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MDGs: countdown to 2015

Weaknesses in the health system continue to be a binding constraint. With less than 5 years to deadline, the country is starting to evaluate how well it is doing in making progress towards achieving the health-related Millennium Development Goals (MDGs). The Federal government, along with the governments of the 36 plus one states of the federation have unequivocally adopted the National Strategic Health Development Plan (NSHDP) 2010–2015, as the road map for reaching set targets. One year into its implementation, the NSHDP is also proving to be the basis for assessing the performance of the Nigerian health system – the vehicle through which targeted MDG health interventions are meant to be delivered. Using administrative data to monitor progress of the annual targets, as outlined in the national results framework of the NSHDP, the 2010 Annual Health Sector Review, jointly conducted by government and its partners (including donors, civil society, and the private sector) has provided some indication of the present situation.

While progress on several outcome indicators are generally off-track, immunisation coverage seems to be improving. The national immunisation programme is said to have embarked on a process of reaching unimmunised children through constructive involvement of traditional and religious leaders, among other strategies, to vaccinate well over 2 million additional children in the past 2 years. Consequently, the percentage of fully immunised children has dramatically increased from very low levels of 13% and 18% in 2003 and 2008, respectively, to 53% by the end of 2010. On polio eradication, the number of cases has come down to about 4 cases in 2010 compared with 735 in 2009. Nevertheless, the national immunisation programme is still considered to be weak as it is heavily dependent on campaigns to deliver vaccines rather than the use of routine immunisation services.

The Review also revealed that similar structural defects within the health system are widespread. For example, it was noted that only a few of the complicated maternal and child health cases needing referral actually got to the next level of care. This was attributed to several factors but chief among these was none existence of transport and communication equipment. On essential medicines, proper forecasting and replenishment of stock was not regularly undertaken, leading to extended periods without vital drugs. Nigeria is currently one of the few countries in sub-Saharan Africa that is purchasing its routine vaccines (with the exception of yellow fever) and tuberculosis drugs. However, there is still no sustainable commitment by the government to allocate and disburse funds to purchase these and other essential drugs and health commodities such as contraceptives, anti-malarial, and anti-retroviral drugs. For outreach services, there were no standard guidelines for their frequency and purpose of outreach services as well as systematic process for monitoring the outreach activities.

The country may not attain the health-related MDGs by 2015 if these systemic weaknesses within the health system are not addressed quickly. The National Council of Health (a forum of the Federal Health Ministers and all the State Commissioners of Health), in acknowledging this fact during its 54th Meeting in Abuja, in May, pledged to apply lessons learnt and best practices recorded in the implementation of the NSHDP in the year 2010 for programme planning and execution for the final years of the MDGs targets. But top on the agenda is improving the capacity of the country to deliver a minimum package of care through a strengthened PHC system.

Dr Tarry Asoka

All hail, National Health Bill!

Slightly quicker in gestation than the National Health Insurance Scheme, the National Health Bill finally emerges. Shima Gyoh muses on its origin and its importance

In May 2011 the Nigerian health sector was excited by the news that the National Assembly had passed the National Health Bill (NHB) that had been in the pipeline for over 5 years. The news immediately ignited the rivalry endemic in the relationship between professions in the health team. One union demanded its immediate withdrawal, claiming that it was not fair to them. Why did they wait this long?

I had all along thought that the NHB was probably a confidential if not a secret document. If it went through the stage of Public Hearing, I never heard of it, but this might well be my fault for failing to keep my eye on the ball – in the dark! The Public Hearing stage of bills in Nigeria today is not at all the well-publicised event it should be. Copies are not made widely available to the public, and unless you live in Abuja, and are lucky enough to pick up the rumours, you would not know about it.

The federal government appointed experienced players in the nation's health sector to constitute the Health Schematic Group, and gave them the job of drafting the policy the government must follow to transform the nation's health sector to be among the world's best 20 in the year 2020. We were given many working documents, but the NHB was not among them. Of the 40 delegates spanning most of the professions in the health team drawn from the public and the private sector, only one, the representative of the Federal Ministry of Health (FMOH) had ever seen the document! We requested to have a copy, but even the FMOH could not provide it. I (the Chairman of the Group) eventually procured a draft copy from the National Planning Commission. It contained many provisions and omissions which were of great concern to us, but we were unable to factor them into our deliberations because it was only days before we wound up and our report was almost ready at the time we got the draft. In any case, no one, including the Health Minister was sure whether it was really the final copy sent to the House! I submitted a critical analysis to the FMOH, pleading that the Bill be recalled for wider consultation and fine-tuning. I did not receive an acknowledgement, not to talk of evidence of interest.

It was only last year that the last Minister of Health sent an electronic copy to the Committee of Chairmen of Federal Government Teaching Hospitals, and we believed it to be the authentic copy. The document was less malignant than the earlier draft I analysed,

but certainly not perfect. Even so, we should never wish to go through another 5 years without it because it provides for greatly improved funding of the health sector. This alone is sufficient for us to endure any sin it might contain. We should start implementing it and immediately begin collecting the information needed to fine-tune it through amendments.

The lesson is that people involved in drafting legislation should no longer take the public for granted. It is probable that, at the formative stage of the NHB, the FMOH, did not discard the top-down approach established during the military era and simply constituted a committee to produce it. Next, most members of the National Assembly do not consult their constituencies even on legislation that they sponsor, if not initiate – no such a meeting has ever been held in my constituency. I have assumed this to be due to our defective electoral process whereby legislators do not quite feel they owe their privileged positions to the electorate. I am not proud that my local government is so backward in everything that the handful of us who are graduates are *ipso facto* prominent citizens; yet I have never personally been contacted by anyone seeking to be a local government counsellor, a member of the State House of Assembly, the national House of Representatives, or a Senator in their bid to represent me. It is common knowledge that votes did not matter before President Jonathan came on the scene. I only hear about 'my' representatives in circulating gossips or when they make it to the press, often in bad light! Once you are not organised to viciously participate in the scramble for the 'National Cake,' you become insignificant. We hope that the power of the plebiscite, which showed signs of recovery at the last general elections, will grow into genuine democracy, restore the supremacy of the people's will and consolidate their power to vote governments in and out of office. When it becomes established, presidents, governors, and legislators would start behaving like servants of the people rather than the overlords they presently are.

But before we reach this desirable goal, we should support the President signing into law the NHB and have something to work on rather than hold back improved funding that the Bill promises. We must work hard to ensure that increased subvention to the health sector translates into radical improvement in health of the people. We must stop an army of financial vampires descending on the sector and leaving us worse off than we presently are. Impossible as that might seem, Nigeria has great potential – either way – and we cannot afford to take chances!

Prof Shima Gyoh, Co-Editor, Africa Health (Nigeria).

News in brief

Much ado about the Health Bill delays Presidential signature

The 1999 constitution describes the structures and responsibilities of the three levels of government (Federal, State, and Local) and of law and order in the country but is not explicit on functions. While health is assumed to be a concurrent responsibility but with Local Government Areas (LGAs) as the main implementing agencies of primary healthcare, there is only a vague reference to LGA responsibility for health ('LGAs are responsible for the provision and maintenance of health services'), otherwise the constitution is largely silent on health services. The lack of an overarching health law, which compensates for this lack of legal mandate in the constitution, gave rise to the development of a National Health Bill. But with protests from various quarters – in particular health professional associations following the passage of the bill by the National Assembly – the proposed health bill may be failing to fulfil this promise.

Shortly after the bill was passed in May prior to the inauguration of the President, a group, which described itself as an Assembly of Healthcare Professional Associations and Unions (nurses, pharmacists, laboratory scientists, radiographers, physiotherapists, community health workers, etc) staged a public protest in Abuja – asking the President not to sign the bill into law as it would create more crises in the health sector. Part of their grouse is that the health bill seeks to overtly or covertly usurp or infringe the specific legal and statutory functions of various professional regulatory councils or boards in the sector. Secondly, they frown at the provision that assigns the position of Executive Chairman of the National Tertiary Hospitals Commission to medical doctors, insisting that modern healthcare is a multi-disciplinary, multi-professional endeavour. Again they want representation on the National Council on Health, which hitherto has been advisory in nature, is

now going to be the apex policy making body in the country on health issues.

While presidential advisers are still studying the matter on how best to advise the President to proceed, the leadership of the Federal Ministry of Health and the National Assembly supported by their legal experts have started to clarify some of the contentious sections of the health bill. To start with, it has been made clear that the health bill does not abrogate the laws of the regulating bodies for health professionals. Within the framework of a 'collaborative federalism' that is supposed to be practised in Nigeria, the National Council on Health – which is a forum of the Federal Minister of Health (Chair), and the State Commissioners of Health and their FCT counterpart – is now given a legal status by the health bill with a view to making its resolutions more binding on the states. More so as it has been institutionally placed above the Federal Ministry of Health, states may feel more comfortable in dealing with the Federal Government on matters related to health through this body – that becomes an accountability mechanism. Since states are the only federating units, professional associations and regulating bodies cannot be members of the National Council on Health. However, they can continue to play a technical advisory role, which they have been doing. With respect to the appointment of medical doctors to head health institutions especially hospitals and even the Federal and State Ministries of Health – this has been an ongoing tension among health professionals in the public sector that is yet to be resolved.

It is not known yet if and when the President will append his signature to the health bill, which has been in the making for the past 6 years. Several observers of the Nigerian health sector, especially the international donor community are hoping that this should happen as soon as possible to give primary health care the much needed lifeline. But many others are equally concerned that the new National Health Act should not worsen an already bad situation. **TA**

Professor Onyebuchi Chukwu reappointed



The Nigerian President Goodluck Jonathan has shown faith in Professor Onyebuchi Chukwu by reappointing him Minister of Health in Nigeria. This will bring some long sought-after stability to the health sector. In the previous 4 years, the Ministry of Health in Nigeria went through four ministers, a situation which makes policy formulation and implementation an impossible task.

Professor Chukwu famously said during his screening by the Nigerian Senate that the National Hospital was 'a national hospital in name only.' Now he has a rare opportunity to drive change in not just the National Hospital but the entire health sector. Getting the Health Bill signed into law by the President will be an early priority.

On his return to the Ministry, he informed his team that the present administration would focus on a transformational agenda which would translate into good quality of life for Nigerians. **CI**

MDCN comes to life

Strikes continue to challenge the ethical foundation of the medical profession. But the era of strikes as the first option in resolving trade disputes by medical doctors may be over, as the Medical and Dental Council of Nigeria (MDCN), which regulates the industry, issued new conditions. Doctors have been instructed to meet before embarking on strikes. Firstly, they will have to hand over their patients to competent and qualified persons to continue with treatment. Secondly they will have to inform the Nigerian Medical Association (NMA) and the MDCN to secure their approval for the planned strike action. Finally – and this may be the most radical decision – any Nigerian that loses a relation due to strikes declared by doctors will be able to petition the regulatory for disciplinary action. If strikes are then approved to go ahead under the new rules, emergency and accident departments must remain open even when the strike is ongoing.

These new guidelines were announced in June by the MDCN Chairman, Prof. Roger Mankanjuola. **CI**

The 54th NHC: counting down to 2015

The National Health Council is the apex meeting of the health calendar. Felix Obi reports on the outcomes and wonders how it might be made more fit for purpose.

After several postponements due to logistical and other challenges, the 54th National Council on Health (NCH) was eventually hosted in May in Abuja. Being the highest policy making body within Nigeria's health sector, the NCH attracted delegates from the 36 states and the FCT comprising state Commissioners of Health, PSS, disease programme managers, representatives of professional regulatory bodies, professional associations, development agencies, NGOs, and the media.

The 54th NCH had the theme, 'Count Down to 2015: National Strategic Health Development Plan as the Road Map for Achieving the Health-Related MDGs' The meeting provided an opportunity for the a coordinated review of the performance of the Nigerian Health Sector in the context of the NSHDP, while highlighting the linkages and contributions to the realisations of the Health-related MDGs. It also provided the states with a platform to learn and share experiences on the progress, challenges and opportunities they were experiencing.

The expectations were high considering that the states had unanimously agreed to implement the strategic goals of the NSHDP at the 53rd meeting to the delight of local and international stakeholders who applauded the laudable initiative. Ahead of the meeting, the Federal Ministry of Health had sent out guidelines for the preparation of memos in line with the 8 strategic priority areas of the NSHDP to all the states and specified the criteria for the classification of these memos into actionable or informational memos. Accordingly, the states responded and a total of 82 memos were received from the states in addition to Progress Reports outlining the level of implementation of health programmes and initiatives that contribute to the realization of the goals and targets of the NSHDP and/or their respective States' SHDPs.

Thursday the 5th of May marked the beginning of the Technical Session which was chaired by the Permanent Secretary of the Federal Ministry of Health, Mr Linus Awute, and reviewed all of the memos received, and forwarded those with merit to the main Council session. On Saturday, the 7th of May an all-day symposium on Disease Surveillance in Nigeria was held for the first time at the NCH and it was chaired by eminent Professor of Public Health, Dr Adetokunbo Lucas whose paper on the overview of disease surveillance in Nigeria set up the tone for the plenary and break-out sessions of the symposium. On Sunday the 8th, an early afternoon meeting was held on Infant Feeding within the context of HIV which was well attended.

The main council session kicked-off on Monday the 9th of May with an elaborate opening ceremony

marked by speeches by the FCT Honourable Secretary of Health, the Honourable Minister of Health and goodwill messages from development partners. After the speeches, there were technical presentations on the findings of the Annual Review of the Health Sector, Health Sector Coordination Mechanism, the Assessment of Workforce and Service Provision in the Private Health Sector in Nigeria. Prof. Adetokunbo Lucas in addition presented a report of the Symposium on Disease Surveillance in Nigeria to the council. The Honorable Minister of Health, Prof C.O Onyebuchi Chukwu chaired the 2-day main council session for the ratification of the memos. Expectedly some of the memos were ratified and adopted as action memos while some of the information memos were also approved.

Among others, the resolutions of the 54th NCH include the approval/establishment of the following: Diaspora and Foreign Missions Unit at FMOH/SMOH, Implementation Guide on BPHCUOR, National Oral Health Policy, Health Service Commission, Babbar Ruga Fistula Centre as National Centre for Prevention, Treatment, Rehabilitation, Training and Research on VVF, Nigeria Child Health Card, Human Resources for Health Unit at Federal and State MOHs, Social Production of NIPRISAN.

Though it is commendable that the 54th NCH focused on the achievement of the MDGs a lot more effort needs to be made to improve the quality of the outputs and decisions to be made at subsequent NCHs. For instance a critical review of the memos submitted showed that so many were not technically-sound or thoroughly thought out or evidence-based. In addition only 16 states plus the FCT reported any progress on the implementation of the Resolutions of the 53rd NCH, while 11 states did not submit any progress report as requested by the FMOH. Furthermore only 18 of the resolutions of the 53rd NCH were reported on by the 16 states plus FCT.

Considering the enormous financial and human resources committed by the government and donors for the successful hosting of each NCH, it is expedient for all stakeholders to demand more value for health for the investments made in this regard. Beyond the adoption and ratification of memos, the FMOH and SMOHs need to also resolutely commit to the implementation of the NCH resolutions which should be time-bound and goal-directed. And beyond the publication of the NCH proceedings in newspapers, and to ensure accountability towards the beneficiaries of the policies, these resolutions need to be shared widely with more stakeholders and the public through other mediums for proper monitoring and follow-up.

Felix Obi, Co-Editor, Africa Health (Nigeria).

Bridging the 'knowledge-doing gap' by capacity building of middle-level managers

Broad-based training to enable PHC programmes to work

Nigeria's National Health Policy has identified primary healthcare (PHC) as the cornerstone of the overall health system, providing a cost-effective, equitable, and sustainable means for delivery of basic health services to its mainly rural population. The implementation of an integrated PHC system remains the most efficient means of significantly improving access to care, scaling-up priority interventions, and ensuring consistent progress towards achievement of Millennium Development Goals (MDGs) 4, 5, and 6. However, the lack of managerial capacity of the health workforce at all levels of the health system is increasingly cited as a binding constraint to scaling-up services and achieving the MDGs.¹ In Nigeria, this critical factor coupled with persistence of internal rural-urban and external south-north drift of skilled human resources, has highlighted the need for creative and more effective management of scarce resources. Furthermore, despite significant improvement in the academic qualifications of PHC leaders at State and Local Government Authority (LGA) levels, these 'managers' have received little if any formal training either broad-based or tailored towards their daily responsibilities on the more generic skills needed to make health systems work, such as management, accounting, procurement, logistics, and the 'softer' managerial skills such as team building and negotiation. At the individual level this manifests as the 'knowledge-doing gap'.

In a bid to address this gap the mid-level management (MLM) training programme for PHC was conceived by the National Primary Health Care Development Agency (NPHCDA) in 2009, with technical support from Duke University, USA in strong partnership with the Federal Ministry of Health, Office of the Head of Civil Service of the Federation, and Centre for Management Development. The entire process has so far been publicly funded from debt relief funds through the Office of the Senior Special Assistant to the President on MDGs.

The first cohort from the MLM training graduated in Abuja in October, 2010. The course for the programme was structured as an in-service training consisting of six residential sessions lasting 1 week each, inter-spaced by 1 month during which participants return to their duty posts and undertake practical exercises which are assessed and scored. A total of 111 participants selected from the 36 states and Federal Capital Territory comprised several disciplines including physicians, nurses and midwives, community health workers, and

health administrators. Each had strong health service qualifications and headship of divisions and units, or were programme officers with a mean of 17 years' experience working in PHC.

The programme comprises 21 course areas condensed into three modules focusing on leadership, analytic skills, and policy. Lectures were co-taught by content and context experts from corporate management, academia, public and private institutions, and experienced staff of the NPHCDA. The core training method was interactive with a hands-on approach, utilising experiential methods such as class discussions, skill stations (including hands-on computing) and inter-session assignments.

The Bill and Melinda Gate Foundation supported the Global Business Schools Network and the University of California Berkeley, to evaluate this first round of the programme. The results gave clear indications of increased confidence among all participants in the performance of their duties, evidence of utilisation of course content, improved organisation and financial management of programmes, and increased knowledge of subject material across the board in each topic area. The MLM training also has provision for longer term assessment of programme impact through mentoring, coaching, and programme graduate support network.

The future vision for the programme is anchoring it within a training institution, where pre-qualified candidates either self-paying or sponsored, can benefit from the course. The NPHCDA is currently exploring future partnership with academia, private sector, within government at country level, and internationally to ensure sustainability. The NPHCDA is now undertaking training of the second cohort of managers on the MLM for PHC programmes.

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A cross-section of trainees at an MLM programme

Dr Nnenna Ihebuzor, Director of Community Health Services, NPHCDA.

The paradox that is Nigeria: reflections on a both uplifting and frustrating term of office in the donor sector

Jane Miller has spent 6 years working for the World Bank and DFID in Nigeria. She has travelled the length and breadth of the country. Before she returned to the UK, Felix Obi interviewed her.



On May 26th 2011, which also recorded the passing of the National Health Bill, Felix Obi of the Africa Health editorial crew had an engaging interview with Jane Miller, the outgoing Senior Health Adviser and Team Leader of Human Development at the Nigeria office of the UK Department of International Development in Abuja. She was also the first Co-chair of the Development Partners Group on Health in Nigeria. Jane holds a masters degree in Public

Health from the London School of Hygiene and Tropical Medicine with a background in Nutrition and Dietetics. Her career in Africa began in Zambia where she lectured on Nutrition and Food Security in a University outside Lusaka for 3 years.

Following the end of apartheid in South Africa, she was posted by the UK government to South Africa to support the health sector reform process in the country in 1995. Her first assignment in Nigeria was as DFID's HIV/AIDS specialist at the World Bank, and thereafter she was posted to Zambia, where she worked briefly before her second assignment as Senior Health Adviser and Team leader of Human Development at DFID Nigeria. Cumulatively she worked in Nigeria for about 6 years, and rounded up her duty in Nigeria in June 2011. By August 2011, she will be taking over as the head of MDGs at DFID headquarters in London.

When did you start work in Nigeria?

I was in the World Bank between 2003 and 2005. I first came into Nigeria in January 2003 and was here for two and half years and then I left for two and half years to Zambia and now I have been back for three and half years. So basically am just coming up to six years in Nigeria.

What was the environment of healthcare like generally then?

When I first came to Nigeria I was focusing on HIV. I think the situation then, particularly with HIV, was that of quite widespread denial of there being a problem despite the statistics that showed that Nigeria (I think) in those days had the third biggest burden in the world for people living with HIV. People didn't really talk much about it. The government didn't talk much about it and there was little donor funding for HIV. And there was a huge conservative feeling in the country and I remember when I first arrived, people were saying you'd never be able to talk about issues like condoms, sex, and behavioural change in Nigeria as those things can't be done.

But things moved quite quickly with Prof Osotimehin coming in to NACA. His really strong leadership, amazing communication skills, and his ability to be able to mobilise and influence people, had an important effect. Just to be seen on television speaking with Governors sharing the whole storyline of HIV/AIDS suddenly became the norm. And suddenly people were now able to talk about HIV and he went about sharing with Governors on what was happening within their states. And he helped states one by one sign on to the fact that there was a crisis and what it is they should be doing. And it was really exciting watching the transformation of a nation; one that was in denial, from one that was doing very little transform to another that had quite a strong vibrant response. And the trajectory of change over those few years was huge and people were now able to talk about condoms. I remember driving around the North, which were conservative states and seeing huge condom banners.

From the perspective of HIV, we've seen huge improvement. If you remember, we now have about 300 000 in Nigeria with HIV on ARVs, and if you had told me when I first came into Nigeria in 2003 that would happen, I don't think anybody would have believed that could be implemented for to be able to do that required a huge amount of work and resources to achieve. Though the PLWHAs were a vibrant, bright group and they were always shouting for things to change and for things to be better, but the resources

were not really available then. But with the work we did with Global Fund and PEPFAR with the Americans, Nigeria was able to achieve a huge task.

How do you assess the overall state of health in Nigeria as at now?

Overall when you're looking at health much more broadly and not just from the HIV perspective, I just think that Nigeria is in a huge crisis at the moment. Nigeria is a paradox. I've loved my time here and I think it's got some of the most energetic, passionate, bright, intelligent, and the most amazing people and it's the people that made me enjoy my stay in Nigeria. People from the most rural North to the vibrant city of Lagos; and you've got the most engaging, really intelligent people with amazing sense of humour. It's just a wonderful, wonderful country. The paradox is that on the other hand it has got the most appalling of statistics: 10% of children that die, 10% of maternal mortality, 10% of children out of school globally, 25% burden of malaria in Nigeria, etc. How could that happen? That is the paradox. You've got this bright, intelligent and wonderful people but on the other hand you've got these awful statistics. Now that paradox to me gives me a huge amount of hope. I do believe that Nigerians have the ability to take themselves out of the current situation. And it's that level of optimism that will make me stay committed to the Nigerian agenda forever, because I do believe the situation can and will change.

And the crisis in healthcare in Nigeria?

What I think needs to happen is that everybody has to acknowledge this crisis. At the moment I go to meetings and you hear the donors and NGOs shouting about this crisis and they seem to be in a state of emergency; the donors are asking what do we do and how do we do this or that seeing that Nigeria is in such a difficult situation and we are thinking of how we can support Nigeria. On the other hand, I don't see the Nigerian political elites like governors and everybody else seeing the same level of crisis that we do amongst the development partners' community. I think once we get to a situation where Nigerian politicians really get to understand this crisis and internalise it. Once we get to that point, I actually think the situation will turn around fast.

What are the solutions?

Most of the things we have to change
There are technical solutions to the situations faced today. They are not complicated and we know how to do it. For instance, Nigeria's National Strategic Health Development Plan (NSHDP) is wonderful and you have heard the international community hail it as being robust, credible, and costed, clear and prioritised. So Nigeria doesn't need a technical solution for they've got the technical solution in front of them on a document they've all signed up to. The

challenge will be in making sure it gets implemented and it will only be implemented when Nigerians and the politicians acknowledge the crisis and are willing to put their energy behind that plan.

Should we be prioritising expenditures on health?

I think this is part of the problem of the real story of Nigeria's problem not being internalised by the senior people. You ask them to develop a strategic plan and priority interventions, and they do; and you ask them what the statistics are and they will tell you, but then what they actually do can be quite different. Another example of an area where the crisis lies is about how money is used in Nigeria and the amount of time and efforts that are put into things that actually are going to help only a handful of people, such as organising the National Council on Health, the building of new health facilities, a new specialist hospital of some sort. Now if you look at how much money that has been spent on the health sector over the last years, it is mammoth, and if you look at the time and effort put in to the health sector in Nigeria and it's been huge. And yet we have got these awful, appalling, and unacceptable statistics.

And I think it's because the efforts are put in the wrong places. They know the technical solutions because they have their own State Strategic Plans and the National Health Strategic Plan. Yet on the other hand, they send memos to the National Council on Health on the building of specialist hospital. In other words, it's about internalising the true health crisis of primary healthcare in Nigeria. If this crisis is internalised properly, then I believe resources will be allocated more appropriately. I think one of the biggest problems in Nigeria at the moment is that insufficient resources are going into the priority areas and too much money is being spent so inefficiently.

You know I love travelling and I travel around the states a lot. For example I go to state Governors and again and again, they tell me about a new specialist hospital they have just built and yet if you look at their immunisation statistics, they are so far off target. Then I



ask why are you building a specialist hospital when you haven't done the basics? At the 2011 National Council on Health you probably heard me say the statement that 'We need more money for health, but we need more health for our money.' In other words, money is being spent so inefficiently at the moment. Yes we need more money for the health sector, but even as important as more money; we need to spend the existing money more efficiently. National Council on Health is a classic example of how efforts and time and resources were being spent on things that were not the highest priority.

We need to be getting state governments to really focus their resources and time on things that will have the biggest impact on its people. They know how to do that, they have got the National Strategic Plan that shows them how to do it. What I would love to see in Nigeria is state governors opening up primary healthcare centre, or launching a health facility committee and not going off cutting the ribbon for another big hospital that is difficult to staff and they don't have the recurrent cost to manage. And in a couple of years, they will hand it over back to the Federal Government because they can't afford to run it.

How might we move from policy to action?

Maybe I should caveat this by saying that Nigeria has some of the best policies in the world. In other words the policy environment for writing policies has been wonderful. Nigerians write the most wonderful policies, and you've got human resources health policies, you've got health management information policies and strategic policies overall for the whole sector, and I don't think there is one area in health where they don't have a good policy. In terms of the environment for writing policies, it has been wonderful and it's an amazing country.

But in terms of implementation, to me that is the biggest challenge in Nigeria. Nigerians could write these policies but in terms of really making it happen, I think it has been very very, slow at the moment. There's a couple of areas of policies that I think have really been exciting that we have seen the implementation

phase. One is the Midwives Services Scheme (MSS) and I think that was a really good example of people acknowledging a crisis of human resources. Writing a simple solution or a solution that could address that problem and then finding the resources and making it happen. And I think to me I want to see more policies like that in Nigeria. The MSS (Midwives Services Scheme) doesn't address the whole human resources for health crisis and it is not the whole human resources for health strategy; it is just picking off of one area of crisis. And I think that is just what Nigeria needs to do more and more of. In other words instead of focusing on these huge strategies that have many different parts, we need to be defining those areas where we can have a direct impact.

And I think the MSS is really a good example of something that was actually implemented and we saw the story happen. I think the other one I am really excited about recently is the removal of fees for family planning commodities and contraceptives. I do feel that it was wrong that a woman could get free malaria treatment, free antiretroviral drugs under the national policy but she couldn't get free family planning commodities.

Throughout the world family planning commodities are nearly everywhere free. Even in England where I come from, I have to pay a set prescription fee for every drug I get; whether it is antibiotics or whatever it might be. Even in England family planning is free. I only feel it's sad that Nigeria carried on with family planning fees for such a long time. To have that removed is to me not the panacea to enabling perfect access, but to me it's one barrier and I think it showed really strong, clear commitment of the national government to women. And for women to be able to choose to space their children, I think it's wonderful. Again this is an example of policy; it's been there and it's actually being implemented. And you and I know that there are many other policies that are there but have not been implemented.

I am incredibly frustrated by the story around data. We've had the most wonderful data strategies; we've got Health Data Consultative Forum and with all the mechanisms in place. The registers are there and the software also made available. But if I was to ask you how the number of women that had their babies through skilled birth attendants say in Jigawa or Ebonyi, or Lagos state, we don't have such routine statistics at the moment. We are relying too much on surveys. To me it is the same storyline of Nigerians having the technical abilities to do these things. We've had some wonderful people in government who having written those amazing policies. The technical side has been done and the next thing is to get that sense of urgency and that sense of crisis so we can actually follow through with these wonderful policies and see them into implementation.

