded by the National Institutes of Health and the National Human Genome Research Institute of the United States[25].

In collaboration with the WABTP, and following the mandate already set out for a functional ethics system in the National Health Bill, the Federal Ministry of Health inaugurated a re-invigorated National Health Research Ethics Committee (NHREC) in October, 2006 and charged it with the mandate to institutionalize a system for protection of human research participants in Nigeria. This was to be achieved largely by providing guidance and ensuring that all institutions that are conducting research establish ethics committees or have access to an ethics committee that ensures that the research it conducts does not harm people, and must hold promise of some social value to the participants and/or their communities.

In its mandate to institutionalize and sustain a functional human research participant protection system for the country, NHREC is expected to:

i. Determine guidelines for the functioning of health research ethics committees;
ii. Register and audit health research committees as a collaborative system for on the job quality assurance and improvement programme;
iii. Set norms and standards for conducting research on humans and animals, including norms and standards for conducting clinical trials;

[24] Abdullahi v. Pfizer Inc. In: S.D.N.Y; 2005.106 Harvard Health Policy Review International

[25] http://www.westafricanbioethics.net

iv. Adjudicate in complaints about the functioning of health research ethics committees and hear any complaint by a researcher who believes that he has been discriminated against by a health research ethics committee;

v. Refer to the relevant statutory health professional council matters involving the violation or potential violation of an ethical or professional rule by a health care provider;

vi. institute such disciplinary action as may be prescribed against any person found to be in violation of any norms and standards, or guidelines, set for the conduct of research; and,

vii. Advice the Federal Ministry of Health and State Ministries of Health on any ethical issue concerning research.

Structure and operations of the National Human Research Protections System

At the Institutional Level: All institutions whose primary mandate includes the conduct of health related research are to establish HRECs. In such cases, the purview of the HREC covers only researches conducted by the researchers within the institution, and/or with research participants in the institution.

Where an institution has no HREC and/or is unable to establish one, such an institution can enter into a collaborative agreement with the HREC of another institution in the same State. Where there is no institution with a suitable HREC in the same State, then at least in the same geo-political region. Where even this is not available, then such institutions should refer all studies to be conducted therein and/or by its researchers to NHREC

At the State Level: All States are encouraged to establish an HREC within a suitable existing structure such as the State Ministry of Health. The State level HREC provides ethical oversight for research activities conducted in State Owned Institutions or by researchers from such institutions

At the National Level: This is the purview of the National Health Research Ethics Committee. The work of NHREC is largely regulatory. However NHREC also conducts ethics reviews in the following circumstances:

- The research is nation-wide in coverage or
- The research involves more than 3 sites in Nigeria or
- The research was referred to NHREC by HREC(s) or
- There is no HREC in an institution and the institution does not have a HREC cooperative agreement or
- The researcher considers the research of such complexity that there may be inadequate expertise in any one local institution or
- At its discretion

Box 1. Levels of Health Research Ethics Committees in Nigeria

The human research participant protection system in Nigeria is a decentralized system. NHREC which is under the Federal Ministry of Health is at the apex of the system. NHREC provides regulations and facilitates its implementation by other HRECs. According to the NHREC guidelines, HRECs have been established at two other levels. - State and institutional levels. The purview of the various HRECs are summarized in box 1 above.

HREC registration and categorisation

NHREC registers HRECs as a process for validating their existence and ensuring that they are constituted in line with best practice guidelines. This was necessary because there is evidence that some HRECs had been established because it was a requirement for the institution to obtain one grant or the other. Furthermore, NHREC categorises HRECs and gives them the types of studies they are allowed to review. This is on the basis of the size of the committee, qualifications, training and experience of its members in research ethics and science, history of the committee (when established, past review activities, record keeping and compliance with requirements of the Code), resources available to the committee, supporting personnel and infrastructure of both the committee and the proposing institution. This will ensure that HRECs consider only studies that they have the capacity and experience to review.

The categories established by NHREC are as follows:

Colour Key

Authorization	Category/ Colour Code	Exclusions
Authorised to review all types of research	A	None
Authorised to review Phases II, III and IV clinical trials, vaccines and biological products trials, genetic, social and behavioural trials, alternative and complementary medicines and epidemiological studies. Also authorised to review trials in vulnerable populations	B	Novel products with potential nation-wide religious, social and security implications and research including use of radioactive pharmaceuticals should be referred to NHREC
Authorised to review Phases III and IV clinical trials, social and behavioural trials, alternative and complementary medicines and epidemiological studies. Also authorised to review trials in vulnerable populations	C	In addition to exclusions for categories above, Phase I and II clinical trials, vaccines and biological research, genetic research
Authorised to review Phases III and IV clinical trials, social and behavioural trials and epidemiological studies.	D	In addition to exclusions for categories above, complementary and alternative medicines research and research among vulnerable populations
Authorised to review epidemiological and social and behavioural studies. No clinical trials authorization	E	In addition to exclusions for categories above, this committee is not allowed to review ANY clinical trial

The various levels of HRECs described above, including processes for quality assurances shows that the structures and processes being supported through NHREC to enhance protection of human research participant protections are far reaching. It is an extensive structure that institutes human research protection programmes, under the HRECs at both national and sub-national levels of the health system. The registration, categorisation, and auditing of HRECs are system checks that are meant to improve the quality of the work the HRECs, while the attestation, which the authorities that constitute HRECs (Hon. Commissioners or their designees, MDs in hospitals, and DGs in research institutes) provide, commits them to provide the HRECs with resources and political support needed for sustainability.

Anecdotal evidence shows that from 2006 to date, there has been unprecedented increase in awareness of the need to ensure that all research proposals must receive favourable review from an independent HRECs before commencement. Furthermore, more HRECs are coming up to get registered with NHREC[26] – showing their desire to contribute to the protection of research participants that are involved in studies in their institutions or by their research staffs. However we are also aware that there is variability in the way operations of HRECs

[26] http://www.nhrec.net/nhrec/hrec_db.php

conform with provisions of the National Code[27]. Similarly, many other researchers are also not aware of NHREC, or other HRECs; neither are they adequately conversant of the need to ensure that their proposed research studies must have received an appropriate determination by a competent HREC, before their begin implementation. Thus as stated by the Honourable Minister of State for Health, Dr. Muhammad Ali Pate, while we are counting our successes, there is a lot more work to be done by NHREC in collaboration with the registered HRECs to strengthen this important reform initiative, the Nigeria Human Research Participant Protection System under the leadership of NHREC. In this effort, the need for Federal Ministry of Health, State Ministries of Health, Research Institutes, Universities and University Teaching Hospitals, other MDAs such as Ministries of Education, Science and Technology, Justice, Environment and Agriculture, among others, as well as Civil Society Organisations, to support and help strengthen this system further, cannot be overemphasised. In the few months to come, NHREC will be engaging with all these stakeholders to build stronger coalition to promote a One National Human Research Participant Protection System for the Country.

[27] Yakubu A, Kass N, Ali J, Hyder AA. Research ethics committees in Nigeria: a survey of operations, functions and needs. (unpublished)

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Health Sector Reform Coalition Meeting withAllied Health Professional Associations held on March 8, 2012, Valencia Hotel, Wuse II, Abuja

The Health Reform Coalition organized a meeting at the Obudu Mountain Resort in December 2011 principally to discuss the reservations of the Allied Health Professional Associations on some of the provisions in the Health Bill. The areas in contention in the Bill were highlighted and extensively discussed while amendments for the various sections of concern were proposed.

Those in attendance at the Obudu Retreat resolved to further bring the outcomes of the meeting to the attention of the leadership and members of their associations for their consideration in order to garner support and reach a consensus. A follow-up meeting was proposed for early 2012.

HERFON recognized the window of opportunity for another review exercise in view of the fact that the Bill is being returned to the National Assembly for re-consideration. Consequently, HERFON took the liberty to organize another meeting of the Allied Health Professionals to address various sections after consultation with the leadership and members as agreed at the Obudu meeting. To this end, a day meeting was organized with them at the Valencia Hotel Abuja on March 8, 2012 with the aim of reaching consensus and ensuring a "unified voice" on the National Health Bill and other health sector reform issues.

The specific objectives of the meeting included the need to:

a. ensure that the "Obudu Resolutions" represented the views of each of the professional associations;
b. reach consensus on recommendations on the amendments that are being proposed; and
c. articulate the need to table for discussion "health rights" as an issue for the consideration of the Constitutional Review Panel.

Participants included the following:

- AfriHealth Optonet Association
- Association of Medical Lab Scientists of Nigeria (AMLSN)
- Association of Radiographers of Nigeria
- CARE-NET Consulting
- Centre for Social Justice (CSJ)
- DFID/Nigeria
- Federation of Muslim Women Association of Nigeria (FOMWAN)
- Federation of Nigeria Women Lawyers (FIDA)
- Health Information Management Association of Nigeria
- Health Reform Foundation of Nigeria (HERFON)
- JHPIEGO
- Little Big Souls
- NASU
- National Association of Community Health Practitioners of Nigeria
- National Association of Nigeria Nurses and Midwives (NANNM)
- National Council of Women Societies (NCWS)
- National Hospital, Abuja
- Nigeria Dietician Association
- Nigeria Optometric Association
- Nigeria Society of Physiotherapy
- Nigeria Union of Pharmacist Medical Lab Scientist and Professional Allied to Medicine (NUPMTPAM)
- Partnership for Transforming Health Systems 2 (PATHS 2)
- Save the Children (SCUK)

The staff of HERFON facilitated the meeting which was chaired by Rev. A.O. Jaiyesimi. Some of the sticking issues were discussed followed by a resolution to reconvene to complete the review exercise.

Dr Godwill Okara of the Assoc. of Medical Lab Scientists in Nigeria (backing the Camera), Dr David Olayemi of Save the Children (fourth from left) and others look on as Rev Wole Jaiyesimi, President of the Nigerian Society of Physiotherapists makes presentation at the Health Sector Reform Coalition Meeting to discuss the National Health Bill with the leadership of Health Professional Associations and notable NGOs in attendance. The meeting was facilitated by HERFON and held at the Valencia Hotel on the 8th of March 2012.

Sitting on Bottom row (R-L): Prof Lai Erinosho, Executive Secretary HERFON, Barr. Christy Mojekwu, FIDA, Dr Nkem Ene, HERFON Programme Manager and Dr Ben Anyene HERFON BOT Chairman, Mrs Anne Emechete of Nigerian Assoc. of Occupational Therapists, Mr Badmus Yussuf, Nat. Assoc. of Nigerian Nurses and Midwives, Dr Mark Okeji, President of Assoc. of Radiographers of Nigeria.
Standing in back row (L-R): Comrade Lawrence Okebiorun of AGS, Ibadan; Wale Adeleye, Capacity Building Officer, HERFON; Comrade Michael Mallo, NASU; Ibama Asiton, National Secretary, Nat. Assoc. of Community Health Practitioners of Nigeria; Dr E. Braimoh, National Assoc. of Optometrists in Nigeria; Comrade O. C. Ogbonna of Nig. Union of Pharmacists, Medical Lab Scientists and Professionals allied to Medicine; Habiba Adamu of FOMWAN; Joy Odewale of Nigerian Dietician Association; Rev. Wole Jayiesimi, President, Nigerian Society of Physiotherapists; Godswill Okara, President Association of Medical Lab Scientists of Nigeria; Dr Olagbegi of the HERFON FCT Chapter; Felix Babawemimo; Mrs Theresa Effa, HERFON Senior Advocacy Officer.

HERFON Collaborates with SuNMAP on Advocacy on Malaria in the Country

Health Reform Foundation of Nigeria is assisting SuNMaP programme to increase community awareness and demand for effective malaria treatment and prevention' in Niger, Katsina, Kano, Anambra, Ogun, Lagos, Yobe, Enugu, Kaduna, and Jigawa.

The implementation of SuNMaP activities is being undertaken with the following partners: Health Partners International (HPI), Federation of Muslim Women Association in Nigeria (FOMWAN), Health Reform Foundation of Nigeria (HERFON), Pharmaceutical Manufacturers Group (PMG-MAN), Christian Health Association of Nigeria (CHAN), CCPN, UNEC, LSHTM, CHAN-Medi Pharm, JHU-CCP, Malaria Consortium, and GRID Consulting.

HERFON in collaboration with SuNMAP developed the methodology for carrying out advocacy to achieve set objectives in the identified states. It involved bringing policy makers, programme managers, and community members together to improve the funding of malaria control activities in the targeted States; increase the level of community participation and awareness to create demand form malaria control intervention/commodities; expand the knowledge and involvement of opinion leaders, traditional leaders; and strengthen the effective supervisory roles of the heads of health care facilities.

The representatives of SuNMaP STLs along with HERFON Advocates and Communication Consultants brain stormed and responded to questions from the audience on the key issues in the set objectives. Participants also collectively identified knowledge gaps, issues, and challenges and how they can be tackled.

The effort was worthwhile as it afforded HERFON advocacy unit an opportunity to use its skill and also gauge knowledge on, and attitudes towards malaria and how to assist in empowering communities to prevent it.

(L-R) Dr. Ma'awuya Aliu, Dr. Lawal A Rubeh, Pharm Lawal Sule Kuro, Ahmed Yahuza Getso and Adama Sule Bakor at the Orientation meeting for the HERFON TAs in Katsina State

(L-R) Dr. Oyekoya Olabode ZPO South West, Mrs Olanike Kehinde, HERFON Consultant, Mrs Bukky A, SuNMaP Communication TA., Dr Emmanuel Taribo, acting STL during a planning meeting with SuNMaP team in their Lagos Office

(L-R) Ms Theresa Effa, Dr Olabode Oyekoya with members of HERFON during orientation meeting to draw up the Advocacy Plan for Ogun State

Ms Theresa Kaka Effa, Senior Advocacy Officer (2nd From left), Dr Oyekoya Olabode, Zonal Programm Officer South West Zone (3rd from right) and HERFON members in Ogun State, during the orientation me to draw Advocacy Plan

(L-R) Henry Onyekwere, Dr. Dennis Aribodor, Dr. R O Nriagu, C O Iloerika and Isaac Adiele at the orientation meeting in SuNMaP Office Anambra State

Grantsmanship Workshop

The first in the series of grantsmanship workshops for 2012 was held from April 23-26, 2012 at Top Rank Hotel, Garki, Abuja. The resources persons, drawn from universities and non-governmental organizations delivered papers. The mode was interactive and participatory. All the Zonal Programme Officers of the Foundation were in attendance.

National Vaccine Summit

National Vaccine Summit took place at the International Conference Centre, Abuja, April 16-17, 2012. The Secretary to the Government of the Federation of Nigeria, Ayim Pius Ayim delivered an opening address while the First Lady Dame Patience Goodluck welcomed delegates. She also invited the delegates to an evening reception in the state house, Aso Rock.

Over five hundred delegates, drawn different parts of the world participated in the Summit with papers presented by various speakers (both Nigerians and foreigners).

A special session was organized for Parliamentarians from the West Africa sub-region on how they can support vaccine access. The session was chaired by the Chairman of Nigeria's Senate Committee on Health, assisted by his Deputy.

It will be recalled that Health Reform Foundation organized one of the six zonal town Hall meetings in the run off to the national Summit in Owerri, Imo State.

National Health Review

Two Panels have been constituted to produce National Health Reviews on the following themes: Maternal Health and Health Care Financing. The former is headed by Professor Friday Okonofua, Co-chaired by Professor O.A. Adetoro; while the latter is headed by Professor Eyitayo Lambo, assisted by Professor Obinna Onwujekwe. The prospective contributors have been contacted.

Training Workshop on Data Management and Analysis

The Foundation is organizing a training workshop on ***Hand-On Quantitative Analysis of Data in Social & Health Research*** is expected to take place in September 10- 12, 2012. Training will be on the use of SPSS and Epi Info. All participants are expected to bring their lap Top to the workshop. The fee is N35, 000 excluding board but including course materials, group lunch and tea break

Capacity Building Seminar on Communicable Diseases in Ogun State

The Ogun Community Women Empowerment and Child Care Forum (OGWECF) organized a two-day workshop in collaboration with the World Health Organization on *preventing the outbreak of communicable diseases and the relevance of community women as health educators* in Lagan Hall, Opposite Gateway Hotel, Ijebu-Ode, Ogun State from May 8 to 9, 2012. HERFON had a strong representation at the workshop. The team included: Professor Lai Erinosho (Executive Secretary), Dr. O. Oyekoya (Zonal Programme Officer), Dr. K. Lawal, and Mrs. Kusahanu, - HERFON members in Ogun State.

The Executive Secretary was among the key speakers at the workshop which attracted about three hundred participants. Other

notable speakers included the WHO representative, Dr. Olaokun Soyinka, the Ogun State Commissioner for Health, and five traditional rulers from Ijebu Division who appealed to women to immunize their children against diseases.

The two-day meeting included medical test for participants, lectures and remarks by Mrs. Eki Inneh-Oloko and Hajia Sherifat Balogun, -Chairperson and Executive Secretary of OGWECF respectively.

Editorial Board

Health Reform Foundation of Nigeria, located at #60 Lobito Crescent, Wuse II, Abuja, Nigeria is an independent membership organization with branches in FCT, thirty six states, and Zonal Offices in the six geopolitical zones of the country. Among the objectives of the organization are to: (a) advocate, facilitate, support and monitor health reform in Nigeria; (b) foster collaboration and co-ordination for health sector reform and promote fellowship among members; (c) build capacity for health sector reform and in particular organize or sponsor a sustained change agent training; and (d) promote and conduct research, write policy analysis and briefs and generate data to influence and inform health sector reform in Nigeria.

Its vision is to be the leading independent non-governmental organization advocating for health sector reforms, better health outcomes, and development while its mission is to promote better health for all Nigerians.

The organization welcomes as members, individuals that are committed to the reform of the health sector. HERFON seeks to achieve its broad objective through advocacy, capacity building, partnership and evidence generation. The Members of the Board of Trustees are:

- Dr. Benjamin Anyene (Chairman)
- Professor Joseph Oluwasanmi
- Dr. Daniel Gana
- Dr. Shehu Sule
- Chief (Dr.) (Mrs.) Monica I. Okom
- Dr. Chidi Marume
- Dr. Halima Y. Adamu
- Hajia Maimuna M.Bala
- Sam Nda Isaiah

This newsletter is published quarterly to provide a platform for members, other interested individuals, and organizations within and outside Nigeria to contribute short think pieces on any issue on health sector reform. It is envisaged that such pieces will generate lively and constructive debate among readers and also promote proactive ideas aimed at reforming Nigeria's health sector.

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