Final Report to Executive Director, NPHCDA

2nd National Stakeholder Workshop on '*Bringing PHC under one roof*'

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Acknowledgements

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The information in this report represents the views of the authors and does not necessarily represent the views of the National Primary Health Care Agency, PATHS2, Health Partners International, Save the Children UK, GRID Consulting or the UK Department for International Development.

Abbreviations and Acronyms

CBOs	Community Based Organisations
CSC	Civil Service Commission
DFID	UK Department for International Development
FG	Federal Government
FMOH	Federal Ministry of Health
LGA	Local Government Authority
LGHA	Local Government Health Authority
LGSC	Local Government Service Commission
MCH/FP	Maternal and Child Health/Family Planning
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
MOLG	Ministry of Local Government
MOWA	Ministry of Women's Affairs
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
PATHS2	Partnership for Transforming Health Systems 2
PHC	Primary Health Care
"PHC under one roof"	PHC under one roof
PRRINN-MNCH	Partnership for Reviving Routine Immunisation in Northern Nigeria – Maternal, Newborn and Child Health Programme
SMOH	State Ministry of Health
SHMB	State Hospital Management Board
SPHCA	State PHC Agency
SPHCB	State PHC Board
ToR	Terms of Reference
U5MR	Under 5 Mortality Rate

SECTION 2 – EXECUTIVE SUMMARY

The Nigerian health system suffers from several challenges resulting in its inability to deliver the required services to its people. The area of greatest weakness has been reported to be at the PHC/LGA level. The challenges are linked to the fragmentation and weak accountability mechanisms. Several initiatives have been used to remedy the situation but most are not provided in a comprehensive and cohesive manner and so the results remain the poor health situation. Recent efforts from some states on bringing "PHC under one roof" are being supported by the NPHCDA to reform the health system by creating a unitary, integrated and decentralised management structure for the secondary and primary health levels.

Two workshops on bringing "*PHC under one roof*" were held in October 2009 and in March 2010 under the leadership of the NPHCDA. The outcome of the 2010 workshop were a concept note, a policy brief and an implementation guide for establishing PHC under one roof structures at the state level. These documents were approved by the 54th session of the National Council of Health in May 2011 for nation- wide implementation. This report describes activities at a follow up workshop in September 2012 which was hosted by the NPHCDA with support from PRRINN-MNCH and PATHS2 to review progress, identify challenges and devise ways of building on the gains made. Participants included stakeholders from the states, LGAs and at the federal level.

Key presentations included those from the Honourable Minister of State for Health (on Strengthening PHC Delivery in Nigeria: The Need to Implement PHCUOR); NPHCDA (on Reviewing Progress in Strengthening PHC Service Delivery); and from PATHS2 (Creating an enabling environment for better health outcomes). In addition, many more (approximately 25) states presented their PHCUOR profile. There were 4 out of the 6 zonal presentations based on an overnight assignment for each geo political zone. State and zonal presentations were followed by discussions and summary of cross-cutting issues.

Findings from the workshop revealed overwhelming support on the PHCUOR initiative from all tiers of government. Twenty one states had established PHCUOR (SPHCDA) structures though the quality of most of the structures was defective; several others had produced legislation ready to set up the relevant structures and a few, mostly from the South Eastern part of the country were yet to make significant progress.

The key outcomes included a stronger resolve by participants to strive and improve the quality of implementation by ensuring States' greater adherence to the core PHCUOR principles and for the NPHCDA and development partners to provide greater support to states for implementation of PHCUOR. A national level PHCUOR task force would be established to provide coordinated support; development partners at the meeting also resolved to strengthen partnerships for PHCUOR.

The workshop agreed on the following next steps to sustain and further build on the gains made so far:

NPHCDA

- With other partners will continue to support the efforts to actualise the passage and signing into law of the Health Bill;
- Facilitate the establishment of a task force with membership from Federal Ministry of Health, NPHCDA and partners to drive support to state implementation initiatives
- Revise the existing "bringing P*HC under one roof*" implementation guide by providing a broad 'how to do' outline on establishing a PHCUOR organisation for the new board;
- Develop regulations and other instruments like funding mechanisms for the flow of the national health fund provided for in the bill to facilitate the implementation when the health fund is established following the signing of the Health Act;

- Create nation-wide awareness on the "P*HC under one roof*" initiative: use the governors forum, organise zonal workshops, engage the media; produce, disseminate and use of appropriate IEC materials
- Provide direct support to existing and new states on implementation of bringing *"PHC under one roof"* inform on advice, build states' technical capacity and provide PHCUOR resource materials; source technical assistance from development partners to support specific states needs
- Establish a regular process of reviewing progress and experience sharing between states on *"PHC under one roof"* implementation.

States

- Adopt the Policy Brief and Bringing *"PHC under one roof"* Implementation Guidelines for implementation at state and LGA levels;
- Present the two documents to the State Council of Health for state-wide adoption;
- As much as possible follow and apply the Implementation Guidelines on *"PHC under one roof"* in state implementation.
- Seek assistance from NPHCDA and development partners in the implementation process;
- Incorporate the implementation activities into state health sector planning and budgeting processes and to ensure adequate budget provision in the 2013 planning cycle
- Make exchange visits to other states and countries for sharing experience and lessons.

Development Partners

- Build stronger partnerships on PHCUOR initiative as corner stone to reform PHC system for better service delivery. Collaboration could cover the following areas:
    - Build in-country technical capacity for the implementation of *"PHC under one roof"*: e.g. support NPHCDA to revise the implementation guide, print and disseminate PHCUOR guidelines and related documents for national and state level dissemination and use; support the taskforce on PHCUOR when established
    - Raise awareness and advocate within the donor community and among Nigerian stakeholders;
    - Build capacity of NPHCDA and states for improved quality of implementation drawing attention and support around issues relating to the key implementation milestones
    - Support states that are yet to set up PHCUOR structures and management teams e.g. support to develop legislation and regulations on *"PHC under one roof"*, advocacy, stakeholder engagement, experience sharing trips, set up and follow up support
    - Support the process of regular reviews and cross state visits and national level visits to learn and share experiences.

The workshop ended with a commitment to get together for the zonal workshops and establishment of a federal task force to facilitate both national and state level implementation.

SECTION 3 – MAIN REPORT

3.1 Background and Introduction

Within the last eight years, there has been concerted efforts to establish an integrated and decentralised health system in many states - Jigawa state and others like Enugu had played prominent roles to establish structures and to set up systems (Gunduma Health System in Jigawa and District health System in Enugu) to actualise this initiative resulting in an integrated, unitary and decentralised system emerging from a fragmented one that had existed. PRRINN-MNCH has supported initiatives in Yobe, Zamfara and Katsina to review the current management arrangements particularly for PHC services and to establish structures and set up management arrangement that will bring *"PHC under one roof"*. As at August, 2012, a total of twenty states had set up organisational structures and put in place various management arrangements to strengthen their PHC services through strengthening management arrangements for PHC.

NPHCDA had also undergone a restructuring process to enable it perform its regulatory and supportive role to states and LGAs for a strengthened PHC service that will improve health outcomes. The NPHCDA sees the bringing of *"PHC under one roof"* as one of its priority strategies to achieve a strong national PHC system that delivers on quality, access and equity.

Most stakeholders interested in better health outcomes see the efforts for the passage and signing of a Health Bill as a step in the right direction which will contribute towards strengthening PHC services. The creation of a joint and substantial funding resource (the National PHC Health Development Fund) when the Health Bill is passed and signed into law is seen as a welcome development to improve PHC funding. The Health Bill is not prescriptive on state structures in line with the principles of true federalism to allow states to move towards a unitary PHC system (i.e. "PHC under one roof")

There has been intense engagement with the NPHCDA on the concept and core principles to implement PHCUOR. From October 2009 till date, three national workshops have been carried out on this issue. The first two workshops led by NPHCDA and supported by PRINN-MNCH and PATHS2 resulted in the following outcomes: development of a concept note, an outline of the key principles and an implementation guide to support NPHCDA, states and LGAs; a memo to the 54th session of the NCH which approved national implementation of the "PHC under one roof" strategy.

This third national stakeholder workshop is intended to review progress made, see the challenges, learn from the implementation process and chart a way forward. This would hopefully ensure that all related work on bringing *"PHC under one roof"* would be better co-ordinated.

3.2 Objective of the Assignment

1. To assess the status, progress, challenges, in the various implementing states and to define the way forward in the implementation of PHCUOR.
2. To clarify roles and responsibilities of NPHCDA and Development partners in the process of PHCUOR initiatives
3. To consider the roles of the Ministry of health-post implementation of the Board
4. To enable states develop plan of actions on the way forward in terms of PHCUOR.

The agenda for the workshop is in Annex 1.

3.3 Approach and Methodology

The first day of the workshop started with an opening ceremony which as anchored under the political support and good will messages from the Minister of State for health and the Executive Director of the NPHCDA all expressing support for the initiative. Good will messages from development partners were also positive towards their support.

The second session provided an overview on: PHCUOR the concept, core principles and implementation guidelines; progress made nationally; PHC and health planning review; and the milestones for guide implementation and assisting in tracking progress.

In the third session, states presented their progress, highlighting key challenges and the way forward; they were scored using a standard score card (annex 13); this was followed by general discussions and cross-cutting issues were highlighted The day closed with an over-night group assignment for each geopolitical zone.

Day two of the workshop was devoted to: a recap of the previous day, presentation of the group assignments from 4 zones (North West, South South and South East, and South West) and cross cutting issues were discussed. There was also a presentation from the Executive Director NPHCDA providing an overview of PEI and RI, MSS, linked with the need to use PHCUOR as a vehicle to drive them; the operating environment for effective PHC was presented and discussed. A wrap up session on workshop highlights followed and next steps were agreed by all participants

The inputs from the states clearly illustrated the challenges that people and institutions face on the ground and also that the process cannot unfold quickly. By its very nature, significant organisational transformation (as envisaged in bringing "*PHC under one roof*" in Nigeria) is a lengthy process.

All the presentations can be sourced from the NPHCDA offices in Abuja as well as from the national offices of PRINN-MNCH, PATHS2 and HERFON.

Participants included a wide range of senior people (inclusive of Commissioners, permanent secretaries and other policy makers at state and federal level; development partners also participated actively and participation was frank, lively and incisive.

3.4 Findings and Analysis

The participatory nature of the workshop - state presentations, zonal assignments and presentations with extensive and frank discussions threw up a lot of useful ideas and suggestions. Among the key outputs from these discussions emerged the following:

a) High level Advocacy

One key element that hinders PHCUOR is limited awareness of its benefits and the process due to weak engagement of both policy makers, health managers and the general public. The meeting resolved to target important stakeholder groups like the federal executive council, the Governors' Forum, national and state level Association of Local Government Chairmen of Nigeria, the national and state assemblies and professional groups is therefore very welcome. This high level advocacy will also include efforts to get the national health bill signed into law.

b) Compile implementation profile across the states

Twenty one states have indicated that they are implementing one form of PHCUOR or the other. Though an impressive coverage, based on presentations at the workshop, the quality of implementation, based on the key PHCUOR principles, is very low. The NPHCDA will follow up and compile a more accurate quality profile as this will also guide its efforts and partners to

better organise the best support needed for each state. This can also provide useful information for knowledge management and advocacy

c) Federal Task force

There was a general consensus on the need to establish a Federal level Task Force with membership from the Federal Ministry of Health and NPHCDA with support from development partners. This task force will strengthen collaboration among key national level partners; it will enhance activities for state level support and build the much needed Federal level and general in-country capacity for implementation of PHCUOR. This issue has been raised in several fora but this is the first time a concise action has been articulated.

d) Zonal workshops

Most of the established PHCUOR structures are facing several challenges partly due to the limited application of the guiding principles. This has been compounded by the wide knowledge gap on PHCUOR concept, its principles and the implication guide at the state and LGA levels; a large number of agencies have been established or undergoing this process in order to meet individual gains than to meet the collective need of improving PHC service delivery. Participants overwhelming requested for and NPHCDA agreed to carry out zonal workshops similar to this national level event. These zonal workshops will address these issues especially those raised from the zonal group work by people who share a lot of similarities in cultures, economic and social factors

e) Strengthening partnerships among development partners and streamline the following and other vertical programs into a PHC system using the PHCUOR platform

This issue is key and most partners have realised the importance of the PHCUOR strategy as the pillar to deliver on their service delivery mandates. Properly supported, it will ensure greater effectiveness and efficiency. The NPHCDA and development partners should harmonise interventions on activities like PHC and planning reviews, PEI, routine Immunisation, MSS and HMIS within the PHUOR platform to sustain these initiatives

f) Span of control

A key issue discussed was the span of control. Most management gurus recommend a span of control of around seven entities (people or units). In bringing "*PHC under one roof*" several of the states will have the state managing 14 or more LGAs. In other states, the LGAs are grouped so as to create a reasonable span of control. Clustering is an issue that each state needs to think through as they implement bringing "*PHC under one roof*".

g) General hospitals

At this workshop like in previous ones, most states do not see the state owned general hospitals as part of the PHC system. During the sharing experience session, some states stated that their hospital services were getting weak, and there is great scramble for resources with the take off of their PHC boards. It is therefore very essential to establish mechanisms to integrate hospital services into health service delivery system. This is a critical issue for states to consider when bringing their "*PHC under one roof*".

h) Greater awareness on the complexity of the issues and steps and time required to introduce reforms and need for deep attention to engagement with stakeholders

The need for greater attention to deepen engagement is a critical factor and was observed to be weak in many states thus hindering progress in implementation or in the quality of the PHCUOR structures established. Since engagement is at the heart of governance reforms it requires understanding the political economy in each state to ensure very careful planning and methods of engagement are applied.

There was greater awareness among most participants of the complexity of the issues involved and the time it takes to establish an effective PHCUOR structure; the idea that one size does not fit all was also appreciated. However, many participants still felt they needed a more prescriptive format from the national level and not simple guidelines. Coming from a young democracy, this is understandable but it is essential to nurture the process carefully in order to ensure appropriate balance between best practices and bureaucratic structures that will go with those who set them up. States should be supported to deepen their engagement and participation at all levels - from state level to community level, among the political groupings as well as others involved in shaping the political economy structures and institutions and agents for any useful change to happen will remain a key strategy

3.5 Conclusions/Emerging Issues

There was a general impression that the stakeholder meeting was timely and successful – participation from all states and presentations from most of the states, greater involvement of policy makers, greater leadership and drive from the NPHCDA; development partners speaking with one voice and participants were more informed of the concept, policy and implementation principles.

States were more resolved to pursue the PHCUOR implementation despite political, capacity and other challenges. Furthermore there were growing expectations of support from NPHCDA and development partners.

The NPHCDA has demonstrated greater resolve to support states and to collaborate with the Federal Ministry of Health, other MDAs and development partners and in outlining its next important steps; to shift to zonal level support and the establishment of a task force to help drive the process.

This demand for PHCUOR implementation and the proposed supply of support to achieve it will require careful nurturing to ensure focus on achieving an integrated health system that delivers sustainable better health for all.

3.6 Next Steps

This final session was presented by Emmanuel Odu and Emmanuel Sokpo. The issues presented were discussed and adopted by the house. They are highlighted under the following sections below:

NPHCDA

- With other partners will continue to support the efforts to actualise the passage and signing into law of the Health Bill;
- Facilitate the establishment of a task force with membership from Federal Ministry of Health, NPHCDA and partners to drive support to state implementation initiatives
- Revise the existing "bringing P*HC under one roof*" implementation guide by providing a broad outline on the structure and functions of the new board;
- Develop regulations and other instruments like funding mechanisms for the flow of the national health fund in the bill to facilitate the implementation when the health Health Act is established;

- Create nation-wide awareness on the "P*HC under one roof*" initiative: use the governors forum, organise zonal workshops, engage the media; produce, disseminate and use of appropriate IEC materials
- Provide direct support to existing and new states on implementation of bringing *"PHC under one roof"* inform on advice, build states' technical capacity and provide PHCUOR resource materials; source technical assistance from development partners to support specific states needs
- Establish a regular process of reviewing progress and experience sharing between states on "*PHC under one roof*" implementation.

States

- Adopt the Policy Brief and Bringing *"PHC under one roof"* Implementation Guidelines for implementation at state and LGA levels;
- Present the two documents to the State Council of Health for state-wide adoption;
- As much as possible follow and apply the Implementation Guidelines on *"PHC under one roof"* in state implementation.
- Seek assistance from NPHCDA and development partners in the implementation process;
- Incorporate the implementation activities into state health sector planning and budgeting process and to ensure adequate budget provision in 2013 planning cycle
- Make exchange visits to other states and countries for sharing experience and lessons.

Development Partners

- Build stronger partnerships on PHCUOR initiative as cornerstone to reform PHC system for better service delivery. Collaboration could cover the following areas:
    - Build in-country technical capacity, eg the implementation of *"PHC under one roof"*: support NPHCDA to revise the implementation guide, print and disseminate PHCUOR guidelines and related document for national and state level dissemination and use; support the taskforce on PHCUOR when established
    - Raise awareness and advocate within the donor community and among Nigerian stakeholders;
    - Build capacity of NPHCDA and states for improved quality of implementation drawing attention and support around issues relating to the key implementation milestones
    - Support states that are yet to set up PHCUOR structures and management teams e.g. support to develop legislation and regulations on *"PHC under one roof"*, advocacy, stakeholder engagement, experience sharing trips, set up and follow up support
    - Support the process of regular reviews and cross state visits and national level visits to learn and share experiences.

Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

TERMS OF REFERENCE FOR SUPPORTING STATE LEVEL INITIATIVES FOR 'BRINGING PHC UNDER ONE ROOF'

Budget activity code: MN.NT.7.1.1.9H	Output and Initiative: Output 7.1.1H
Date of draft: 4th March 2012	Lead STA: Andrew McKenzie
Decision Date:	Dates: throughout 2012
Responsible Persons: Ben Anyene	Status: Draft

Background

The DFID-funded Programme for Reviving Routine Immunisation in Northern Nigeria (PRRINN) has been operational since late 2006. In September 2008 the Consortium implementing PRRINN (Health Partners International, Save the Children UK, and GRID Consulting) was awarded additional funding from the Norwegian government (channelled through DFID) to implement an integrated maternal, neonatal and child health (MNCH) programme. The two programmes are currently being managed and implemented in an integrated way, with the focus on routine immunisation giving way to a broader emphasis on improved supply of and demand for MNCH services within the context of a strengthened PHC system.

The purpose of the PRRINN/MNCH programme is: improved quality and access to MNCH services in four northern Nigerian states. Key outputs are:

- **Output 1:** Strengthened state and LGA governance of PHC systems geared to RI/MNCH
- **Output 2:** Improved human resource policies and practices in the PHC system
- **Output 3:** Improved delivery of RI and other MNCH services via the PHC system
- **Output 4:** Operational research providing evidence for PHC stewardship, RI and MNCH policy, service delivery and effective demand
- **Output 5:** Improved information generation; knowledge being used in policy/practice
- **Output 6:** Increased demand for RI and MNCH services
- **Output 7:** Improved capacity of Federal Ministry level to enable States' routine immunisation and MNCH activities

The delivery of PHC is fragmented. Management of HR is usually split between the LGA (level 6 and below) and the LGSC (level 7 and above); finances are controlled by the SMoH, the MOLG, LGA chairmen and NPHCDA/SPHCDA; service delivery is often a joint effort between all three levels of government. Many states are now trying to resolve this issue and this has led to the creation of a SPHCDA in Katsina and the Gunduma system in Jigawa, for example. Both systems have strengths and weaknesses.

At Federal level, the memo and guidelines on bringing PHC under one roof were approved at the NCH meeting in 2011. In addition, the Health Bill has passed both Houses and now awaits signing by the President. In line with the proposed new Health Bill both Yobe and Zamfara states have passed a bill creating a SPHCB and the accompanying regulations. Many other states are also pushing ahead with the creation of SPHCBs.

At Federal level it is proposed to host a national level workshop (with the support of the NPHCDA, FMOH and PATHS2) to review progress in Bringing PHC under one roof and plan how to support the rollout process. At this workshop the draft implementation manual (with associated indicators and M&E tools) will be presented and discussed.

In a sense (and based on experience in Jigawa and elsewhere) the journey has just begun. Thus at state level, the key areas that need ongoing support include strengthening the transitional committee and the new SPHCB; repositioning the MDAs to their new roles and responsibilities; reorganizing the service components; and restructuring the HR and financial aspects of the new system. This work will focus on Yobe and Zamfara states. It is not clear at this stage what progress will be made in Katsina and Jigawa is largely supported by PATHS2.
In Katsina, the national governance/systems advisor will be advised by the STM for Katsina on what support should be offered.

The work will be strongly aligned with other activities at state level (e.g. output 2 work on HR) and with the federal level activities (output 7).

Over the last eight years, progress in this area (in both the PATHS and PRRINN-MNCH programmes) has been documented in various formats: technical briefs, implementation guidelines, case studies.

The state level work will largely be supported by output 1 work (see approved ToR P.NT.1.1.2.1. H) and state specific ToRs. This ToR will support federal level and KM activities. But, it is important for all the work to be coordinated.

Rationale
The fragmented PHC system does not allow for effective delivery of PHC services. By reviewing the status and system and then moving towards a single PHC system in each state, the chances of reviving PHC are strengthened. Thus, the move to 'bring all PHC under one roof' is a move that is ongoing in Nigeria as all states move purposely to implement what is contained in the proposed Health Bill.

Purpose of Assignment
At Federal level, the focus is on increasing ownership and supporting the rollout of the guidelines approved by the NCH. The programme will provide technical assistance to HERFON in developing an implementation manual, indicators and M& E tools for nationwide advocacy, roll-out and tracking. Finally, the programme will focus on documenting the process and successes to date and sharing this with a wider audience both nationally and internationally.

While PRRINN-MNCH will support the state level and knowledge management work, it is expected that the federal level work will be supported by PRRINN-MNCH, NPHCDA and PATHS2. This will only be achieved through close working with the output 7 national advisor.

Specific Tasks

The specific tasks for the consultants are:

Federal level activities
Task 1 (National Workshop)
- Be briefed by the national governance/systems advisor and the output 7 advisor
- Plan the national level workshop for Q2 in conjunction with NPHCDA, FMOH and PATHS2
- Facilitate the two day workshop
- Based on the PRRINN-MNCH format, to write a report of no longer than 10 pages on the assignment. A draft version will be submitted to STM and national TA before the end of the in-country work and a final version within 10 working days of the end of the assignment.

Task 2 (Implementation Manual)
- Be briefed by Governance/systems advisor and the output 7 advisor
- Plan and draft the implementation Manual (inclusive of indicators and M&E tools) with selected relevant HERFON and NPHCDA members. This will be ready for the Q2 workshop.
- Pre-testing of the Manual and tools will occur after the Q2 workshop
- Finalising the tools
- Write a report of not more than 10 pages with relevant annexes. A draft version to be submitted at the end of the assignment and a final version within 10 working days of the end of the assignment.

Task 3 (Support NPHCDA to institutionalise PHCUOR for national roll out)
- Briefing with output 7 advisor
- Briefing with NPHCDA to agree on institutional home/department to house PHCUOR initiative and identify focal persons to lead the process
- With the NPHCDA, agree on a plan of action including approach to state support
- Mentor and support focal persons on PHCUOR institutionalisation and state roll out

Knowledge management activities
- Review all knowledge activities to date on bringing PHC under one roof, including the Gunduma work.
- Draft a technical brief for the OPR; a policy brief and advocacy factsheets for the national workshop in Q2; develop an abstract and a paper/presentation for the Beijing Conference (Health Systems Research) in line with their timelines; write a peer-reviewed journal article following the Beijing Conference.

Expected Outputs

By the end of the assignment the following outputs will be expected:

Federal level activities
- PHCUOR implementation Manual (inclusive of indicators and M&E tools) drafted
- Ongoing support provided to NPHCDA to institutionalise, own and manage PHCUOR initiative
- Draft and final reports submitted on time to the national governance/systems advisor and the output 7 advisor.

Knowledge management activities
- KM documents produced as per the agreed timeline

While PRRINN-MNCH will support the state level and knowledge management work, it is expected that the federal level work will be supported by PRRINN-MNCH, NPHCDA and PATHS2. This will only be achieved through close working with the output 7 national advisor.

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The specific tasks for the consultants are:

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Task 2 (Implementation Manual)
- Be briefed by Governance/systems advisor and the output 7 advisor
- Plan and draft the implementation Manual (inclusive of indicators and M&E tools) with selected relevant HERFON and NPHCDA members. This will be ready for the Q2 workshop.
- Pre-testing of the Manual and tools will occur after the Q2 workshop
- Finalising the tools
- Write a report of not more than 10 pages with relevant annexes. A draft version to be submitted at the end of the assignment and a final version within 10 working days of the end of the assignment.

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- Ongoing support provided to NPHCDA to institutionalise, own and manage PHCUOR initiative
- Draft and final reports submitted on time to the national governance/systems advisor and the output 7 advisor.

Knowledge management activities
- KM documents produced as per the agreed timeline

Type of Consultants Required

All consultants must be conversant with the PHC under one roof concept and must also have knowledge and experience in their area of work. An experience of working on similar assignments with the program will be an added advantage.

Federal level activities
The workshop will be planned and facilitated by PRRINN-MNCH staff and advisors – inclusive of Emmanuel Sokpo, Ben Anyene, Ebenezer Ajimokunola, Shehu Sule, Andrew McKenzie, Bryan Haddon.
The implementation manual will be drafted by Andrew McKenzie and Emmanuel Sokpo.

Knowledge management activities
Andrew McKenzie will be contracted for this work and will work with Emmanuel Sokpo.

Timing of Consultancy

The federal level workshop and tools development are planned for Q2.

The Knowledge management documents will be ready as follows:

1. Technical brief by 20th February for the OPR
2. Policy brief and factsheets by the Q2 national workshop.
3. Abstract and paper/presentation for the Beijing Conference according to the conference guidelines
4. Peer reviewed journal article submitted by end 2012.

Activities	Band A Emmanuel Sokpo	Band A Andrew McKenzie	Nkemdilim (HERFON consultant)	Band A Bryan Haddon, Shehu Sule, Ebenezer Ajimokunola
Task 1 (national workshop)				
Meet and plan federal level workshop	3 days	2 days	3 days	1 day each x 3
Advocacy with federal level bodies to support the process	5 days		3 days	2days
Facilitate workshop	2 days	2 days	2 days	2 days each x 3
Report writing	1 day	1 day	1 day	
Task 2 (Implementation manual)				
Plan with federal level bodies	1 day	1 day	1 day	
Draft implementation manual	2 days	10 days	2 days	
Pre-test manual and tools	5 days		5 days	
Finalise manual and tools	1 day	3 days	1 day	

Report writing	1 day	1 day	1 day	
Task 3 (Support rollout)				
Plan with NPHCDA	2 days		2 days	
Provide ongoing support	10 days		10 days	
Report writing	1 day		1 day	
Total	**34 days**	**20 days**	**34 days**	**3 days x 3 = 9 days**

Knowledge management activities
A total of 30 days will be allocated to Andrew McKenzie which will include one field trip to collect appropriate data.

Annex 2
Consultants Biodata
Dr Emmanuel Aondongu Sokpo is a medical graduate from the University of Ibadan, Nigeria and a health systems specialist with about 31 years experience working in the health sector. He is a fellow of the Nigerian Post Graduate Medical College and Fellow of the West African College of Physicians and holds a post graduate diploma in decentralised management of people and resources from University of Leeds, UK.

Emmanuel has worked a consultant clinician and chief executive of a 600 bed mission hospital also managed other missionary health services; in the public sector, he served as the Executive Secretary of Benue State Hospitals Management Board where he was also the Nigerian counterpart to the Benue Health Fund Project Manager. On the DFID- funded and supported PATHS program, he was State Team Leader with responsibility for both Jigawa and Kano States; he was the Health Systems Adviser on the DFID and Norwegian government funded and supported PRRINN-MNCH program. He has worked as a consultant on various aspects of health systems strengthening in and outside Nigeria and currently provides consultancy services on health governance and health systems strengthening issues on several health projects.

Emmanuel is a Partner to the Health Partners International (HPI) a UK based international health organisation with experience in over 40 countries supporting middle and low income countries to provide pro-poor services.

Dr Eno. Nkemdilim, Nonyem is the Programme Manager for the Health Reform Foundation of Nigeria. She coordinates advocacy programmes for health reform in the 36 states plus FCT, working with and through the membership of 37 State Chapters, 6 Zonal Programme Officers and the programme staff at the National Secretariat.

She has over 19 years work experience in the health sector across three continents, North America, Europe and Africa. She rose to become a Director in the New York City Public Health System before returning to Nigeria in 2009, having demonstrable skills in hospital operations, policy development, quality improvement, regulatory compliance and health systems management.

She also possesses a Master's in Public Health Degree from Columbia University in New York with an emphasis on Health Policy and Management, as well as a Medical Degree from the University of Nigeria. She is an active member of Nigerian Medical Association, American College of Health Care Executives, the Nigerian Health Economics and Policy Association and is a Fellow of the Royal Society of Public Health (UK).

Annex 3: Agenda

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY, ABUJA
2ND NATIONAL STAKEHOLDERS MEETING ON BRINGING PRIMARY HEALTH CARE UNDER ONE ROOF
NICON LUXURY HOTEL, ABUJA

DAY 1 (MONDAY 3RD SEPTEMBER 2012)

TIME	ACTIVITY	PRESENTER	SESSION CHAIR
8:30-9:00	Arrival & Registration	All	All
OPENING CEREMONY			
9:00-9:15	Arrival of Hon. Minister of State for Health		ED NPHCDA
9:15-9:30	National Anthem		
	Opening Prayer		
	Meeting Background, Purpose & Expected Results	Dr Odu Emmanuel	
	Self-Introduction (Name & Designation)		
9:30-9:45	Welcome Address	ED NPHCDA Dr Ado J.G.	
9:45-10:30	Goodwill Messages	WHO, DFID, EU, UNICEF	
10:30-10:45	Key Note Address- Strengthening PHC Delivery in Nigeria: The Need to Implement PHCUOR	Hon. Minister of State for Health	
10:45-10:55	Vote of Thanks	DR Odu Emmanuel	
10:55-11:30	**TEA BREAK**		
TECHNICAL SESSION 1			
11:30-11:45	Reviewing Progress in Strengthening PHC Service Delivery (Rescheduled)	Dr Ado J. G.	Dr Shehu Sule
11:45-12:30	Overview of PHCUOR Concept, Policy Briefs and Implementation Guide and 54th NCH Resolution on PHCUOR	Dr Odu Emmanuel	
12:30-1:00	Overview on Progress Made in PHCUOR	Dr EmmanuelSokpo	
1:00-2:00	**LUNCH BREAK**		
	TECHNICAL SESSION 2		
2:00-2:30	Implementing the PHC component of the NSHDP; PHC & Health Plan Review	Dr Otoh Daniel	Dr Odu Emmanuel
2:30-2:50	Key Milestones in Tracking PHCUOR Implementation	Bryan Haddon	

2:50-4:50	Experiences in Nigeria to date in Bringing PHC Under one Roof (State Presentations)	All States	Dr Odu Emmanuel & Dr I Anyene
4:50-5:30	Discussions and Comments	All States	Dr Emmanue Sokpo, Dr C Emmanuel, & Ebere
5:30-6:00	Presentations on Cross-Cutting Issues and Challenges	Dr Eric Amuah & Dr Usman Samuel	
6:00pm	Overnight Assignment for Groups (States grouped by zones and NPHCDA and Development Partners) Cross-cutting Challenges and Ways Forward and Developing a Realistic Plan for 2013 in terms of PHCUOR.	All	
6:00pm	Closing/Evening Tea Break	All	

AGENDA: Day 2

TIME	ACTIVITY	PRESENTER	SESSION CHAIR
DAY 2 (TUESDAY 4TH SEPTEMBER, 2012)			
8 :00- 8 :25	Registration of participants	ALL	ALL
8 :25 -8 :30	Opening prayers		
8 :30 – 9 :00	Recap of day 1 activity	Theresa Effa	Dr Odu Emmanuel
9 :00 -10 :30	States Presentations (Continued)		
10 :30– 11 :00	Finalisation of Group work	ALL	ALL
11.00 - 11.15	Progress in strengthening PHC: Key Issues, Key Programme Challenges & the Role of states	ED/NPHCDA	
11 :15- 11.45	TEA BREAK		
11,45 - 12.30	Feedback from group work	All Groups	Dr Idris Garba/Bryan Haddon
12.30 - 12.45	Creating enabling environment for Better PHC Service Delivery in the context of NSHDP	Dr. Mike Egbo	
12.45 -1.45	LUNCH BREAK		
1.45 -2.00	Cross cutting strategies emerging from group presentation that can be used to address challenges	Dr Eric & Usman, Bryan Haddon	Dr Ado Mohammed
2:00-2.15	Wrap up and way forward	Dr Odu Emmanuel & Dr Emmanuel Sokpo	
2.15-2.30	Closing Remarks	Dr Ado Mohammed	
2.30-2.40	Closing prayers		

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Annex 5
Reflections on Health Sector Reform

The Nigerian Immunization Coverage Survey (NICS) for 2010 reported major improvements across the whole country, apparently reflecting better organisation of routine immunization and vaccine availability from the National PHC Development Agency (NPHCDA).

Good immunisation coverage requires (and is an indicator of) a well-functioning primary health care system. It depends on effective routine immunization (as opposed to campaigns), which in turn needs functioning health facilities and delivery of reasonable quality and accessible services, so that mothers and children are attending clinics and health centres regularly and are getting immunized as well. It also needs a flow of recurrent funding for the different levels of the health system and good management of finance, human resources, logistics and the supply-chain (for provision of vaccines etc.). Preferably there should also be community outreach services.

From the late 1980's, Nigerians were aware of the extreme weakness of health services from Local Government Authorities (LGAs), as well the very serious impediments to changing them. This is particularly important because LGAs are responsible for delivering almost all PHC services from the public sector. It was also clear that the core problems were issues of governance, in particular:

- ***fragmentation of responsibility*** for staff, financing and service delivery
- ***inadequate financing*** of health services, especially PHC as well as very weak financial management
- ***lack of LGA accountability*** for delivering services or for their funding, let alone any accountability to the people they were meant to serve
- ***very weak support and supervision*** from the state level to LGAs and LGAs to facilities, as well as from federal to state level.

Health sector reform at any level require at least ten key ingredients which are potentially very pertinent to the work and roles of the NPHCDA and the Federal and State Ministries of Health as they strengthen and support PHC services through the *"Bringing PHC under one roof"* initiative:

1) Very careful attention to engagement with stakeholders at many levels affected by reforms, who must lead and implement the reform process. This engagement is at the heart of governance reforms, but it is not automatic nor simple to execute. It requires

understanding the political economy in each state, very careful planning and methods of engagement, as well as constant attention.

2) Multi-faceted health system change initiatives. Too often interventions address a small corner of the health system so their results tend to be short-lived, because different elements of the system are integrally inter-connected and inter-dependent so narrow changes are difficult to sustain. Health sector reformers need to work widely across the health system, addressing issues of governance, finance, institutional management, demand and accountability, service delivery, etc., – frequently at the same time.

3) Capacity to respond flexibly to local conditions and grasp opportunities when they come up for addressing core elements of health system functionality, while still maintaining consistency and persistence.

4) A sectoral approach to governance reform. Experience suggests that the struggle for reform may be easier within a sector such as health, rather than across the whole of government. Key players are often prepared to give ground on a limited portion of their finance, staff, structure, systems, etc., in the expectation of fairly tangible, popular benefits (e.g. better health care or education services).

5) A "*systems approach*" to developing organisational and institutional management. It has proved extremely important to get basic systems up and running for financial management, support and supervision, patient care management, logistics, drug supplies and so on.

6) Linking up governance reforms with systems strengthening. This link is seldom made. All the critical issues in managing health services (e.g. budget allocations and disbursement, staff management, drug procurement and capital investment) have governance implications and requirements as well. These need to be understood and then strategies adopted to improve systems *in the context* of the prevailing governance milieu and where necessary with support for governance reforms.

7) Strengthening management capacity, especially through a work-based, problem-based, mentoring approach.

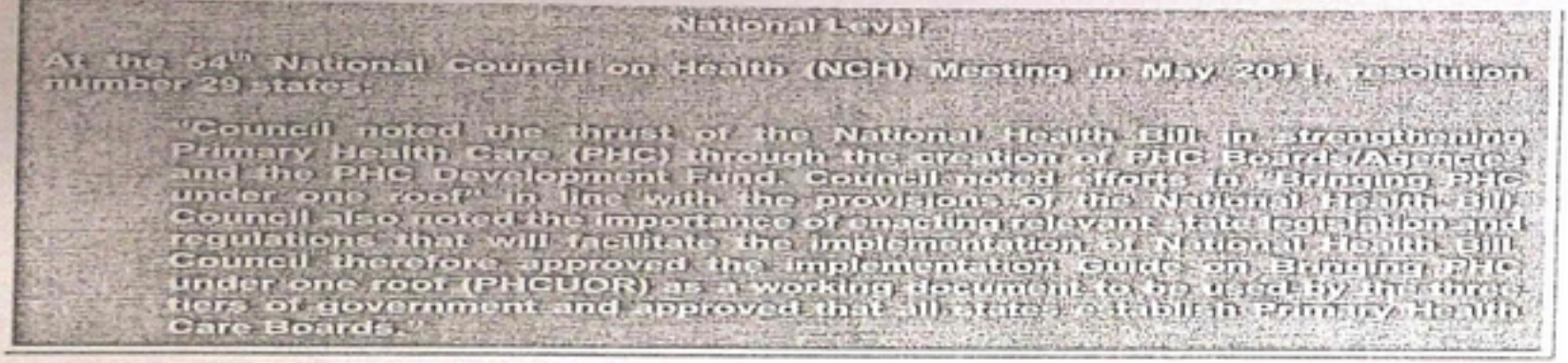
8) Attention to *coverage* and *scale-up* from the beginning. Time and again pilot projects targeting a few LGAs have not gone to scale. A whole-state approach is vital for realistic, real change and replicability.

9) Appropriate technical support. Health managers battling on their own cannot find the time, energy and resources to carry forward major reforms or to identify and assess the best options to pursue. Access to capable, supportive assistance and shared experience from similar situations can therefore be very valuable. Ideally, Federal agencies, such as the FMOH or NPHCDA, if they had the resources and willingness to change their functions radically, would provide this support.

10) Hard sustained work. Many people believe that they can come in, spend some time, wave the wand and all things will miraculously improve - this is delusional. Experience shows that you need senior, experienced support over a long time to make a difference.

Stakeholders on the ground won't trust you, let alone listen to you, until you have served some time, paid careful attention to those directly facing the problems every day, understood the complexity of the issues, etc, etc. Turning systems around needs the kind of sustained input that often is not allowed for. It is also important to realise that important systemic changes will suffer setbacks. There are good reasons why the existing system works the way it does and we want to change this. Thus, while on the surface it makes sense to improve and make a better functioning, more efficient health delivery system, this is not necessarily what the power-brokers want. So substantial reforms inevitably require a sustained struggle with very careful strategizing, some inevitable setbacks and above all persistence.

Annex 6
Bringing PHC under one roof - overview



The PATHS1 programme introduced, in 2003, the integrated district health system in Enugu and the "Gunduma" health system in Jigawa, both of which are very far-reaching changes to the governance and organisation of health services in each state. More recently this has been taken forward by the PRRINN-MNCH Programme as *"Bringing PHC Under One Roof"* (PHCUOR) in Yobe and Zamfara States.

However, the history goes back further when under Health Minister Olikoye Ransome-Kuti, PHC was emphasised and states were encouraged to form State PHC Agencies. Some states (e.g. Jigawa, Katsina) forged ahead with these bodies but a key problem was that these SPHCAs were not responsible for all PHC services with the SMOH and the LGAs continuing to play a role in PHC services.

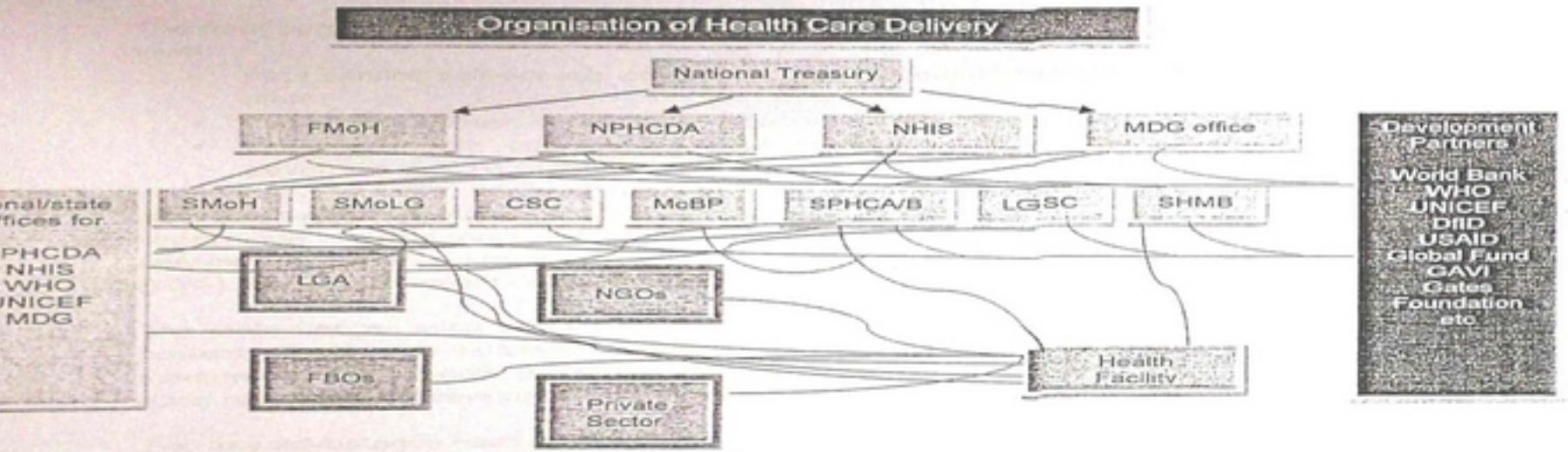
NPHCDA hosted two workshops in 2009 and 2010 to explore *"Bringing PHC Under One Roof"*. These workshops culminated in a concept note and an implementation guide, both on *"Bringing PHC Under One Roof"*, being adopted as policy by the NPHCDA. The NPHCDA then presented a memo to the 2011 National Council for Health where the implementation guide was adopted and states were encouraged to forge ahead with *"Bringing PHC Under One Roof"*.

Why the need to "Bring PHC under one roof"?

The organisational problems of the Nigerian health system have been described repeatedly. Efforts to improve Nigerian health services are continually undermined by a variety of structural and institutional weaknesses. Health services remain fragmented with multiple health providers (local government, state, federal, faith-based and private for profit organisations). Overlap in service delivery between private and public sectors has resulted in wasteful duplication. The public sector faces shortages of staff, equipment and supplies and health facilities are in need of rehabilitation. Many programmes (e.g. malaria, TB, and HIV/AIDS) are organised along vertical lines resulting in poor integration and limited co-ordination between them. There is no organised referral system in place. Multiple management structures co-exist, roles and responsibilities

remain unclear and are often duplicated within and between the three tiers of government. There is only limited supervision and staff morale is low. The quality of services is often poor and communities have little confidence in these. As a result, utilisation is very low. At some health centres for instance people on average are coming less than once every 30 years.

The fragmentation[1] in the public sector is both vertical (relationships between the three tiers of government are not well defined) and horizontal (a myriad of different departments, directorates and units exist at each level with overlapping responsibilities).



The Approach

"Bringing PHC Under One Roof" is modelled on WHO's guidelines for integrated district-based service delivery and is based on the following key elements:

- **Integration** of all PHC services delivered under one authority - at a minimum consisting of health education and promotion, MCH/FP, immunisation, disease control, essential drugs, nutrition and treatment of common ailments.
- A **single management body** with adequate capacity that has **control over services and resources** (especially human and financial). As this is implemented this will require repositioning of existing bodies.
- **Decentralized authority, responsibility and accountability** with an appropriate "span of control" at all levels. Roles and responsibilities of the different levels will need to be clearly defined.
- Principle of "three ones" (**one management, one plan and one M&E system).**
- An **integrated supportive supervisory** system managed from a single source.
- An **effective referral system** between/across the different levels of care.
- Enabling **legislation and concomitant regulations** (inclusive of the key elements).

[1] This schematic representation does not do justice to the complexity of the Nigerian health sector

Annex 7

Basket Fund in Zamfara – model

"It is an innovative pooled funding mechanism that provides guaranteed funds to finance crucial recurrent PHC activities, through a transparent disbursement and efficient utilization mechanism."[2]

The fund began in September 2009 and was created to address three interlinked issues at LGA level:

- poor service delivery e.g. coverage of routine immunization services was very low in the state;
- inadequate release of resources or poor utilization of released funds; and
- challenges with coordinating different sources of funding for PHC and RI (from government, WHO, UNICEF, PRRINN-MNCH, EU PRIME, etc)

Activities supported include routine immunisation, supplemental immunisation, maternal health, supervision, routine data collection, community mobilisation, allowances for the midwives service scheme and currently exploring funding the free MNCH services. Funding is from LGAs (70%), state government (20%) and partners (10%) plus the partners provide technical support.

The state has an account as does each LGA with adequate checks and balances re signing powers. Funds are released directly to the PHC finance officers who submit retirement statements every month signed by the LGA chairman. Subsequent funds are only disbursed upon retirement of previous funds collected.

Two key advantages have been noted:

- it creates a platform for transparent fund disbursement and utilisation; and
- it promotes coordinated financing of interventions and removes duplication of funding for the same activities by different funding sources

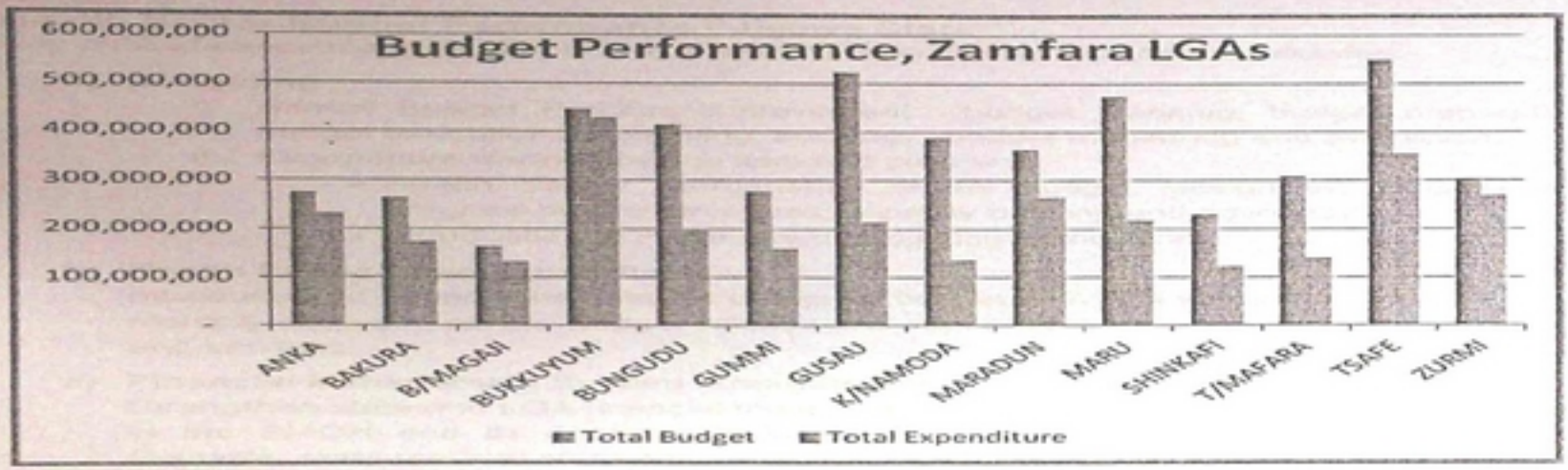
Use of the fund has contributed to an increase in the routine immunisation coverage, reduction in the wild polio virus cases, monthly supervision visits in all LGAs, improvement in data collection. In addition, it has led to interest from federal level bodies and other states.

LGA Budget Performance

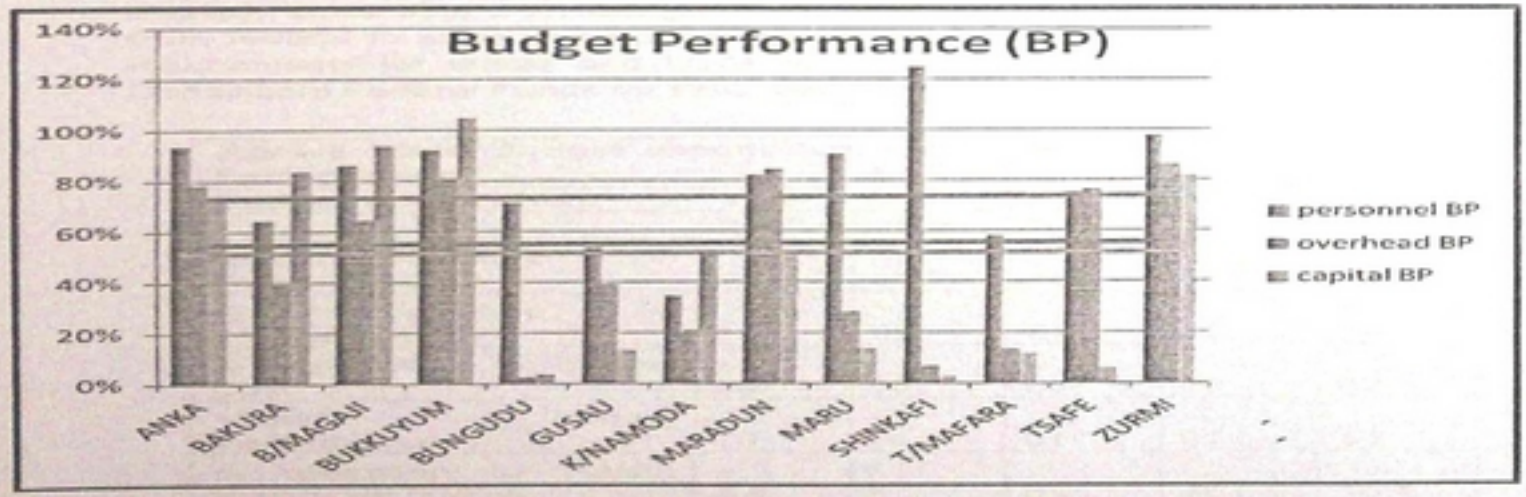
Linked to the basket fund has been increasing support to the public finance management system at LGA level - supporting Budgeting; Health Public Expenditure Reviews; Financial Management System strengthening; and facilitating the mobilization of Federal Government resources by States and LGAs for PHC.

Budget performance at LGA level in 2011 was 59% overall but this masks significant differences between the LGAs. Of equal importance was the ability to collect and analyse financial information at the LGA level.

[2] Presentation by Yusuf Musa, DPHC, SMOH, Zamfara State



In addition, budget performance between the three areas (personnel, overhead and capital) also fluctuates.



What is interesting is that while most LGAs perform relatively well on personnel budget performance, there is a mixed picture with regard to the other two areas - overhead and capital budget performance. This is something that warrants further investigation.

Annex 8

Health Sector Budget Performance - Jigawa State

Key public finance management (PFM) interventions in Jigawa include the following:

a) **Budgeting**

i) Annual Budget Process improvement: budget planning, budget preparation, budget execution (accounting, auditing), budget monitoring and evaluation,

ii) Expenditure tracking by line item and program

- Health Sector Performance of the budget: design the program/sub-program budget structures; capacity building and advocacy
- Introduction of the program budgeting framework.

b) **Health Public Expenditure Reviews**

Introduce and support the concept of regular budget activity reviews – carried out at 3-6 monthly intervals, review budget release and expenditure; relationship between release and services.

c) **Financial Management System strengthening**

Strengthen state and LGA financial management systems. This covers financial systems in the SMOH and its agencies including the Gunduma Health System Board and Councils, state medical store and at health facility level, with a special focus on the drug supply system.

d) **Facilitate mobilization of Federal Government resources by States and LGAs for PHC**

Design, streamline and strengthen financial mechanisms for leveraging funding flows from federal to state and LGA levels for immunization and health care: and financial mechanisms for states and LGAs to prepare, collect, expend, retire and report on Conditional Federal Funds for PHC, GAVI and other funding.

Jigawa State Budget expenditure profile (2007 - 2011) - Budget Performance					
Budget Activity Item	**Year**				
	2007	2008	2009	2010	2011
% Expenditure on Personnel Cost	96	117	107	107	72
% Expenditure on Overhead Cost	104	62	81	85	36
% Expenditure on Capital Cost	30	90	68	76	32
Health Budget Performance	76	93	81	91	59
% allocation to Health from State budget	4.4	8.9	8.4	10.6	15.4
NB- 2011 budget information covers only 8months					

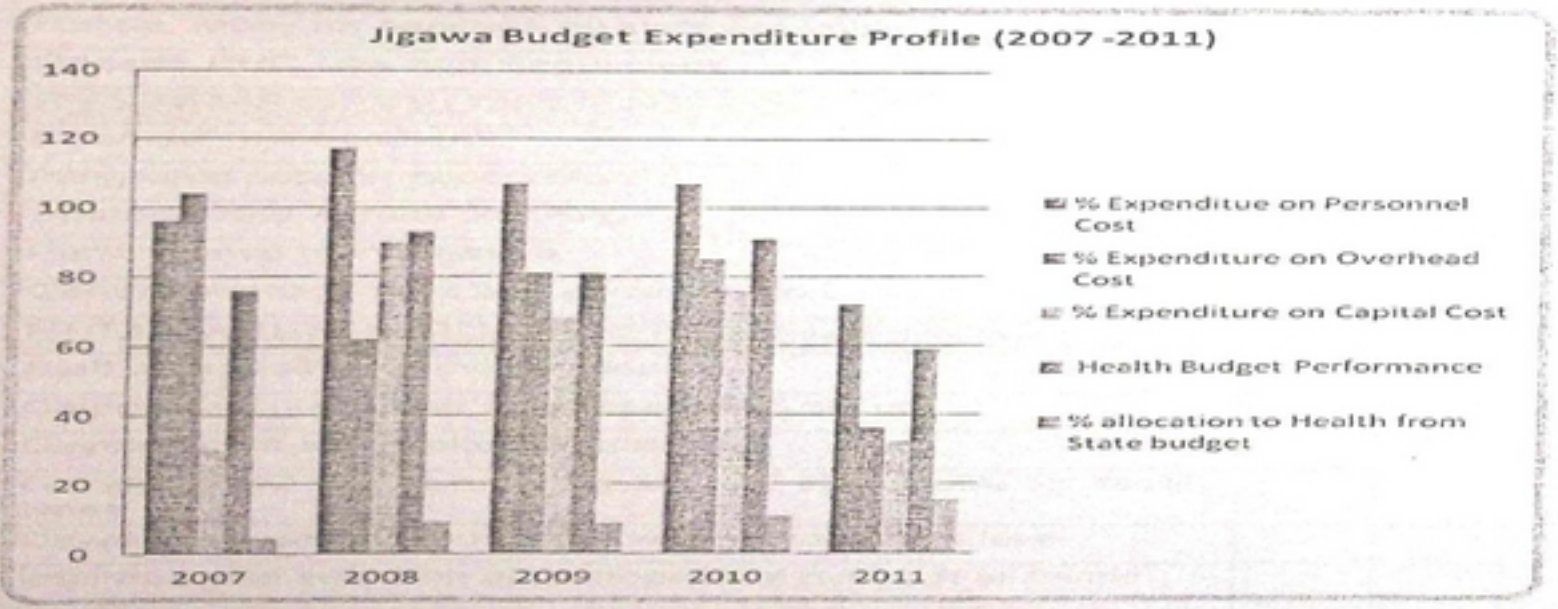
The table above and the chart below highlight the budget performance trends in the Jigawa State health sector for the past four years. It is essential to note that the picture for 2011

contains information for only eight months (January to August 2011) as complete financial data was not available at the time of producing this technical brief.

Key points include:

- Jigawa has increased its allocation to health consistently over the period under review, reaching the 15% allocation as recommended
- The state has also demonstrated substantial release giving rise to a budget performance of not less than 70% in the period under review
- Budget performance on personnel is near or over 100%, overhead budget performance fluctuates but is generally excellent, while capital budget performance fluctuates the most
- In 2011, the budgeted per capita health allocation was N2,184 or $15.

This is a demonstration of high level commitment by the government and efforts to support and strengthen the Gunduma health system which is providing results to warrant its establishment.



The Gunduma Health System Board and Gunduma Councils have been supported to establish a 'Gunduma Health System Pool Account' by preparing operational guidelines for the 'Pool Account', designing a template for reporting and training all Gunduma accounts staff.

Annex 9
Checklist for Monitoring Progress

Extensive health sector reform requires a sustained effort over considerable lengths of time. For example, the health sector reform process in Jigawa started in 2003 and started to bear fruit around five years later. Still today there are tasks that need to be completed.

To monitor progress, the table below is suggested as a guideline for managers in the state health sector to keep an eye on progress and to develop and implement solutions to bottlenecks as they are unearthed during the proposed quarterly review process. The checklist should be seen as a guide and can be adapted for local use.

Theme and Key Activities	Timelines			
	Qtr 1	Qtr 2	Qtr 3	Qtr4
LEGISLATION				
Produce draft PHC Bill and Regulations				
Refine, lobby for passage by state assembly				
Gazette PHC Law and Regulations				
SYSTEMS DEVELOPMENT				
Financial management				
Integrated support supervision				
Strategic and Annual planning				
Performance management				
General management and administration				
HUMAN RESOURCES				
Staff affordability norms developed				
Compile accurate staff database (HRIS set up)				
Develop right-sizing plan for staffing				
Develop PHC Board organogram and staff profile for facility types				
Develop job descriptions: start with management level				
Interview and selection of management teams at all levels				
Working environment needs identified - office space, furniture, computers, HR tool kit				
Deployment and staff movement completed: postings finalised				
FUNDING STRUCTURE AND SOURCES OF FUND				
Develop mechanisms for contribution from different role players				
Set up pooled fund for services/operations				

Release of take-off grant				
Develop and produce financial guidelines/manuals				
Integrate funding into state budget system				
Establish budget process				
Track release				
REPOSITIONING				
Define new roles and responsibilities emanating from Bill and Regulations				
Re-orientate managers in old and new structures				
Build capacity of managers in all structures				
Establish mentoring/coaching system for all managers				
OPERATIONAL GUIDELINES				
Pool together procedures and policies from all sources on different aspects of Board functioning				
Establish job descriptions, funding mechanisms, M&E mechanisms, accounting procedures, protocols				
Establish PHC Board procedures and rules				
COMMUNITY OWNERSHIP				
Capacity building of PHC Board teams and community members on roles and accountability to communities				
Orientation of committees and staff on new roles				
Awareness creation: radio programs, factsheets, materials, use of CSOs,				
INFRASTRUCTURE AND FURNITURE				
Selection of PHC Board offices: State and sub-state levels				
Rehabilitation of offices				
Furnishing and handover of offices				
Transport requirements established and met				
Computers and internet services provided				
Security services provided				
MINIMUM SERVICE PACKAGE (MSP)				
Adopt MSP of care for different levels of facilities				
Institute facility investment planning: assess and select facilities for implementation				
Identify resource gaps -additional resources needed (human and material) for implementing the MSP				

Annex 10
PHCUOR Principles

The approach adopted in the different states has followed the maxim that not-one-size-fits-all. Nigeria is a large country and it is imperative that states adopt changes that are specific to the contexts that they find themselves in.

However, the key principles or elements that need to be considered in drafting appropriate legislation include:

- **Integration** of all PHC services delivered under one authority - at a minimum consisting of health education and promotion, MCH/FP, immunisation, disease control, essential drugs, nutrition and treatment of common ailments.
- A **single management body** with adequate capacity that has **control over services and resources** (especially human and financial). As this is implemented this will require repositioning of existing bodies.
- **Decentralized authority, responsibility and accountability** with an appropriate "span of control" at all levels. Roles and responsibilities of the different levels will need to be clearly defined.
- Principle of "three ones" **(one management, one plan and one M&E system).**
- An **integrated supportive supervisory** system managed from a single source.
- An **effective referral system** between/across the different levels of care.
- Enabling **legislation and concomitant regulations** (inclusive of the key elements).

With these principles in mind, states have adopted essentially two models:

1. Jigawa has adopted a model that integrates both Primary Health Care and Secondary Health Care under the Gunduma System consisting of a Gunduma Board and nine Gunduma Councils. This model follows that as propounded by the WHO and copies what exists in many countries in Africa.
2. Yobe and Zamfara have adopted a model that integrates all PHC services under a body - usually call a State PHC Board. There are a variable number of structures beneath the SPHCB. This model follows that put forward in the National Health Bill. Some of these states see this model as a stepping stone to the one developed by Jigawa where both PHC and SHC services are integrated.

Whatever the model adopted, the Legislation (and accompanying Regulations) have required significant changes in the following key areas:

- Control and management of financial and human resources
- Control and management of services

Thus, there has been a need to define the roles and responsibilities of the existing structures (e.g. the SMOH) and the new structures (e.g. the SPHCB or the Gunduma Board). This repositioning has taken significant time and energy.

Annex 11

NATIONAL HEALTH BILL 2011

ARRANGEMENT OF CLAUSES

Clause

A BILL

FOR

AN ACT TO PROVIDE A FRAMEWORK FOR THE REGULATION, DEVELOPMENT AND MANAGEMENT OF A NATIONAL HEALTH SYSTEM AND SET STANDARDS FOR RENDERING HEALTH SERVICES IN THE FEDERATION, AND OTHER MATTERS CONNECTED THEREWITH, 2011

[ ] Commencement

BE IT Enacted by the National Assembly of the Federal Republic of Nigeria as follows -

PART 1 - RESPONSIBILITY FOR HEALTH AND ELIGIBILITY FOR HEALTH SERVICES AND ESTABLISHMENT OF NATIONAL HEALTH SYSTEM

1. (1) There is hereby established for the Federation the National Health System, which shall define and provide a framework for standards and regulation of health services, and which shall – Establishment of the National Health System

(a) encompass public and private providers of health services;

(b) promote a spirit of cooperation and shared responsibility among all providers of health services in the Federation and any part thereof;

(c) provide for persons living in Nigeria the best possible health services within the limits of available resources;

(d) set out the rights and duties of health care providers, health workers, health establishments and users; and

(e) protect, promote and fulfil the rights of the people of Nigeria to have access to health care services.

(2) The National Health System shall include -

(a) the Federal Ministry of Health;

(b) the State Ministries of Health in every State and the Federal Capital Territory;

(c) parastatals under the federal and state ministries of health;

(d) all local government health authorities;

(e) the ward health committees;

(f) the village health committees,

(g) the private health care providers; and

(h) traditional and alternative health care providers.

2. (1) The Federal Ministry of Health shall— Functions of the Federal Ministry of Health

(a) ensure the development of national health policy and issue guidelines

for its implementation;

(b) collaborate with the states and local governments to ensure that appropriate mechanisms are set up for the implementation of national health policy;

(c) collaborate with national health departments in other countries and international agencies;

(d) promote adherence to norms and standards for the training of human resources for health;

(e) ensure the continuous monitoring, evaluation and analysis of health status and performance of the functions of all aspects of the National Health System;

(f) co-ordinate health and medical services delivery during national disasters;

(g) participate in inter-sectoral and inter-ministerial collaboration;

(h) conduct and facilitate health systems research in the planning, evaluation and management of health services;

(i) ensure the provision of tertiary and specialized hospital services,

(j) ensure and promote the provision of Quarantine and Port Health Services;

(k) determine the minimum data required to monitor the status and use of resources;

(l) promote availability of good quality, safe and affordable essential drugs, medical commodities, hygienic food and water; and

(m) issue guidelines and ensure the continuous monitoring, analysis and good use of drugs and poisons including medicines and medical devices.

(2) Without prejudice to the foregoing functions, the Federal Ministry of Health shall:-

(a) prepare strategic, medium term health and human resources plans annually for the exercise of its powers and the performance of its duties under this Act,

(b) ensure that the national health plans referred to in paragraph (a) of this subsection shall form the basis of—

(i) the annual budget as required by the Federal Ministry of Finance; and

(ii) other governmental planning exercises as may be required by any other law; and

(c) ensure that the national health plans shall comply with national health policy.

(d) ensure the preparation and presentation of an annual report of the State of health of Nigerians and the National Health System to the President and the National Assembly.

(3) The Federal Ministry of Health shall where necessary provide to State Ministries of Health—

(a) technical assistance in the development of state health policies and plans;

(b) commodities and technical materials, including methodologies, policies and standards for use in programme implementation including monitoring and evaluation; and

(c) other technical assistance as may be necessary.

(4) The Minister shall supervise the departments and parastatals of the Ministry to enable him carry out the functions assigned to the Ministry by this or any other Act.

3. (1) The Minister, in consultation with the National Council on Health may prescribe conditions subject to which categories of persons may be eligible for exemption from payment for health care services at public health establishments.

Eligibility for exemption from payment for health services in public health establishments

(2) In prescribing any condition under subsection (1), the Minister shall have regard to:-

(a) the range of exempt health services currently available;

(b) the categories of persons already receiving exemption from payment for health services;

(c) the impact of any such condition on access to health services; and

(d) the needs of vulnerable groups such as women, children, older persons and persons with disabilities.

(3) Without prejudice to the prescription by the Minister, all Nigerians shall be entitled to a guaranteed minimum package of services.

4. (1) There is hereby established the National Council on Health (in this Act referred to as "the National Council" or "Council") which shall consist of —

Establishment and Composition of the National Council on Health

(a) the Minister, who shall be the Chairman;

(b) the Commissioners responsible for matters relating to Health in the States of the Federation;

(c) the Secretary of Health and Human Services in the Federal Capital Territory, Abuja;
(d) Professional Association-

(i) Nigerian Medical Association.

(ii) Pharmaceutical Society of Nigeria.

(iii) National Association of Nurses and Midwives of Nigeria.

(2) The Permanent Secretary of the Federal Ministry of Health shall be the Secretary to the National Council.

(3) The National Council shall meet not less than two times in a year.

(4) The National Council shall have powers to regulate its proceedings.

5. (1) The National Council which shall be the highest policy making body in Nigeria on matters relating to health, shall – Functions of the National Council

(a) have responsibility for the protection, promotion, improvement and maintenance of the health of the citizens of Nigeria, and the formulation of policies and prescription of measures necessary for achieving the responsibilities specified under this paragraph;

(b) offer advise to the Government of the Federation, through the Minister, on matters relating to the development of national guidelines on health and the implementation and administration of the National Health Policy;

(c) ensure the delivery of basic health services to the people of Nigeria and prioritize other health services that may be provided within available resources;

(d) advise the Government of the Federation on technical matters relating to the organization, delivery and distribution of health services;

(e) issue, and promote adherence to, norms and standards, and provide guidelines on health matters, and any other matter that affects the health status of people;

(f) identify health goals and priorities for the nation as a whole and monitor the progress of their implementation;

(g) promote health and healthy lifestyles;

(h) facilitate and promote the provision of health services for the management, prevention and control of communicable and non-communicable diseases;

(i) ensure that children between the ages of zero and five years and pregnant women are immunized with vaccines against infectious diseases;

(j) coordinate health services rendered by the Federal Ministry with health services rendered by the States, Local Government, Wards, and private health care providers and provide such additional health services as may be necessary to establish a comprehensive national health system;

(k) integrate the health plan of the Federal Ministry of Health and State Ministries of Health annually; and

(l) perform such other duties as may be assigned to the Council by the Minister.

(2) The National Council shall determine the time frames, guidelines and format for the formulation of the National and State Health Plans.

(3) The National Council shall be advised by the Technical Committee established in terms of this Bill.

6. (1) There is hereby established a Technical Committee of the National Council on Health (in this Bill referred to as "the Technical Committee"). Establishment and Composition of the Technical Committee of

(2) The Technical Committee shall comprise —

the National Council

(a) the Permanent Secretary of the Federal Ministry of Health who shall be the Chairman;

(b) all Directors of the Federal Ministry of Health;

(c) the Legal Adviser of the Federal Ministry of Health;

(d) the Permanent Secretaries and any two Directors of all State Ministries of Health and FCT Department for Health and Human Services;

(e) one representative each of the Christian and Muslim umbrella health organizations;

(f) one representative each of the Armed Forces Medical Corps; that is, Army, Air Force and Navy;

(g) one representative of the Prisons Medical Services;

(h) one representative of the Police Medical Services;

(i) one representative each of the parastatal of the Federal Ministry of Health;

(j) one representative each of all statutory health regulatory agencies or councils;

(k) the Chairman of the Committee of Chief Executives of Teaching and Specialist Hospitals and Federal Medical Centres;

(l) one representative each of the registered health professional associations including trado-medical practitioners; and

(m) one representative of the private health providers.

(3) The Federal Ministry of Health shall provide the Secretariat for the administrative activities of the Technical Committee.

Functions of the Technical Committee

(1) The Technical Committee shall advise the National Council on its functions as contained in section 5(1) of this Act and any other matters that the council may refer to it.

(2) The Technical Committee shall strive to reach its decisions by consensus but where a decision cannot be reached by consensus; the decision of the majority of the members shall prevail and be regarded as the decision of the Technical Committee.

(3) The Technical Committee may create one or more ad hoc committees of experts in health matters to advise it on any matter with which it is concerned.

(4) The Technical Committee shall determine the proceedings for its meetings and the quorum for its meetings shall be not less than one third of its membership, including the person presiding at any such meeting.

Establishment of the National Tertiary Hospitals Commission

(1) There is hereby established, a body to be known as the National Tertiary Hospitals Commission (in this Bill referred to as the Commission) which shall be a body Corporate, with perpetual succession and a common seal, and may sue and be sued in its corporate name.

(2) The Commission shall consist of Executive Chairman, hwo shall be a Medical Director of the status of a Professor with a minimum of ten years working experience in a Teaching Hospital set up and the following members, that is –:

(a) the Permanent Secretary or his representative of the following Federal Ministries –

(i) Health;

(ii) Finance;

(iii) Establishment matters, office of the Head of Service of the Federation; and

(iv) Education

(b) the Chairman of the Committee of Chief Executives of Tertiary Hospitals;

(c) The Registrars of -

(i) Medical and Dental Council of Nigeria;

(ii) Nursing and Midwifery Council of Nigeria;

(iii) Medical Laboratory Science Council of Nigeria;

(iv) Pharmacists Council of Nigeria;

(v) Institute of Health Service Administrators;

(vi) Medical Rehabilitation Board;

(vii) Radiographers Registration Board of Nigeria;

(d) six persons appointed on merit, one from each geographical zone to represent the public interest, at least one of which must be a woman.

(e) one person to represent the organized private sector; and

(f) the Executive Secretary of the Commission, who shall be a member and Secretary of the Board.

(1) The functions of the Commission shall be to –

Functions of the Commission

(a) advise the President through the Minister on matters affecting the establishment of tertiary hospitals in Nigeria;

(b) prepare periodic master plans for the balanced and coordinated development of hospitals in Nigeria;

(c) establish minimum standards to be attained by the various tertiary health facilities in the nation and also to inspect and accredit such facilities;

(d) make relevant investigations and recommendations to the Federal and State Governments on tertiary health care services in the national interest;

(e) advise the Federal Government on the financial needs, both recurrent and capital, of tertiary health services and in particular investigate and study the financial needs for training, research, and services and ensure that adequate provisions are made for these;

(f) set standards and criteria for allocation of funds from the Federal Government; monitor their utilization, source for grants as laid down by the Commission;

(g) collate, analyse and publish information in relation to tertiary health care services annually;

(h) lay down broad operational guidelines in all areas of management for use by the Hospital Management Board;

(i) monitor and evaluate all activities and receive annual reports from the tertiary hospitals, reward performance, apply sanctions and supervise annual peer reviews; and

(j) carry out such other activities as are conducive for the discharge of its functions under this Act.

(2) The Minister may give the Commission directives of a general nature not relating to the particular matters with regard to the exercise by the Commission of its functions under this Act.

10. (1) There is hereby established a Fund to be known as the National Primary Health Care Development Fund (in this Act referred to as "the Fund").

Establishment of Primary Healthcare Development Fund

(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.

(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 eligible primary health care facilities through the National Health Insurance Scheme (NHIS);

(b) 25 per cent of the fund shall be used to provide essential drugs for eligible primary healthcare facilities;

(c) 15 per cent of the fund shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities; and

(d) 10 per cent of the fund shall be used for the development of Human Resources for Primary Health Care.

(4) The National Primary Health Care Development Agency shall disburse the funds for items 3 (b, c, d) above through State Primary Health Care Boards for distribution to Local Government Health Authorities.

(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 per cent of the total cost of projects; and

(b) in the case of a Local Government not less than five per cent of the total cost of projects

as their commitments in the execution of such projects.

(6) The National Primary Health Care 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 Bill;

(b) State and Local Government that fails to contribute its counterpart funding and;

(c) States and local governments that fail to implement the national health policy, norms, standards and guidelines prescribed by the National Council on Health.

(7) The National Primary Health Care Development Agency shall develop appropriate guidelines for the administration, disbursement and monitoring of the fund.

1. (1) There is hereby established the Federal Capital Territory Primary Health Care Board (in this Bill referred to as "the Board")

Establishment, Composition and Tenure of the Federal Capital Territory Primary Health Care Board

(2) The Board shall comprise –

(a) a part-time Chairman;

(b) an Executive Secretary with experience in health management who shall be the Chief Executive and Accounting Officer of the organisation;

(c) three other full-time members who shall have qualification and experience in human resources, financial management and administration;

(d) an Executive Secretary with experience in medical practice,who shall be the Chief Executive and Accounting Officer of the organization;

(e) one part-time member to represent each of the area councils;

(f) one representative of private healthcare providers in the Federal Capital Territory; and

(g) one representative of the Federal Capital Territory Hospital Management Board.

(3) The members of the Board shall be appointed by the Minister of the Federal Capital Territory on the recommendation of the Secretary of Health and Human Services.

(4) Members of the Board shall hold office for a term of four years in the first instance and may be reappointed for a further term of four years and no more on such terms and conditions as may be specified in their letters

of appointment.

(5) The Board shall:-

(a) ensure coordination of planning, budgetary provision and monitoring of all primary healthcare services in the Federal Capital Territory;

(b) advice the Minister of Federal Capital Territory and Area Council health authorities in the Federal Capital Territory on any matter regarding primary healthcare services in the Federal Capital Territory;

(c) recruit, promote, post, transfer, train and discipline staff on grade level 07 and above;

(d) pay salaries and allowances to primary healthcare staff;

(e) disburse funds provided to it by the National Primary Health Care Development Agency and other sources;

(f) undertake capital projects;

(g) ensure that annual reports are rendered by primary healthcare facilities in the area council health authorities;

(h) ensure annual auditing of accounts of primary healthcare facilities in the Area Council Authorities;

(i) consider applications for, and issue Certificate of Needs and Standards appropriate primary health care institution in its area of jurisdiction; and

(j) perform such functions as may be assigned to it by the Minister of the Federal Capital Territory or any other recognized authority.

(6) The Board shall establish and maintain a separate account into which shall be paid monies from the Government of the Federation or any other source.

PART II - HEALTH ESTABLISHMENTS AND TECHNOLOGIES

12. (1) The Minister-in-Council shall by regulation –

Classification of Health Establishment and Technologies

(a) classify all health establishments and technologies into such categories as may be appropriate, based on:

(i) their role and function within the national health system;

(ii) the size and location of the communities they serve;

(iii) the nature and level of health services they are able to provide;

(iv) their geographical location and demographic reach;

(v) the need to structure the delivery of health services in accordance with national norms and standards within an integrated and coordinated national framework; and

(vi) in the case of private health establishments, whether the establishment is for profit or not; and

(b) in the case of federally owned tertiary hospitals, determine the

establishment of the hospital board and the management system of such tertiary hospital.

(2) Nothing in the foregoing provision of this section shall preclude the House of Assembly of any State from making laws for that State for the regulation and inspection of private and non-governmental health facilities in that State..

13. (1) Without being in possession of a Certificate of Standards, a person, entity, government or organization shall not :- Certificate of Standards

(a) establish, construct, modify or acquire a health establishment, health agency or health technology;

(b) increase the number of beds in, or acquire prescribed health technology at a health establishment or health agency;

(c) provide prescribed health services; or

(d) continue to operate a health establishment, health agency or health technology after the expiration of 24 months from the date this Bill took effect.

(2) The Certificate of Standards referred to in subsection (1) of this section may be obtained by application in prescribed manner from the appropriate body of government where the facility is located. In the case of tertiary institutions the appropriate authority shall be the National Tertiary Hospital Commission.

14. Any person, entity, government or organisation who performs any act stated under section 13(1) without a Certificate of Standards required by that section is guilty of an offence and shall be liable on conviction to a fine of N500,000.00 or to imprisonment for a period not exceeding two years or both. Offences and Penalties in respect of Certificate of Standards

15. (1) The Federal Ministry of Health shall not operate or manage any establishment other than a tertiary establishment. Provision of Health Services at Public Health Establishments

(2) The Minister, in respect of a tertiary hospital, and the Commissioner, in respect of all other public health establishments within the State in question, may:-

(a) determine the range of health services that may be provided at the relevant public health establishment; and

(b) in consultation with the relevant Treasury, determine the proportion of revenue generated by a particular public health establishment classified as a hospital that may be retained by that hospital, and how those funds may be used.

(3) The Minister, in consultation with the National Council may prescribe conditions subject to which categories of persons may be eligible for exemption from payment for health care services rendered by public health establishments.

(4) Without prejudice to any prescription made by the Minister, in terms of subsection (2) of this section, all citizens shall be entitled to a basic minimum package of health services.

16. (1) The Minister in Council may prescribe:- Health Services at Non-Health

(a) minimum standards and requirements for the provision of health services in locations other than health establishments, including schools and other public places; and

Establishments and at Public Health Establishment other than Hospitals

(b) penalties for any contravention of or failure to comply with any such standards or requirements.

(2) The Minister may, subject to the provisions of any other law, prescribe conditions relating to traditional health practices to ensure the health and well-being of persons who are subject to such health practices.

(3) Without prejudice to the above the House of Assembly in any State may make laws for the provision of health services at non health establishments in the state.

17. (1) Subject to this Act, a user may attend any public health establishment for the purposes of receiving health services.

Referral from one Public Health Establishment to another

(2) If a public health establishment is not capable of providing the necessary treatment or care, the public health establishment in question must transfer the user concerned to an appropriate public health establishment which is capable of providing the necessary treatment or care.

18. (1) The Minister shall prescribe mechanisms to ensure a co-ordinated relationship between private and public health establishments in the delivery of health services.

Relationship between Public and Private Health Establishments

(2) The Federal Ministry, any State Ministry or any Local Government may enter into an agreement with any private practitioner, private health establishment or non-governmental organisation in order to achieve any object of this Bill.

19. (1) All health establishments shall comply with the quality requirements and standards prescribed by the Minister after consultation with the National Council.

Evaluating Services of Health Establishments

(2) The quality requirements and standards stated in subsection (1) may relate to human resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety and the manner in which users are accommodated and treated.

(3) The National Tertiary Hospital Commission shall monitor and enforce compliance with the quality requirements and standards stated in subsection (1) as it relates to Tertiary Hospitals.

PART III - RIGHTS AND DUTIES OF USERS AND HEALTH CARE PERSONNEL

20. (1) A health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason.

Emergency treatment

(2) Any person who contravenes this section is guilty of an offence and is liable on conviction to a fine of N10,000.00 (ten thousand naira) or to imprisonment for a period not exceeding three months or to both fine and imprisonment.

21. (1) No health care personnel shall be discriminated against on account of his status and duties.

Rights of Health Care Personnel

(2) Subject to any applicable law, the head of the health establishment concerned may in accordance with any guideline determined by the Minister, Commissioner or any other appropriate authority impose conditions on the services that may be rendered by a health care provider or health worker on the basis of health status.

(3) Subject to any applicable law, every health establishment shall implement measures to minimise—

(a) injury or damage to the person and property of health care personnel working at that establishment; and

(b) disease transmission.

(4) Without prejudice to section 19(1) and except for Psychiatric patients, a health care provider may refuse to treat a user who is physically or verbally abusive or who sexually harasses him or her, and in such a case the health care provider should report the incident to the appropriate authority.

12. Subject to not being found negligent, a health care provider or other officers or employees of a health care establishment shall be indemnified out of the assets of the health care establishment against any liability incurred by him in defending any proceeding, whether civil or criminal in which judgement is given in his favour or is acquitted, if any such proceeding is brought against him in his capacity as a health care provider, an officer or employee of a health care establishment.

Indemnity of the HealthCare provider, Office or Employee of a HealthCare Establishment

13. (1) Every health care provider shall give a user relevant information pertaining to his state of health and necessary treatment relating thereto including:-

User to have full knowledge

(a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;

(b) the range of diagnostic procedures and treatment options generally available to the user;

(c) the benefits, risks, costs and consequences generally associated with each option; and

(d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.

(2) The health care provider concerned shall, where possible, inform the user in a language that the user understands and in a manner which takes into account the user's level of literacy.

14. The Federal Ministry, every State Ministry of Health, every Local Government Health Authority and every private health care provider shall ensure that appropriate, adequate and comprehensive information is disseminated and displayed at facility level on the health services for which they are responsible, which shall include—

Duty to Disseminate Information

(a) the types of health services available;

(b) the organisation of health services;

(c) operating schedules and timetables of visits;

(d) procedures for laying complaints; and

(e) the rights and duties of users and health care providers.

25. Subject to applicable archiving legislation, the person in charge of a health establishment shall ensure that a health record containing such information as may be prescribed is created and maintained at that health establishment for every user of health services. Obligation to Keep Record

26. (1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential. Confidentiality

(2) Subject to section 26, no person may disclose any information contemplated in subsection (1) unless—

(a) the user consents to that disclosure in writing;

(b) a court order or any law requires that disclosure; or

(c) non-disclosure of the information represents a serious threat to public health.

27. A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interest of the user. Access to Health Records

28. (1) A health care provider may examine a user's health records for the purposes of:- Access to Health Records Health Care by Provider

(a) treatment with the authorisation of the user; and

(b) study, teaching or research with the authorisation of the user, head of the health establishment concerned and the relevant health research ethics committee.

(2) If the study, teaching or research under subsection (1)(b) of this section reflects or obtains no information as to the identity of the user concerned, it is not necessary to obtain the authorisations contemplated in that subsection.

29. (1) The person in charge of a health establishment who is in possession of a user's health records shall set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept. Protection of Health Records

(2) Any person who—

(a) fails to perform a duty imposed on them under subsection (1);

(b) falsifies any record by adding to or deleting or changing any information contained in that record;

(c) creates, changes or destroys a record without authority to do so;

(d) fails to create or change a record when properly required to do so;

(e) provides false information with the intent that it be included in a record;

(f) without authority, copies any part of a record;

(g) without authority, connects the personal identification elements of a user's record with any element of that record that concerns the user's condition, treatment or history;

(h) gains unauthorised access to a record or record-keeping system, including intercepting information being transmitted from one person, or one part of a record-keeping system, to another;

(i) without authority, connects any part of a computer or other electronic system on which records are kept to—

(i) any other computer or other electronic system; or

(ii) any terminal or other installation connected to or forming part of any other computer or other electronic system; or

(j) without authority, modifies or impairs the operation of—

(i) any part of the operating system of a computer or other electronic system on which a user's records are kept; or

(ii) any part of the programme used to record, store, retrieve or display information on a computer or other electronic system on which a user's records are kept, commits an offence and is liable on conviction to imprisonment for a period not exceeding two years or to a fine of N250,000.00 or both a fine and such imprisonment.

Laying of Complaints

9. (1) Any person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated.

(2) The Minister, Commissioner or any other appropriate authority shall establish a procedure for the laying of complaints within the areas of the national health system for which the Federal or State Ministry is responsible.

(3) The procedures for laying complaints shall—

(a) be displayed by all health establishments in a manner that is visible for any person entering the establishment and the procedure shall be communicated to users on a regular basis;

(b) in the case of a private health establishment, allow for the laying of complaints with the head of the relevant establishment;

(c) include provisions for the acceptance and acknowledgment of every complaint directed to a health establishment, whether or not it falls within the jurisdiction or authority of that establishment; and

(d) allow for the referral of any complaint that is not within the jurisdiction or authority of the health establishment to the appropriate body or authority.

(4) In laying a complaint, the person stated in subsection (1) shall follow the procedure established by the Minister or a Commissioner, as the case may be.

PART IV - NATIONAL HEALTH RESEARCH AND INFORMATION SYSTEM

1. (1) There shall be established by the Minister, a National Health Research Committee (in this Bill referred to as "the Research Committee").

Establishment, Composition and Tenure of National Health Research Committee

(2)(a) The membership of the Research Committee shall consist of not more than 15 members appointed by the Minister on the recommendation of the various research institutions and other related bodies in the Federation.

(b) the membership of this research committee established in terms of this section shall as much as possible reflect the federal character of Nigeria.

(3) There shall be for the committee -

(a) a Chairman who shall be an acknowledged health researcher and be accomplished and renowned in a health discipline.

(b) a secretary who shall be the Director of Health Planning and Research in the Federal Ministry of Health.

(4) A person appointed pursuant to subsection (2)(a) of this section shall –

(a) hold office for a term of three years in the first instance and may be re-appointed for another term of three years and no more, under such terms and conditions as may be specified in his letter of appointment; and

(b) vacate his office if he resigns through a letter written under his hand or is requested by the Minister to do so in the public interest.

(5) The Research Committee shall have the responsibility to –

(a) determine the extent of health research to be carried out by public and private health authorities;

(b) ensure that health research agenda and research resources focus on priority health problems;

(c) develop and advise the Minister on the application and implementation of an integrated national strategy for health research; and

(d) coordinate the research activities of public and private health establishments.

(6) The Minister may prescribe the manner in which the Research Committee shall conduct its affairs and the procedure to be followed at its meeting, including the manner in which decisions are to be made and implemented.

(7) A member of the Research Committee who is not employed on full-time basis in the public service shall in respect of his service as member be paid such remuneration as may be determined by the Minister.

2. (1) Notwithstanding anything to the contrary in any other law, every research or experimentation on a living person shall only be conducted:-

Research or Experimentation with Human subject

(a) in the manner prescribed by the relevant authority; and

(b) with the written consent of the person after he shall have been informed of the objects of the research or experimentation and any possible effect on his health.

(2) Where research or experimentation is to be conducted on a minor for a therapeutic purpose, the research or experimentation may only be conducted -

(a) if it is in the best interest of the minor;

(b) in such manner and on such conditions as may be prescribed; and

(c) with the informed written consent of the parent or guardian of the minor.

(3) Where research or experimentation is to be conducted on a minor for a non-therapeutic purpose, the research or experimentation may only be conducted —

(a) in such manner and on such conditions as may be prescribed by the research committee; and

(b) with the informed written consent of the parent or guardian of the minor.

Establishment, Composition, Function and Tenure of National Health Research Ethics Committee

33. (1) There shall be established by the Minister the National Health Research Ethics Committee (in this Bill referred to as "the National Ethics Committee").

(2) The membership of the Ethics Committee shall consist of not more than 15 persons which shall include -

(a) a Chairman;

(b) a medical doctor;

(c) a legal practitioner;

(d) a pharmacist;

(e) a nurse;

(f) not less than two religious leaders representing the Christian and Muslim religions;

(g) a community health worker;

(h) one researcher in the medical field;

(i) one researcher in the pharmaceutical field; and

(j) three other persons one of whom shall be a woman who in the opinion of the Minister are of unquestionable integrity.

(3) A member of the Ethics Committee shall be appointed for a term of three years in the first instance and may be reappointed for another term of three years and no more under such terms and conditions as may be specified in his letter of appointment.

(b) with the written consent of the person after he shall have been informed of the objects of the research or experimentation and any possible effect on his health.

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(c) with the informed written consent of the parent or guardian of the minor.

(3) Where research or experimentation is to be conducted on a minor for a non-therapeutic purpose, the research or experimentation may only be conducted —

(a) in such manner and on such conditions as may be prescribed by the research committee; and

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(3) A member of the Ethics Committee shall be appointed for a term of three years in the first instance and may be reappointed for another term of three years and no more under such terms and conditions as may be specified in his letter of appointment.

(4) A member of the Ethics Committee shall vacate his office if he resigns or is requested in the public interest by the Minister to do so.

(5) If a member of the Ethics Committee vacates his office or dies, the Minister may fill the vacancy by appointing a person in accordance with subsection (2) for the unexpired term of office of his predecessor.

(6) The National Ethics Committee shall have power to determine the guidelines to be followed for the functioning of Institutional health research ethics committees, and for the avoidance of any doubt shall-

(a) set norms and standards for conducting research on humans and animals, including clinical trials;

(b) adjudicate in complaints about the functioning of health research ethics committees and hear any complaint by a researcher who believes that he has been discriminated against by any of the health research ethics committees;

(c) register and audit the activities of health research ethics Committees;

(d) refer to the relevant statutory health professional council, matters involving the violation or potential violation of an ethical or professional rule by a health care provider;

(e) recommend to the appropriate regulatory body such disciplinary action as may be prescribed or permissible by law against any person found to be in violation of any norms and standards, or guidelines, set for the conduct of research under this Bill; and

(f) advise the Federal Ministry of Health and State Ministries of Health on any ethical issues concerning research on health.

(7) For the purposes of subsection (6)(a), "clinical trials" means a systematic study, involving human subjects that aims to answer specific questions about the safety or efficacy of a medicine or method of prevention and treatment.

34. (1) Every institution, health agency and health establishment at which health research is conducted, shall establish or have access to a health research ethics committee, which is registered with the National Ethics Committee.

Establishment and functions of health research ethics committees

(2) A health research ethics committee shall:-

(a) review research proposals and protocols in order to ensure that research conducted by the relevant institution, agency or establishment will promote health, contribute to the prevention of communicable or non-communicable diseases or disability or result in cures for communicable or non-communicable diseases; and

(b) grant approval for research by the relevant institution, agency or establishment in instances where research proposals and protocol meet the ethical standards of that health research ethics committee.

(c) perform other functions that may be referred to it by the Minister.

35. (1) The Federal Ministry of Health shall facilitate and co-ordinate the establishment, implementation and maintenance by State Ministries, Local Government Health Authorities and the private health sector of the health

Coordination of National Health Management Information

information systems at national, state and local government levels in order to create a comprehensive National Health Management Information System. System (NHMIS)

(2) The Minister may, for the purpose of creating, maintaining or adapting databases within the national health information system desired in subsection (1), of this section prescribe categories or kinds of data for submission and collection and the manner and format in which and by whom the data is to be compiled or collated and shall be submitted to the Federal Ministry of Health.

(3) The Minister and Commissioners shall publish annual reports on the state of health of the citizenry and the health system of Nigeria including the States thereof.

36. The Secretary of Health and Human Services shall by this Bill establish a committee for FCT to maintain, facilitate and implement the health information systems under section 34(1) of this Bill, at FCT and area council levels. Duties of a FCT as regards Health Information

37. Each Area Council, which provides health services shall establish and maintain a health information system as part of the national health information system as specified under section 34(1) of this Bill. Duties of FCT Area Councils

38. (1) All private health care providers shall:- Duties of Private HealthCare Providers

(a) establish and maintain a health information system as part of the national health information system as specified under section 34(1) of this Bill; and

(b) ensure compliance with the provision of sub-section (1)(a) as a condition necessary for the grant or renewal of the Certificate of Standards.

(2) Any private health care provider that neglects or fails to comply with the provision of subsection(1) of this section shall be guilty of an offence and on conviction shall be liable to imprisonment for a term of six months or a fine of N50,000.00.

(3) Nothing in the foregoing precludes a State Assembly from making laws with regards to health information system for that State and the Local Government Areas and the private health sector within that State.

39. (1) There shall be a compendium of drugs approved for use in health facilities throughout the Federation- (in this Bill referred to as the "National Formulary") which shall be under the dynamic periodic review of the National Council. National Formulary Control of Safety of Drugs and Food Supply

(2) Indigenous and local manufacture and production of as many items in the formulary as practicable shall be encouraged.

(3) The National Agency for Food and Drugs Administration and Control (NAFDAC) shall exercise its functions as provided in the enabling Act, Cap. N1, LFN 2004.

40. (1) The National Health Insurance Scheme (NHIS) shall exercise its functions as provided in the enabling Act, Cap. N42, LFN 2004. National Health Insurance

(2) It shall be the responsibility of the Council to ensure the widest possible catchments for the scheme throughout the Federation or any part

thereof.

(3) The Minister may, subject to conditions as may be reviewed from time to time, give direction and determine persons eligible for exemption form payment of health services at public health establishment.

(4) Nothing in this section of the Bill shall be prejudicial to the powers of the House of Assembly of a State to make laws for that State to regulate the implementation of the scheme, as well as exemptions for payment of health services in that State.

PART V - HUMAN RESOURCES FOR HEALTH

41. (1) The National Council shall develop policy and guidelines for, and monitor the provision, distribution, development, management and utilisation of, human resources within the national health system.

Development and Provision of Human Resources in National Health System

(2) The policy and guidelines stated in subsection (1) shall amongst other things facilitate and advance—

(a) the adequate distribution of human resources;

(b) the provision of appropriately trained staff at all levels of the national health system to meet the population's health care needs; and

(c) the effective and efficient utilisation, functioning, management and support of human resources within the national health system.

42. The Minister, with the concurrence of the National Council shall determine guidelines that will enable the State Ministries and Local Governments to implement programmes for the appropriate distribution of health care providers and health workers.

Appropriate Distribution of Health Care Providers

43. The Minister shall make regulations with regard to human resources management within the national health system in order to:-

Regulations Relating to management of Human Resources in the Health System

(a) ensure that adequate resources are available for the education and training of health care personnel to meet the human resources requirements of the national health system;

(b) ensure the education and training of health care personnel to meet the requirements of the national health system, including the prescription of a re-certification programme through a system of continuing professional development;

(c) create new categories of health care personnel to be educated or trained;

(d) identify shortages of key skills, expertise and competences within the national health system, and prescribe strategies which are not in conflict with any other existing legislation, for the:-

(i) education and training of health care providers or health workers in the Federation, to make up for any shortfall in respect of any skills, expertise and competences; and

(ii) recruitment of health care personnel from other countries,

(e) prescribe strategies for the recruitment and retention of health care

personnel within the national health system and from anywhere outside Nigeria;

(f) ensure the existence of adequate structures for human resources planning, development and management at national, state and local government levels of the national health system;

(g) ensure the availability of institutional capacity at state and local governments levels of the national health system to plan for, develop and manage human resources;

(h) ensure the definition and clarification of the roles and functions of the Federal Ministry of Health, state ministries of health and local government health authorities with regard to the planning, production and management of human resources; and

(i) prescribe circumstances under which health care personnel may be recruited from other countries to provide health services in the Federation.

44. (1) The National Assembly may make laws in respect of the establishment and management of Health Training Institutions as well as the prescription of a minimum standard of quality and content of training and teaching in such institutions for personnel in all cadres in the health services of the Federation. Training Institutions

(2) The National Council shall ensure that there is adequate plan for manpower development throughout the federation or any part thereof to keep pace with evolving trends of expansion and improvement in health care delivery.

(3) Without prejudice to the provisions of subsections (1) and (2) of this section, the House of Assembly of any State may make laws for the establishment of any institution for training and teaching of Health personnel in cadres as may be determined by the National Council.

45. (1) The National Assembly may make laws for the Federation or any part thereof with respect to the health, safety and welfare of persons employed to work in factories, and industrial and commercial outfits. Industrial Health

(2) The National Council shall ensure that the provisions made for industrial health and safety pursuant to subsection (1) of this section are complied with throughout the federation or any part thereof.

(3) The House of Assembly of any State shall have powers to make laws to enforce compliance with the provisions of this section in that State.

46. (1) Without prejudice to the right of all cadres and all groups of Health Professionals to demand for better conditions of service, health services shall be classified as Essential Service, and subject to the provisions of the relevant law. Industrial Dispute

(2) Pursuant to subsection (1) of this section, industrial disputes in the public sector of Health shall be treated seriously and shall on no account cause the total disruption of health services delivery in public institutions of health in the federation or in any part thereof.

(3) Where the disruption of health services has occurred in any sector of National Health System, the Minister–in–Council shall apply all reasonable measures to ensure a return to normalcy of any such disruption within

fourteen days of the occurrence thereof.

47. Without prejudice to the right of any Nigerian to seek investigation and treatment anywhere within and outside Nigeria, no public officer of the government of the federation or any part thereof shall be sponsored for medical investigation or treatment abroad at public expense except in exceptional cases on the recommendation and referral by relevant expertise in respect of the investigation in Nigeria, and which recommendation or referral shall be duly approved by the Minister or the Commissioner of Health of the State as the case may be. Medical Treatment Abroad

PART VI - CONTROL OF USE OF BLOOD, BLOOD PRODUCTS, TISSUE AND GAMETES IN HUMANS

48. (1) The Minister shall establish a National Blood Transfusion Service for the Federation. Establishment of National Blood Transfusion Services

(2) The Minister shall make regulations for the establishment and maintenance of the National Blood Transfusion Service.

(3) Without prejudice to the provision of sub-section(1) of this section, the States may set up Blood Transfusion Service as they find appropriate within their jurisdiction.

49. A person may not remove tissue, blood or a blood product from the body of another living person for any purpose unless it is done:- Removal of Tissue, Blood or Blood Products from Living persons

(a) with the informed and written consent of the person from whom the tissue, blood or a blood product are removed granted in the prescribed manner; and

(b) in accordance with prescribed conditions by the appropriate authority.

50. (1) A person may use tissue removed or blood or a blood product withdrawn from a living person only for such medical or dental purposes as may be prescribed. Use of Tissue, Blood or Blood Products removed or withdrawn from living persons

(2) (a) The following tissue, blood or blood products may not be removed or withdrawn from a living person for any purpose stated in subsection (1):

(i) tissue, blood or a blood product from a person who cannot give consent; or

(ii) tissue which is not replaceable by natural processes from a person younger than 18 years.

51. (1) A person shall not without the prior written approval of the Minister:- Prohibition of Reproductive, therapeutic Cloning of Human Kind

(a) manipulate any genetic material, including genetic material of human gametes, zygotes or embryos; or

(b) engage in any activity, including nuclear transfer or embryo splitting, for the purpose of the reproductive cloning of a human being.

(2) No person shall import or export human zygotes or embryos without the prior written approval of the Minister on the recommendation of National Ethics Research Committee.

(3) Any person who contravenes a provision of this section or who fails to comply therewith is guilty of an offence and is liable on conviction to

imprisonment for a minimum of five years with no option of fine

(4) For the purpose of this section:-

(a) "reproductive cloning of a human being" means the manipulation of genetic material in order to achieve the reproduction of a human being and includes nuclear transfer or embryo splitting for such purpose; and

(b "therapeutic cloning" means the manipulation of genetic material from adult, zygotic or embryonic cells in order to alter, for therapeutic purposes, the function of cells or tissues.

52. (1) A person shall not remove tissue from a living person for transplantation in another living person or carry out the transplantation of such tissue except:- Removal and Transplantation of Human Tissue in Hospital

(a) in a hospital authorised for that purpose; and

(b) on the written authority of:-

(i) the medical practitioner in charge of clinical services in that hospital or any other medical practitioner authorised by him or her; or

(ii) in the case where there is no medical practitioner in charge of the clinical services at that hospital a medical practitioner authorised thereto by the person in charge of the hospital.

(2) The medical practitioner stated in subsection (1)(b) shall not be the lead participant in a transplant for which he has granted authorisation under that subsection.

53. (1) Only a registered medical practitioner or dentist may remove any tissue from a living person, use tissue so removed for any of the purposes stated in this Bill or transplant tissue so removed into another living person. Removal, Use or Transplantation of Tissue and Administering of Blood and Blood Products by Medical Practitioner or Dentist

(2) Only a registered medical practitioner or dentist, or a person acting under the supervision or on the instructions of a medical practitioner or dentist, may administer blood or a blood product to, or prescribe blood or a blood product for, a living person.

54. (1) It is an offence for a person:- Payment in Connection with the Importation, Acquisition or Supply of Tissue, Blood or Blood Product

(a) who has donated tissue, blood or a blood product to receive any form of financial or other reward for such donation, except for the reimbursement of reasonable costs incurred by him or her to provide such donation; and

(b) to sell or trade in tissue, blood or blood products, except as provided for in this Bill.

(2) Any person found guilty of an offence under subsection (1) is liable on conviction to a fine of N100,000 (one hundred thousand naira) or to imprisonment for a period not exceeding one year or to both fine and imprisonment.

55. (1) Human organs obtained from deceased persons for the purpose of transplantation or treatment, or medical or dental training or research, shall only be used in the prescribed manner. Allocation and Use of Human Organs

(2) Human organs obtained under subsection (1) shall be allocated in

accordance with the prescribed procedures.

(3) The National Tertiary Hospital Commission shall prescribe:-

(a) criteria for the approval of organ transplant facilities; and

(b) procedural measures to be applied for such approval.

(4) A person who contravenes a provision of this section or fails to comply therewith or who charges a fee for a human organ is guilty of an offence and shall be liable to imprisonment for a minimum of five years without option of fine.

56. (a) A person who is competent to make a will may:- Donation of Human Bodies and Tissue of Deceased Persons

(i) in the will; or

(ii) in a document signed by him and at least two competent witnesses; or

(iii) in a written statement made in the presence of at least two competent witnesses,

donate his or her body or any specified tissue thereof to be used after his or her death, or give consent to the post mortem examination of his or her body, for any purpose provided for in this Bill.

(b) A person who makes a donation as stated in paragraph (a) above may nominate an institution or a person as donee.

57. (1) A donation under section 55 may only be made for the purposes of:- Purposes of Donation of body, tissue etc

(a) training of students in health sciences;

(b) health research;

(c) advancement of health sciences;

(d) therapy including the use of tissue in any living person; or

(e) production of a therapeutic, diagnostic or prophylactic substance.

(2) This Bill does not apply to the preparation of the body of a deceased person for the purposes of embalming it, whether or not such preparation involves the:-

(a) making of incisions in the body for the withdrawal of blood and the replacement thereof by a preservative; or

(b) restoration of any disfigurement or mutilation of the body before its burial.

58. A donor may, prior to the removal for transplantation of the relevant organ into the donee, revoke a donation in the same way in which it was made or, in the case of a donation by way of a will or other document, also by the intentional destruction of that will or document. Procedure for revocation of any donation

PART VII – REGULATIONS AND MISCELLANEOUS PROVISIONS

59. The Minister, in consultation with the National Council, may make regulations with regard to any other matter which is reasonably necessary Regulations

or expedient to prescribe in the implementation of this Bill.

60. (1) The Minister may, after consultation with the National Council, establish such number of advisory and technical committees as may be necessary to achieve the objects of this Bill. Powers of Minister to appoint Committees

(2) When establishing an advisory or technical committee, the Minister may determine by notice or circular:-

(a) its composition, functions and working procedure; and

(b) any incidental matters relating to that advisory or technical committee.

61. (1) The Minister may assign any duty and delegate any power imposed or conferred upon him by this Bill, except the power to make regulations to: Assignment of Duties and delegation of powers

(a) any person in the employ of the Federal Government; or

(b) any council, board or committee established in terms of this Bill.

(2) A Commissioner may assign any duty and delegate any power imposed or conferred upon him or her by this Bill, except the power to make regulations to any officer in the relevant State Ministry or any Council, Board or Committee established in terms of this Bill.

(3) The Permanent Secretary of the Federal Ministry may assign any duty and delegate any power imposed or conferred upon him or her by this Bill to any official in the Federal Ministry.

(4) The Permanent Secretary of a State Ministry may assign any duty and delegate any power imposed or conferred upon him or her in terms of this Bill to any official of that State Ministry of Health.

62. (1) Anything done before the commencement of this Bill under a provision of any other relevant Act or regulation which could have been done under a provision of this Bill shall be regarded as having been done under the corresponding provision of this Bill. Savings and transitional provisions

(2) The Minister may prescribe such further transitional arrangements as may be necessary in the circumstance.

63. In this Bill, unless the context otherwise requires:- Interpretation

"appropriate authority" means any other authority apart from the Minister, Commissioner, Executive Secretary, Chairmen of Boards or Chairman of Agency;

"basic minimum package" means the set of health services as may be prescribed from time to time by the Minister after consultation with the National Council on Health;

"blood product" means any product derived or produced from blood, including circulating progenitor cells, bone marrow progenitor cells and umbilical cord progenitor cells;

"certificate of standards" means a certificate under section 14;

"Commissioner" means the Commissioner of a State responsible for health;

"communicable disease" means a disease resulting from an infection due to pathogenic agents or toxins generated by the infection, following the direct or indirect transmission of the agents from the source to the host;

"Constitution" means the Constitution of the Federal Republic of Nigeria, 1999;

"death" means brain death;

"embryo" means a human offspring in the first eight weeks from conception;

"Federal Ministry" means the Federal Ministry of Health;

"gamete" means either of the two generative cells essential for human reproduction;
"gonad" means a human testis or human ovary;

"health agency" means any person other than a health establishment:-

(a) whose business involves the supply of health care personnel to users or health establishments;

(b) who employs health care personnel for the purpose of providing health services; or

(c) who procures health care personnel or health services for the benefit of a user, and includes a temporary employment service involving health workers or health care providers;

"health care personnel" means health care providers and health workers;

"health care provider" means a person providing health services under Act of Law;

"health establishment" means the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health service under section 13;

"health research" includes any research which contributes to knowledge of:-

(a) the biological, clinical, psychological or social processes in human beings;

(b) improved methods for the provision of health services;

(c) human pathology;

(d) the causes of disease;

(e) the effects of the environment on the human body;

(f) the development or new application of pharmaceuticals, medicines and related substances; and

(g) the development of new applications of health technology;

"health research ethics committee" means any committee established under section 35;

"health services" means health care services that are preventive, protective, promotive, curative and rehabilitative in respect of physical mental and social well being;

"health technology" means machinery or equipment that is used in the provision of health services, but does not include medicine as defined in the Drugs and Related Products Registration etc Act. No. 19 of 1993;

"health worker" means any person who is involved in the provision of health services to a user, but does not include a health care provider;

"hospital" means a health establishment which is classified as a hospital by the Minister under section 13;

"Minister" means the Minister charged with responsibility for matters relating to health;

"National Council on Health" means the Council established by section 5.

"national health policy" means all policies relating to issues of national health as approved by the Federal Executive Council on the advice of the National Council on Health through the Minister;

"National Health Research Committee" means the Committee established under section 34;

"National Health Research Ethics Committee" means the Committee established under section 35;

"National health system" means the system within the Federal Republic of Nigeria, whether in the public or private sector, concerned with the financing, provision or delivery and regulation of health services;

"non-communicable disease" means a disease or health condition that cannot be contracted from another person, an animal or directly from the environment;

"norm" means a statistical normative rate of provision or measurable target outcome over a specified period of time;

"NPHCDA" means the National Primary Health Care Development Agency established under section 11;

"Office of Standards Compliance" means the Office established under this Bill;

"oocyte" means a developing human egg cell;

"organ" means any part of the human body adapted by its structure to perform any particular vital function, including the eye and its accessories, but does not include skin and appendages, flesh, bone, bone marrow, body fluid, blood or a gamete;

"Permanent Secretary" means the administrative head of the Federal Ministry of Health or a State Ministry of Health;

"premises" means any building, structure or tent together with the land on

which it is situated and the adjoining land used in connection with it and includes any land without any building, structure or tent and any vehicle, conveyance or ship;

"prescribed" means prescribed by regulation made under section 62;

"primary health care services" means such health services as may be prescribed by the Minister to be primary health care services;
"private health establishment "means a health establishment that is not owned or controlled by an organ of state;

"public health establishment" means a health establishment that is owned or controlled by a government body;

"rehabilitation" means a goal-orientated and time-limited process aimed at enabling impaired persons to reach an optimum mental, physical or social functional level;

"State Ministry" means any State Ministry responsible for health;

"Statutory Health Professional Council" means a professional regulatory body established by an Act or Law,

"Technical Committee" means the committee under section 7;

"tertiary hospital" means a public or private hospital approved by the National Tertiary Hospital Commission to provide health services at a tertiary specialist level of care;

"this Bill" includes any regulation made thereunder;

"tissue" means human tissue, and includes flesh, bone, a gland, an organ, skin, bone marrow or body fluid, but excludes blood or a gamete;

"use", in relation to tissue, includes preserve or dissect;

"user" means the person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service, and if the person receiving treatment or using a health service is—

(a) below the majority age, "user" includes the person's parent or guardian or another person authorised by law to act on the first mentioned person's behalf; or incapable of taking decisions, "user" includes the person's spouse or, in the

(b) absence of such spouse, the person's parent, grandparent, adult child, brother, sister, or another

(c) person authorised by law to act on the first mentioned person's behalf,

"zygote" means the product of the union of a male and a female gamete.

64. This Bill may be cited as the National Health Bill 2011. Short Title

EXPLANATORY MEMORANDUM

The Bill seeks to provide a framework for the development and management of a health system within the Federal Republic of Nigeria.

Annex 12
Legal Opinion re State Laws on *"Bringing PHC under one roof"*[3]

In summary, while there is no explicit section in the Constitution providing for the power of a state, through its House of Assembly, to enact health legislation, general legislative powers or competences of a [State] House of Assembly are provided for in section 100 of the Constitution.

Additionally, section 13 of the Constitution mandates that all organs of government are obliged to exercise legislative powers to ensure that the State's fundamental objectives and directive principles are implemented as a matter of policy and law. Standing alone, section 13 of the Constitution provides the requisite power for states to enact health legislation within frameworks legislated by the National House of Assembly.

The National Assembly, acting for the Federation, and the Houses of Assembly, acting for their respective states, have concurrent legislative competence with respect to health and may develop health policy and enact legislation, with the caveat that Federal legislation shall prevail over State legislation in the event of a conflict of federal and state laws. Any other conclusion would violate Constitutional provisions reserving powers to the federal, state and local governments.

It is noted, however, that states meeting threshold federal requirements in proposed legislation and laws may strengthen legislation with additional requirements that are not in contravention of mandated federal policies and acts. This could potentially include altering suggested (but not mandated) federal structures and requirements but not, in any event, falling below federal norms and standards.

The Constitutional imperative to enact legislation ensuring the implementation of fundamental objectives and directive principles of the State is buttressed by the six provisions in the National Health Bill authorizing the passage of state laws.

The National Health Bill implicitly assumes that states will establish a State Primary Health Care Management Board, which would preferably be enshrined in legislation rather than an administrative act.

State legislation establishing State Primary Health Care Management Boards also serves as a springboard to define primary health care services, create required institutional structures, provide for management and financial requirements, including a primary health care fund, and related matters.

It would also be in the interests of State Primary Health Care Management Boards to consider contracting, with penalties and incentives as appropriate, to buttress adherence to the law and improve and strengthen enforceable external relationships.

[3] This is a extract from a legal opinion presented at the PHCUOR workshop hosted by NPHCDA in March 2010

Annex 13

SCORECARD FOR IMPLEMENTATION OF PRIMARY HEALTH CARE UNDER ONE ROOF

S/No	States	SPHCB established	Legislation	System Devt	HR	Funding Structure & Source	Repositioning	Operational Guidelines	Community Ownership	Infrastructure & Furniture	MSP
1.	Benue										
2.	Delta										
3.	Ekiti										
4.	Enugu										
5.	Imo										
6.	Jigawa										
7.	Lagos										
8.	Niger										
9.	Ogun										
10.	Sokoto										
11.	Yobe										
12.	Zamfara										

Annex 14

Advocacy material from HERFON on National Health Bill:

NATIONAL HEALTH BILL PROVIDES: - AN ESSENTIAL LEGAL FRAMEWORK FOR IMPROVING PRIMARY HEALTH CARE DELIVERY IN NIGERIA

Nigeria wants to play in the big league of economic developed nations by 20 - 20 -20 but her current socio-economic indicators ranks amongst the worst globally. A nation's human capital is intricately linked to the health of its population, who constitute the workforce and consumers to drive the economy. Health is a key driver of development, economic growth and security. Thus, a healthy nation is a wealthy nation.

The World Health Organization (WHO) 2000 assessment on performance of health care systems ranks Nigeria 187 out of 191 countries. Nigeria health system and ability to deliver quality health care is weak as evident in the country's persistent health indicators. The Federal Ministry of Health (FMOH) estimated in 2005 that 85.5% of all health facilities in Nigeria are primary health care (PHC) facilities. These are the facilities that are closest to the people and by policy, should be able to provide cost effective interventions such as immunization, treatment of diarrhea, antenatal care, deliveries, and management of malaria, TB and HIV/AIDS prevention and others, for improving the health of women, children and the general population. Unfortunately the PHC have over the years been grossly underfunded especially by States and Local governments, leading to decayed infrastructure particularly in rural areas, lack of essential drugs and other commodities and poor staffing practices. These have resulted in lack of access to quality basic packages for a significant proportion of the population especially the poor and rural dwellers.

Crowded waiting room for maternal health

Due to poor primary health care delivery, maternal and child mortality have remained major challenges in the country. About 55,000 women die as a result of complication of child birth and close to one million children die annually from largely preventable causes (NDHS 2008). At the current 63% Immunization coverage, Nigeria has one of the lowest figures in the World. HIV prevalence among adult population is 4.1 % (FMOH 2010). Life expectancy at birth is only 47years (NDHS 2008). Nigeria is one of the 57 countries in the world with critical shortage of human resources for health. About 65 - 70% of Nigerians buy Health services directly.

Although some modest progress have been made to improve health care in Nigeria since the last stock taking in 2008 there are still a lot that needs to be done. One of the immediate and major steps that need to be taken to accelerate current efforts to strengthen Nigeria heath system and performance is the passage of the National Health Bill and signing it into law by the President of Nigeria.

The national health bill when it becomes law will create a Primary Health Care fund that will ensure joint funding of PHC by all tiers of government. The law if properly implemented will provide the following key benefits :

1. **Equity**: Guarantees fairness in the allocation of resources or the treatment outcomes among different individuals or groups. Also sets up criteria for eligibility for exemption from payment for health services in public health establishments
2. **Efficiency:** Allow Nigerians to obtain the best possible value for the resources used. As well as set out the rights and duties of health care providers, health workers, health establishments and users
3. **Access**: Allows Nigerians to have access to the health services they need by removing or reducing financial and physical barriers.
   - Provides for the protection, promotion and fulfillment of the rights of the people of Nigeria to have access to health care services.
   - Guarantees the entitlement of all Nigerians to Minimum Package of Services
4. **Quality**: improve quality of health services in Nigeria.
   - Provision of a framework for standards and regulation of health services section
   - Makes it compulsory for all health establishments in Nigeria to have Certificate of Standards
   - Prescribes penalties for non-possession of Certificate of Standards

What National Health Law will do

- Allocate Resources appropriately
- Revive the Primary Health Care through the provision of State PHC Boards.
- Reduce Barriers to Access Health Care
- Encourage evidence-based Partnership
- Ensure Health Information, Communication, Promotion and Education
- Provides for Community participation and ownership

he National Primary Health Care evelopment Fund shall be used to finance he following:-

50% of the fund shall be used for the provision of basic minimum package of health services to all citizens, in primary health care facilities through the National Health Insurance Scheme (NHIS);
25% of the fund shall be used to provide essential drugs for primary health care;
15% of the fund shall be used for the provision and maintenance of facilities, equipment and transport for primary healthcare;
10% of the fund shall be used for the development of human resources for primary healthcare.

5. **Sustainability**: Existence of robust provisions for coordination, financing, expenditure tracking and community participation which will ensure sustainability.

-Establishes clear functions for the tiers of government for a well-coordinated system

-Establishes a clear funding support for Primary Health Care in Nigeria

- Provides that the health budgets align with plans and that plans align with policies