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Modern technologies for glucose monitoring and insulin replacement

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Delivering quality children's healthcare means delivering children's rights

Ebola: The World Health Organization affirms its leadership position

Contents

02 News Update: National Health Insurance Scheme coverage still low: Only 3.5 million Nigerians covered after 10 years; JOHESU leader emerges as the Nigerian Labour Congress's new President

05 Political leadership change is not a system change: Overcoming the inertia of 'change' in the Nigerian health sector
Dr. Tarry Asoka

07 Confronting weak health workforce governance in Nigeria
Dr. Arnold Ikedichi Okpani

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Whither the Nigerian Health Services?

During the era of military rule, governments were changed, not through the will of the citizens, but by coups d'état, and the new head of state had to persuade the people that the change was justified. Since everyone was dissatisfied with the quality of Nigeria's health services, they became reliable pointers to the failure of sacked regimes, receiving colourful descriptions of which 'our hospitals have become consulting clinics' became a household phrase. New regimes tended to ignore projects initiated by their predecessors, and started their own. Award of contracts for the building of grandiose hospitals and the purchase of expensive medical equipment became evidence of progress. Where the project made it to completion, the day of commissioning, for many, proved to be the zenith of their glory, as poor quality and lack of maintenance assured rapid decline.

Health workers became the issue in health sector. As they strove for better conditions of service, governments increased salaries and allowances, but the allocations to health institutions remained almost static in real terms. As the remuneration of staff climbed, the resources for its services, capital development, and even maintenance diminished to the extent that approximately 80% of government allocation to health institutions was spent on personnel emoluments. It was as if public health institutions existed primarily to provide income for a section of the population.

The time for change has truly arrived. Better outcomes can be achieved if the health infrastructure is strengthened, and systems and processes set up to provide effective services and improve the well-being of the public. It would not involve starting anything new, but simply improving and upgrading what the country already has in the healthcare system at the primary, secondary and tertiary healthcare levels, including much greater attention to sewage disposal and environmental sanitation. With the tremendous fall in the income from the petroleum industry, it is smart to do this and fight medical tourism through encouragement of overseas providers who are already very keen to come and set up institutions of high-tech medicine in Nigeria.

Shima Gyoh

Emergency 58th National Council on Health approves State-supported health insurance scheme

An emergency National Council on Health (NCH), the first in 2015, was held in Abuja in March. The NCH is the highest policy-making body within the Nigerian health system as enshrined in the 2014 National Health Act. One of the key decisions taken at the NCH included the approval of the State-Supported Health Insurance Scheme, which provides a platform for the 36 States to establish and run their own respective insurance schemes with technical support and guidance from the National Health Insurance Scheme.

At the NCH, the Minister of Health, Dr. Khaliru Alhassan also inaugurated the Steering Committee and the Technical Working Group (TWG) for the implementation of the 2014 National Health Act. The Steering Committee is chaired by the Minister of Health with the Coordinating Minister of the Economy/Minister of Finance as Co-chair. Other members include the Minister of National Planning, Minister Women Affairs and Social Development, Permanent Secretary for Health, the Director of Planning Research and Statistics of FMOH (as Secretary), Accountant General of the Federation, representatives of Central Bank of Nigeria, Accountant General of the Federation, Healthcare Federation of Nigeria, House Committee Chairman on Health, Senate Committee Chairman on Health, a World Health Organization Representative, World Bank Representative, Chairman of DPG, Health Reform Foundation of Nigeria (HERFON), Catholic Bishops Conference of Nigeria, and the Supreme Council of Islamic Affairs.

The Steering Committee has the responsibility of providing overall leadership, guidance and oversight in implementation of the National Health Act. It will also be expected to consider the reports, guidelines, manuals, suggestions and technical proposals of the TWG, and offer final guidance before passing on to the NCH for final ratification.

National Health Insurance Scheme coverage still low: Only 3.5 million Nigerians covered after 10 years

At the eighth Enugu State Council on Health, held in April 2015, the former Executive Secretary of the National Health Insurance Scheme (NHIS), Dr. Femi Thomas (pictured), reported that the Federal Government had spent N2.8 trillion on the scheme. In terms of coverage, he said that 96% of Federal Civil Servants and their dependents, representing over 3.5 million are the main beneficiaries of the scheme, which started in 2015. It is evident from available figures that the NHIS is far from achieving the Presidential Mandate of achieving 30% coverage by the end of 2015.

Photo from www.msh.org

Nigeria's first, Africa's third medical sciences university gets government approval

The first Medical Sciences University in Nigeria and the third of its kind in Africa is set to begin operations in Ondo state, southwest Nigeria following its approval by the Nigerian government through the country's National Universities Commission (NUC).

The newly approved Ondo State University of Medical Sciences will be fortieth state-owned and 139th registered university in Nigeria, according to the NUC Executive Secretary, Professor Julius Okojie.

'I write, on behalf of the Board, Management and staff of the NUC, to convey to His Excellency, that with effect from 22nd April 2015, the Ondo State University of Medical Sciences, has been recognised as the 40th State University and the 139th University in Nigeria,' Okojie said in a letter to Ondo State Governor, Dr. Olusegun Mimiko.

Reacting to the government's approval, Governor Mimiko thanked the NUC for the recognition saying that it shows that the agency has its focus on human capacity development. He said that the Trauma Centre, part of the University, had already been accredited by the National Postgraduate College for residency training in Orthopaedic and General Surgery.

'We have put in place world class facilities that have already received acclaim and recognition from requisite professional bodies in the medical sciences. In less than two years of operation, the Trauma Centre has performed more than 2000 cutting edge surgeries and attended to more than 5000 patients. So, we are ready for the university which will not only boost medical tourism but will be almost self-funding and self-sustaining,' Mimiko said.

Online forum launched to accelerate end of AIDS, malaria and tuberculosis

A new e-Forum has been launched by the Global Fund to stimulate discussions on strategies that would accelerate the end of AIDS, tuberculosis (TB) and malaria. This is in line with the fund's process of developing its new 2017-2021 Strategy.

This new strategy, the Fund said, is expected to be adopted by the Board of the Global Fund in Spring 2016. It will guide the Global Fund's partnership's work in a crucial moment in the fight against the three diseases.

The Global Fund is a twenty-first century partnership, working closely with a wide diversity of partners - implementing governments, donors, civil society, international development organisations, the private sector, and communities living with and affected by the diseases. They actively support country-owned approaches that develop and implement effective, evidence-based programmes to accelerate the end of AIDS, TB and malaria as epidemics.

The e-Forum is an integral part of this extensive consultation process. Borderless, open to all, and in multiple languages, it is uniquely positioned to engage all sectors of society in an inclusive and participatory way to collectively shape the future work of the Global Fund.

This year's e-Forum commenced on 20 April and runs over a 10-week period. During this period, all stakeholders are invited to discuss the nine high-level strategic thematic areas of the Global Fund.

'The e-Forum 2015 is your opportunity to help shape the strategy and ensure the Global Fund's increasing impact for the three diseases and global health. Your contribution will help define our strategic framework to most effectively fight the three diseases,' the Global Fund said in a statement.

Against a rapidly shifting landscape in global health and development, the Global Fund's approach to defining its strategic direction is firmly based on this principle of partnership through which all partners take part in decision-making.

Photo from www.theglobalfund.org

JOHESU leader emerges as the Nigerian Labour Congress's new President

The leader of the Joint Health Workers' Union of Nigeria (JOHESU) Dr. Ayuba Wabba has been elected the new president of the Nigerian Labour Congress (NLC). His election brings to an end factional leadership within the NLC.

During the election of the congress, a faction within the NLC announced that it had elected the General Secretary of the National Union of Electricity Employees, Mr. Joseph Ajaero, as the leader of the congress. But the Federal Ministry of Labour and Productivity said it recognised Wabba as the leader of the NLC.

Minister of Labour and Productivity, Sen. Joe Ikenya said: 'For us in the ministry, we want to tell you that you did your election; actually our ministry also supervised it.

'We have not heard and we have not got any letter from anywhere in respect of any other NLC and it was in the knowledge of every Nigerian that there was an election here in Abuja and our ministry participated in it.

'Therefore we will not run into any controversy because that is internal; the ministry is not part of it and we know that you will sort yourselves out because there is a process and I know that all of you know that process.'

Before emerging as the new President of the NLC, Wabba led JOHESU's campaigns for better treatment for its members. He was also the President of the Medical and Health Workers' Union of Nigeria (MHWUN).

In a congratulatory message, the President, National Executive Officers and the entire members of the Association of Medical Laboratory Scientists of Nigeria said they rejoice with Dr. Ayuba Wabba on his election as the President of the NLC. The National Public Relations Officer of the Association of Medical Laboratory Scientists of Nigeria (AMLSN), Adeyeye Adetunji Tam said Dr. Wabba's elevation to the apex leadership of the labour union in Nigeria did not come to AMLSN as a surprise given his record of achievements in unionism as depicted by the visionary and vibrant leadership of the MHWUN/JOHESU.

'As he steers the ship of NLC, may God give him wisdom and good health to defend the course of the Nigerian workers,' Tam said.

Methanol mass poisoning kills scores in Ondo, southwest Nigeria

More than 20 people were reportedly killed following a mass methanol poisoning that occurred in Ode-Irele suburb in Ondo state, southwest Nigeria.

Initially dubbed OndoX disease, the condition was subsequently identified to be connected to the consumption of a local gin popularly called Ogogoro.

The survivors were treated at Nigeria's premier teaching hospital, the University College Hospital (UCH) Ibadan. Recounting his ordeal, one of the survivors, Olorunwa Jero, a father of six described is experience as a sojourn in the 'throes of death'.

He said: 'By the time I was brought here (UCH) I had gone blind. I could not identify my wife, I could not identify anything. I did not even know when I arrived here. But I thank God and the management and staff for bailing me out. I can see all of you here clearly. I can even identify the clothes each one of you is putting on.'

Describing how the hospital's medical team confirmed the outbreak was caused by methanol poisoning, Chief Medical Director of the UCH, Prof. Temitope Alonge said several tests were conducted on patients and samples of the drinks they took.

'All the relevant health personnel worked for almost two weeks before they detected the likely cause of the neurotoxicity exemplified by sudden blindness. The medics correlated their findings with the toxicants in the blood, urine and the local gin samples,' he said.

Before a definitive diagnosis was made, several theories were suggested including claims that the outbreak was caused by spiritual forces. High Chief Moses Enimade, the Oyewoga of Ode-Irele attributed the deaths of the victims to a sacrilege done to Molokun, the god of the land. According to him, the youths entered the shrine and made away with traditional items in a bid to acquire extraordinary powers and engage in money ritual.

Since those affected by the condition died within 24 hours, some residents believed the disease was a highly pathogenic and more virulent form of the Ebola outbreak although all the deaths were preceded by symptoms of sudden blurred vision, headache and loss of consciousness. The neurologic clinical symptoms include blindness, and loss of consciousness.

Political leadership change is not a system change: Overcoming the inertia of 'change' in the Nigerian health sector

The electorate has spoken, with a decisive mandate to the APC. But, as Tarry Asoka explains, the incoming administration will find introducing change more complex then they may imagine

Though Nigeria and Nigerians continue to confound external observers following the 'peaceful' turn out of the Presidential Election in March, this year at home, some people seem to have a cautionary outlook on how things might progress in the coming months ahead. At the monthly economic news and views session for business leaders in Lagos, in April 2015, Mr. Bismark Rewane of the Financial Derivatives Company Limited warned that despite regime change and the hope for a new political dispensation, 'leadership change is not system change'. He identified corruption, poor planning, and lack of capacity as three key factors that may continue to largely undermine economic performance in Nigeria, irrespective of political leadership change at the Federal level.

Earlier analysis have also reported that overall public governance systems, including financial management systems, tend to be weak in Nigeria, but these are sometimes influenced by the values and behaviour of those outside governments at all levels (Federal, State and local councils). This is because a large proportion of social, economic, and political transactions take place outside the formal system - even where a formal system exists. Therefore, it would not be sufficient for reform initiatives to engage with the formal system alone as the strength of informal arrangements - patronage politics, traditional authority, extra-legal arrangements and activities, often circumvent or replace the formal system.

As the institutional environment of the health sector reflects this wider political economy and social milieu that exist in the country, it has been shown to have significant impact on the governance systems for healthcare in Nigeria as well. Although mainly characterised by organisational confusion among various factors on their respective roles - consequent upon the political economy of a 'Federal country' with sub-national levels (State governments and local government councils) that have a significant degree of political and economic autonomy - it is 'vested interests' and a tendency to 'maintain the status quo' that have mainly caused the present disjuncture in policy and strategy development, which has led to the poor performance of the Nigerian health system.

Furthermore, States in Nigeria often contest territory in several areas with the Federal government, the health sector inclusive. We are also aware that Federal Legislation can be interpreted in the States in several ways - parts of it that are relevant would be implemented, while others would not be carried out. There are numerous cases where State interpretations of a national legislation have stood following legal judgement and in practice. With respect to the health sector, State governments have direct authority over healthcare provision within their jurisdictions, while the Federal government exerts very little influence on what happens at the front-line of service delivery, except for some tertiary care (through the Federal teaching hospitals or Federal medical centres that are located in each State). Even at policy implementation level, the Commissioner of Health in each State is accountable to the Governor (who has his own agenda, irrespective of political affiliations) rather than to the Federal Minister of Health. Yet the latter is responsible for the achievement of the national health objectives.

And contrary to opinions in certain quarters that the Federal government can rely on some levers to influence the States, such as setting standards, technical assistance, and supply of health commodities - in reality, because the relationships between Federal health agencies and their State counterparts tend to be only 'technical', a culture of seeking to achieve national public policy convergence, necessary for 'joint accountability' (Federal and States) is lacking. In relation to persistent vested interests being displayed by key health sector actors, the behaviour of agents of both Federal and States health authorities in Nigeria is influenced by a desire to retain existing channels of expenditure, and the political and financial opportunities that these provide. Therefore, irrespective of formal rules and technical operational guidelines, a significant obstacle to be overcome in order for collaborative service delivery (among the tiers of the public health system) to take root in Nigeria, is how these exiting cultural norms that are widely seen as appropriate and normatively sanctioned are dislodged and lose their force.

Given these circumstances, it is unlikely that the performance of the Nigerian health system will improve within the next four years (2015 to 2019) of the new Federal Administration. Nevertheless, there are ways of taking advantage of the regime change at the Federal level, with the anticipation for concerted efforts at 'changing attitudes' towards better national socioeconomic performance. Here is 'how' and 'what' specifically needs to be done in order for the health sector to benefit from the political leadership change.

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Photo from www.thedailybeast.com

A doctor administering a vaccine to this young mother

First, in Federal contexts, much like the European Union with the European Commission, Member States, regional and local governments, and other Federal countries, in which vertical relations between centres of power exist; extensive collaboration is needed where sub-national governments are required to implement policies and legislation from higher levels. Consequently, the Federal Ministers of Health should persistently advocate to policy-makers at the State level, especially the 'purse holders' (the Governors) - not about being 'rolled-in' into any specific Federally designed health programmes and projects, but to get the State Ministries of Health and Federal Ministry of Health develop the capacity for collective intentionality towards delivering the national health objectives.

Second, unlike the legacy of the military era still perpetuated by the Federal Ministry of Health, where States in Nigeria mainly carried out delegated functions, the present democratic dispensation allows the 36 States to make policies to effectively arrive at a balance between conflicting pressures, and to steer their jurisdictions towards shared community goals. Thus, the Federal Ministry of Health has to redefine its role from that of managing the national health system, to becoming a resource that the States can access in order to facilitate policy-making and implementation in line with the national policy goals.

Related to this, the Federal Ministry of Health should stop running parallel health initiatives (no matter how populist they may appear), but use 'funding mechanisms' such as the Millenium Development Goals Fund, SURE-P, and the proposed Primary Health Care (PHC) Fund as effective instruments of influence to secure commitments from the States to reform their health systems towards better performance, as well as leverage additional resources that advance the attainment of specific health status targets, for example reducing maternal and child mortality. There is good evidence to believe that the desire in setting up State primary health development agencies or boards in several States, though with the intention to streamline the financing and management of primary health care, is premised on the anticipation of receiving funding from the national PHC Fund as stipulated by the new National Health Act.

Third, as the national health system operates in an institutional framework characterised by a mix of governance modes - hierarchies and markets - it is critical that attempts at collaborative service delivery (among and) between the three tiers of the government delivery system, and the private sector is informed by knowledge about inter-organisational networks of service providers that go beyond clinical care to include community-based services provided by Non-Governmental Organisations (NGOs) and the informal commercial sector, jointly working across organisational boundaries in delivering care that is integrated across time, settings and providers to achieve improved health outcomes for Nigerians. In this instance, the key role for the Federal Ministry of Health is to work towards policy reforms that fosters a culture of networking behaviour among healthcare actors such as managers, clinicians, funders and patient groups. Interestingly, using the HIV/AIDS service cluster model in the local government areas that has been operating for some years in Nigeria, there is strong evidence to suggest that such an alternative mode of service provision is technically feasible. What is left is an institutional context that allows them to be sustainable.

As the idea of the 'service cluster model' is being tried in several problem areas such as integration of maternal and child healthcare, primary and secondary care integration at the local government areas level, etc., and given the nature of the political economy of the country (where constitutional power and national resources are shared between the Federal government and the 36 State governments), this time of leadership change at the Federal level provides a rare opportunity to adopt a collaborative governance model in the health sector that allows the Federal, States and local government areas to discharge their collective responsibility for healthcare services to the citizens of country, by jointly reorganising health services around people's needs and expectations.

Sadly, a vestige of the military era when the country operated a unitary system, and where power and authority resided at the Federal level persists in the Nigerian health sector. We hear about a Working Group to operationalisse the National Health Act, with several committees meeting in Abuja, at the exclusion of the States. Such behaviour and several others outlined previously are precisely what the new Federal government that assumes office on the 29th May 2015 needs to address, to begin to create a system change within the health sector, along the lines in which the new administration has ascended to political authority at the Federal level in Nigeria.

Confronting weak health workforce governance in Nigeria

Dr. Arnold Ikedichi Okpani explores the background to Nigeria's lamentable record on industrial disputes between government and health workforce

Disruption of public sector health service delivery by labour disputes has become commonplace in Nigeria. The aim of this article is to examine the causes and effects of these disputes and to suggest how improved health system governance can lead to a long lasting solution.

Labour disputes in Nigeria's health sector

In the period between August 2013 and February 2015, publicly owned health facilities were closed at different times for a duration totalling more than 140 days due to labour disputes.[1,2] This duration does not include partial closures or withdrawal of services in individual health institutions due to local labour disputes. Predictably, with out-of-pocket payment accounting for 66% of health expenditure, many families would have been pushed to the brink of financial catastrophe as they had no choice but to seek emergency medical care in expensive privately owned health facilities.[3] Reports abound of people who lost their lives because they could not access affordable healthcare due to closure of government health facilities.[4] With the rich opting for treatment outside the country, Nigeria has become a leading contributor to global medical tourism.[5] For a country with very poor health outcomes (such as contributing to over 10% of global maternal mortality with just 2% of world population), this is not the way to go.[6,7]

With the return of democratic rule in Nigeria after decades of military rule and underinvestment in healthcare, health professionals have been able to form labour unions in order to press for better working conditions from the government. Over the years, these labour unions have had mixed success in their engagement with government and a very familiar pattern has evolved: First the unions identify an issue and demand that government should intervene to address it; the government largely ignores them; the unions issue ultimatums and threaten to go on strike unless the issues are addressed; government calls for negotiations; negotiations drag on until the unions become impatient and go on strike; government ignores them again until public outcry forces them to resume negotiations; agreements are reached and the strike is suspended; the government starts to implement the agreements but does not do so fully; time passes and the unions become impatient; then the cycle is repeated.[8]

The labour unions go to great length to ensure services are not provided by their members during strikes, sometimes resorting to violence and threats of violence to ensure that services are not provided. I once had to treat HIV patients under the shade of trees, away from the health facility, after members of labour unions laid siege on the hospital to enforce a strike. I was threatened with violence when I was caught performing an emergency Caesarean Section during yet another strike. There is little disincentive for embarking on strikes as salaries and wages continue to be paid by government. In situations where government declares 'no work, no pay', payment is eventually made in full at the end of the strike to avert another dispute over unpaid (albeit unearned) wages.

The place of health work force governance

The World Health Organization (WHO) describes a health system as 'all organisations, people and actions whose primary intent is to promote, restore or maintain health'.[9] The health system also encompasses factors external to the health sector that influence health.[10] At a minimum, a country's health system should ensure good quality healthcare that is responsive to need and protects from financial ruin while ensuring efficiency, accountability and equity.[9] Healthcare human resource is a key health system building block. As with other components of a health system, stewardship is the determinant of the value that can be obtained from available healthcare human resources.

The primary responsibility for coordinating health system components and turning public sector resources into improved health outcomes lie with government: the Nigerian Federal Ministry of Health (FMOH). The FMOH determines the policy direction of Nigeria's health system and supervises several agencies that regulate the activities of health workers. The FMOH also directly employs thousands of health workers in hospitals, clinics, university hospitals, healthcare research institutions, and many health-related agencies. In 2014, 4.5% (US$1.3 billion) of the total national budget went into paying the salaries and wages of health workers employed by the FMOH.[11] The foregoing demonstrates the considerable influence that FMOH can potentially exercise in determining the terms of engagement of health workers, as well as regulating their training and activities.

The recurrence of strikes and other disruptive activities by public sector health workers demonstrates suboptimal leadership by the FMOH. Government has failed to anticipate, or has ignored the potential reaction of different health sector unions to changes it has introduced. The result is that when one union is appeased and calls off its strike action, the other unions become outraged and declare their own strike. Besides legitimacy, accountabil-

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ity, transparency, responsiveness, effectiveness and efficiency, a key characteristic of good governance is vision.[9] So far, that has been lacking in government dealings with health sector unions in Nigeria.

A new approach is required

A new approach to managing Nigeria's healthcare workers, their responsibilities and their expectations is urgently required. To begin with, FMOH needs to be clear that responsibility for the delivery of healthcare to Nigerians lies with it, and frequent closures of health facilities and denial of life-saving services to the population is a failure of leadership on its part. As stated in the 2006 World Health Report: 'the ultimate responsibility for the overall performance of a country's health system must always lie with government'.[12]

With the emergence of rivalry between doctors and other professional groups in the health sector as the most prominent cause of the recent disputes and strikes, government must walk down the difficult path it has largely ignored: it must clearly define job descriptions and the limits of activities for each professional group; it must establish and enforce standards for administration in health institutions; and it must do these in a transparent and inclusive manner.

Civil society organisations (CSO) also have a role to play. Whereas they have been largely silent, perhaps for fear of being seen as taking sides, they should give voice to the expectations of the recipients of health services. They should hold the government and labour unions to account for the pain and suffering caused. They should demand to have a say in negotiations between government and labour unions. An active civil society contributes to good governance.[13]

Fairness to all stakeholders should be pursued at all times and government must be firm in pushing through reforms that have been agreed in an inclusive manner. It is poor governance for government to be ambushed by health workers and forced to reach agreements that it has neither the intention nor the capacity to implement as is often the case. Government should strengthen the agencies it has set up to regulate the activities of health professionals. These regulatory agencies need to be empowered to reign in the excesses of labour unions.

A significant opportunity for action

After ten years of delays and controversies, the National Health Act eventually received presidential accent in December 2014. Besides providing a legal framework for the planning, financing and regulation of the Nigerian health sector, the Act also defines roles and responsibilities of the tiers of government and other health sector stakeholders. If FMOH had no legal basis for introducing health work force reforms, it now has. The Act specifies that FMOH should set the health human resource agenda for Nigeria. Part Five of the Act is dedicated exclusively to human resources for health. Section 45 of the Act specifically states:

(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. (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 shall apply all reasonable measures to ensure a return to normalcy of any such disruption within fourteen days of the occurrence thereof.[14]

FMOH must utilise the opportunity presented by the Act to retake the initiative and demonstrate the strong leadership needed to rework its strategy for health human resources in Nigeria.

Every day that people cannot get the care they need because of disputes between organised labour and government, vital trust is eroded, lives are lost, avoidable suffering is inflicted on millions, and healthcare investments are wasted. A government that cannot ensure reliable access to quality healthcare loses legitimacy.

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