ACHIEVING THE SUSTAINABLE DEVELOPMENT GOALS ON HEALTH(SDG3)

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TRIBUTE

First, I must express my sincere gratitude to the Chairman and Board of Directors of the Development Policy Centre for their kind invitation to participate as a speaker on this 25th Anniversary Policy Dialogue. It is also pertinent to commend the Board of Directors of DPC for keeping the hope and aspiration of the Ancestor alive

Prof.OjetunjiAboyade was an icon, he helped to nurture and implement various National Development Plans from the 60's to the 90's. He was very selfless throughout his advisory roles with various NigerianGovernments by rejecting various juicy political appointments.

INTRODUCTION

The saying that goes 'Health is Wealth' is pertinent in a country like Nigeria where the promptings of International Organizations like the UN and World Health Organization form the template of health care delivery services. The SDG3 ensures healthy lives and promotes wellbeing for all at all ages. When world leaders adopted the UN Millennium Declaration Goal (MDG) in 2000 which committed the nations of the world to a new global partnership, aimed at reducing extreme poverty and other time-bound targets with a stated deadline at 2015, Nigeria was found wanting. Although significant progress was made worldwide, Nigeria was lagging behind for a variety of reasons which include

a) Bureaucracy
b) Poor resource management in the health care system
c) Sequential Health care Worker Industrial Action
d) Boko Haram insurgency in Northern Nigeria and kidnappings in some southern parts of Nigeria.

The above mentioned challenges have to be resolved for Nigeria to significantly advance with new sustainable development goals on health by 2030.

What are the Sustainable Development Goals on Health?

1. Reduce the Global Maternal Mortality ratio to less than 70 per 100,000 live births.
2. By 2030, end preventable deaths of newborns and children under 5years of Age, with all countries aiming to reduce neonatal mortality to at least 25 per 1000 births.
3. By 2030, end the epidemics of AIDS, Tuberculosis,, Malaria and neglected tropical diseases. To combat Hepatitis, water borne diseases and all other communicable diseases.
4. By 2030, reduce by one-third the premature mortality from non communicablediseases through prevention and treatment, and promote mental health and wellbeing.
5. Strengthen the prevention and treatment of substance abuse, including Narcotics abuse and harmful use of Alcohol.
6. By 2020, halve the number of global deaths and injuries occurring from road traffic accidents.
7. By 2030, ensure universal access to sexual and reproductive health care services, including family planning information an education, and the integration of reproductive health into National strategies and programs.

8. To achieve Universal Health Coverage, including financial risk protection, Access to quality health care services and access to safe, effective quality,anaffordable essential medicines and vaccines for all.
9. By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, soil pollutions and contamination.
    a) Strengthen the implementation of WHO frame work Convention on Tobacco control in all countries as appropriate.
    b) Support the Research and Development of Vaccines and Medicines for Communicable and Non-communicable diseases that primarily affect developing countries, provide access to affordable Essential Medicines and Vaccines in accordance with the DOHA Declaration on the TRIPS Agreement and Public Health which affirms the right of developing countries to use the full provisions in the Agreement on Trade Related Aspects of Intellectual Property rights regarding flexibilities to protect public health, and an in particular provide access to medicines for all.
    c) Substantially increase health financing and recruitment, development, training and retention of the health workforce in developing countries especially in the least developed countries and small island states.
    d) Strengthen the capacity of all countries for early warning risk reduction and management of national and global health risks.

SDG 3 aspires to ensure health and wellbeing for all, including a bold commitment to end the epidemics of AIDS, Tuberculosis, Malaria and other communicable diseases by 2030.

It also aims to achieve Universal Health Coverage and provide access to safe and effective medicine and vaccines for all. Supporting research for vaccines is an essential part of the process as well as expanding access to affordable medicines.

ENSURING HEALTHY LIVING AND PROMOTION OF WELLBEING FOR ALL AT ALL AGES

ISSUES AND CHALLLENGES

Sustainable development for health requires expanding services in order to achieve all theSDGs by 2030, the SDG health targets in 67 low and middle income countries that account for 75% of world population must be progressively expanded. Analysis shows investments to expand services towards universal health coverage and other health targets could be enormous. The universal health coverage is ultimately a political choice of responsible Government.

Health systems investments usually involve

a) More health workers.
b) Building and operating new clinics/cottage clinics in rural areas.
c) Hospitals and laboratories.
d) Medical equipment.

All these above projects account for 75% of the total costs, the other 25% are for

a) Medicines, vaccines and other consumables.
b) Training, health campaigns and outreach to vulnerable communities.

The developed countries provide universal health coverage with essential health services to their citizens. It is also observed that in some developing countries like Nigeria, higher spending does not necessarily translate to improved health services delivery, it is making the right investment on time that yields success.

In Nigeria, Public health data have been guess work, not the actual informed estimates.

The World Health Organization produced a list of Essential Drugs which satisfy the priority health care needs of the population and the proportion of the population with access to affordable medicines and vaccines on a sustainable basis.

ESSENTIAL MEDICINES AND SDG 3

Essential medicines are defined by WHO as medicines that satisfy the priority health care needs of the population. These are drugs that people should have access to at all times in sufficient amount. The prices should be generally affordable. A model list of essential medicines was published by WHO and each country is encouraged to prepare their own lists taking their own priorities into consideration.

The essential medicines list enables health authorities, especially in developing countries like Nigeria, to optimize pharmaceutical resources. The essential medicines list contains a Core list and a Complementary list.

a) Core list presents a list of minimum medicine needs for a basic health care system, hence listing the most efficacious, safe and cost effective medicines for priority conditions. Priority conditions are selected based on current and estimated future Public Health Relevance and Potential for safe and cost effective treatment.
b) The Complementary list presents Essential Medicines for priority diseases, for which specialized diagnostic or monitoring facilities are needed. Medicines may also be listed as complementary on the basis of higher cost or less attractive cost effectiveness,

This list is important because it forms basis of national drugs policy in more than 155 developing and developed countries of the world.

Many Governments refer to WHO's recommendation while taking decisions on health spending.

However, we have to acknowledge that we have some problems that divide the health system and the medicine communities i.e. pharmaceutical manufacturers, pharmacists, etc. we seem to ignore that the definition of access to healthcare or essential health services is not the same.

Access to health care services is measured in terms of

a) utilization and it depends on availability of services,
b) physical or geographical accessibility and acceptability. This implies that health services are of adequate quality and that access dimension captures equity.

Hence, WHO defines the term 'Access to Medicine' under the heading of Trade, foreign policy, Diplomacy and health.

It acknowledges that Access to medicines depends on these factors.

a) Rational selection and use.
b) Affordable prices
c) Sustainable financing
d) Reliable health and supply system.

It focuses on affordable prices as the main factor affected by globalization and describes strategies to increase medicines affordability; pricing policies as well as some principles of the DOHA declaration on patent protection, such as parallel imports or compulsory licensing.

DOHA declaration on TRIPS agreement (Trade Related Aspects of Intellectual Property Rights) and public health enacted 14th Nov 2001 in Qatar, DOHA. It was adopted by the World Trade

Organization Ministerial conference. It reaffirmed flexibility of TRIPS on member states in circumventing patent rights for better access to essential medicines.

Hence, "access to medicines for all" can then translate to access to and Appropriate use of affordable medicines of good quality for all.

In 2016, the Federal Government of Nigeria released the sixth edition of the National Essential Medicines List, EML, recalling that the 1st edition was published in 1989 in accordance with decree 43 of 1989.

The EML and the operational programs have played an important role on the supply of medicines in the pharmaceutical section of the health care delivery system of Nigeria.

The Committee of Experts from Federal Ministry of Health(FMOH) and Other stake holders including representatives from WHO and Clinton Health Access Initiative, put together an update of WHO model of Essential Medicines. The EML intended to prudently use medicines and foster rational, safe and cost effectiveness in the provision of health care.

Healthcare providers at all levels are advised to limit their choice of medicines to the list so as to realize the objectives set for its use. A statutory provision however exists for use of medicines outside the list. This provision seeks to ensure that no patient is deprived of standard and expected care when needed.

NATIONAL DRUG DISTRIBUTION AND ADMINISTRATION IN NIGERIA

Due to the chaotic pattern of drug distribution in Nigeria and the attending dangers, the major stakeholders in conjunction with the Federal Ministry of Health set up a committee to produce strategy to monitor drug distribution in Nigeria.

INTRODUCTION

Nigeria remains the biggest pharmaceutical manufacturing country in West Africa, accounting for more than 65% of local manufacture of medicines relevant to the people and diseases of the nation and West African sub-region. Some of the product lines include Antimalarial, Antiretroviral, Analgesics, Herbal preparations and medicine for Sickle cell disease. The maiden National Drug Policy (NDP) was launched in1990 to curb the myriads of challenges against the inadequacies in drug availability, supply and distribution. These challenges include

a) High dependence on foreign sources for finished drug products, pharmaceutical raw materials, reagents and equipment,
b) Inadequate storage facilities, poor transportation and
c) Distribution of drugs were inclusive.
d) Ineffective and poor drug administration and control activities.
e) Poor selection and procurement practices.
f) Involvement of unqualified persons in procurement, distribution and sale of drugs. The effectiveness and efficiency of drug distribution lies on good system design, efficiency, effective management and standard logistic management information system (LMIS)

One of the major challenges of the pharmaceutical sector and health care delivery system in Nigeria is the uncoordinated drug distribution system.

The Federal Government of Nigeria in line with good drug supply management, which the National Drug Policy stipulates consequently setup a Presidential Committee on the Pharmaceutical Sector Reform (PCPSR)

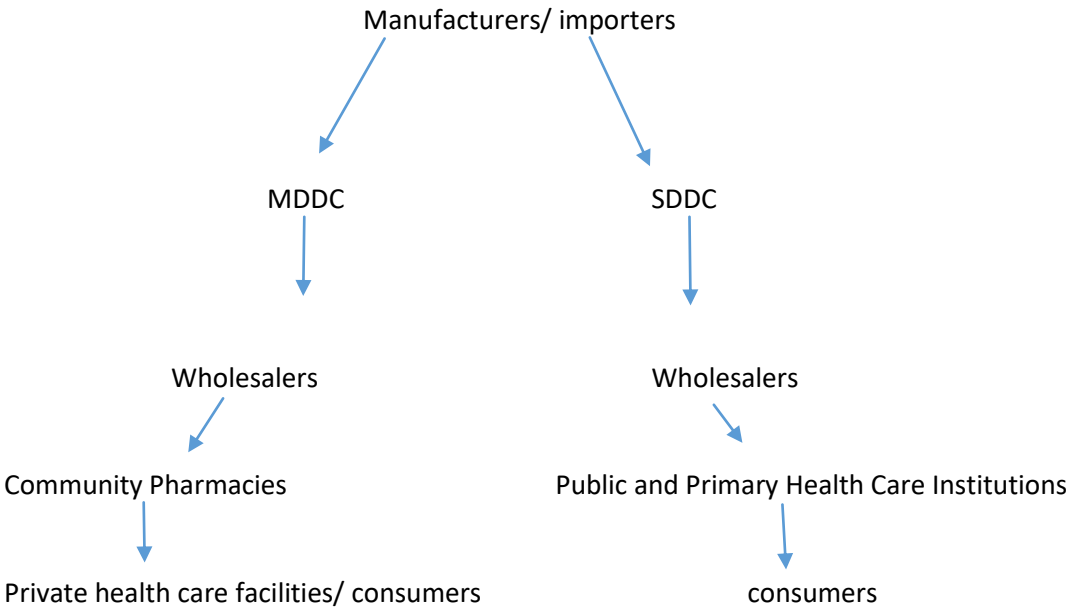
The PCPSR was charged among others with the responsibility to develop strategies toward the establishment of a well ordered drug distribution system in Nigeria. This committee developed the National Drug Distribution Guidelines (NDDG) to provide guidance for drug distribution in Nigeria.

The guidelines established the State Drug Distribution Centers (SDDCS) which will be supervised by a standing committee, while the Private Sector established Mega Drug Distribution Centers (MDDCS) sited in the six geopolitical zones before they were registered as (MDDCS).

The SDDC is meant to services the public sector at the state level. The SDDC will cater for all public health facilities in the state and is allowed to sell to national health programs. The MDDC is allowed to sell to wholesalers who occupy a pivotal position in the value chain. Purchases could be made from SDDC or MDDC but not from the manufacturers or importers. The wholesalers can sell to community pharmacies, public and primary health care facilities, and private health institutions. This is to checkmate unauthorized persons from flooding the county with fake and substandard drugs.

At the bottom of the chain, we have community pharmacists, Public and Private Health Institutions who sell directly to consumers. The Pharmacists Council of Nigeria (PCN) is mandated to register private hospitals, local Government clinics and any other facility that directly or indirectly makes use of medicines. This is a clear departure from the previous systems where everything goes. To be a superintendent pharmacist, one must have at least 5 years' experience, post qualification for retail and 10 years for wholesalers.

Organogram



The guidelines are being operated based on the existing PCN and NAFDAC laws. This is necessary to bring sanity to the drug distribtuion system plagued by activities of the Charlatans and non professionals in the sector.

CONCLUSION ON DRUG DISTRIBUTION GUIDELINE IN NIGERIA

Drug supply system in Nigeria needs a drastic system overhaul and streamlining. This will

1. Encourage the laminar flow of quality and efficacious drugs from the Manufacturers/ Importers to the consumer at affordable prices while eliminating the disastrous activities of Charlatans in the value chain.
2. Strict enforcement by the regulatory agencies with sustained monitoring and evaluation should be upheld at all levels of drug supply chain. From previous attempts, poor monitoring and evaluation culture has been a major limitaion to laudable drug delivery systems in developing countries inclding Nigeria.
3. It will eliminate the circulation of fake and substandard products and the activities of illegal operators. It wil be the panacea to chaotic distribtuion system and facilitate

sustained and improved actualisation of thegoals of the National Drug Distribution Guideline and National Drug Policy (NDP).

The dynamics of todays Global Drug Distribution aims at reaching consumers easily while minimizing and eliminating the activities of weak and limited intermediaries, charlatans and unskilled people in value chain.

Perhaps the most important SDG is the one that targets Universal Health Coverage for all Nigerians, this includes financial risk protection, access to quality essential health care services, and access to safe, effective quality and affordable essential medicines for all.

In Nigerian health delivery systems, medicines account for about 68% of total health expenditure and note that 90% of total medicine expenditures are out of pocket.

The Nigerian Government like most other developing countries decided to give her citizen the universal health coverage. Hence, the National Health Insurance Scheme (NHIS), a corporatebody was established under Act 35 of 1999 constitution. This act is to improve the health delivery to all Nigerians at an affordable cost. It also provides adequate and affordable health care, hence improving the health status of Nigerians who participate in its various programs/ products.

THE NATIONAL HEALTH INSURANCE SCHEME

This is a social security system that guarantees the provision of needed health services to persons on payment of token contributions at regular intervals. The stakeholders include

Federal Government of Nigeria (FGN), employers, employees, health maintenance, organizations, Board of Trustees, health care providers:

a) Primary health care providers
b) Secondary and tertiary health care providers: these include, general hospitals (OPD and in-patient), specialist hospitals, pharmacies, dental clinics, laboratories, physiotherapy clinics and radiography

Other stake holders include

a) international organizations, Collaborating partners who provide technical and financial support to ensure successful implementation of the scheme, especially among the self-employed, rural communities, permanently disabled persons, and children under 5 years of age.
b) Non-Governmental Organizations (NGOs), community leaders, the banks, the media, insurance companies and brokers.
c) Professional bodies- Nigerian Medical Association (NMA), Pharmacists Council of Nigeria (PSN)

CHALLENGES OF NHIS

The challenges of NHIS include

a) Failure to define coverage population, failure to outline funding mechanism for the under priviledged and also failure to outline ways of collecting funds from the informal sector, which form more than 90% of the population.
b) Poor implementation- although good operational strategies were made to improve coverage in the scheme, none was implemented. These factors hampered the success of the scheme.

   Enrollees point at poor service delivery with long waiting time, use of substandard drugs and poor attitude from the health providers. All these inadequacies festsered because of poor supervision and weak regulation.
c) Poor Government funding- the Nigerian expenditure on health is relatively low even when compared to the African countries. The Total Health Expenditure (THE), as the percentage of Gross Domestic Product (GDP) from 1998 to 2000 was less than 5%,

falling behind Kenya 5.3%, Tanzania 6.8%, and South Africa, 7.5%. However the 2018 health budget presented to the national assembly is N340 billion naira which translates to 3.9%v of the 8.6 Trillion naira total budget. This is poor and almost insignificant since Nigeria signed the Abuja declaration to spend 15% on Health.

d) Optional enrolment policy- the fact that NHIS is not compulsory has hampered the expansion of the scheme. Formal sector i.e. civil servants, armed forces and paramilitary employees were enrolled by the federal Government. The states are not included and efforts to reverse this trend was rebuffed by the 6th and 7th NASS.
e) Inappropriate practices by the regulatory authority- NHIS operations have been hampered by corruption in successive administrations e.g. allocations made to the scheme were not properly channeled and utilized.
f) Inadequate risk management systems – this has exposed the HMOs , providers and enrollees to risk e.g. a situation where the same premium is paid by a 75 year old and a 15 year old is absurd,
g) Lack of political will- Many attempts were made to start the scheme but failed until 2005. The bill to amend the act to make the scheme mandatory for all Nigerians, has been gathering dust in the national assembly. FGN should give priority to sustainable development of health care delivery to Nigerians.

CONCLUSION

Ensuring healthy living and promotion of wellbeing for all demands

a) Necessary data (facts) not estimates to make meaningful projection for sustainable development for health delivery services.
   Nigeria for example executed various important health delivery initiatives without true and validated baseline data e.g.essential drugs lust, National Drug Distribution Guidelines, National Drug Policy and National Health Insurance Schemes with shaky backgrounds.
b) To succeed with this development goal, there should be real Healthcare Leaders, not Managers to drive SDG 3. Medical Qualification and years of experience in the health industry may not be sufficient in the choice of leaders. Individuals who have the right leadership orientation, skills and competencies should be tasked with the assignment of insuring sustainable delivery of health services.
c) There is the need for full integration rather than verticalization of health services. This will enhance by leveraging of resources, development of sustainable processes and health systems as well as maximization of economies of scale. Further benefit of this approach will reduce data load on health care workers, prevent monotony in delivery of health care services.
d) Proper and measurable process of evaluation should be built into the implementation plan of the SDGs. Systems are put in place in all segments of the health system including funding management. Health workers should be trained and retrained to ensure proper reorientation with a new integrated care mentality.
e) Monitoring all the above processes can be pivotal to the success of the Sustainable Development Goals for health.

Thank you for listening.

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