

Contents

- 02** The National Health Bill: a chequered journey, a tortuous history
Felix Obi traces the extraordinary history of the Bill
- 03** Emergency preparedness
Prof Shima Gyoh on the vital necessity of training and practice
- 04** Can primary healthcare (PHC) be effective in Nigeria
Dr Chima Onoka considers the hurdles that need to be vaulted if primary healthcare is to be brought under one roof
- 07** Great people, great memories, great prospects: more urgency?
Jane Miller has returned to DFID's London office after 6 years in Abuja. This is Part II of Felix Obi's interview with her

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Consumer crisis in the Nigerian health sector

'Consumer confidence' is a term more closely associated with economic indicators than with the health sector, but there is no better way to describe the general perception of the healthcare services in Nigeria in 2011. With a growing middle class, more discerning in their demands, and with better earning power many are choosing with their feet, fleeing Nigeria to India, Egypt, UAE, and South Africa, where they feel much better looked after both in terms of the actual healthcare and the services around it. A more worrying trend is that this is no longer the exclusive preserve of the relatively rich. Almost every week there is some fund-raising event or the other to support a medical evacuation to India, tapping into the renowned Nigerian communal spirit. Hospital services in India are also adding their famed entrepreneurial instincts to provide a complete door-to-door service specifically targeting Nigerians, providing not only for the patient but including their carers.

So the question is, despite the often quoted huge number of Nigerian medical professionals in the diaspora as well as at home, Nigeria's exponentially growing financial services industry, as well as a section of the population that can pay for health services, why is the healthcare industry seeing such a breakdown in confidence? If there was an obvious answer, it would have emerged, but sadly there is not. This is a complex problem with roots in a lack of clinical governance and industry standards, a banking sector eternally focused on short-term returns, and hospitals that still have only their hands and legs to work with. This does not even include deep societal problems of insecurity, electricity, and transport, which are all intricately intertwined with the health sector.

But, with any big problem lies a big opportunity! The health sector in Nigeria is on the verge of exponential growth if only we can figure out a way to align solutions across sectors to serve the best interest of the Nigerian citizen. The challenge is that the solution will not come from any single professional or population demographic, but will require an amalgamation of expertise from different sectors and interests. In all this, as a society, we must not forget the health of the patients that cannot afford the trip to India. For now it is disheartening that for both those that can and cannot pay, our health sector has failed to inspire confidence.

Who wants to be a millionaire? Solve this one and you could be!
Dr Chikwe Ihekweazu

The National Health Bill: a chequered journey, a tortuous history

Felix Obi traces the extraordinary route the Bill has taken in its journey so far

The National Health Bill has stirred much controversy within Nigeria's health sector since it was passed by the National Assembly in May 2011. But not many health professionals have an idea how long the journey has been and some even question its necessity since we do have a national constitution. To the latter point, the plain fact is that the writers and creators of the 1999 Constitution forgot to make provisions for a health service for Nigerians.

Interestingly, the proposed 1988 constitution which didn't see the light of day apparently prescribed that the three tiers of Government would be responsible for the provision of healthcare. But in keeping with the principles of federalism in a democratic setting, the 1999 constitution carefully side-stepped that provision; even though the National Health Policy readopted the three tier principle even though it knew it wasn't backed by the 1999 constitution.

During the Health Sector Reform Programme the National Health Policy was reviewed to better position the healthcare delivery systems to respond to the needs of Nigerians. Realising the lack of enabling laws to drive the reforms, some of the Nigerian health professionals who partook in the Change Agents Programme (CAP) (which later transformed into the Health Reform Foundation of Nigeria (HERFON) began to moot the idea of having a National Health Bill to fill the gap. By 2004, the Change Agents sent the initial concept paper/draft they developed to the Honourable Minister of Health, Prof. Lambo who deliberated on it with the Top Management Committee (TMC) of the Federal Ministry of Health.

Realising how important the bill was and in yielding to reason, the TMC approved the initial draft, which was presented to stakeholders at the National Council on Health as a memo in 2004 where it was approved and adopted. Some Honourable Commissioners had expressed reservations (especially those who had a background in Nigerian law) on the grounds that the federal system doesn't allow the federal government to legislate for the states and a local government authority since health was on the concurrent list.

By September 2005 the National Assembly's Committee on Health initiated moves for the consideration of a National Health Bill and a 1-week workshop on the bill was held which was facilitated by HERFON at the Nigerian Air Force Club in Kaduna. There were hopes that the bill could be passed by the legislators before the Christmas break of 2005. However

for some unforeseen reasons, the bill wasn't be sent to the National Assembly by the executive on time. Thus the initial hope of giving Nigerians the 'Christmas gift' of a health bill was regrettably missed.

In 2006, while the FMOH was holding its National Council of Health in Bauchi, the National Assembly's Senate Committee on Health under the leadership of the late Dr Martins Yelowo held a public hearing on the bill during which HERFON provided about 50 copies of the bill. Following the public hearing, a consultation was held in Port Harcourt where over 450 stakeholders in the health sector comprising of professional associations, the private sector among others endorsed the bill.

Subsequently, the FMOH sent the bill to the Federal Executive Council where it was passed. And by early 2007 it was submitted for approval by the wider National Council of State. Considering that the bill was to be financed from deductions from the consolidated revenue of the Federation Account. The Senate eventually passed the bill before the end of their term as legislators 2007. Unfortunately, the Federal House of Assembly didn't pass the bill as expected. Hence there was no harmonisation of the bill between the Senate and House Committees on Health before the end of President Obasanjo's second tenure by May 2007.

In 2008, the whole cycle began afresh once again. The new Senate Committee on Health with Dr Iyabo Obasanjo-Bello brought the bill for consideration by the Senate. During this period, HERFON and PATHS 1 provided technical support to both the Senate and House Committees on Health and also sponsored the 'controversial' retreat for the Senate Committee on Health to Ghana. Also present at the retreat were representatives of the Pharmaceutical Society of Nigeria, the Nurses and Midwifery Council, etc.

The Senate passed the National Health Bill in 2008, but the House of Representatives didn't pass their own version of the bill. During this period, the Ministry of Justice vetted the bill, as well as legal officers of the National Assembly to resolve areas of potential conflicts with the constitution and other extant laws of the nation.

At the 2010 United Nations General Assembly (UNGASS), which focused on the MDGs, it was clear that Nigeria would have attracted more funding for maternal and child health programmes from the international community had the National Health Bill been passed.

A new controversy arose after it was realised that the version of the bill belatedly passed by the House of Representatives had some changes purportedly introduced by the FMOH which differed with the one

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the Senate had previously passed. The FMOH was alleged to have inserted provisions that will guarantee it a 5% stake for 'emergency preparedness' for epidemics response from the proposed 10% human resources development from the PHC fund provided for by the bill. It was not until April 2011 that this controversial insertion was subsequently expunged to make way for the harmonisation of the bill by the National Assembly's joint Committee on Health.

Many stakeholders had almost given up hope that the harmonised bill would be passed before May 29, 2011 until a Coalition of Civil Society Organisations pushing for the passing of the health bill mobilised market women to demonstrate at the National Assembly complex. Beyond the wildest imaginations of most stakeholders, the National Health Bill finally ended its long and tortuous journey through the chambers of the National Assembly on May 26th, 2011 when it was passed.

Those who thought the President Goodluck Jonathan would sign the Bill into law would receive a rude shock when oppositions to the signing of the Bill suddenly arose from professional associations like the Pharmaceutical Society of Nigeria and the Medical Laboratory Scientists Association of Nigeria over some provisions of the bill. Various groups have used the media to advance their opposition to the Bill, requesting that the President sends it back to the National Assembly for amendment and resolution of provisions that have been at the centre of the controversy.

Notwithstanding the obvious deficiencies in some aspects of the Bill, the general consensus favours

its signing by Mr President. Of note have been the concerted efforts by members of the Health Reform Coalition who have been holding consultations with aggrieved professional associations to reach a consensus through dialogue and discussions over the contentious issues. The coalition comprises of members drawn from HERFON, Advocacy Nigeria, Save the Children, UK, PATHS 2, Public Health Foundation of Nigeria, Nigerian Medical Association, National Council of Women Societies, Federation of Women Lawyers, White Ribbon Alliance, and others.

The Coalition had on 25th August 2011, convened a stakeholders consultative forum with representatives of health professional associations and the registrars of the registration boards of health professionals to reach a consensus on how to resolve the opposition to the signing of the Bill. This is premised on the fact that the Bill provides a legal framework for the policy and institutional re-organisation of the national healthcare system to position it for effective and efficient service delivery. More importantly, if signed into law the Bill will in principle guarantee every Nigerian citizen a basic minimum package of healthcare, and other benefits.

The signing of the National Health Bill into law by the President though crucial will not be the end of the journey, for a lot more work awaits all stakeholders who will need to align together to develop guidelines for managing the PHC fund, set up institutional structures, and implement strategies that will ensure the realisation of the expected outcomes that will impact positively on the health of Nigerians in general.

Emergency preparedness

Shima Gyoh on the necessity of practice

Emergency Preparedness is not just a matter of the acquisition of offices and purchase of the relevant equipment. Only frequent practices provide the necessary essential skill for managing emergencies. When I was a casualty officer in Newcastle upon Tyne, UK, we had regular emergency practices. On one occasion, there would be simulation of the crash-landing of an airplane at the airport. Actors would be trained and made up to simulate all sorts of injuries – fractures, burns, head or abdominal injuries, etc. With the sounding of a siren, the emergency services would swing into action at the airport, while a call was made to the hospital. Our ambulance crews would rush to the airport, perform first aid on the 'casualties' then rush them to the hospital. At the hospital, all staff would be summoned and they would go into action. Some of the 'patients' would be rushed to the operating theatres, and theatre staff would get out their gear and simulate action in all seriousness, though of course no operation would be done. It was a serious affair, and the practice was being audited by very senior observers, including our supervising consultants. A report would be prepared and studied to identify weaknesses in the reaction of the hospital to sudden unexpected disasters. The audit report would be discussed by all the participants, and action taken to rectify the identified weaknesses at the next exercise.

Identified faults would include the late arrival of staff, and if you were a doctor, you would not like to be listed among the tardy responders, for your consultant would not be amused, and that could be dangerous for your career!

After three such exercises, everyone knew what to do, and if we had had a real disaster, rescue and resuscitation would have gone smoothly, saving many lives and minimising the undesirable sequelae of bad management. These exercises cost money but they were considered essential to make the emergency services achieve a high degree of preparedness.

In the developed world, fire drills are also conducted at regular intervals. They were done at least once every month in the medical college where I worked. As soon as the alarm rings, we would drop everything and make our ways downstairs without using the lifts. The fire engines would rush from their stations, sirens blaring, and arrive to put out a bonfire made in the garden.

Since I returned to Nigeria, I tried to get emergency preparedness exercise in Kaduna and Jos where I was a senior doctor in charge of the teaching hospital. Neither the State Government nor the Federal Ministry of Health would fund the exercise. In an environment where one could hardly procure the essential materials and drugs to save life on a daily basis, it looked crazy to insist on funding an exercise which everyone told me God would not permit to happen! In fact, people looked askance at me as if I was trying to perform a ritual to bring calamity to society! Everyone I approached for help turned the discussion into a joke and urged me to have more faith in God.

I would like to say here, in no uncertain terms, that if there is no practice, emergencies will always result in exceedingly poor reaction from those who are supposed to manage it, save lives, and minimise subsequent disablement, no matter how well-equipped they are. Emergency preparedness is a skill which can only be acquired by training and maintained by exercise on the part of those who are involved. In Nigeria, fire drills and hospital emergency practice? – God forbid a bad thing!

Can primary healthcare (PHC) be effective in Nigeria?

Chima Onoka considers the hurdles that need to be vaulted if primary healthcare is to be brought under one roof

Introduction

Recently, the senate of the Federal republic of Nigeria passed the National Health Bill. The Bill makes provision for additional resources for primary healthcare (PHC) development, provides for financial risk protection (through exemptions) for some categories of persons, the right to emergency treatment, a system of certification for health establishments, coordination of health research; in addition to mechanisms for strengthening health information systems and health service delivery.

The elation that greeted the passage of the Bill to an Act was mixed with anxiety regarding the practicalities of certain provisions of the Bill, such as the institutional, economic, and structural feasibility of implementing section 10 of the Bill, which deals with the financing of PHC. These uncertainties thus warrant a detailed exploration of this section of the Act in order to tease out the contentious issues, and the potential options for implementation. What is presented in this paper is a content analysis of each of the seven sub-sections, followed by a presentation of a model upon which implementation can be based.

Review of Section 10 of the National Health Act

A. Section 10.1 *There is hereby established a Fund to be known as the National PHC Development Fund (in this Act referred to as 'the Fund')*

The fund has been defined as a National PHC Development Fund, making its purpose very explicit – *Development of PHC*. However, unless all stakeholders that have roles to play agree ex ante, to work towards this goal, the objectives of establishing this fund will be stillborn. As the principle of PHC development is the motivation behind the fund, a sense of unselfish commitment is required from all interest groups (including relevant ministries, parastatals and agencies of government, development partners, and professional associations), if the potential impact of this objective is to be met.

B. Section 10.2 *The Fund shall be financed from: (a) the consolidated fund of the Federation, an amount not less than two per cent of its value; (b) grants by international donor partners; and (c) funds from any other source.*

This fund serves as additional funding to the existing statutory allocations provided to the health sector from

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the federation account, in addition to contributions from states, development partners, and the private sector – although these may be unpredictable in terms of both regularity and level.

The Universal Basic Education Commission¹ receives 2% of the consolidated revenue fund; the amount for 2010 was N44.3 billion (US\$295.6 million).² Assuming that this PHC Fund gets a similar amount, based on the US\$31.63 per capita annual cost of delivering the essential health package as recommended by the National Strategic Health Development Plan (NSHDP)³ (an amount that is close to US\$34 recommended for delivery of an essential package of care in developing countries),⁴ it can only cover 9.35 million Nigerians with quality and affordable PHC services. While this may be considered small compared to the magnitude of need, it can be considered as seed resource to the PHC Fund, and one that can be used to stimulate the development of an insurance culture in the country. The challenge is for relevant agencies to demonstrate the existence of internal capacity and transparency to mobilise and manage complementary resources from other sources – states, individuals, development partners, and the private sector to enhance the depth of the fund, and to create trust in the system.

C. Section 10.3 *Money from the fund shall be used to finance the following: (A) 50% of the fund shall be used for the provision of basic minimum package of health services to all citizens, in PHC facilities through the National Health Insurance Scheme (NHIS); (b) 25% of the fund shall be used to provide essential drugs for primary healthcare; (c) 15% of the fund shall be used for the provision and maintenance of facilities, equipment, and transport for primary healthcare; (d) 10% of the fund shall be used for the development of Human Resources for PHC.*

Two explicitly defined underscoring objectives revealed here include moving essential healthcare services to all Nigerians and a refocus of PHC delivery at primary health centres. PHC has as its components a broad range of services within which primary care itself is subsumed. Therefore, there is a need for definition of the basic minimum package – currently the Ward minimum package developed by the NPHCDA varies with the benefit package provided by the NHIS. Secondly, the service is targeted at all citizens indicating that more resources would be required. Thirdly, the focus is on PHC facilities, but there is no experience with insurance (not free services) in those facilities apart from a few community based health insurance

schemes going on in the country. Fourthly, the NHIS will be the channel through which 50% of the fund managed by the NPHCDA would be administered in these primary health facilities, which are supervised by the NPHCDA. This means the two bodies must have a clear memorandum of understanding with respect to guidelines before any implementation.

D. Section 10.4 *The National PHC Development Agency shall disburse the funds for items 3 (b, c, d) above through State PHC Boards for distribution to Local Government Health Authorities.*

This subsection seeks to promote the principle of decentralisation, and has already stimulated the development of State PHC Boards in many states. The recently concluded 54th National Council on Health also approved the setting up of this state-led mechanism in order to bring PHC under one roof. The State PHC boards can serve as the focal point through which PHC-related programmes in each state are deployed. However, the roles in the state will need to be explicitly defined to avoid conflicts with the established roles of the state ministries of health. There is need for the NPHCDA to develop a policy/guideline to be adapted by states in their establishment of state PHCD boards.

E. Section 10.5 *For any State or Local Government to qualify for Federal Government block grant pursuant to sub-section 1(1) of this section, such State or Local Government shall contribute: (a) in the case of a State not less than 10% of the total cost of projects; and (b) in the case of a Local Government not less than 5% of the total cost of projects as their commitments in the execution of such projects.*

F. Section 10.6 *The National PHC Development Agency shall not disburse money to any (a) Local Government Health Authority if it is not satisfied that the money earlier disbursed was applied in accordance with the provisions of this Act; and (b) State and Local Government that fails to contribute its counterpart funding.*

States are expected to provide counterpart funds for the projects covered by the funds to be disbursed through the NPHCDA. Similar approaches have been used in the past. They aim to provide a desirable degree of ownership and accountability. Nothing is mentioned about counterpart funding for the part to be used for provision of the basic minimum package at the primary health facilities. And given the federating nature of the country, states are likely to be sensitive to the impact of ongoing projects before committing to counterpart funding arrangements. A burning question that relevant agencies need to ask is why states and local governments default with counterpart funding agreements. The reason seems to be beyond the assumption of resource deficiency and needs to be documented. Since states are federating units and have no obligation to remit funds upwards, a decision to withdraw the funds directly from the federal level will receive significant social resistance and this has also been declared illegal by the Supreme Court in its 2002 judgment on such matter.

G. Section 10.7 *The National PHC Development Agency shall develop appropriate guidelines for the administration, disbursement and monitoring of the fund.*

This sub-section achieves some degree of delineation of activities as it invariably places NPHCDA with the responsibility of regulation for the use of the PHC Fund. In essence, NPHCDA will develop guidelines and monitoring systems and so serve as regulator, while the purchasers from an insurance point of view will be the NHIS (for basic health package), and State and LGAs (for projects and consumables).

In order to do this, result oriented guidelines are required but they need to be developed in a way that ensures stakeholder acceptability and cooperation. Given some potential for stakeholder resistance to the provisions of this section, the best approach will be to have a technical team comprising NHIS, NPHCDA and FMOH along with technical partners develop these guidelines. The various stakeholders have strong focal areas, which they should be expected to contribute to a harmonized mechanism. The NPHCDA would need to specify what health care package is basic for delivery at primary health services and what indicators are sensitive enough to monitor implementation by the purchasers.

A model for operationalising Section 10 of the National Health Act

A strong platform will be necessary for coordination of PHC development and financing activities owing to the political, legal, social, and economic context differences across the states. The NPHCDA is charged with the responsibility of developing, monitoring, and ensuring the implementation of PHC activities in the country.⁵ NHIS on the other hand has a role in financing (including the regulation of key players in the health insurance market, and advocacy to mobilise funds for the system including subsidy fund for the poor and other vulnerable groups). Presently, both agencies implement their mandate through their individual structures.

The development of State led PHC Development Boards in line with the provision of the Act can be used as a galvanising point for working towards the goal of PHC Development. These boards will serve as state coordinating mechanisms for PHC activities in the state and receive technical support from NPHCDA, NHIS, development partners, and the private sector. A possible model (see Figure 1) for such a mechanism, which incorporates existing health system structures, and could address multiple stakeholder interests while ensuring stakeholder alignment to health systems improvement in the country is presented on the following page. Its five components of operationalisation and potential benefits are summarised as follows:

- The NPHCDA, NHIS, FMOH, development partners, and other players shown would need to work together with the state PHCDA and its local governments to develop the state led platform at the state level by providing basic guidelines, enhancing state level capacity and ensuring support for operational plans of the states.
- The state led mechanism must identify the gaps in

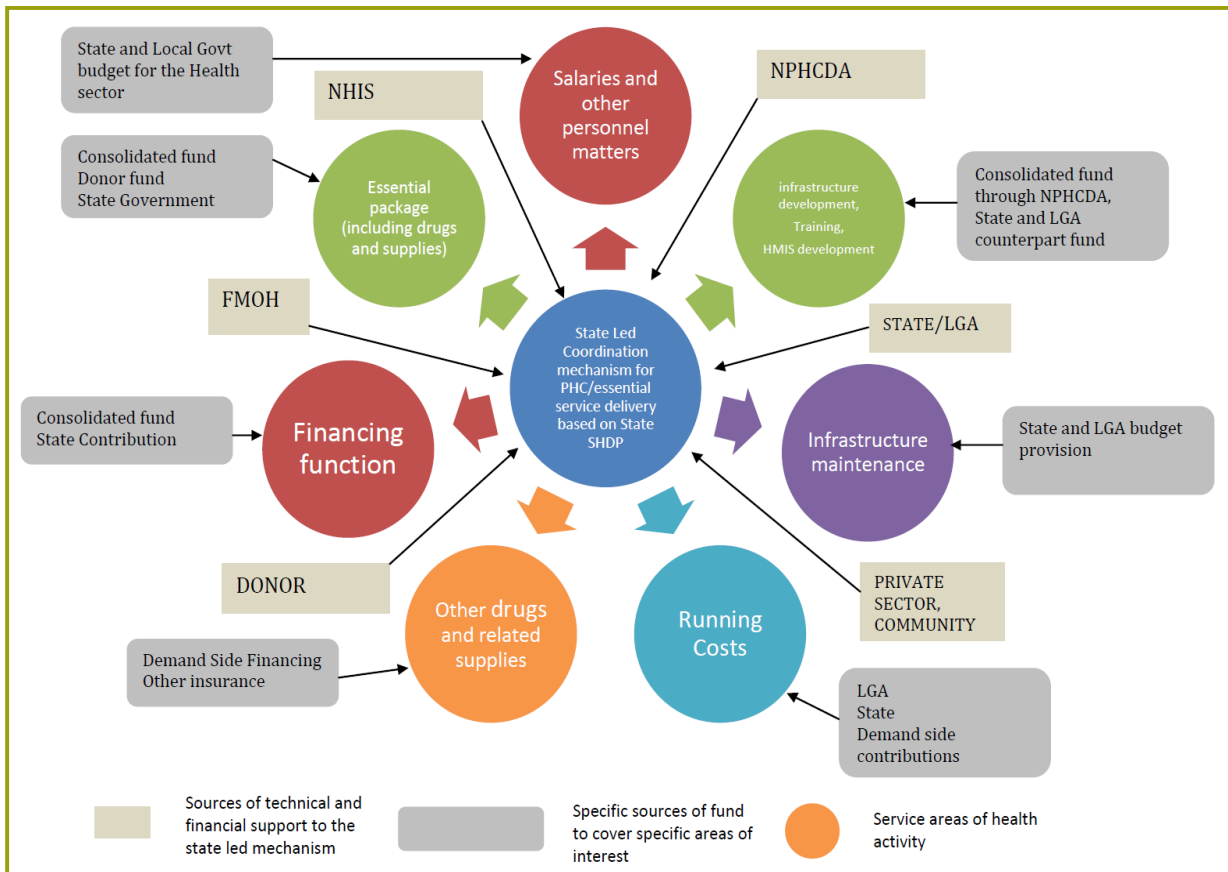


Figure 1 Holistic view of institutional arrangement, service delivery system and funding mechanism for delivery of the essential package of care through the PHC Fund

infrastructure and equipment for various facilities within the state using the existing Ward system as the focus, and periodically review changes to ensure strategic financing. Based on existing epidemiologic and cultural differences, the state board can also recommend to NPHCDA, state-specific adjustments that are necessary concerning the basic package of care, human resource for health mix and equipment and infrastructure.

- The state led platform will then ensure the coordinated implementation of the seven aspects (circles) necessary for health service provision. Current and potential sources of fund for the seven aspects are shown, and the SPHCB would bear state-level responsibility for holding and deploying this fund as stipulated in the act. For example, salaries and other personnel matters will be funded by the State and Local Governments and should be seen as a counterpart fund for overall service delivery through this platform. Donor funds, support from political systems such as constituency allowances, and donations such as insecticide treated nets and antimalaria drugs can all be deployed by coordinating sectors (e.g. state malaria unit) through this mechanism. Such resources fill the gap needed for subsidies and exemptions.
- The ward through the PHC facilities (in line with the provisions of the Act) would serve as the unit for health care service provision, human resource

management and provision of medicines and technologies. Households resident in each ward should be registered at the ward level to receive services at the ward level. The unit of registration should be the household even if service provision in the initial phase is targeted at a sub-group such as mothers and children. This will end the repeated wasteful vertical enumeration of households in a ward for every donor, government or NGO project introduced in the state. Additionally, leadership and governance will have to be strengthened at the ward level. Ward Development committees (WDCs) already exist in many states and can be better utilized. Training manuals are already available with the NPHCDA and this could serve as the basis of community level component of human resource for PHC development.

On the financing side, NHIS would need to develop an acceptable guideline for financing healthcare at the ward level. It should be ready to market this to NPHCDA, which bears overall responsibility for accountability regarding the fund, as well as the SPHCB, which needs to be convinced by NHIS of its capacity to deliver the benefit package in PHC facilities in the state in line with the provisions of the act. This will include the strategy of revenue collection, pooling, and purchasing. This guideline will have to be somewhat flexible to accommodate differences in context across urban/rural and geopolitical region.

Great people, great memories, great prospects: more urgency?

Jane Miller has returned to DFID's London office after 6 years in Abuja. This is Part II of Felix Obi's interview with her (Part I appeared in Africa Health July)

What of the contribution of donors to the achievement of major milestones in health?

I think you will probably find traces of donor involvement in many policies. For instance, the formulation of the National Strategic Health Development Plan started with the letter and policy briefs the development partners sent to the then new Minister of Health at the beginning of her term, stimulated the very first steps and that started the ball rolling. The health bill has been supported by the donors. And if you look at malaria – the bed nets and treatment protocols – the development partners were influential in making it all happen. And if you look at family planning and the removal of fees on contraceptives, it certainly had some advocacy of the development partners; the terrible threesome of me, Agatha (UNFPA), and Sharon (USAID).

What's really been wonderful is that development partners have really worked together in Nigeria. I have seen in other countries' donors really having their own agendas and conflicting with one another. In Nigeria that rarely happens for we are a really strong, cohesive group. Partly because not only do we technically agree, we also socially agree and we are actually good friends. To be able to socialise and being able to understand one another has made a very strong force for advocacy.

If you remember Nigeria is not a donor-dependent country, and I think we've been privileged as donors with the amount of opportunities we've been given to influence policy. In other words we've had the openings and opportunities to be able to speak with ministers, governors, and commissioners about what the real issues are. And I feel humbled by the fact that many things I've said have actually translated into policies. It's very exciting and it's a wonderful country and I do go away from Nigeria with hope. I do believe that things can change partly because the skills are there and they have the ability to do it. The policy environment in the last few years has been conducive to good policy. And I think we do need to have an era that is conducive to strong implementation.

I am proud of the fact that I was behind the development of the very first Terms of Reference for the Development Partners Group on HIV/AIDS during my first term in Nigeria as the HIV Specialist at the World Bank in 2003. In my second term, I developed the terms of reference for the Development Partners Group on Health. And it's really been exciting seeing both of them

becoming really vibrant groups. We are not there to scheme behind the government's back. I am very much not so. We try to be a cohesive force so we can be consistent with the government.

I think what is awful is when you

get donors who have different messages, don't agree on issues and don't even know each other is doing. I think it is our responsibility as donors to get our house in order; which is why we supported putting together the two development partners groups, to really make sure we have the space to get our hands together as donors. If all of us end up going to government with different messages, different strategies and approaches, we end up taking the time of government from getting on with their real business and distracting them towards what the major issues are.

Do you discern a sense of urgency?

The laidback approach and lack of technical efficiencies in the management of meetings from the government's side reflects the sense of urgency or the lack thereof. In other words, the donors at the moment seem to show the sense of urgency. For instance, if the donors have a meeting at the UN House by 10 o'clock, we get there at 10 o'clock because it's urgent; we get things moving.

At the National Council on Health I don't think we see yet the sense of urgency behind the crisis. In terms of management of meetings, I think huge work needs to be done in terms of time-keeping, speeches made, and protocol lists. A lot of that would be corrected if people really saw that it is a crisis, and showed a sense of urgency that we need to get things done.

What might we do in the next NCH?

What I think we need to do at the next NCH is to find a mechanism to get some really powerful speakers, and really evangelistic people with a real sense of verve. Charismatic evangelists for change in the health sector. I want to see some energy so that people will walk away with the feeling that we have got to make



Jane Miller at her PATS2 send-off party in Abuja

things happen. To me, that should be one of the most important outcomes.

There is also the meeting management thing as well which I think could be hugely improved. The National Council of Health needs to be businesslike, with delegates spurred to go back to their states to start real movement in Nigeria. How can we manage meetings efficiently? So we actually get through minutes and make decisions, and for someone to inspire change. This can be in different ways, even with the use of comedy! We must make sure long protocols with no substance are cut out.

How do policies end up being implemented?

There are things that technocrats and policy-makers need to know about making sure that policies are implemented in their states. I would commend the book, *Health Policy: An Introduction to Process and Power* by Gill Walt. In it she tries to answer the question of how do policies end up being implemented using the policy triangle.

On one side of the triangle you've got the technical side, where you need to ask have you got the evidence, are you able to articulate a good document, are you able to have sound strategies, etc. And many of us focus so much effort on the technical side and this is the classic example of the NSHDP. We've got a great document but that's only one part of the whole story.

The other part of the whole story is looking at the policy process; whether you are at a point to implement the policy in an incremental or radical way. And there are different ways in which a policy can be implemented. For example in implementing the midwives' scheme in a radical way, we can have say let's have 50 000 people benefit now or let's have a human resources strategy which builds capacity slowly. We could start something in a radical way with big effort, big funfair, and campaigns put into the policy process.

The other side is the policy environment. Just before or after elections, you've got different things you can do. The last few months have been very slow for policy in Nigeria but straight after the elections you've got a huge opportunity. Probably what is most important is the people who are right in the centre of the policy triangle: the ministers, the unions, technocrats and bureaucrats, private sector, professional bodies, NGOs, and development partners; and how all these people come together is critical to policy implementation. So we have got to think about how policy needs to be implemented, the environment and timing and most importantly the people. I have seen a lot of technically excellent policies not going through to be implemented in Nigeria and that's because the timing was wrong, the wrong people were involved, or it was implemented in a way that wasn't right for that time.

I actually think the time is now and as development partners we need to be putting that sense of urgency into Nigerians. Helping them acknowledge that it is not a hopeless cause and that Nigeria has the opportunity to reverse the current trends.

The fact that a million children die yearly is

unacceptable. The fact that 30 000 families are devastated yearly because a mother dies out of child birth is not acceptable. These are all preventable and I do believe that with concerted efforts of all of us together; development partners, government, civil society, private sector, and everybody together, we can make a change.

DFID's future plans for health in Nigeria?

The DFID has made the decision to scale up its work here in Nigeria which is really exciting. Since the elections have gone well and we do believe there is a commitment for our work. And we'll be scaling up our work to support the national strategic development plan. And particularly focusing on those areas where the MDGs are being slowest to change and where we believe by supporting Nigeria we can have the greatest impact. This means in particular areas such as maternal and child health, nutrition, malaria, but also looking at some innovative ways to support Nigeria.

One area of innovation we are working on in partnership with the National Primary Health Care Agency at the moment is looking at how we can help Nigeria to have more female workers in the North of Nigeria. As you know one of the reasons why most women in northern Nigeria don't go to health facilities is because the services are being provided by men. So we need to have more female workers, going out to people's homes to provide really strong outreach services, and having more female workers in clinics to assist other women to deliver their babies.

And the social side of Nigeria?

Nigeria is a most wonderful country and I do believe it has the potential to be an amazing tourist place. I have been all over.

I love the stories of Nigeria; the stories of the Emirs, the well in Daura, Ibadan, Ife, the festivals, and all the things that make up Nigeria's culture. I have been up to Argungu for the fishing festivals up there; I have been to Durbars in Kano and in Zaria.

It's a wonderful country. I mean Nigerians have a huge amount to be proud of and I think Nigerians don't realise how beautiful their own country is. When I tell Nigerian people where I have been and they see me being excited, and they'd like say 'This woman must be mad!'

I went to Nok recently for the Nok archeological dig somewhere between Abuja and Kaduna south area, which is amazing, looking at Terra cotta sculptures that have been created by the people between 200 BC to 500 AD. And it is that kind of history that this country has got. I have been to so many festivals. You have a wonderful country.

What will you miss about Nigeria?

It is the Nigerian people that I'm going to miss, their passion and brightness. It is just so fun to go into a meeting with Nigerians having a really feisty interesting conversation and really getting into a debate. I think in some other parts of Africa it feels too sleepy; the energy is not there and the drive for change isn't there.