



Quarterly Newsletter of the Health Reform Foundation of Nigeria

Vol. 1, Number 1 (New Series), March-April 2012

Some Thoughts on Accountability in, and Responsibility for Health in Nigeria

-Olayiwola Erinosh

The ordinary meaning of accountability is to “render an account” or “bear the consequences for failure to perform as expected” while that of responsibility is to “take care of one’s duties” or answer for one’s actions” (Webster Dictionary, 1913). Accountability and responsibility are about stewardship. The concept of stewardship is not new from a historical standpoint (Saltman and Ferroussier-Davis, 2000). However, what is probably new is its incorporation into discourse of health policy and programmes as amply indicated in the WHO Health Report of 2000. According to the report, stewardship is about “effective trusteeship of national health”.

Nigeria still lags behind many other developing countries like Ghana and South Africa in sub-Sahara in the development and reform of its health sector. An awareness of the dismal state of health care delivery among other health development indicators in the country prompted the Obasanjo Administration to embrace a reform agenda that is articulated in NEEDS. The Administration also signed up to the Millennium Development Goals (MDG) (NPC, 2004). These steps were

conceived to make health care accessible, equitable, affordable, and also to reduce disease burden that is brought about by the scourge of infectious diseases, and HIV/AIDS which had reached an all time high of 5.8% sero-prevalence in 1986, and other communicable diseases (FMOH, 2004b; FRN, 2004; NACA, 2002).

This piece will briefly appraise the role of Nigerian Governments in health care provisioning with a focus on a number of issues, namely, immunization, public-private partnership in health, legislative initiatives, human health resource, essential health data, and equity in health.

Immunization and Child Health

Nigeria has so far failed to achieve the immunization coverage of nearly 80% of its population since the 1990s when Professor Olikoye Ransome-Kuti was at the helms of affairs as the Minister of Health. Recent report indicate the coverage is about 50% while the worst affected are the northern states. The efforts of donor agencies such as DFID have paid off in states like Kano and Jigawa. The challenge is how to institute routine immunization (RI) which is the key to high coverage. While sporadic efforts may pay off in

the short-term, what is required is a more sustained approach such as putting in a place the routine immunization of children. Consequently, a call for a more proactive community-oriented immunization that engenders the active involvement of change agents on a sustained basis may be the answer. But are Nigerian governments willing to invest in such a strategy that requires considerable resources in funds and human resources? That is the question.

Public Private Partnership in Health

One of the effective ways of improving access to health care is by *harnessing all available resources* for the benefit of the population. Nigeria's health sector is replete with traditional and cosmopolitan health care providers that operate in the public and private spheres. Paradoxically, the governments of Nigeria have so far not effectively harnessed all the available and abundant health care resources within these spheres for the benefit of the population¹. As a result, all the resources within Nigeria's health sector have so far not been integrated into a national system for the overall benefit of the population. The challenge is how to harness the resources for improved health of significant numbers in the population.

Legislative Initiatives

One factor which has limited the effective role of the various tiers of government is lack of clarity in the roles and responsibilities of the different tiers of government and institutions

¹ A number of states have sought to promote public private partnership by ceding some services to private sector. For example, quite a number of states are inviting the private sector to manage their laundry, catering and mortuary services. But PPP is much more than such initiatives because there are other potential areas of mutual benefit such as intramural practice.

even though health is presumably in the concurrent list (i.e., an item that could be handled by all the tiers) in the 1979 and 1999 Constitutions (Akande, 1999; FRN, 1979; FRN, 1999). Various tiers either had always overstepped or failed to play their expected role.

The Obasanjo administration recognized this as an important issue/problem that ought to be addressed. Consequently, efforts to revise the Constitution and also outline the roles and responsibilities of the three tiers of government on health began in earnest with the support of development agencies. The efforts paid off with the formulation of a national health bill which has been passed by the federal legislative houses. The bill is a major landmark in the history of the country because it delineates the roles and responsibilities of the various tiers of government, professional bodies, other institutions and it also takes into account the role of the private sector in health care provisioning (FRN, 2004).

This notwithstanding, it is one thing to pass a bill and another to sign it into law which the President has failed to do to-date. The failure by President Jonathan to sign the law is no doubt sending the wrong signal to stakeholders and the development partners that have invested colossal amounts of money into the reform initiative. Indeed, inaction on the part of the President will set the country back for years.

Health Human Resource

There are now about twenty-five accredited medical schools, not less than a hundred and fifty schools of nursing, thirty-six schools of health technology and various others that train paramedical personnel in Nigeria. As such, appreciable numbers of health personnel are being produced annually.

The authorities took the initiative to develop a human health resource policy years ago and also

to also revise it (FMOH, 1990; 2002; 2008). Further attempt is being made to revisit the policy in the context of on-going health sector reform Initiative. This notwithstanding, there is however no evidence to suggest that the Nigerian Government has responded to the health human resource problems of the country. First, the serious economic crises, following the adoption of SAP prompted the flight of highly skilled and experienced health personnel who were in search of opportunities, better life, and job fulfillment to the Middle East, United States, the United Kingdom, and South Africa (FGN, 1995). This resulted in the depletion of skilled level health human power in a country that is in dire need of their services (Federal Republic of Nigeria, 2005). Secondly, there is a glut in certain cadres of primary health care workers while some are overproduced. Thirdly, distribution of health workers is highly skewed, with many more in urban than rural areas. For example, nearly thirty percent of all doctors in Nigeria practice in Lagos State. Besides, about 7% of doctors in Nigeria work in non-health related contexts/organizations or are in administration according Dare etc. al. These challenges should be addressed in the context of health sector reform.

National Management Health Information System (NHMIS)

Nigeria's public sector institutions currently lag behind the private sector in the deployment of information and communication technologies (ICT). Unlike the banking sector that has effectively used ICT, the health sector has not. The various departments of planning and research in the ministries of health all over the federation are glorified by name and not in their function. Consequently, the use of ICT declines by each tier of government. The much talked about National Health Management Information

System (NMHIS) has not taken off due to failure to use ICT to collate and manage health data.

The result is that interested individuals and organisations are unable to access up-to-date information on Nigeria's health sector. The data that are required for planning and programme development are not always current or poorly kept and/or unavailable. The failure to take advantage of ICTs is attributable to:

- a. Inertia on the part of senior level public officials to use ICT to collect, collate and process data;
- b. Lack of capacity to co-ordinate data that are generated across institutions, sectors, and tiers of government; and sometimes
- c. Dearth of funds.

The key to reliable data is an NMHIS. The health sector reform agenda is unlikely to achieve set objectives until an effective and efficient national health information system is established. NMHIS is a veritable tool for resource allocation and planning. NMHIS could be salvaged if Nigerian Governments take advantage of the abundant requisite skill of the human resource in the private sector.

Access to and Equity in Health

One of the goals of health sector reform is to improve access to health care and also to make it affordable. This is being tackled through the provision of primary health care which is being implemented by all the tiers of government. Efforts are being made to expand immunization coverage after years of decline. Also, the authorities re-launched the national health insurance scheme after years of inaction. The scheme is currently targeted at public sector workers and/or those in formal employment.

While these efforts are laudable, it seems that vast proportions of Nigerians still cannot access affordable health care. The self-employed and/or those in the informal sector have not been

brought on board of the national health insurance scheme. This group constitutes about 75% of the population of Nigerians. Expanding access to affordable care is a priority if the economic potentials of the country are to be achieved. It is the responsibility of government to devise a package for the unemployed, under-employed, itinerant workers, including all of those in the informal sector of the economy through community-based financing Schemes which are still not fully developed.

Concluding Remarks

The challenge facing responsible national authorities after the gains of the mid 1980s when the country achieved great strides in the implementation of the 1988 national health policy is to demonstrate wholesome commitment to the well-being of Nigerians not merely by blueprints/proposals but through discernible and result-oriented action. Even though efforts are being made to reform the health sector, nonetheless, the impact of these efforts have not been as overarching as they ought to. Consequently, it has been *lots of motion but limited movement*.

Poverty is still widespread in Nigeria despite the country's huge human and material resources. Nigeria's National Bureau of Statistics recently claimed that nearly 70 percent of Nigerians live in absolute poverty, with significant proportions in the North East and North West Zones of the country². Secondly, equity in health care provisioning remains a mirage. Thirdly, the failure to develop NMHS undermines our capacity to plan and develop effective programmes. Fourthly, several states including the federal government have not been proactive on the role of the private sector in health care delivery (PATH, 2005). Finally, and perhaps most important is the inertia on the part of the

² Daily Trust Tuesday February 14, 2012.

President to sign the national health bill. Nigeria will not achieve Vision 20:20:20. Nor will the country develop until there are healthy Nigerians.

Bibliography

Akande, J.O. (1982) *Introduction to the Nigerian Constitution*. London: Sweet and Maxwell.

Federal Ministry of Health (2004b) "Achieving Health-Related Millennium Development Goals in Nigeria – A Report of the Presidential Committee on Achieving Millennium Development Goals," Executive Summary, August 9.

Federal Ministry of Health (1981) *National Health Human Resource Policy*, Lagos: FMOH.

Federal Ministry of Health (2002) *National Health Human Resource Policy*, Abuja: FMOH.

Federal Ministry of Health (2004c) *Revised National Health Policy*, September, Abuja: FMOH.

Federal Ministry of Health (2005a) *Reports on the Public Private Partnership in Health*, Vols. 1 and 2, Abuja: FMOH.

Federal Republic of Nigeria (1979) *The Constitution of the Federal Republic of Nigeria*, Abuja: Government Press.

Federal Republic of Nigeria (1999) *The Constitution of the Federal Republic of Nigeria*, Abuja: Government Press.

Federal Republic of Nigeria (2004b) Draft National Health Bill, 2004, Abuja: Change Agent Programme (Dr. Ibrahim Oloriegbe, Dr. Ben Anyene, and Dr. Muhammed Lecky).

Federal Republic of Nigeria (2005) *A Blueprint for Revitalizing Primary Health Care in Nigeria*, November.

National Action Committee on AIDS (2002) *HIV/AIDS Emergency Action Plan (HEAP)*. March Abuja: NACA.

PATHS/DFID (2004) *Report on the Review of Health Laws in Nigeria*, Abuja: PATHS/DFID.

National Planning Commission (2004) *Nigeria: National Economic Empowerment and Development Strategy (NEEDS)*, Abuja: National Planning Commission.

Saltman, R.B. & Ferroussier-Davis, O. (2000) The Concept Stewardship in Health Policy, *Bulletin of World Health Organisation*, 78(6), 732-739.

Olayiwola Erinoshio, professor of health sociology is the Executive Secretary, Health Reform Foundation of Nigeria, Abuja, Nigeria

Impact of National Health Insurance Scheme (NHIS) and Managed Care on Nigeria's Health Indices

Ben Anyene

There is hereby established a scheme to be known as the National Health Insurance Scheme (in this Decree referred to as "the Scheme") for the purpose of providing health insurance which

shall entitle insured persons and their dependants the benefit of prescribed good quality and cost effective health services as set out in this Decree.

Introduction

The provision of quality, accessible and affordable healthcare remains an important issue in Nigeria (Agba et al., 2010). There is no denying the fact that Nigeria's healthcare index is very poor³, and that the people are suffering. Today, Nigeria has one of the highest maternal morbidity and infant mortality rates in the world⁴.

for the advance financing of medical expenses through contributions or taxes paid into a common fund to pay for all or part of health services specified in an insurance policy or law". The key elements are advance payment of premiums or taxes, pooling of funds, and eligibility for benefits on the basis of contributions, or employment without an income, or assets test.

The Encyclopaedia Britannica Concise Dictionary defines health insurance as "system

Health insurance may apply to a limited or comprehensive range of medical services and may provide for full or partial payment of the costs of specific services. Benefits may include the right to certain medical services or reimbursement of the insured for specified medical costs. Private health care insurance may be organized and administered by an insurance company, other private agency, and/or government. Both forms of health insurance are to be distinguished from socialized medicine and government medical-care programmes, in which doctors are employed directly or indirectly by the government, which also owns the health-care

³ Nigeria lags behind considering some health indicators among the countries like Ghana, Kenya and Senegal which share the same socio-economic status with Nigeria see the appendix.

⁴ Nigeria mortality rate is higher than sub Saharan African average, see the appendix

facilities (e.g., Britain's National Health Service).

Thus, health insurance can be defined as a contract between an insurance provider (e.g. an insurance company or a government) and an individual or his sponsor (e.g. an employer or a community organization). The contract can be renewable (e.g. annually, monthly) or lifelong in the case of private sector insurance, or may be even mandatory for all citizens in the case of national health plans. It involves resource mobilization (generation and collection), pooling, allocation, and purchasing. A health insurance scheme should provide quality, equitable, accessible, affordable, and efficient care. It should assure a significant reduction in out-of-pocket expenditures and it should provide universal coverage. It should also provide comprehensive, good quality, and cost-effective health services to the insured persons and their dependents in the formal sector, self-employed persons, rural communities, the poor and the vulnerable groups (Agba, 2010).

Purpose of National Health Insurance Scheme (NHIS) and Managed Care Organizations

In order to address a number of problems plaguing the health system in Nigeria and to improve coverage and access, the National Health Insurance Scheme (NHIS) was promulgated in 1999 (Decree 35 1999 now Act 35 of 1999) by the Military regime of Abdusalam Abubakar and launched in 2005 by the Obasanjo Administration (1999-2007). Although, the idea was conceived in 1962 (Halevi Committee's Lagos Health Bill) it was implemented forty three years later due to the absence of political will by successive military and civilian Administrations (Falegan, 2008).

The objectives⁵ are to:

- a. ensure that every Nigerian has access to good health care services;
- b. protect families from the financial hardship of huge medical bills;
- c. limit the rise in the cost of health care services;
- d. ensure equitable distribution of health care costs among the different income groups;
- e. maintain high standards of health care delivery services within the Scheme;
- f. ensure efficiency in health care services;
- g. improve and harness private sector participation in the provision of health care services;
- h. ensure equitable distribution of health care facilities within the Federation;
- i. ensure appropriate patronage at all levels of health care; and,
- j. ensure the availability of funds to the health sector for improved services

Managed care as the name implies refers to a system for organizing doctors, hospitals and other providers into groups to enhance the quality of health care services and assure that they are delivered in a cost-efficient manner. Managed care organizations coordinate all aspects of health care delivery system in order to manage all the costs in the system (Awosika, 2005). Rather than bill patients on fee-for-services basis, managed care systems set pre-arranged fee structures and utilization review procedures, agreed upon by contract between health care providers and the managed care organization (Awosika, 2005). Thus managed care helps in actualizing the purpose of NHIS.

It is the believed that the purpose of NHIS will be achieved through the NHIS benefit packages,

⁵

http://www.nhis.gov.ng/index.php?option=com_content&view=article&id=52&Itemid=69

itemized below that are delivered through managed care:

- a. Curative care by a provider
- b. Out-patient diagnostic and treatment services
- c. Short-term rehabilitation and physician therapy
- d. Pediatric and adult immunization services
- e. Family planning
- f. Ante-natal and post-natal care
- g. Eye examination but not the provision of spectacles
- h. Consultation with specialists
- i. Hospital care in a standard ward in a public or private hospital during a stated duration of stay for physical or mental disorders.
- j. Emergencies in and out of the HMO service area
- k. Detoxification and treatment of substance abuse.
- l. Diagnostic and therapeutic radiology services
- m. Primary dental care, as defined- pain control, extractions, amalgam fillings, etc.

All benefit packages under the Scheme shall be provided or made available in Nigeria only (Awosika, 2005). Participation in the Scheme is optional except for workers in the private and public sectors who are expected to contribute 5 percent of their basic salary to the scheme while their employers pay 10 percent for each worker. This entitles a contributor, a spouse, and four children to Medicare from any approved service provider. As at February 2009, the Scheme had registered over 4 million federal civil servants and their dependants (Agba, 2010).

Impact of NHIS/Managed on Nigeria Health Indices

We will examine the impact of the NHIS and Managed Care Organizations in Nigeria based on the following objectives:

Accessibility to Good Health Services

Access to health insurance provides a good proxy for measuring access to health services. The NHIS has been able to enroll up to 3% of Nigerians under the formal sector health insurance programme (Kujenya, 2009). About 1% is covered in the private sector by Health Maintenance Organizations (HMOs). There are concerns that this figure is low, but it represents a step in the right direction of providing health insurance coverage for all Nigerians.

There has not been appreciable improvement in national health indices if the MDGs are used as a guide. Moreover, the little improvements are localized and often are directly attributable to intervention programmes and projects designed, funded, and implemented by non-public actors in the health sector.

It is universally accepted that improved national health indices can only be possible if the health services delivered are acceptable, available, accessible, accountable, and affordable. For this to happen, a strengthened and evidence-driven health system must be in place. The six core functions of the health system are Stewardship/Governance, Human Resources for Health (HRH), Health Financing, HMIS, Medical Technology/Supply and Service Delivery. An NHIS needs this platform to deliver the expected results. Thus, it should be helpful to interrogate the performance of these core functions. Beneficiaries have been limited to employees of the Federal Government and large corporations.

Control/reduction of arbitrary increase in the Cost of Health Care Services in Nigeria

The NHIS reimbursement system managed by HMOs uses a capitation system for primary care and a fee for service schedule for referral care. The whole idea is to achieve the objective of controlling cost of services. So far, these have worked though there are challenges limiting its effectiveness. There is a tendency for reduction in quality of care by providers to stay within a specified cost level. Thus, even though one achieves cost control, quality also gets impacted. We need to start monitoring service delivery in Nigeria's health facilities. In many developed countries, performance monitoring is routine rather than ad-hoc. We can only talk about the effectiveness of cost control efforts when we know that service quality has not been negatively impacted on.

Protection of Families from High Cost of Medical Bills

It can be said that families who are already covered by the scheme and by the private sector insurance programmes already receive a reasonable level of protection from the high cost of medical bills. The challenge here is still the fact that less than 1 in 20 Nigerian families are included in this. Again, some illnesses such as renal conditions and HIV/AIDS are not included and do lead many households into poverty. Expansion of health insurance in Nigeria should help to address these challenges in order to improve the ability of households to cope with illness events. This should also not be done in isolation from the overall challenges being faced in Nigeria with the cost of doing business. Most times medical bills are high because prices of goods and services are high. National investment in the power sector and transportation is critical to the reduction in the cost of doing business. While we hope that government interventions in these areas will be appropriately implemented, it

must be said that NHIS and HMOs need to work together to expand coverage and increase cross subsidization across sectors where possible, so that the wealthier members of the society help to protect the poorer ones from facing high costs of health care. Nonetheless, the implementation of these programs shows that it is possible to achieve the objective of distributing service costs across income groups.

Equity in the Distribution of Healthcare Service Cost across Income Groups

While the ongoing NHIS formal sector programme has provided some level of equity in distribution of service costs amongst enrollees, its MDG programme has helped in the exemption from payment of some of those who cannot pay for maternal and child health services in the areas where this has been provided. However, as noted earlier, the population of Nigeria that is benefitting from this is quite low. Given this limitation, most people continue to pay for health care directly from their pocket, and this has significant implications for access (Nnamuchi, 2007). Out-of-pocket expenditures still account for 70% of health care financing in Nigeria, thus making health care services economically inaccessible especially to the population in greatest need. Considering that 70.8% of Nigerians live below the poverty line (i.e., on less than \$1 a day) and are therefore not in a position to afford the high cost of health care, it means that millions are left without any form of coverage. This leads to the downward spiral of Nigeria's key health indicators (Nnamuchi, 2007). This is not the case in Ghana where the NHIS succeeded in extending health insurance coverage to 45% of Ghanaians by the end of 2008, a level of coverage unprecedented in the region (UNICEF, 2009). More so Gyapong et al. 2007 while evaluating the effect of NHIS in Ghana indicates that:

- The insured are more likely to seek formal health care than uninsured.
- Insured inpatients are significantly more likely than uninsured patients to receive an x-ray.
- Insured patients are largely able to afford their care.
- Uninsured patients do not have sufficient cash reserves to pay their bills.
- Insured women are significantly more likely to deliver by caesarean.
- Insured pay significantly lesser amounts of money for delivery of care than uninsured women.

Maintenance of a High Standard of Healthcare Delivery Services to Beneficiaries and Provision of Efficient Health Care Services

Amongst beneficiaries, there are varied opinions about the standard of health care delivery services. However, the NHIS and the Managed Care Organizations seem to be delivering what is possible given the enormous challenges within the health sector.

Indeed the country suffers from perennial shortage of modern medical equipment such as X-ray machines, computerized testing equipment and sophisticated scanners (Johnson & Stoskopf, 2009). Where these equipment are available, repairs/services are always a problem due to corruption (Oba, 2009). Globalization has also facilitated the growth of a flexible and mobile labour market. Shortages of medical doctors and nurses in the high income countries, whose governments are keen to maintain adequate health services for their people, have encouraged the migration of an already disgruntled workforce (Gyapong et al., 2007). Implementation of better performance monitoring of health facilities and workers as well as measurement of consumer satisfaction will help provide information about the quality

of services to enable planning. Health insurance funds are used in many high income countries to drive efficiency and improvements, and this can be done in Nigeria as well.

Improving and Harnessing Private Sector Participation in the Provision of Health Care Services

The private sector has increasingly become part of health care delivery in Nigeria. While public providers are used for health service delivery, private providers have served the important purpose of providing care especially in urban areas. More HMOs have also emerged to provide services for enrollees covered by the Scheme. Despite these successes, the private sector has had minimal involvement in the provision of health insurance in rural areas where majority of Nigerians live. The paucity of this private sector activities in such areas have to be bridged through better collaborative activities amongst all stakeholders to help achieve the objectives of NHIS.

Equitable Distribution of Healthcare Facilities in Nigeria

Accessibility remains a problem, with most of the health care facilities concentrated in urban areas, far removed from rural areas where the majority in the population lives and where the need is more urgent. Public hospitals are grossly ill-equipped⁶ while private hospitals provide cash and carry services. Self-medication is on the increase. Governments at all levels provide little support for the health sector (Abati, undated). The number of doctors in Lagos alone is more than the number in all the northern states put together. This implies that even workers and the self-employed who have access to the NHIS do not get the best treatment because of the

⁶ As a result when Nigeria's big men fall ill, they enter the next available flight to seek health abroad

dearth of health care facilities and personnel. The dearth of health care personnel in clinics, primary care centers, general, and tertiary hospitals is limiting the effectiveness of NHIS in Nigeria (WHO, 2007a).

NHIS has disbursed about 23 billion naira to 7850 accredited health facilities nationwide (Kujenya, 2009). The poor distribution of health care facilities means that this fund has been focused mainly on the richer population sub-groups, throwing up equity challenges. It is important that decision-makers begin to look into ways of using the funds to stimulate the public and private sector to improve availability and quality of health services especially in the rural areas.

Appropriate Patronage at all Levels of Health Care

The implementation of health insurance Scheme in Nigeria has supported use of private care facilities for primary care, as well as the use of secondary and tertiary facilities from primary to tertiary level care. In addition, the MDG MCH programmes focused on use of public primary level facilities for the provision of services to pregnant women and children. Apart from the challenge of scaling up these services, there are concerns which are recognized. There is a need to improve and use public primary care facilities as providers of primary care especially in the rural areas. There have also been concerns about the appropriateness of the use of tertiary facilities to deliver primary care. At the moment, up to 60% of Nigeria's health expenditure is allocated to tertiary facilities which actually take care of less than 25% of the health problems of Nigerians. These issues need to be understood, and dealt with to improve patronage of all levels of care and those managing health insurance should develop strategies that will ensure that the available funds are deployed in ways that stimulate use of these facilities.

Maintaining and Ensuring Adequate Flow of Funds for the Smooth Running of the Scheme and the Health Sector in General

By and large, adequate funding remains a major problem to the Scheme. Government allocation to health sector has always been between 2% to 3.5% of the national budget which is far below the Abuja Declaration target of 15% (WHO, 2007a; Odubanjo et al., 2009; Agba et al., 2010). The federal government has continued to pay the employers' contributions for its employees. This was a major step for health insurance to expand in 2005. The MDG funds have also contributed to the pool for maternal and child programmes for which states are required to make counterpart funding. The provisions in the National Health Bill which we still hope will be signed by the president will further increase the funds that are available for services. However, workers are yet to start making contributions and it is still unclear how well funds from those in the informal sector can be collected. These are significant challenges for technocrats and politicians alike, which must develop feasible and acceptable strategies for harnessing such domestic funds. While health insurance systems seek to convert out-of-pocket payments to prepayment Schemes, having the Scheme end up as a free one operating only with government contributions will not lead to the desired goal of having adequate funds.

Moving forward

There are challenges that must be sorted out if at all the goal of covering all Nigerians by 2015 is to be met. States need to cover their workers. Government needs to cover people who are unable to pay premiums. Those in the informal sector and rural areas need to be covered as well and it will be good to have a reinsurance mechanism for NHIS/Managed Care in order to strengthen their pools. Again, workers have to start making contributions. The agencies

involved in insurance have to play the roles they should, – regulation, monitoring for quality improvement, improvement in preventive care, efficient purchasing of services, and effective health service delivery. The gaps between tertiary, secondary and primary systems should be bridged through effective referral structures. Industrial actions need to be controlled to make public facilities appealing to potential enrollees. These challenges need a collective positive response with effective civil society action and professional groups. Making the changes will require research to generate evidence about why people are unwilling to join or contribute, effective advocacy using research evidence, and the selfless will of decision-makers and policy implementers to use such evidence to guide decisions towards expanding coverage.

The demand side is poorly understood and articulated in Nigeria. There is a need to promote the Scheme to the nooks and crannies of Nigeria through a community-based strategy that involves mass mobilization of Nigerians to participate in the Scheme (Chikwe, 2011).

There will be a need to better organize the providers of health care to ensure more efficient use of funds and appropriate referral system. Furthermore, adequate and well trained medical personnel's should be employed to man the various hospitals, clinics, labs and health care centres of the facilities used by both current and potential beneficiaries in underserved areas. In-service training should be organized to boost the knowledge of current staff members in the health sector and there is an opportunity to use staff such as Community Health Workers (CHWs) in many areas where highly trained staff members are not available.

The minimum standard for the service providers must be clearly defined by the government, followed by proper supervision by the supervisory agencies. This should be followed

by appropriate monitoring and regulatory activities.

Health workers need to be motivated to contain the spate of brain drain. Evidence has shown that the migration of health workers to high income countries is also a major challenge to the health system. There is also movement of health workers within countries, from public to private sectors; rural to urban; primary care settings to tertiary health care institutions; and also to out of health profession to other professions. This may be so because, the skills of these health professionals either may be under-utilized due to lack of modern equipment because the incentives are available in the urban or private sectors may not be available in the rural or public sectors. Migration exacerbates the shortage within the sector and increases the workload of the remaining workforce (Gyapong et al., 2007).

Governments at all levels must allocate more funds to the growth of the health sector in line with global best practices. Special attention must be paid to health training institutions to ensure quality training of medical personnel and other health workers in ways relevant Nigeria. Government infrastructure in rural areas should be used and incentives given to all health professionals who work in the rural areas (Omoruan et al., 2009).

Data management should be an integral part of the Scheme rather being seen as an *ad hoc* stopgap.

The National Health Bill provides for a national health system. It provides the legal framework for equity, efficiency, access, quality, and sustainability; all the necessary conditions for NHIS to achieve its potential. Its implementation would help the health sector and in particular NHIS to effectively contribute to the human capital development component of the Transformation Agenda of the current government.

Concluding Remarks

NHIS and Managed Care Organizations in Nigeria have been able to provide health insurance cover to Nigerians though the expected goal of universal coverage still seems distant. Overall, their impact on Nigeria's health indices is not known because of the low coverage and absence of empirical evidence. The scheme can impact positively on all the sectors of the economy, since it takes good health to be productive if properly managed with the support of all stakeholders and the willingness of implementers to use evidence to institute reforms. Where to begin will be the genuine commitment by all through programmed and targeted health system actions to fix the health sector.

References

- Abati, R., (undated) Nigeria's Problematic Health Insurance Scheme, Newspaper editorial.
- Agba, A.M., Ushie, E.M., & Osuchukwu, N.C. (2010) National Health Insurance Scheme (NHIS) and Employees' Access to Healthcare Services in Cross River State, Nigeria, *Global Journal of Human Social Science*, Vol. 10 Issue 7, (Ver 1.0).
- Agba, M.S. (2010) Perceived Impact of the National Health Insurance Schemes (NHIS) Among Registered Staff in Federal Polytechnic, Idah, Kogi State Nigeria; *Studies in Sociology of Science*, Vol. 1, No. 1, 2010, 44-49.
- Awosika L. (2005) Health Insurance and Managed Care in Nigeria, *Annals of Ibadan Postgraduate Medicine*, Vol. 3 No 2.
- Balabanova, D., Mckee M., & Mills, A. (eds.) (2011) Good health at Low Cost 25 years On, *What Makes a Successful Health System?* London: London School of Hygiene & Tropical Medicine.
- Britannica Encyclopedia Concise Dictionary. Health Insurance, Online available at: <http://www.answers.com/topic/health-insurance#ixzzlegycxtrX>, Accessed on November 24, 2011.
- Chikwe, A. (2011) Health Insurance, Solution to Nigeria's Poor Health Indices
- Falegan, I. J. (2008) Health Care Financing in the Developing World: Is Nigeria's National Health Insurance Scheme a Viable Options? *Jos Journal of Medicine* 3(i): 5 – 6.
- Gyapong, J., Garshong, B., Akazili, J., Aikins, M., Agyepong, I., Nyonator, F., (2007) Critical Analysis of Ghana's Health System With a focus on equity challenges and the National Health Insurance, Shield Workpackage 1 Report.
- Johnson, J. A., & Stoskopt, C., (2009) Comparative Health Systems: Global Perspectives Online available at :<http://books.google.com.ng/books?id=9vWpcQsfeJuc&pg=PA310>. Accessed online November 21 2011.
- National Health Insurance Scheme Decree No 35 of 1999 Laws of the Federation of Nigeria, Online available at: [http://www.nigeria-law.org/National Health Insurance Scheme Decree.htm](http://www.nigeria-law.org/National_Health_Insurance_Scheme_Decree.htm), Accessed on November 24, 2011.
- NHIS (2009) NHIS – News: States Partners with NHIS. Online available at: <http://www.nhis.gov.ng/index.php?> Accessed on November 21, 2011.
- Nnamuchi, O. (2007) The Right to Health in Nigeria. Right to Health in the Middle East Project, Law School, University of Aberdeen, <http://www.abdn.ac.uk/law/hhr.shtml>, Accessed on November 21, 2011.

Oba, J. O. (2008) Nigeria: Yar'Adua and the Resuscitation of Health Sector. Online available at:<http://allatrica.com/stories/200806021431.html>. Accessed on November 21, 2011.

Odubanjo, M.O., Badejo, A., & Sofola, S., (2009) Strengthening Health Systems in Nigeria, Nigeria Academy of Science (NAS), Workshop Summary.

Ohanyido, F.O., Components of an Ideal Health Insurance System. Digital Journal 2011. <http://digitaljournal.com/blog/14047>.

Oladimeji, O. J., (2009) Potentials for Micro Health Insurance in the Nigeria Health Financing System, Working Group Session II, Presentation Pro MHI Africa conference on *Lessons Learnt and Lessons to Learn in the Field of Micro Health Insurance in Africa*, 2nd and 3rd December, Lilongwe.

Omoruan, A. I., Bamidele, A. P., & Phillips, O. F., (2009) Social Health Insurance and Sustainable Healthcare Reform in Nigeria, *Ethno-Med*, 3(2): 105-110.

Strategies for Health Insurance for Equity in Less Developed Countries (SHIELD) (2010) Access Barriers to the Use of Health Care in Ghana, SHIELD Information Sheet.

UNICEF (2009) Maternal and Child Health: The Social Protection Dividend in West and Central Africa, *Briefing Paper/Social Policies*, UNICEF West and Central Africa Regional Office.

WHO (2010) *Achieving Sustainable Health Development in the African Region. Strategic Directions for WHO 2010–2015*, World Health Organization Regional Office for Africa.

WHO (2007a) *World Health Statistics 2007*, Geneva: WHO.

WHO (2007b) Health Financing and Social Protection. Online available: <http://www.who.int/countries> Retrieved November 20, 2011.

++ *Keynote Address at Annual General meeting/Scientific Conference of Health Care Providers Association of Nigeria on November 29, 2011*

Ben Anyene, a physician and former Commissioner for Health, Anambra State, is currently the Chairman, Board of Trustees, Health Reform Foundation of Nigeria, Abuja, Nigeria

Access to Health Care and the Politics of Exclusion in Nigeria

Ogoh Alubo

Health is a much valued concept, eulogized in Nigeria variously as being wealth, and a healthy nation is a wealthy nation. How exactly health translates to wealth need not detain us; suffice it to note that the search for health can become lucrative avenue for wealth. The immediate concern here is with the various meanings of health and how so often, some of these meanings may not correspond with resources and services necessary to attain health. Irrespective of how it is conceived, access is an important factor in the discourse of health, ill-health, and health care.

In what follows, I define concepts and discuss contending notions of health which will place one in a better position to address the question of access to health care. Access to health care here refers to the extent to which individuals who perceive themselves to be sick or have an indentified ill-health condition can be attended to at a source known to offer reliable, safe, and effective care. It is needless to argue that such care should also be acceptable and affordable.

Contending Conceptions of Health

Nigeria's appreciation for health may be seen from common daily greetings between neighbours. Often, the daily meetings are occasions to ask after the health of family members of both parties. In some other parts of Nigeria, similar questions are also asked about the health of domestic animals!!! Just what exactly is health and what it means is often assumed rather than explained. When can one say s/he is healthy? Is health or being healthy the ability to fulfil daily obligations alone? Is health the absence of disease? Is this what Nigerians mean in daily greetings when they respond *Lafia* to the parties they meet?

Perhaps, notions of absence of disease and feeling 'well' are contained in responses to greetings. While such notions may differ from one context to the other, the World Health Organisation's definition of health is generally accepted. According to the WHO, health is "a state of complete physical social and mental wellbeing and not just the absence of disease and infirmity". This definition is a recognition of the material basis of health and ill-health because a state of complete physical and mental wellbeing goes beyond actions commonly taken to tackle ill-health through medications for example. Health is fundamentally rooted in the structures of power, privileges and what people have access to, as well as what they need but do without.

Flowing from this definition, what constitutes health care must include all one needs to stay healthy, - be this food, clean water, a safe environment and/or general feeling of wellbeing. Health care is therefore the sum total of all resources that individuals require to maintain, retain, and promote their good health, as well as meet challenges of ill-health and disease. In a related manner, ill-health is a condition in which an individual recognises abnormalities in the system such as pains or other symptoms as well as conditions of existence which deny access to food in quality and quantity, safe domicile free of parasites, rodents, vectors which transmit diseases, and general conditions which negate wellbeing.

So defined, ill-health includes the common manifestation of diseases as well as conditions of life which make it difficult to avoid diseases. In effect, health is tied to the conditions individuals find themselves in life. In daily lives, issues of power, gender and class and how these determine who lives in sickness rather than in health, is commonly manifest. Where

individuals are located in the stratification order is the key to the range of conditions they contend with. Some are poor and therefore cannot afford the necessary resources to stay healthy. The middle class can sometimes afford and at other times cannot while the members of the upper class can always afford all their needs.

In health discourse in Nigeria the primary concern is often about medical care and the related resources of hospitals and drugs and seldom about the conditions which make drugs and hospitals necessary. From the medical standpoint, health care has been equated with medical care and health policies, especially in Nigeria, have stressed the intensification of curative medical services (Erinosho, 1982; Alubo 1985). Other aspects of health such as preventive, promotive and rehabilitative dimensions are ignored. Politicians are comfortable with the medical perspective and the policy thrust has revolved around the following initiatives:

- The training of more personnel to achieve a better practitioner-patient ratio. Nigeria's various governments have been proud of increases in both the ratio and absolute number of various cadres of personnel trained.
- Building of more clinics, hospitals and treatment centres and expanding existing ones. Even in a situation where existing facilities are in crisis and most atrophied, new ones are being built.
- Procurement and better distribution of drugs, equipment and other materials (Federal Government in Nigeria, 2006).

This orientation neatly fits the modernization path to health care development especially that it creates markets for drugs and equipment manufacturers.

This *medical* orientation of health is different from Hippocrates', the acclaimed father of modern medicine. For him, health is a relationship between the individual and the environment, including the political and economic:

Health means a healthy mind in a healthy body and can be achieved only by governing daily life in accordance with natural laws which ensures equilibrium between the forces of the organism and those of the environment (Dubos, 1965:323).

The modernization path appears to be a universal phenomenon in underdeveloped countries as,

The poorer...countries have tended to copy both the philosophy and development priorities of the developed world, even though their problems and population structures are different. In following the health delivery trends of the technologically sophisticated societies, African countries have so far failed to make their health system effective, let alone efficient. Clearly, the system does not fit the population (Mburu, 1981:17)

There are hardly questions about the impact of this perspective on health problems. At issue is how medicines can solve problems whose root causes are political and economic. The common diseases in Nigeria are *nutritional* such as kwashiorkor and marasmus; *parasitic* like malaria and *water borne* such as cholera and guinea worm. How can cure to these conditions be achieved without attending to the root causes?

Equally important is the distinction between *cure* and *care*. there is a huge imbalance in health investment in favour of cure. This is a deliberate ideological strategy, for as Navarro (1977) long argued, reducing problems of political and economic origins to medical problems serves an important legitimacy function for the capitalist system:— makes people believe that structural problems can be resolved through the individualist approaches of modern medicine. It diverts attention from poverty and deprivation, the resolution of which will pose threats to the accumulation process. This is because,

By situating the diagnosis and treatment of disease at the level of the individual, (Medicine) provided the ruling class with a means of social

control: patients would fail to make common cause with each other or to protest the external, underlying conditions that make them ill. The effect is to depoliticize malnutrition, alcoholism, drug addiction and mental illness by defining them as medical problems (Turshen, 1977:57).

The medical paradigm remains the guiding principle of health which has informed Nigeria's health care policy and practice. There are regular references to *health care delivery*, as if, in the words of Wildavsky, "the welcome wagon was supposed to roll up to the door and deliver health wrapped in a neat package" (Wildavsky, 1977:112). In the illusory pursuit of health care delivery over 80 percent of health budgets has consistently gone into *curative medicine* (Alubo, 1985). Whether such huge investments yield the desired outcome in health indices seems immaterial.

An alternative conception which closely mirrors the WHO definition is the materialist conception-- The materialist conception of health care is anchored on this fundamental assumption: health is part and parcel of society within which the individual lives, has a being; reproduces him/her self and relates to other human beings in these processes. Health is experiential and holistic rather than being a commodity which can be bought and sold.

So conceived, health is inseparable from the political economic conditions under which people live, meet (or fail to meet) their daily needs and reproduce life. The recent fuel subsidy policy has profound impact on the life of Nigerians, especially the poor. Since the removal on January 1, 2012 there is a new round of general inflation as traders adjust prices to meet higher costs of transportation on which they rely to ferry their wares.

For this material notion, bio-physical malfunctions are important not in their own rights, but for the politico-economic contradictions they symptomatize. *Kwashiorkor*,

for example, is only the bio-physical manifestation of the contradictions in the social relations of production which cannot guarantee adequate nutrition. Similarly, worm related infections and water-borne conditions are not really the disease. The real problem is the nature of society; its reward structure and individual's location within it. The disease and ill-health arise from the political economy of reward structure which benefits some while placing others at a disadvantage.

The materialist notion of health is not new, it is only long ignored. As far back as the 12th century, long before the discovery of bacteria and its derivation, the germ theory, the relationship between low socio-economic status and low life expectancy for all courses was observed (McKewon, 1979). Furthermore, Karl Marx and Friedrich Engels, jointly and individually discussed how poor material conditions predisposed people to disease in works like the Communist Manifesto and The Conditions of the Working class in England. Because of the obvious ideological implications, this conception has remained ignored.

From the foregoing, there is little question that health, very much sought after in Nigeria, is primarily a political issue. What remains problematic are the resources as well as what services are involved in health care and why. In the proceeding section, we examine the question of access to this valued condition.

Access to Health Care in Nigeria: The Politics of Denial and Exclusion

Health care debate goes beyond competing paradigms; equally crucial are health outcomes and access. By outcomes we mean usual indices (such as infant and maternal mortality, life expectancy, etc) among the population. Available data, mostly "guessestimates", indicate a poor health status for the population, of which the table below is a reflection.

Table Some of Nigeria's Health Indicators

1.	Life Expectancy at Birth	48 to 52 years
2.	Under five mortality	191 in 1000 live births
3.	Maternal Mortality	545 in 100,000

Nigeria's maternal mortality is particularly dire as it comprises only 1 percent of the world's population but accounts for 10 percent of maternal mortality. According to the 2010-2015 National Strategic Health Development Plan (2010-2015), the main causes for maternal mortality are:

- Haemorrhage 23%
- Infection 17%
- Anaemia 11%
- Obstructed Labour 11%
- Unsafe abortion 11%
- Eclampsia 11%

Source National Strategic Health Plan 2010:28

Though couched in medical vocabulary, it is easy to tease out the social and cultural causes such as the association between anaemia, poverty and poor nutrition as well as most infection with poor hygiene. There is also the related issue of poverty and unsafe abortions as the well to do have access to proper medical care. Finally, literature (e.g., Harrison, 1997; Wall, 1998) indicates that obstructed labour is more common in teenage pregnancies, most of who are poor and have little education.

The situation of infant deaths is equally dire as child malnutrition results in the underweight and the stunting of up to 54 percent of under-five children. There is clear class character to the epidemiologic profile in general and infant mortality in particular. There is evidence that:

Infant and child mortality rates are high. At present, one out of every 8 children dies before his first birthday and one out of 6 before his fifth birthday. child mortality in the country is slightly higher than what its income per capita would suggest. in the case of infant mortality, ...it is still lower than countries with similar income (National Strategic Health Plan 2010:24).

The major causes of under-five mortality are:

- Malnutrition 53%
- Neonatal tetanus 26
- Malaria 24%
- Pneumonia 20%
- Diarrhoea 16%
- Measles 6%

Source: National Strategic Health Plan 2010:28.

According to the Strengthening Health System document "children and infants among the poorest 20% of the population are about three times more likely to die than among the richest 20%. The disparity is even greater for under 5 mortality where the mortality rate is 87 per 1,000 among the wealthiest population and a staggering 219 per 1,000 among the poorest" (Federal Ministry of Health, 2009:1).

The situation is compounded by frequent outbreaks of communicable diseases like cholera. Indeed, at almost every point in time in the past decade, there is a raging cholera outbreak somewhere in Nigeria. Most of the cholera is from contaminated water. I note here in passing that in water supply in most cities has decreased. What is more, the public water boards have turned themselves into veritable distribution centers for the sale of water to water tankers who in turn sell this to clients. Further, the business of "pure water" and bottled water is brisk and further indication that access to clean water now depends on the ability to pay.

It is recognized in policy documents that Nigeria's health outcomes are poor and several steps behind those of other sub-Saharan countries (Federal Government, 2005: National Strategic Health Development Plan, 2010).



HERFON Members from the South South Zone including, Dr. N. Ene, Programme Manager and Professor Lai Erinsho, Executive Secretary



HRH Eze Samuel Agunwa Ohiri, Chairman, Imo State Traditional Rulers Council & Members of the Board and Management of HERFON at the Town Hall Meeting, Near Owerri, Imo State



Mrs. O. Olukoya, Zonal Co-ordinator of the South West, & members of the HERFON in Ondo State



Mrs. O. Olukoya, Zonal Coordinator of the South West and Members of HERFON in Oyo State



Participants at the Zonal Town Hall Meeting on Immunization, Imo State



Lady I. Agbaso, Wife of the Deputy Governor of Imo State at the Town Hall Meeting on Immunization in Owerri

In the background to strengthening National Health System (Federal Ministry of Health, 2009), it is stated that:

Nigeria's health indicators rank poorly when compared to those of countries with similar per capita income...inequalities exist between rural and urban countries, between northern and southern zones, and across income groups (Federal Ministry of Health, 2009:1).

The situation is blamed on increasing poverty and weakness of the "health care system". It is here observed that what is described as the health care system is essentially the various levels of the medical care system.

The situation relates to social conditions of individuals of the overwhelming majority and hence,

most of the causes of deaths and serious illnesses, which occur among Nigerians, can be treated or prevented with simple remedies...communicable diseases are often compounded by malnutrition (Health Policy, 2006:226).

The New Assault on Maternal and Infant Mortality and Morbidity

The federal government has mounted relentless efforts to change the situation for the better as contained in health policy as well as programme activities. As part of Millennium Development Goals, especially three and five, there are now spirited efforts to change the situation for the better. However, these efforts have concentrated for the most part on medical rather than the social and cultural dimensions of health and ill-health.

With reference to maternal mortality, there are issues about poor nutrition during pregnancy due mostly to poverty; unremitting hard work (such as working in construction sites, mobile yam/other commodity vending and farming) if only because food cannot be accessed. Yet the new assault has concentrated on the medical aspects. Since 2009, there is now Midwifery Service Scheme whose overall aim is to re-

engage midwives to boost access to trained helpers during labour (Federal Republic of Nigeria, 2010). Thousands have been engaged and posted mostly to primary health clinics. The programme has no specific focus on nutrition, or on any of the non-medical factors in pregnancy and child bearing. In keeping with medical model many states in the North of Nigeria where maternal mortality is highest, now offer free ante-natal care including free medications. Nutrition is not part of the package nor are environmental issues such as malaria, or safe water with implications for infections.

The new impetus on combating infant mortality is similarly medically circumscribed. There is a new vigour on vaccination. The objectives of the new immunization policy concentrate on improving routine immunization of all antigens to 90% by 2020; halt the transmission of polio by 2013 and eliminate maternal and neonatal tetanus by 2010 (National Immunization Policy, 2009:7). There are huge campaigns urging parents (especially in Northern Nigeria where vaccines were rejected in the 2003/2005 period) to bring children for immunization. The new initiative does not include nutrition even as the lack of proper nutrition accounts for 53 percent of childhood diseases and deaths. There is no attention to safe water which has implications for diarrhoea. In a similar manner, questions about child labour through which children become exposed to harmful substances (such as the loss of over 4000 children in Zamfara state, in the 2010-2011 period, from lead poisoning as they mine gold and other precious metals).

It may thus be seen that efforts to combat health problems are limited to medical care. As we turn in the next section, even as it receives the lion share of resources, a huge percentage of the population does not access existing medical services on offer.

Access to Care

According to official documents only an estimated 54% of Nigerians has access to modern health services. The document also recognizes that "rural communities and the urban poor are not well served" (Health Policy,

2005: 225). At issue here is access to available care; what happens to the 46% of the population without access to modern health-- actually medical-- care?

There are no reliable data on where the people excluded from the formal system seek care. However, the following is known to be wide spread:

- Varying types of medical service centres which provide array of services; the training of many of the service providers are as questionable as the services they offer.
- There is a wide spread medical "bukas" replete with substandard facilities
- Many patent medicine shops as well as pharmacy shops offer one-stop services where consultations, diagnosis, and prescriptions are carried out by providers who may not have any formal training
- Growing market of traditional healers who rent the airways to peddle their wares; they also hold trade fairs. Their training and quality of their wares are difficult to verify. They claim to offer "cures" for virtually all conditions, including HIV/AIDS. A recent book has rich documentation of their business practices including sales gimmicks and wild claims (Trovalla, 2011). Trovalla's book is appropriately titled "Medicine for Uncertain Futures"; a suggestion which speaks both to the outcome of the ailment as well as future where this brand of care becomes dominant.
- Many are also turning to spiritual healers/homes where the sick are "cured" through laying of hands, prophesy, and spiritual powers. Here too, many of the cures are difficult to verify and hence the National Communications Commission compelled TV station to stop airing footages of miraculous cures.

In a recent newspaper report a spiritual healer claimed: "Just mention any kind of human diseases. Be it HIV/AIDS, diabetes,

hypertension, syphilis, strokes, cancers, rheumatism and sight problems.....I am able to cure all with ordinary water" (Omolchin, 2012:12).

He claims to have spiritual powers which come in waves and cure is effected once the waves establish contact with the sick. He is aware that clients are "mostly the down trodden who have no financial means to seek conventional medication (Omolchin, 2012:12). In many cases, faith healers either demand payments for services or ask patients to make a "sacrifice" or donation. Amounts vary, depending on the individual beneficiary.

Access to medical care in Nigeria is a class issue. While some can afford the best centres within Nigeria, including elaborated private hospitals; many more can only afford the General Hospitals. Others attend the informal medical sources. These combined sources apparently add up to 54% of Nigerians recorded as accessing medical care.

Many other Nigerians are travel abroad for medical abroad. The destinations for medical tourism have changed from Europe and America to the Middle East and India. There are regular reports of VIPs visits to these destinations as well as missions which are unsuccessful. There is little doubt that overseas remains the last port for medical care for the rich.

There are regular stories in the Press about the afflicted poorer Nigerians who need money to undergo life saving procedures. Many newspapers run appeals for donations from the public (e.g. see the Sun newspaper of 10/2/12). There are no data about others whose afflictions are not carried in the media. In other instances, Nigerians who received treatment in some medical centres are held hostage when they are unable to fully meet the bills (Alubo, 1990; 2001). Nigeria now has a National Health Insurance Scheme which is largely confined to the formal sector where employers pay premium. The scheme does not reach the general populations who foot their own bills or survive by turning to alternative sources, including those of dubious consequences. As indicated above,

many are held hostage when bills are not paid. In many locations, newborns are also part of this ordeal and thus commence life as hostages to Nigeria's political economy.

Concluding Remarks

The foregoing seeks to draw attention to nature of health discourse in Nigeria. It is shown that for all practical purpose, whether in reference to budgetary allocation or policy, health care is equated to medical care. The broader dimensions well articulated in the WHO definition receives short shrift. Yet, improvements in health indices around the world depend more on non-medicinal issues such as access to safe water, improved nutrition and general environment hygiene. As Mckweon (1979) has shown, these improvements already led to low mortality and morbidity rates in Europe even when medicine was of doubtful quality and utility. Focusing overly on medical care has its limitations, part of which is the unflattering health indices. The health situation in Nigeria results largely on the great equation of medical care with health care. Even where scourges point to issues of power and inequality, such as high maternal mortality, the investment goes into medical care and midwives, with little attention on gender and poverty.

The situation is compounded by the exclusion of large percentage of the population from available medical services. The best estimates are that 54 percent have access to "modern medical care". The nature of such care is not specified but there is evidence that medical care in many of the centers are rudimentary where service providers have little or no training. There is therefore a huge gap between the health needs and available services. This gap is filled by a wide range of alternative care givers such as patent medicine dealers who treat diseases as well as traditional and faith healers. For the excluded, any episode of ill-health drives them to sources which are affordable but which may not resolve such problems. It is this exclusion from sources known to be beneficial and the neglect of political and economic dimensions which translate to high infant and maternal morbidity and mortality rates, low life

expectancy and regular bouts of cholera and other epidemics. The change that may lead to turning the tide has scarcely begun where the emphasis remains in bio-medical care to the exclusion of social and political aspects of diseases causation and where a holistic concept of health is ignored.

References

- Alubo, O. (1985) Drugging the People: Pills, Profits and Underdevelopment in Nigeria, *Studies in Third World Societies*, 24:89-113.
- Alubo, S. O. (1987) Power and Privileges in Medical Care: An Analysis of Medical Care in Post-Colonial Nigeria, *Social Science and Medicine*, 24-5: 453-462.
- Alubo, S. O. (1990) Doctoring as Business: A Study of Entrepreneurial Medicine in Nigeria, *Medical Anthropology*, 12-13: 249-318.
- Alubo, S.O (2001) The Promise and the Limits of Private Medicine: Dilemmas in Health Policy Options in Nigeria, *Health Policy and Planning*, 16 (3) 313-321.
- Dubos, R. (1978) *Man Adapting*, New Haven: Yale University Press.
- Erinosho, O (1982) Health Planning in Nigeria, *Nigerian Journal of Sociology and Anthropology*, 8:34-49.
- Federal Ministry of Health (2006) National Health Policy Nnebe, H ed. *Policies of the Federal Republic of Nigeria* (1999-2007).
- Federal Ministry of Health (2009) *Strengthening National Health System* Abuja: Federal Ministry of Health.
- Federal Republic of Nigeria (2010) *National Strategic Health Development Plan, 2010-2015*.
- Harrison, K. (1997) Maternal Mortality in Nigeria: The Real Issues, *African Journal of Reproductive Health*, 1 (1): 7-13.

Federal Republic of Nigeria (2010) *The MDG-DRG Funded Midwives Service Scheme*

Mburu, T. (1981) Implications of Ideology and Implementation of Health Policy in a Developing Country, *Social Science and Medicine*, 15A: 17-24.

McKeown, T. (1979) *The Role of Medicine: Dream, Mirage or Nemesis*, New Jersey: Princeton University Press.

National Primary Health Care Development Agency (2009) *National Immunization Policy*, Abuja: NPHCDA.

Navarro, V. (1976) *Medicine under Capitalism*, New York: Prodist

Powels, J. (1973) On the Limits of Modern Medicine, *Social Science and Medicine*, 1:1-30.

Shiffman, J. (2007) Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries, *American Journal of Public Health* 97(5): 796-803

Turshen, M. (1977) The Political Ecology of Disease, *Review of Radical Political Economics*, 9(1):45-60.

Trovalla, U.A. (2011) *Medicine for Uncertain Futures*, Uppsala: University of Uppsala.

Wall, L. (1998) 'Dead Mothers and injured Wives: The Social Context of Maternal Mortality in Northern Nigeria, *Studies in Family Planning*, 29(4): 341-359.

Wildavsky, A. (1977) Doing Better and Feeling Worse: The Political Pathology of Health Policy, John Knowles (ed.) *Doing Better and Feeling Worse* New York: WW Norton, 105-123.

Ogoh Alubo is professor of health and social development, Department of Sociology, University of Jos, Jos, Plateau State, Nigeria

HERFON'S Programme Update, 2012

1.0 Partnerships and Networks

- 1.1 GAVI/JHU IVAC Project – HERFON has been contracted by The Immunization and Vaccine Access Centre of John Hopkins University in Baltimore Maryland to run its Parliamentarians Advocating for Immunization in Nigeria (PAFIN) project. Similar to the model used in the UK. Project commenced in January, 2012. Have identified 7 parliamentarians to advocate for adequate and predictable vaccine financing, participate in the National Assembly press briefing and the National Vaccine Summit as well as trade experiences and information with other parliamentarian advocates during the 126th Assembly of International Parliamentary Union in Uganda in early April, 2012.
- 1.2 NHIS – Partnering in verification of mutual, coops and CSOs, as part of roll out of CBHI, ensuring equity and access for potential subscribers - ongoing. HERFON designed the tool and facilitated implementation workshop. We are in the process of analyzing the data collected using SPSS to inform the recommendations to be made.
- 1.3 GAVI –HERFON is hosting the interim secretariat of the CSO Coalition for Immunization, while the CSO consortium structure and funding framework are being finalized. Selection Criteria for membership of the wider body have been agreed upon and a tool developed. The structure has secured a name and will complete the legal registration process in a few weeks.
- 1.4 NPHCDA – Mapping of Development partner activity nationwide to facilitate dialogue for better synergy and limit duplication of effort. Parameters include sub-populations served, intervention type, staff strength, project/programme duration, etc - ongoing
- 1.5 Governor's Forum – Working with the DG's office to advocate to Governors for the establishment of SPHCDA's to facilitate the offering of all PHC services under one roof.

2.0 Advocacy

- 2.1 Scorecard – Currently working on health spending trends at both State and Federal levels, highlighting departures from recommended priorities in the National Strategic Health Development Plan. Last two scorecards focused on Wild Polio Virus and Midwives Service Scheme.
- 2.2 Nat. Health Bill – The President may likely refer the Bill back to the National Assembly. This presents an opportunity to have the concerns by allied professional and religious groups addressed in a possible amendment to the Bill. A meeting of Allied Health Professionals will be hosted by the National Health Sector Coalition here in Abuja on March 8th for that purpose, as follow-up to the Obudu retreat resolutions. Later the religious groups that had issues with 1 or 2 sections of the Bill will be engaged before advocacy for its passage in the house can be undertaken.
- 2.3 Zonal Engagement of Stakeholders in the South-South, South East, North West, North East & North Central Zones – Zonal advocacy themes identified. State delegations identified their priorities for advocacy and work plans have been developed in 13 states so far. State plans will be monitored for performance.

2.4 John Hopkins University Immunization and Vaccine Access Centre has commissioned a series of Town Hall Meetings to ascertain peoples' knowledge, attitudes and perceptions in reference to Routine Immunization and its delivery in their localities. One of these Town Hall meetings will be coordinated by HERFON in Imo State. It will engage representatives of various groups (policymakers, health workers, caregivers, youth, women, etc.) and will attempt to articulate their recommendations to Government as to make routine immunization better.

3.0 Capacity Building

3.1 Grantsmanship workshop has been designed and advertised for roll-out throughout the year.

3.2 Train the trainer Advocacy workshop to commence soon in Abuja, will be attended by Zonal trainers who will step down the training to the states. The names of the trainers are being submitted to HQ and will close at the end of next week. Resumes will be reviewed and the most appropriate candidates selected to participate.

4.0 Evidence Generation and Use

4.1 The Review Advisory Committee is being reconstituted to identify the next 5 themes for the annual NHR. Next edition will focus on Immunization and, in addition to print, will be available as an e-book to facilitate distribution and limit postage costs.

4.2 Newsletter Editorial Committee has been constituted for the Quarterly HERFON newsletter. It will highlight successful reforms going on in the country and internationally and advocacy activities ongoing in the States.

5.0 Institutional Strengthening

5.1 HERFON Output to Purpose Review 2011 -- Conducted in September with recommendations to strengthen state chapters. Also recommended re-focusing on core purpose, i.e. advocating for health reforms

5.2 Signed a contract with E4A as Host Agency - will be providing office space, facilitating networking with maternal health stakeholders, logistics and admin support, will manage their financial records, etc.

5.3 Exploring programmatic collaborations with BroadReach Healthcare VA, USA; Concern UK, AfricaHealth and PATHS2

New Appointments at Foundation

Executive Secretary

Olayiwola Erinosh, a product of the Universities of Ibadan and Toronto, taught at the University of Ibadan and Olabisi Onabanjo University before his appointment as the foundation Executive Secretary, Social Science Academy of Nigeria. He held several academic and administrative positions, - Head of Department; Dean of Faculty; Visiting Research Professor, NISER, Ibadan; Visiting Fellow, National Institute for Policy and Strategic Studies, Kuru, Jos; Senior Fellow, African Development Foundation, Washington DC, and also as Consultant to Aro Neuropsychiatric Hospital, Abeokuta, USAID, UNDP, WHO, PATHS1 and PATHS2. Lately the Co-Chair of the WHO/TDR Thematic Group on Health Systems and Implementation Research, and now President, African Sociological Association.

Senior Advocacy, Communication, and Knowledge Management Officer

Theresa Kaka Effa has over 12 years experience working in the Nigerian NGO sector as a volunteer, employee, and consultant in Behaviour Change Communication, strategic planning, policy and legislative advocacy, coalition and network building. She has been involved in the formulation of several national and state level policies, guidelines, and plans on HIV/AIDS, population and reproductive health, and also trained several health and development advocates in the public and private sectors. Effa is on the advisory boards of a couple of non-governmental organizations, a freelance writer, and a member of Lions Club International District 404A

Zonal Programme Officers

Health Reform Foundation recently appointed the following ZPOs:

South West:

Dr. Olabode O.Oyekoya, a product of Kings College, Lagos He obtained MB ChB at the Olabisi Onabanjo University, Ago-Iwoye and MPH of the University of South Florida, Tampa, USA, specializing in Global Health.

South East:

Mr. Tochukwu Christopher Amalu received his secondary education at St. Patrick's Secondary School, Emene, Enugu and Special Science School, Ihe-Agwu. He obtained the BSc Zoology and MSc Parasitology at the University of Nigeria. He is currently enrolled in the PhD programme at UNN.

North East:

Mr. Ahmad Yahuza Getso, graduated from the Ahmadu Bello University, Zaria with a B.A. honours degree in Arabic. He also holds the Masters in International Affairs and Diplomacy, Masters in Public Policy and Administration, and Higher Professional Diploma in computer studies of Bayero University, Kano.

North Central:

Mr. Onyeke, Augustine Obe obtained B.A. English Literature, University of Maiduguri and MSc. (Gender Studies), Benue State University. He is currently pursuing another Masters in development studies at same university in Makurdi.

North West:

Dr. Ahmed Ibrahim Isofo is a recipient of the DVM (University of Maiduguri) and MPH (Ahmadu Bello University, Zaria).

Call for Membership of Health Reform Foundation of Nigeria

Health Reform Foundation of Nigeria is an independent membership organization with branches in FCT, thirty six states, and Zonal Offices in the six geopolitical zones of the country. The organization welcomes individuals that are committed to the reform of the health sector as members. HERFON seeks to achieve its broad objective through advocacy, capacity building, and partnership with reform minded individual and bodies.

This is a call is to invite reform minded members of the public to join the movement to reform Nigeria's health sector, Secondly, the call is to encourage any member of the public who has skill to offer as Consultant on projects in the health sector to provide his/her bio-data for storage in HERFON's data bank. Such bio-data will be made available to interested national/international agencies that may require their service.

Application for membership/storage of bio-data should be forwarded through:

Hefron12@gmail.com

In accordance with the following format before March 20, 2012:

1. Name (starting with Surname):
2. Present Position:

3. Institutional Base:
4. Full Address:
5. Email Address:
6. Telephone:
7. Educational Qualifications(to include degree, university, date of award only):
8. Areas of interest in Health Sector Reform in Nigeria:
9. List Not more than **10 most recent (2002- 2011) health policy/programme-linked papers/projects** executed including the funders
10. List Not more than **10 most recent (2002-2011) publications on health in indexed scholarly journals:**

- (a) Membership fee is N6000 per annum with the following benefits to members: placement of bio-data in Herfon's web site; opportunities to be nominated as a Consultant to National/International Bodies; opportunity to serve as member of Board, state chapter, or Zonal Co-ordinator; and access to health reform data).
- (b) Current Members are required to **validate their membership otherwise their names will be deleted from the Herfon's register**

Grantsmanship Workshop

Grantsmanship implies the capacity and/or ability to attract grant or win research grants. Winning grants is a taxing exercise because a

prospective grantee usually competes with hundreds or sometimes thousands of other applicants. Funding agencies often support

very small numbers among the prospective applicants for their grants. Consequently, any prospective applicant must recognize the fact that he/she is participating in a highly competitive exercise. The capacity to submit the right proposal together and get grant is critical. It is considered a serious business in the developed countries. As such, training programmes are organized to develop capacity of would-be researchers to attract grants.

Nigeria lags behind other countries in the development of good and fundable proposals. Because of this, we are losing out and not able to take advantage of many opportunities for research grants for our pet projects.

General Objective

The principal goal is to develop/enhance the capacity of social scientists, clinicians and other interested researchers in Nigeria's institutions on how to attract grants.

Specific Objectives

The specific objectives are to:

- a. Enlighten participants on the place of research and publications in professional staff development;
- b. Discuss key issues in grantsmanship;
- c. Outline framework for research proposal
- d. Discuss types of social and health services research
- e. Examine and underscore ethics in social and health research
- f. Identify funding sources for research
- g. Stimulate the development of concept proposals
- h. Prepare a report for the funders of the workshop

Methodology

The workshop will be interactive and participatory. Attempt will also be made to

encourage hands-on approach in formulation of concept proposals by the participants. The highlights on the methodology at the workshop will include the:

- a. formal presentation on each of the sub-themes of the training by resource persons drawn from public health, clinical medicine and sociology with the aid of PowerPoint, followed by discussion;
- b. breakdown of participants into small groups to explore key issues during plenary sessions in greater detail;
- c. distribution of ample literature/materials on the presentations and/or relevant to the key issues among the participants;
- d. practical demonstration on how to source for literature and funders of research, using the Internet;
- e. development of concept proposals severally or collectively by participants; and
- f. evaluation of the impact of the workshop.

Course Content

The Place of Research and Publication in Staff Development

The presentation will address the following questions:

- What are the primary and secondary goals of research institutions?
- What is the mission of social researchers and clinicians?
- How can researchers in all calling achieve their primary/secondary goal?
- What are the benefits or a fulfilled career in research?
- What are the snags in unfulfilled career in research?

Types of Research

This presentation will identify the types of research including, attributes and challenges

of, and/or in each type. The discussion will focus on:

- Solo vis-à-vis Group research
- Uni-disciplinary vis-à-vis Interdisciplinary Research
- Academic vis-à-vis Consultancy research
- Pure vis-à-vis Applied research
- Esoteric vis-à-vis Empirical research

Key Elements of Grant Winning Proposal I

The presentation will outline the key issues to be addressed in grant winning proposals which will cover the following:

- Identification/selection of research problem;
- Justification for research problem using extant literature
- -Field or social and clinical research methods with reference to the examples of primary and secondary data; retrospective, cross-sectional, prospective studies

Key Elements of Grant Winning Proposal II

- Team and teaming building
- Time line
- Budget and justification
- Management of research
- Bibliographic materials

Analysis of Data and Report Writing

These are extremely important in research and deserve to be addressed by prospective grantees. The focus will be on:

- Data entry
- Data cleaning
- Preparation of dummy tables
- Analysis, using appropriate software/techniques
- Report writing

Ethics in Research

Ethics which is about what is morally right must be addressed in research. This is because

of past atrocities in research work. Examples are the experiments conducted the Nazi doctors on Jews, the Tuskegee experiments in the United States etc. Everyone is required to apply ethical principles in research. The following will be discussed:

Respect for persons, community etc
Beneficence – ensuring that no harm is done

Distributive justice – equality of individuals and that the benefits and risks should be distributed fairly

Grantsmanship

Grantsmanship is defined as the capacity of researchers to attract funds from prospective funders towards their pet projects. The presentation will discuss:

Accessing Research Grants
Scaling the first hurdle
Review Process for the short-listed proposals
Scoring proposals
Criteria for Selection of proposals

Financing Research Proposal

- a. Searching for research funds
- b. Major funding domestic and international funding agencies

Number of Participants: 30

Workshop Materials: To be Provided

Cost:

N35, 000 per participant including group lunch and tea breaks (**excluding accommodation in Abnja**)

**Application should be forwarded through:
Hefron12@gmail.com**

Date

S/N	Schedule for 2012	Date
1.	First Quarter Workshop: Deadline for Application is March 10, 2012	April 23-26, 2012 (Arrival 15 April)
2.	Second Quarter Workshop: Deadline for Application is June 10, 2012	July 17-19 2012 (Arrival 16)
3.	Third Quarter Workshop: Deadline for Application is October 10, 2012	November 20-22, 2012 (Arrival 19)

Zonal Reports

South East

As part of efforts to promote routine immunization and access to vaccine in Nigeria, the *International Vaccine Access Center (IVAC)* is supporting a National Vaccine Summit scheduled to hold from April 16-17, 2012, in Abuja. The meeting will bring policy makers, programme managers, key players in the private sector, development partners, and delegates from abroad together.

Prior to the National Summit, six zonal town hall meetings across Nigeria were held to gauge opinion and garner information on perception of immunization. The outcomes of the meeting are expected to feed into the National Summit.

The Health Reform Foundation of Nigeria (HERFON) was privileged to facilitate one of the six zonal meetings at Umuorieubi, the capital of Mbaitoli LGA, on March 22, 2012, Imo State. The meeting provided a platform for participants from the states in the zone to:

- a. identify factors which act as barriers to access to vaccines and immunization from the supply and demand standpoints;
- b. articulate opinions concerning immunization and access to vaccine; and,
- c. reach a consensus on how to strengthen routine immunization in their zone/state.

About three hundred and fifty participants attended the meeting which included the following:

- Dr. Ben Anyene, Chairman, HERFON;
- Lady I. Agbaso, wife of the Deputy Governor of Imo State who represented the First Lady;
- HRH Eze Samuel Agunwa Ohiri, Chairman of Imo State Council of Traditional Rulers;
- Dr. S. O. Amaechi, Imo State Governor Special Adviser on Health;
- Dr. Okeagu who represented Imo State Commissioner for Health; and,
- HERFON Zonal and State Chairmen.

South West

- The leadership of the Oyo state chapter recently met with the State Team Leader of Nigerian Urban Reproductive Health Initiative's (NURHI) and is determined to assist in the implementation of the advocacy of its activities.
- The Zonal Programme Officer in Ogun State is working with the SuNMaP State Team Leader in the implementation of advocacy activities which will start on March 27, 2012.
- The Ekiti State chapter held a meeting on Thursday March 15, 2012 and agreed that a membership drive should be embarked upon to diversify its membership base.

North West

The Zone collaborated with:

- NURHI in fast tracking the passage of the bill on free maternal and child health in Kaduna State;

- SuNMaP in baseline survey in Kaduna State;
- Joint Annual Review exercise in Kaduna and Kebbi State
- NURHI and Kaduna State Government on the launching of emergency transport scheme for reducing inaternal mortality in the state.

North Central

Niger State Ministry of Health invited HERFON to assist in:

- capacity building of staff in the Department of Planning, Research and Statistics;
- the development of health information system;
- financial management of projects; and,
- the promotion of good interpersonal relations among doctors and nurses working in the State's Ministry of Health.

Address of Her Excellency Nneoma Rochas Okorocho, First Lady, Imo State

It gives me great pleasure and a sense of fulfillment to participate in this occasion holding today. Therefore it is with a great sense of duty and responsibility to provide an overview of the State's Government health policy objectives.

Immunization has become a vital part of health care delivery worldwide since the creation of the first vaccine for small pox in 1790s by Edward Jenner. As the injunction *prevention is better than cure*, it is true to say that immunization remains one of the most effective public health intervention methods to combat preventable child and adult health challenges.

Vaccine have been frequently cited as the most equitable, low cost, high impact public health measures that save millions of lives annually if provided at the national level. Over, the last 40 plus years, the use of small pox, measles, diphtheria, tetanus, pertussis, and poliomyelitis vaccines have eradicated diseases in countries where immunization is widely provided/accepted.

More attention is now focused on improving the health of the population of sub-Saharan Africa than at any previous time because of increased funding from

governments, multilateral and bilateral donor, as well as new public-private partnerships and foundations. Funds are now available for the delivery of effective health interventions.

This town hall meeting is especially important as it would provide the forum for discussing and assessing the challenges to achieving vaccination targets. The report of this meeting will provide government with data for good and sound judgment on how to deliver future effective health programmes as well as achieve MDGs4,5, and 6. Consequently, the importance of this town hall meeting cannot be over emphasized.

The Imo State Government under His Excellency Owelle Rochas Anayo

Okorocho has articulated programmes including the *Health at your door step* project to ensure that the objectives of the MDGs are met before the 2015 set date.

I congratulate HERFON for this noble project and thank you for bringing this town hall meeting to Imo State. I use this opportunity to invite other like minded NGOs and donor organizations to complement the rescue mission of the Imo State Government on health.

No doubt when this is done Imo must be better.

Delivered by Lady I. Aghaso, Wife of the Deputy Governor, Imo State, Nigeria, March 22, 2012.

Editorial Board

Managing Editor

Professor Olayiwola Erinoshó

Editor

Dr. Nkem Ene

Members of the Board

Adewale Adeleye

Ahmad Yahuza Getso

Augustine Obe Onyeka

Christopher Amalu

Dr. Olabode Oyekoya

Dr. Tsofo Ahmed

Innocent Ekene Nwankwo

Rebecca Ogbimi

Theresa Effa

Editorial Secretary

Gladys Edungbola

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.

Short pieces should be forwarded to the Managing Editor, hefron12@gmail.com

ISBN: 978-978-2137-47-2



...Better Health For All Nigerians