

NIGERIA

A paper produced by DFID's Health Systems Resource Centre for the UK Department for International Development

The population of Nigeria is an estimated 118 million people. With a projected average annual growth rate of about 3.0 per cent (1995 – 2000), a total fertility rate of 5.84, a crude death rate of about 16 per 1,000 and a projected population of 255.6 million by the year 2025, Nigeria has one quarter of the population of the African continent. It has a UNDP HPI-1 ranking of 62¹. There has been rapid urbanisation and by 1997 41 per cent of the population was urban.



Introduction

Nigeria is a federation of 36 states. National government is located in the Federal Capital Territory (FCT), based in the capital Abuja. Below State level there are 774 local government areas. Of the 250 ethnic groups, the most dominant are the Hausa in the north, the Ibo in the east and the Yoruba in the west. The population in the south is mainly Christian while the north has a Muslim concentration.

Nigeria has a GNP of US\$36 billion (41 per cent of West Africa's GNP). With substantial human and natural resource endowments, Nigeria has the potential to be the engine for economic growth in the sub-region. However, its economy is highly distorted and inefficient (oil accounts for 40 per cent of GDP and over 95 per cent of exports). Nigeria has been badly affected by military rule, corruption and economic mismanagement. The most recent military dictatorship ended in 1999 when Olusegun Obasanjo, a former military leader and political prisoner, was elected president. The return to civilian democratic rule promises a period of stability, although crime and ethnic violence in the Delta area is high and a cause for concern. The President came to power promising to stamp out widespread corruption and to support strategies to improve health. Progress on this has been slow

Poverty

The annual per capita income has been estimated to be \$260¹, with a Gini Index² of 37.5. The incidence of poverty in Nigeria is widespread and increasing with some of the worst poverty linked health indicators in Africa. There has been a sharp increase in poverty from 1992 to 1996, with an estimated third of the population living below \$1 per day and nearly two thirds below \$2 per day.

Rural women work an average of 4-8 hours per day more than rural men. Although they produce 80 per cent of the food, they have no legal right over the land they cultivate, have difficulty getting formal credit, have little control over family finances, and a limited voice in decision-making organisations, which are dominated by older men. The Federal Office for Statistics' Poverty Profile (1999) indicates that the incidence of poverty in female-headed households has increased continuously over the last 16 years. Poverty also consistently increases when the size of

¹ Preliminary World Bank estimates calculated using the WB Atlas method.

² The Gini Index measures the extent to which the distribution of income among individuals or households within an economy deviates from a perfectly equal distribution. A Gini Index of zero would represent perfect equality, and an index of 100 would imply perfect inequality.

the household rises above five members. Women, and increasingly men, are ill equipped to cope with these trends.

The incidence of poverty is higher in the north of the country than in the south. Regional disparity may be related to inequitable investment in social services and infrastructure. Investment is biased disproportionately to the southern part of the country where, for example, 80 per cent of the hospital beds are located. Poverty levels are also higher in rural areas; 66 per cent of the poor live in rural areas where incomes are up to 30 per cent lower than in urban areas.

Key health indicators

Nearly 15 per cent of Nigerian children do not survive to their fifth birthday. Two leading causes of child mortality are malaria (30 per cent), and diarrhoea (20 per cent). Malnutrition contributes to 52 per cent of deaths of children under five.

Table 1: Key health indicators

Indicator:	Value:	
	Data from the World Health Report 1999, WHO	Data from the World Development Report 1999/2000, World Bank
Life expectancy	Male: 49, female: 52yrs	Male: 52, female: 55yrs
Infant mortality (per 1000 live births)	81	77
Under-five mortality (per 1000 live births)	Male: 154, female: 140	122
Maternal mortality (per100, 000 live births)	1000	1000
Total fertility rate	5.2	5.3
Contraceptive Prevalence rate	Not available	6 %
Immunization against measles	69 % (based on data from 1997)	Not available

For the adult population, as in the rest of Sub-Saharan Africa, cases of malaria are on the increase. The number of deaths from malaria is not known but it is estimated that nearly a million people are seriously ill from the disease each year. Less than half of the population has access to safe water and water borne disease is widespread.

The spread of HIV/AIDS is now alarming and Nigeria is in the epidemic phase of the AIDS pandemic. The reported prevalence of HIV/AIDS has risen from 1.8 per cent in 1990 to 4.5 per cent in 1995. A new seroprevalence survey shows a rate of 5.4 per cent³ among women attending antenatal services but in some areas this figure is over 20 per cent. With the new presidency, HIV/AIDS is higher

³ Data from author's personal communication with DFID field manager, Nigeria.

on the agenda. A multi-sectoral approach has been adopted and is coordinated by a National Action Committee on AIDS (NACA) under the control of the presidency. Similar multi-sectoral committees are being planned at both the state and local government levels. Only one Nigerian woman in ten practices any form of contraception. Female genital mutilation and other harmful practices are major public health concerns.

There is a growing incidence and prevalence of non-communicable diseases. For example hypertension is generally estimated at 8-10 per cent for rural and 10-12 percent for urban communities.

The table below gives the key health indicators for the country. Whilst not being the worst in Sub-Saharan Africa they still represent substantial morbidity and mortality, particularly among the poor. For example, the maternal mortality ratio varies from 339/100,000 in the south-west of the country

to 1,716/100,000 in the north-east.

Health service structure and provision

All three levels of government, the Federal, State and Local Government Areas (LGAs), have responsibilities for the provision of health care. The 36 States and 774 LGA's are responsible for all financial aspects of Secondary Health Care (SHC) and Primary Health Care (PHC) departments, including personnel costs, consumables, running costs and capital investment. The Federal government sets overall policy goals, co-ordinates activities, ensures quality, training and implements sector programmes such as immunisation. The co-ordination of activities is generally poor.

The National Primary Health Care Development Agency (NPHCDA) provides a source of technical knowledge and expertise on the provision of PHC and monitors PHC

delivery on behalf of the Federal Ministry of Health. Capacity to undertake this is limited. Public PHC services are funded and administered by the state MoHs, which provide technical assistance to the LGAs under the PHC Director in the State MoH. PHC services are the direct responsibility of LGAs whilst SHC services come under the State Hospital Management Board (HMB). However, there are very few links between the two. As a result, the referral system is weak and undeveloped.

Hospitals are providing virtually no support or technical supervision of services provided by PHC facilities, and there are no outreach clinics or visits by hospital staff. In addition the relative independence of States means that pursuing consistent national policies across the country is problematic.

Many of the health problems that the country faces could be reduced through improvements at the primary care level, but there are many constraints.

Inadequate financial resources (\$2-3 per capita) for the health sector is a major problem. Since the beginning of the economic crisis in the 1980s the health sector has suffered dramatically in as has all other public service activity. Development and recurrent expenditure has declined resulting in a scarcity of drugs and medical supplies, and the deterioration of facilities.

Each LGA employs a primary care co-ordinator but communication and co-ordination between different service levels are poorly developed and data for planning purposes and management are sparse. Available resources are often not employed in a cost-effective manner where they would bring the highest benefit. In addition, health care is available from private and voluntary/mission sectors. The private sector and the traditional medicine settings are very important and jointly account for 60-80% service provision. There is little regulation and standardisation of services. One of the main reasons for the very low utilisation rates for public sector clinics has been the poor standard of facilities and care. User charges are also perceived as too high. In theory there should be some accountability of public facilities to the community through village development committees, and a range of systems at hospital level. In practice however these rarely function effectively.

Key health policies

The current policy framework is derived from the National Health Policy, the draft National Health Plan, the National Vision 2010 Report

and President Obasanjo's health priority statements.

The vision for health sector reform is to improve the health status of all Nigerians, and to attain a level of health care that would permit all Nigerians to live a socially and economically productive life.

A Draft Plan of Action 2000-2002 has been the subject of wide and varied consultative inputs from across the country. The planned Health Sector Reform initiative is particularly auspicious, coming as it does at a time of increased stability and rapidly improving macro-political and economic conditions and the civilian government's determination to alleviate poverty.

The Draft Plan identifies 13 objectives (see Annex) on which it is intended to make progress over the term of the Obasanjo administration. However the Plan still remains an aspiration.

Health sector financing

According to the World Bank, public financing of the social services at 0.3 per cent of GNP remains lower in real per capita terms compared with the late 1970s and early 1980s.

About 60 per cent of health service expenditure now occurs outside of the public sector on a range of non-profit, traditional and modern practitioners⁴. Nationally, the principal actors in the formal private sector are for-profit patent medicine vendors and registered pharmacies, which numbered 22,640 and 1821 respectively in 1992.

DFID involvement in Nigeria:

During the previous regime, DFID focused its efforts at state level and below, and working with the NGO sector. Informal links were maintained with government officials. The new democratic government has provided the opportunity to reopen a dialogue and partnership with the Federal Ministry of Health and other players at national level.

Existing DFID support includes the following:

- | Institutional Strengthening of the Christian Health Association Nigeria (CHAN). To improve CHAN's organisational effectiveness and ability to mobilise resources and networking capacity.

⁴ Better Health in Africa: Experience and lessons learned, World Bank 1994.

- | Oju LGA Water & Sanitation. To improve the quality of life of men, women and children in Oju LGA, Benue State, through improved access to, and use of, safe and sustainable water and sanitation facilities.
- | Benue Health Fund project. To improve essential health services in 47 target LGAs, 9 hospitals and 33 communities in Benue State, covering a population of about 1 million people, by identifying cost effective interventions and providing support through a Health Fund.
- | Contraceptive Social Marketing. To increase knowledge, access and use of modern contraception for prevention of STDs, HIV/AIDS and unplanned pregnancy, with major focus on HIV prevention, and responsible for 80% of the condoms used in Nigeria.

Other HIV related projects.

DFID is working on a strategy for care and support, prevention in high risk groups, surveillance, HIV testing, life planning education and counseling.

Proposed activities.

DFID's Health Programme in the Country Strategy Paper aims to support the Federal and focal State governments in strengthening their health systems and building capacities to improve health services and outcomes. Rapid impact programmes that will focus on insecticide treated bednets and immunization will also be developed.

The HIV/AIDS programme aims to strengthen Nigeria's response to the pandemic by supporting the development and implementation of a national strategic plan. The contraceptive social marketing programme will be extended for a further seven years.

Role of other development agencies

An international section has just been established within the federal ministry of health with the mandate of donor coordination.

USAID: Areas of assistance include: child survival immunisation and Vitamin A deficiency control, reproductive health and HIV/AIDS.

UNICEF: Operates across the country. Principle activities include – provision of basic health services, immunisation, safe motherhood, adolescent reproductive health, MTCT, malaria control, onchocerciasis and guinea-worm eradication and nutrition.

World Bank: Developing a health systems development programme which will operate in each state and at federal level. There will also be a major loan to support the Interim Action Plan for HIV control.

UNFPA: This agency supports the Federal, 12 States and their LGAs in improving quality and access to integrated and sustainable Regional Health services, including a focus on adolescent reproductive health.

Key references

All statistical data sourced from the Federal Ministry of Health, Jan 2000; Health Sector Reform Medium Term Plan of Action 2002-2002, unless otherwise specified

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WHO, 1999; *The World Health Report 1999: Making a Difference*

World Bank, 2000; *The World Development Report 1999/2000: Entering the 21st Century*

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Annex: Draft Medium Term Action Plan 2000-2002

Objective 1 - To expand and strengthen primary health care services throughout the country.

Objective 2 - To eradicate, eliminate and control childhood and other vaccine preventable diseases through adequate routine immunisation activities.

Objective 3 - To integrate and strengthen all disease control efforts and health promotion activities into health care at primary care level.

Objective 4 – To address the demographic problems through the provision of family and reproductive health services including the necessary services to reduce the incidence of STD and HIV infection.

Objective 5 - To reduce environmental and occupational health related morbidity and mortality.

Objective 6 - To rapidly resuscitate and improve the services of secondary health care to serve as an effective referral for PHC.

Objective 7 - To improve investigative, diagnostic and treatment capability of tertiary health facilities to serve as an effective apex referral system to all health facilities in the country.

Objective 8 – To ensure the attainment of the goals and objectives of the National Drug Policy (NDP), which focuses on self-reliance in essential drugs, vaccines and biologicals through local manufacture and an effective drug administration and control system.

Objective 9 – To protect the public from the harmful effects of fake drugs, unregistered medicines and processed foods.

Objective 10 - To ensure that the support given by donors, NGOs and UN agencies is provided within the framework of the national health policy and plans.

Objective 11 - To broaden financing options to expand and improve access to affordable and adequate health care to a majority of Nigerians.

Objective 12 - To strengthen policy formulation, general management, financial management, and planning capacity of the Federal Ministry of Health and parastatals.

Objective 13 - To strengthen the capacity to develop, implement, monitor and evaluate evidence-based national health policy, planning, programmes and activities.