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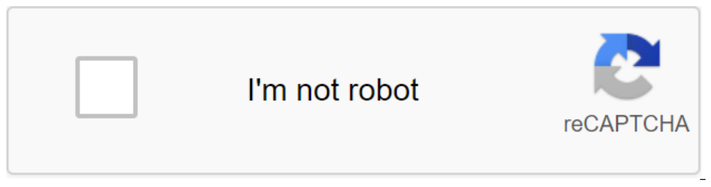

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Abuja, 22 June 2016 - The National Health Policy, revised to ensure universal health coverage (IOD) and other health-related Sustainable Development Goals (SDGs), has been finalized in Abuja. The Chair of the National Health Policy Meeting in Abuja on 18 June 2016, the Minister of Health, represented by the Permanent Secretary of the Federal Ministry of Health (FMOH), Dr. Amina Samaki, stated that Nigeria had drafted and implemented two more documents in 1988 and 2004 prior to the drafting of the current national health policy document. Both were developed at critical stages in the development of Nigeria's health system and had far-reaching implications for improving the efficiency of the system during their lifetime. However, the Minister noted that over the past two (two) and a half decades, Nigeria had recorded some progress in its health system. This includes improving key indicators of major infectious diseases (HIV/AIDS, tuberculosis and malaria) as well as maternal and child health. Recently, Nigeria has been able, in particular, to halt the transmission of wild poliovirus, to eradicate guinea worm and to successfully contain the spread of the deadly Ebola virus disease. The key lesson of these successes is the need to build a sustainable health system in the country that ensures access to basic health services in a sustainable manner, the minister said. In addition, he assured of a good foundation that Nigeria was in the right direction, as the country was sincerely committed to achieving the visionary goal of the WIS. In his submission, WHO country representative Dr Rui Gama Vaz said he was inspired by Nigeria's commitment to achieving WOE through primary health care (PMG), but said citizens deserved to receive quality and equitable health services without financial and other barriers. According to Dr. Vaz, this commitment requires the creation of basic elements of the health system, which include comprehensive and coherent health policies, the establishment and sustainable integrated office/local health with active community participation, strengthening mechanisms that remove geographical, social and financial barriers to access to health care, and improving information for decision-making at national, subregional and levels. He added that the provision of quality health services required detailed plans and investments in expanding and retaining human health resources in all states, with the right combination of skills and competence. WG further noted that the achievement of the WWW requires investment in the sector governments and health partners who were not optimal throughout the region. He noted that only eight (8) countries had achieved the goal of the Abuja Declaration on the allocation of 15% to 15% health sector budgets and in 77% of Member States out-of-pocket patient payments are still higher than 20% of total health expenditures - a level that indicates the existence of financial barriers to access to services. With approximately 70% of pocket costs in Nigeria, WHC through PCC, which includes public sector funding, initiates much-needed financial protection, especially for the poor. The technical working group was chaired by Professor Eiitayo Lambo, with the active participation of officials from the Federal Ministry of Health, all health commissioners and development partners. For more information, please contact: Technical Contact: Dr. Tenin Gakuruh; Tel: 234 803 979 5149; Email: gakuruht (on) who.int_blank'gt;gakuruht (on) who.int media contact: Ms. Warigon Charity; Tel: No234 810 221 0093; Email: warigonc (on) who.int target _blank'gt's warigonc (on) who.int below: 01. (L-R) Dr. Shamaki, Professor Lambo and Dr. Vaz at a stakeholder meeting in Abuja 02. Dr. Vaz gave a speech 03. The National Health Council meeting in Abuja on Thursday endorsed the National Health Policy document. Health Minister Isaac Adewale announced the approval of the document after a discussion by council members. The National Health Policy presents it with a comprehensive health document outlining the functions and responsibilities of all levels of government. In his speech, Mr. Adewole, a professor, said the overall policy objective was to strengthen Nigeria's health system, especially the primary health subsystem, to provide quality, effective and comprehensive health services for all Nigerians. The Minister called on state governors to allocate at least 15 per cent of their annual budget to the health sector in accordance with the Abuji Statement on the implementation of national health policy. According to him, the federal government intends to allocate at least one percent of the Consolidated Income Fund for the creation of the Basic Health Care Fund provided by the Health Care Act 2014. He called on state governors to ensure timely release and allocated health funds to meet the National Health Policy goal. He called on state governors and health commissioners to explore additional ways to fund national health policy in various states. He added that both the federal and state governments are ready to work with to support the health sector. Imploring wealthy people to contribute some of their resources to the development of the health sector, he called for the widespread dissemination of this policy. Mr. Adewale, however, advised state governments to also develop their own Strategic Health Plan in accordance with the new national health policy. The Federal Executive Council has approved a new national health policy aimed at improving the health of Nigerians in order to accelerate the country's socio-economic development. This was stated by the Minister of Health, Professor Isaac Adewale, when he informed the correspondents of the State Chamber of the outcome of the FEC meeting chaired by the Acting President, Professor Emi Osinbajo.He said that this policy, which was initially approved by the National Health Board, was carefully sanctified by the council until final approval. He said the policy was the third health policy in Nigeria's history.The Nigerian News Agency recalls that the first national health policy was in 1988 and the second policy was prepared in 2004. It also emphasizes primary health care as the basis of our national health system in addition to providing financial risk protection for all Nigerians, especially the poor and vulnerable. This administration is known for being pro-poor, and we are quietly committed to alleviating the problem of poor Nigerians, the vulnerable unemployed and the disadvantaged, he said. The Minister also explained that before embarking on a new health policy, his Ministry had drawn up a technical working committee chaired by former Minister of Health Professor Eitayo Lambo to examine the context of the country, the problems of what had gone wrong in the past and how we could change the health sector. According to the Minister, the policy reflects the main factors in ensuring the reduction of maternal and child mortality, greater immunization coverage and improved control and prevention of public health emergencies. He was optimistic that Nigerians would be proud of the country's health system when it was fully implemented. Adewole also said that his ministry will be signing a memorandum memorandum with the European Union that will interfere in the country's medical facilities in 774 local authority areas of the federation. Protecting NAN's social and financial risks to the poor and vulnerable is a major development and policy challenge around the world. There are many definitions of social protection. In the context of health, social protection is defined as programmes and measures to remove financial barriers to access to health services and to protect the poor and vulnerable impoverished by the effects of health care costs. Financial risk protection is a key component of universal health coverage (HSS) and the goal of the health system to ensure access to quality health services without financial difficulties. Protecting social and financial risk risks programs and measures that are rooted in the law. Lack of social and financial protection against risks leads to high levels of poverty, vulnerability and health inequalities. When the majority of the country's population faces the above-mentioned problems, Governments must respond and develop programmes that are rooted in the law. Case Nigeria: Health services Since independence in 1960, Nigeria has very limited legal protection coverage for social protection, in addition, more than 90% of the Nigerian population without health insurance. Over the years, the Nigerian health system has evolved through health reforms to address the public health challenges it faces. This includes: National Health Insurance System (NHIS), National Immunization System (NICS), Midwifery Service Scheme (MSS) Nigerian Performance Payment Scheme (P4P). Despite this, the continued and high levels of poverty and weakness of the health system have contributed to the continued and high levels of poverty and weakness of the health system. Political instability, corruption, limited institutional capacity and an unstable economy are the main factors that have curbed the poor development of health services in Nigeria. Households and individuals in Nigeria bear the burden of a dysfunctional and unfair health system - delays or no access to care and having to pay out-of-pocket for medical services that are not affordable. NHIS After numerous attempts to implement health insurance legislation since 1960, NHIS, although established in 1999, was eventually launched only in 2005. NHIS's goals were: to provide access to quality health services, to protect financial risks, to reduce the increase in health care costs, and to ensure the effectiveness of health care through programmes such as: The Formal Sector Social Security Program (FSSHIP), Mobile Health Care, voluntary contributors' Social Health Insurance Program (VCSHIP), Higher Education Social Security Program (TISHIP), Community Health Insurance Program (CBSHIP) , the State Social Health Insurance Program for Primary School Students (PPPP) and the provision of health services to children under the age of 5, prisoners, the disabled, pensioners and the elderly. Vulnerable populations and free health care were expected to provide social and financial risk protection by reducing the cost of health care and ensuring equitable access to basic health services. To the most Nigerian groups include children, pregnant women, the disabled, the elderly, displaced persons, the unemployed, pensioners and the sick. While these vulnerable groups sometimes benefit from free free services and liberation mechanisms, they largely have to pay for medical services. Free medical services and exoneration mechanisms are often politically motivated, poorly implemented, not fully functioning, and sometimes last only a few years. States such as Osun, Niger, Kaduna, Kano, Ekichi, Lagos, Ondo, Enugu and Jigawa are known to have at one time or another provided some free health strategies after the return of democracy in 1999. Free health care and exemption mechanisms are expected to provide financial risk protection for the most vulnerable, but evidence suggests that they are ineffective and have not been achieved. Although in states such as Niger, Kano and Kaduna, infant mortality despite the fact that pregnant women and children under the age of five are the sole beneficiaries of free health policies, in 2013 it fluctuated between 100-150 cases per 1,000 live births, similar to national indicators of countries such as Chad, Mali and Bissau. In the northern Nigerian region, the under-five mortality rate is significantly higher (100-250 per 1,000 live births) than in the southern region (50-100 per 1,000 live births). According to the World Health Statistics 2016, Nigeria's maternal mortality rate remains fairly high, at 814 per 100,000 live births. Across the country, pregnant women and children under the age of five typically charge access to health services, despite the federal government's announcement of free health care for pregnant women and children under five in 2005. The Minister of Health, Professor Isaac Adewale, announced plans by the federal government in 2016 to provide free medical services to 100 million Nigerians in the next two years. Under this new health agenda, pregnant women across Nigeria are expected to benefit from free primary care (PHC) primary care (PHC) services. Free health care and liberation mechanisms often emerge as election promises by political actors to voters and fail to meet the health needs of the most vulnerable. According to the Nigerian Demographic Health Survey (NDHS) in 2013, more than 60% of pregnant women aged 15-49 give birth at home without attending antenatal care. In rural areas, this value reaches 76.9%. The situation is critical in the north-eastern and north-western regions of Nigeria, where more than 79% of pregnant women in 15-49 year olds give birth to their children at home. More than 60% of pregnant women in Bayels, Plateau and Niger give birth at home, not in a health facility. The distance to the homes of pregnant women from the health facility and the cost of medical care are among the reasons why they do not give birth in a health facility. Cost Cost care and the perceived poor quality of public care is said to be responsible for the poor use of maternal and child health services in Nigeria. In addition, health care costs in Nigeria are low and this is the cause of over-reliance on out-of-pocket payments for medical services. Poor coverage Despite its launch in 2005, NHIS covers less than 10% of Nigeria's population, leaving the most vulnerable populations at the mercy of health services that are not available. This means that the most vulnerable groups in Nigeria are not afforded social and financial protection against risks. The poor population makes up about 70% of Nigeria's population. They do not have access to basic health services, which should provide social and financial protection against risks because they cannot afford it. The KBPI is expected to meet their health needs as well as provide social and financial risk protection for this group, which is predominantly rural. As evidenced by the high level of pocket payments for health services, poor people contribute more financially to health care than official health and funding programmes in Nigeria. From pocket payments for health services limit access and use of basic health services for the poor (23, 24.27, 28), hence the low coverage of basic health care for the poor. The quality of care provided is poor and remains a huge source of concern. Most of the PCG institutions that are supposed to meet the health needs of the poor and rural is in poor condition because of poor budgetary allocations. Recommendations: i. Public health insurance policy makers and policy makers need to develop health reforms to address the lack of social and financial protection for the poor and vulnerable. Part of this reform is the expansion of NHIS. States should be given a mandate to provide health insurance for all residents. The creation of non-essential health insurance for states over the years has affected NHIS's ability to increase coverage. (ii. Public funded private health insurance While the CBHI mandatory scheme is being scaled as an additional measure, state governments should enroll poor residents in a private health insurance plan and be responsible for paying a monthly premium per person to a health organization (HMOs). It's not enough to have health insurance policy, it is important to ensure that health insurance is provided to the poor and most vulnerable in the manner of the human right to health. Priorities for children and vulnerable groups, although the NHIS Act provides for children who are Nigeria's largest population, many children still have to pay for health care, despite the fact that they were born into poor families that are unable to pay for health services and, as a result, suffer from financial difficulties. Free health policies and exemption mechanisms provided by some states targeting children, pregnant women and the elderly are not social and financial risk protection policies, as these groups are largely responsible for health care costs because the free health care programme barely covers their basic health services. A 2016 study concluded that the Basic Health Care Fund (BHCPF), set up by the NSC to strengthen and

improve PMG, could not provide HSC or universal financial protection for the basic minimum benefit package for all pregnant women and children under five years of age. However, governments need to develop and implement NHS schemes as a strategy to address the high levels of poverty, vulnerability and high levels of health inequalities for which the poor and vulnerable are disadvantaged. Iv. The universal health sector Is another way to provide social and financial protection for risks to the poor and vulnerable is to establish a legislative framework for the HSD system and allocate funds to it. Data from Thailand show that OHP schemes through PCG affect increased access to health care for the poor and vulnerable. It has also been proven that HEA schemes improve the use of health services and health. In order to finance and reach policy makers, policy makers and all stakeholders in the health sector, a government-funded system of social and financial risk protection should be established through a common tax financing system for the poor and vulnerable and investment in basic rural health infrastructure to ensure quality health services. NHS schemes are essential to address poor coverage, limited access to health care and poor quality of health services. The Nigerian Law has yet to adopt innovative ways to protect the poor and vulnerable from the financial risk of ill health. It is important by law to guarantee the right to health care for all Nigerians. While the National Health Act (NHA), which was signed in 2014, stated that all Nigerians are entitled to a basic minimum package of health services, it is not clear if provisions made by the NHS are capable of achieving Nigeria. In addition, the NSC has not yet been put into operation for two years after being introduced into law. Conclusion that some low- and middle-income countries (LMICs) have been able to provide social and financial risk protection schemes for the poor and vulnerable in the right to health. Therefore, there is a need for social health protection systems targeting these groups in Nigeria. Poor and vulnerable groups should not be impoverished by the inability to obtain much-needed health services. Governments should cut out-of-pocket payments for household health services by adopting a tax scheme that does not contribute to the NHS. Links 1. Emtsov R. World Bank and Social Protection Review. 2013. Available by 20Yem.... (Access to November 8, 2016). 2. Hormansdorfer K. Health and Social Protection. B: Promoting the growth of the poor: social protection. Oecd. 2009. 145-153. Available on ... (Access to November 8, 2016). 3. Saxena., Hsu J., Evans D (2014). Financial risk protection and universal health coverage: problems related to evidence and measurement. PLoS Med; 11(9): e1001701. 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