Overview

Nigeria is one of the largest countries in Africa, with a population of 177 million people occupying an area of 923,678 square kilometres; just over half of Nigerians live in rural areas. Primary Health Care (PHC) is the foundation of the Nigeria National Health System. The 2013 National Demographic Health Survey (NDHS) shows that common preventable diseases such as malaria, diarrhoea and malnutrition are major causes of morbidity and mortality in children; maternal mortality is 576/100,000; and the under-five mortality rate is 69/1000 live births. Antenatal care attendance and delivery by skilled health providers are 61% and 38% respectively; and only about a quarter of children are fully vaccinated. Nigerians have an average life expectancy of 52.62 years.

With a gross domestic product (GDP) per capita of US$1091 and income inequality expressed as a Gini coefficient of 43.7, Nigeria is still ranked among the poorest countries in the world, with about 70% of the population living below US$1 per day. Economic indicators show that as of 2013, total health expenditure as a proportion of GDP was 3.7%, and out-of-pocket payments represent over two thirds of health expenditure. The World Health Organization (WHO) Global Health Observatory reports a physician per 1000 population of 0.4 and nurse per 1000 population of 1.6, with gross inequity in rural–urban distribution in terms of both number and skill range.

Alongside a programme of health sector reform, several significant new policy initiatives in the health sector were developed, including: A revised National Health Policy; a framework for achieving the health-related MDGs in the country; revitalization of the National Council on Health; launch of a National Health Insurance Scheme; and the signing of the National Health Act. Several sub-sectoral policies/strategies/plans on public–private partnership, human resources for health, health care financing, research for health, drug policy, maternal and child health, malaria control and health sector response to HIV/AIDS have been developed and implemented.

The National Health Policy emphasises that equity in health care and health for all Nigerians is a goal to be pursued just as it affirms that health and access to quality and affordable health care is a human right. Primary health care is a basic level of health care that is directed at the promotion of health, early diagnosis of disease or disability and prevention of diseases. It is an essential health care made available to people in the community, within the available resources and this can only be possible through the interconnected efforts of the different functional elements of the primary care systems.

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# Nigeria Case Study

## Table 1. Key demographic, macroeconomic and health indicators of the country

<table>
<thead>
<tr>
<th>Results</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population of country</td>
<td>177,155,754</td>
</tr>
<tr>
<td>Sex ratio: male/female</td>
<td>Total population: 1:1</td>
</tr>
<tr>
<td>Population growth rate</td>
<td>2.47% annual rate</td>
</tr>
<tr>
<td>Population density (people/sq km)</td>
<td>442 people per square kilometre</td>
</tr>
<tr>
<td>Distribution of population (rural/urban)</td>
<td>49.6%/50.4% (rural/urban)</td>
</tr>
<tr>
<td>GDP per capita (US$)</td>
<td>1091</td>
</tr>
<tr>
<td>Income or wealth inequality (Gini coefficient)</td>
<td>43.7</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>52.62 years</td>
</tr>
<tr>
<td>Top 5 main causes of death (ICD – 10 classification)</td>
<td>Vaccine-preventable diseases, malaria, diarrhoea, acute respiratory infections and malnutrition.</td>
</tr>
<tr>
<td>Total health expenditure as proportion of GDP</td>
<td>3.7%</td>
</tr>
<tr>
<td>Public expenditure on health as proportion of total expenditure on health</td>
<td>23.9%</td>
</tr>
<tr>
<td>Private expenditure on health as proportion of total expenditure on health</td>
<td>76.1%</td>
</tr>
<tr>
<td>Out-of-pocket payments as proportion of total health expenditure</td>
<td>69.35%</td>
</tr>
<tr>
<td>Voluntary health insurance as proportion of total expenditure on health</td>
<td>76%</td>
</tr>
<tr>
<td>Proportion of households experiencing catastrophic health expenditure</td>
<td>14.8%</td>
</tr>
<tr>
<td>Number of physicians per 1000 population</td>
<td>0.403</td>
</tr>
<tr>
<td>Number of nurses per 1000 population</td>
<td>1.605</td>
</tr>
<tr>
<td>Number of community health workers per 1000 population</td>
<td>0.137</td>
</tr>
</tbody>
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c WHO Global Health Observatory (http://apps.who.int/gho/data/node.main.75?lang=en).

d See: Onoka et al., 2011.

e WHO. Global health expenditure database (http://apps.who.int/nha/database/Key_Indicators/Index/en).

Governance and health service architecture

Nigeria operates a federal system of government comprising 36 States and the Federal Capital Territory. The health system is based on a three tier structure of government (e.g. Federal, State and Local Government Area (LGA)) each with substantial autonomy. Each State and LGA has a Ministry of Health (SMoH) and Local Government Health Department respectively. However, the roles and responsibilities of the different levels of the health system, with respect to PHC, remain unclear. Overlaps in roles often result in duplication of effort, wastage, or total neglect.

The Federal Ministry of Health (FMoH) is responsible for overall stewardship and leadership for health and provision of tertiary health care, through the network of tertiary (teaching and specialist) hospitals. But several states manage and finance tertiary health care facilities within their state territories. In addition, development partners also provide resources to the FMoH through the Federal Ministry of Finance (FMoF). State Ministries of Health (SMoH) provide health care services through secondary level health facilities, as well as technical assistance to the LGA Health Departments. LGAs own and fund PHC facilities and have overall responsibility for this level of care with the health posts and clinics, health centres and comprehensive health centres providing basic primary care services. In addition to the efforts of the LGAs, PHC services have been jointly managed by SMoH, Ministries of Local Government Affairs (SMoLG), Local Government Service Commission (LGSC), Civil Service Commission (CSC), Ministry of Budget and Planning (MoBP), State Hospitals Management Board (SHMB), faith-based organizations (FBOs), nongovernmental organizations, Zonal and State offices of the National Primary Health Care Development Agency (NPHCDA), FMoH, National Health Insurance Scheme (NHIS), Development Partners, among others. A dynamic private sector fills parts of the gap left by a weak PHC system. Figure 1 provides a summary of the health system architecture and governance.

Figure 1. Health system architecture at PHC level
Timeline of relevant policies to PHC

Challenges to the delivery of PHC services in Nigeria have led to a series of reforms to improve its effectiveness.
Health care financing

Health care in Nigeria is financed through various sources, including tax revenue, out-of-pocket payments, international donor funding and health insurance. Households continue to be the major source of health financing in Nigeria, through out-of-pocket spending.

Revenue collection and administration is highly centralized; the Federal Government collects most of the national revenues (e.g. primarily from oil) on behalf of the three tiers of government. Federal revenues are pooled into either: an excess crude account; a Federation account; a value added tax (VAT) pool; or a ‘Treasury Single Account’ (TSA). These are subsequently shared among the three tiers of Government in accordance with an existing formula. Of the funds in the Federation account and VAT pool, 20.6% and 35% respectively are channelled to LGAs. LGAs also have their own internally generated revenues, but these comprise only a small proportion of their overall revenues.

The Federal Ministry of Health developed a National Health Financing Policy in 2006. The policy sought to promote equity and access to quality and affordable health care, and to ensure a high level of efficiency and accountability in the system through developing a fair and sustainable financing system.3 The National Health Act (NHAct) on the other hand targets universal coverage through an efficient primary healthcare system providing at least basic services in primary care facilities. Specifically, NHAct establishes the Basic Health Care Provision Fund (BHCPF) which is to be financed from the consolidated revenue of the Federation with an amount not less than one per cent of its value and other sources such as grants by international donor partners.

The Federal PHC budget – which includes spending on the National Programme on Immunization, the Roll Back Malaria initiative, the Midwives Service Scheme, PHC, Community and Environmental tutor programmes – has been steadily decreasing over the past four years as a proportion of the total Federal health budget. It decreased from 8.4% of total spending in the health sector in 2012 to 4.7% in 2015, as shown if Figure 2.

Although states allocate reasonable budgets to their health sector; there is evidence of erratic release of the allocated budgets. At the local government level, financial allocations often do not extend beyond the payment of salaries, with accountability and transparency among the weakest of all areas of the national public finance system.

Overall, the per capita health expenditure of $10 is far below the $34 recommended by the Macro-Economic Commission on Health.4 However, there has been significant improvement in funding for some diseases/ programs e.g. immunization, AIDS, tuberculosis, malaria, and the midwife services scheme.

Figure 2. Percentage of budget for PHC activities

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>8.4%</td>
</tr>
<tr>
<td>2013</td>
<td>7.5%</td>
</tr>
<tr>
<td>2014</td>
<td>7.4%</td>
</tr>
<tr>
<td>2015</td>
<td>4.7%</td>
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Source: Federal Ministry of Health (2012–2015 Budget)

Human resource for health

All government tiers are expected to actively use adapted versions of the National Human Resources for Health (HRH) Policy and related plans. By the end of 2015, however, only 15 states (42%) had adapted the HRH policy. None of the 774 LGAs in the country have so far elaborated policies or strategic plans for HRH. Imbalances in the skill ranges and large disparities in the distribution of the health workforce between rural and urban areas, and across the six geopolitical zones, compound the matter further, with the northern areas being particularly under-resourced.5

The main categories of human resources at the PHC level are community health extension workers and community health assistants, community health officers, doctors, nurses, midwives, laboratory staff and public health nurses.6 The availability of various staff category varies between zones, as shown in Figure 3. Most doctors and nurses work in higher level and private practices: 88% of 26,361 practising doctors work in hospitals, with the majority of those (74%) working in private hospitals. Only about 12% of practising doctors work in PHC services (private or public sector).4

Poor attraction and retention of health workers has resulted in inequitable distribution of community health workforce at the PHC level, and the consequent inequity in access to quality health services.

Planning and implementation

Government roles and contributions to strengthening the national health system include leadership, domestication of international and regional initiatives, effective management, national capacity building, strong political support, and monitoring and evaluation.7 At national, state and local government levels, programme

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management is supported by multiple partners through various mechanisms, including direct secondment of staff, capacity building and organisational or technical support. Development partners and the Federal Ministry of Health provide guidance to states on how to improve PHC service delivery through the concept of ‘one management, one plan and one monitoring and evaluation for PHC’, otherwise referred to as ‘PHC under one roof’. This is based on the principles of integration of all PHC services delivered under one authority with effective and efficient referral mechanisms, and an integrated and supportive supervision system. However, this referral and supportive supervision system remains very weak at present. In addition, the ‘Ward Minimum Health Care Package’ outlines minimum standards for PHC in Nigeria, and is expected to be in place in every health centre.

The guidelines for the development of the PHC system also incorporate various levels of Community Development Committees to ensure community participation and accountability. However, committee involvement in facility management is limited due to inadequate capacity, and lack of incentives. The National Strategic Health Development Plan (2010–2015) also makes provision for intersectoral collaboration in relation to health. However, there is presently very little collaboration between the health sector and other key sectors to address the social determinants of health.

Regulatory process

There are policies and implementation guidelines for health service quality and medicines regulation among state and non-state health care providers. Respective SMoHs are responsible for providing oversight and maintaining and enhancing the quality of health services provided within their spheres of control. The establishment of SERVICOM in public health facilities and SMoHs ensures that health services are delivered proficiently, pleasantly and promptly.

Existing policies also specify the training and skills requirements of various cadres of primary care providers. These are backed by training curricula including content appropriate for specific health worker cadres, as well as protocols for periodic reviews. There are presently 14 professional regulatory bodies charged with the responsibility for regulating and maintaining standards of training and practice for various health professionals. However, they are limited by weak structures and institutional capacities to carry out statutory functions, effective monitoring and accreditation of training institution programmes.

Monitoring and information

In 2006, the harmonization of vertical monitoring and evaluation tools and systems culminated in the incorporation of key programmatic indicators in the health sector into the National Health Management Information System (NHMIS). SMoHs are expected to support and oversee the primary care activities of the local government, while the later supervises the activities in the primary care facilities. The health facilities report monthly to the LGA, which in turn reports to the SMoH.

Departments of Planning Research and Statistics of the SMoH are responsible for collation of routine health information from the community and facility level, and for onward transmission to the federal level database. The DSN 001 form, used at the PHC level, captures 48 health care indicators. Many states and health facilities have reported improved quality of care through improved supportive supervision and team work, but these are yet to be fully documented and validated by studies.

Although the current information management system may be adequate in terms of data collation and transmission, a 2014 assessment revealed a weak NHMIS, there is potential for the system to be transformed into a strong and viable building block for the Nigerian health system. Most of the challenges are in the areas of data governance, data quality and use of information.

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Ways forward and policy considerations

• Effective implementation of the provisions of the National Health Act, which sets out the responsibility and roles of different players in the Nigerian health sector and provides for a basic health care provision fund to improve PHC.

• The provisions of the National Health Act remain to be effectively implemented, including clear allocation of responsibility and roles of different players in the Nigerian health sector and establishment of a basic health care provision fund.

• Health in all policies: Should ensure that all relevant sectors (e.g. labour, environment, education etc.) factor health into their agendas by establishing a health desk in respective ministries and improved public/private partnerships in the provision of PHC.

• Ongoing development of a new National Health Policy based on the National Health Act.

• Interventions to improve the quality of health management information system at the PHC level.

• Strengthening PHC referral system: Transportation, communication and other logistics for referrals need to be put in place to ensure effective referrals through a robust, two-way referral system.

• Strengthening accountability, transparency and responsiveness of PHC system through community participation and supportive supervision.

• Strengthening institutional frameworks for human resources management practices at the PHC level: LGAs should be encouraged to develop strategic plans for human resources for health.

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This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, as part of the Primary Health Care Systems (PRIMASYS) initiative. PRIMASYS is funded by the Bill & Melinda Gates Foundation, and aims to advance the science of primary health care in low- and middle-income countries in order to support efforts to strengthen primary health care systems and improve the implementation, effectiveness and efficiency of primary health care interventions worldwide. The PRIMASYS case studies cover key aspects of primary health care systems, including policy development and implementation, financing, integration of primary health care into comprehensive health systems, scope, quality and coverage of care, governance and organization, and monitoring and evaluation of system performance. The Alliance has developed full and abridged versions of the 20 PRIMASYS case studies. The abridged version provides an overview of the primary health care system, tailored to a primary audience of policy-makers and global health stakeholders interested in understanding the key entry points to strengthen primary health care systems. The comprehensive case study provides an in-depth assessment of the system for an audience of researchers and stakeholders who wish to gain deeper insight into the determinants and performance of primary health care systems in selected low- and middle-income countries.