



Nigeria's health transitions

Country impact profile

October 2021

Nigeria has embarked on a journey to provide universal health coverage (UHC) to its citizens by incorporating a Basic Health Care Provision Fund (BHC PF) in the National Health Act 2014. The fund aims to cover all Nigerians with a basic minimum package of health services (BMPHS). The fund will finance a BMPHS through a federal government annual grant, donor grants, and funding from other sources. However, Nigeria is undergoing four crucial transitions—in demography, disease patterns, donor spending on health, and domestic health financing (the “4Ds”)—which will have profound impact on Nigeria’s ability to move towards UHC. In the face of these transitions, there are many challenges that the country needs to tackle for it to successfully achieve UHC.

1 Demographic transition

Nigeria is a young country with about 54% of Nigerians below the age of 19, and will remain relatively young for the next couple of decades.² The country is also rapidly urbanizing with more Nigerians currently living in urban centers than in rural areas. Its government will need to understand the current and changing demography to fulfill the health needs of its population. See the [demographic transition section](#) for more details.

2 Disease (epidemiological) transition

Nigeria is increasingly facing the problem of a double-disease burden. In 2016, according to the World Health Organization (WHO), maternal and neonatal diseases still accounted for about 63% of deaths, and communicable (including maternal and neonatal) diseases were the top 4 causes of deaths in 2019.²³ At the same time, deaths from non-communicable diseases (NCDs) such as cardiovascular disease have also increased in the last 10 years. See the [disease transition section](#) for more details.

3 Domestic finance transition

Only about 5% of Nigerians are covered by health insurance.³ The domestic general government health expenditure (GGHE-D) as a percent of gross domestic product (GDP) in Nigeria is around 0.5%, which is below the average across Sub-Saharan African countries and across low- and middle-income countries. Most Nigerians spend out-of-pocket on health, which accounts for about 77% of the current health expenditure in the country. Nigeria will need to transition towards domestic financing of healthcare to provide UHC to its population.⁶ See the [domestic finance transition section](#) for more details.

4 Donor health aid transition

Heavy dependence of donor financing to fund healthcare in Nigeria is a major impediment towards reaching UHC. Many donors have exit criteria such as reaching a particular threshold per capita income. When these criteria are met, the donors begin to exit the country. Nigeria is already a lower-middle income country and has reached, or is about to reach, the exit criteria established by many donors. Therefore, Nigeria needs to prepare itself for the donor health aid transition to avoid experiencing a sudden shock of a reduction in development assistance in health. See the [donor health aid transition section](#) for more details.



Background

Nigeria is the most populous country in Africa, with a population of about 202 million. It has the world's largest number of poor people living below US\$1.90 a day (87 million).¹² According to World Population Prospects 2019, Nigeria will add 200 million more people to its population between 2019 and 2050. Nigeria has a large youth population: more than 63% of the population was below 24 years of age in 2019. United Nations (UN) projections estimate that most of Nigeria's population will be below 30 years of age in 2030 and 2050.¹⁴ In addition to a growing and large young population, Nigeria also has a high age-dependency ratio (the ratio of dependents, people younger than 15 or older than 64, to the working age population). In 2018, the age-dependency ratio was 87.3% and it has not fallen below 80% during past five decades.¹⁵

Nigeria is an oil rich nation and is currently categorized as a lower-middle-income country by the World Bank. However, in 2016, public spending on health was US\$11 per capita whereas the average health spending in low income countries in 2017 was US\$41 per capita.^{3,16} In 2017, out-of-pocket expenditure (OOPE) comprised of about 77% of current health spending, down one percent from 78% in 2010. The average OOPE in low- and lower-middle-income countries in 2017 was 41% and 40%, respectively.^{1,16,17}

Between 2010 and 2017, Nigeria's domestic general government health expenditure (GGHE-D) as a percentage of gross domestic product (GDP) has hovered around 0.5%, which was more than one percentage point below the average across sub-Saharan African and more than two percentage points below the average across low- and middle-income countries.⁶ The story is similar for Nigeria's GGHE-D as a percentage of current health expenditure (CHE). The GGHE-D as a percentage of CHE has lingered around 15% since 2010. During the same period, the average across sub-Saharan countries was about 35% and the average across low- and middle-income countries was more than 50%.¹⁸

External donors are the major source of healthcare financing in Nigeria. During the last decade, major health funders included the United States (US), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), the World Bank, the United Kingdom (UK), Gavi, the Vaccine Alliance (Gavi), and European Union (EU) institutions.

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Donors have financed control of a diverse set of diseases and some have supported health system strengthening. For example, US funding to Nigeria has focused on HIV/AIDS, tuberculosis, malaria, and maternal and child health¹⁹, funding from the UK supports family planning, maternal health and health policy and administrative management,²⁰ and Gavi investments have been in vaccinations. However, most donors have established exit criteria; i.e., if the country reaches a certain per capita threshold, or achieves a certain set of goals set out by the donor, the donor reduces or ends its support to the country. Nigeria faces the impending exit of several donors, including Gavi, the World Bank's International Development Association (IDA), the Global Polio Eradication Initiative (GPEI), and the Global Fund and it needs to be prepared for these donor transitions. Table 1 captures some important development and health statistics.

Nigeria is undergoing four key transitions which we call "the 4Ds" of transition, referring to shifts in demography, disease patterns, domestic financing, and development assistance for health (DAH).

These transitions will have a profound impact on Nigeria's progress towards universal health coverage (UHC); such coverage is enshrined in Nigeria's National Health Act 2014. In the next section, we examine the impact of these four transitions on three dimensions of UHC—population coverage, service coverage, and financial risk protection—to understand the challenges in achieving UHC, and the opportunities that can help manage these challenges.



Table 1. Overview of key health and development indicators^{1,6,17,21}

Development indicators		Health statistics	
Gross domestic product (2018)	US\$397.27 bn	Life expectancy at birth (2018)	54.7
Gross national income per capita (2018)	US\$1,968	Infant mortality rate, per 1,000 live births (2018)	75.7
Domestic public health expenditure % GDP (2017)	0.5%	Maternal mortality ratio, per 100,000 live births (2017)	917
Adult literacy rate (2018)	62.016%	Number of physicians per 1,000 population (2016)	38.9
Human development index (2019)	0.534	Health expenditure % GDP (2017)	3.8%

Source: World Bank Development Indicators^{1,6,17,20}

Demographic transition

Challenge: Change in population age structure—a large young and working age population

Nigeria has a large young population. In 2017, 45% of its population was below 15 years of age and those aged 10-24 years made up 33% of the population.¹ In 2000, more than 80% of the total population was below 40 years of age. By 2018, the population mix remained the same, and it is predicted that this will not change much by 2030 (Figure 1). A large young and working age population can generate huge economic opportunity for Nigeria but it can only be achieved if the country can keep its large young population healthy by providing adequate, universal, and quality healthcare.

Challenge: Rapidly increasing and urbanizing population

Nigeria's population is predicted to continuously increase well into the century for the medium and high growth scenario predictions as per the UN's projections. Nigeria's population is expected to almost double or more than dou-

ble by 2050. Almost all the age group categories in Nigeria will see growth in their absolute numbers until 2050. The 0-14, 15-24, and 25-64 age groups will see substantial growth (Figure 2). The 65+ age group is also expected to grow, though more slowly than the other age categories.

Nigeria's total fertility rate (TFR) was 5.5 in 2017, above the average TFR across sub-Saharan countries and well above the average for low- and middle-income countries (Panel A, Figure 3). Furthermore, there is a huge gap between the crude birth rate and the crude death rate, which is continuously feeding into natural growth in the population (Panel B, Figure 3). While the TFR and the gap between the crude birth and death rates in Nigeria is declining, the decline is gradual and it will take decades before the gap between the crude birth and death rates narrows enough for the growth in population to slow down. Thus, Nigeria will have a large young, working age population for many decades, but it will need to make strong investments in health if it wants to capture the dividends of a youthful population over the next few decades.

Figure 1. Population pyramid of Nigeria in 2000, 2018, and 2030

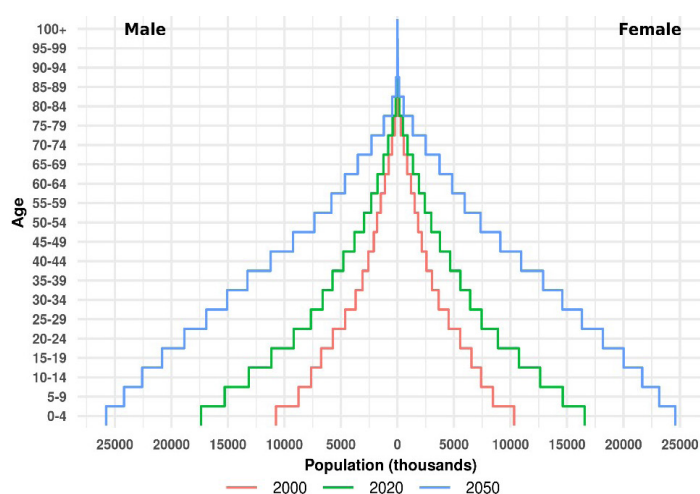
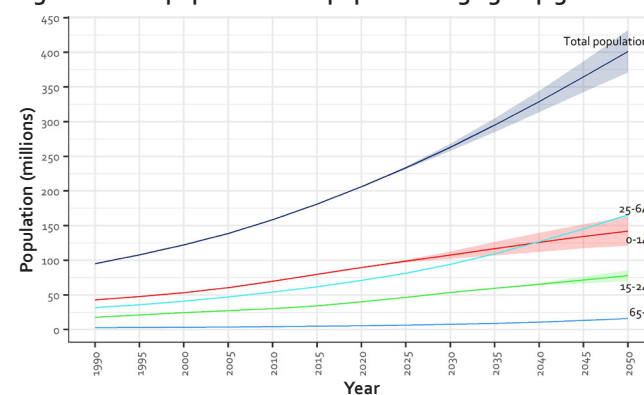
Source: Authors' creation using data from the United Nations, Department of Economic and Social Affairs²¹

Figure 2. Total population and population age group growth in Nigeria

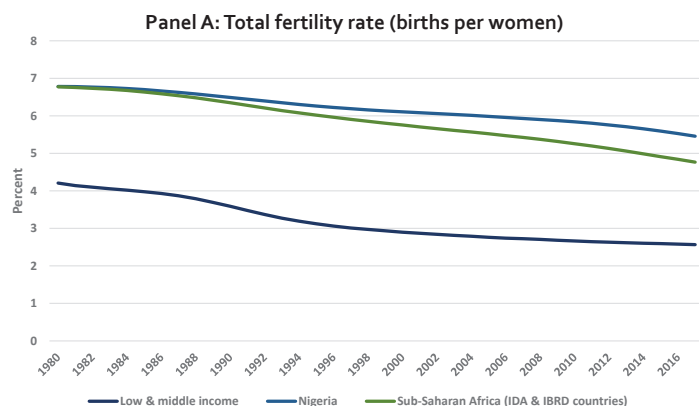
Source: Authors' creation using data from the United Nations, Department of Economic and Social Affairs²¹

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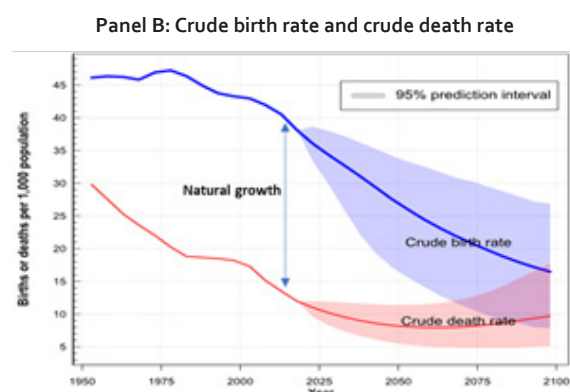
Along with a growing population, Nigeria is also experiencing rapid urbanization. From 2000 to 2020, the urban population grew at a rate of about 3.5% higher than the rural population.²² In 2019, due to the higher urban growth rate, more people were living in urban areas in Nigeria than

in rural areas (Panel A, Figure 4). The rural growth rate is expected to gradually decrease and then plateau by 2050, but it is predicted that the urban population will continue to rise (Panel B, Figure 4).

Figure 3. Total fertility rate, Crude birth rate and crude death rate

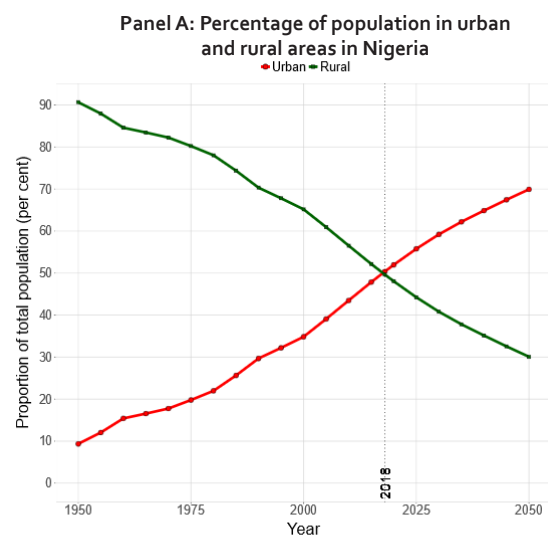


Source: Authors' creation using data from the World Bank Indicator⁶



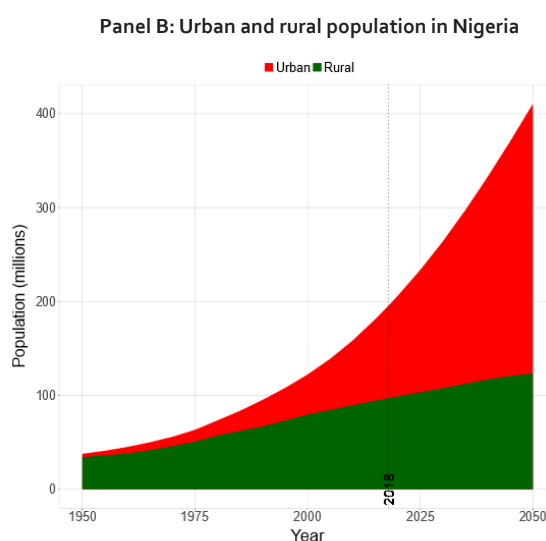
Source: United Nations, Department of Economic and Social Affairs²¹

Figure 4. Urban and rural population growth in Nigeria



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Note: Urban and rural population in the current country or area as a percentage of the total population, 1950 to 2050.

Source: The United Nations, Department of Economic and Social Affairs - Population Dynamics²¹



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Demographic transition takeaways

- Currently, Nigeria has a 'young' population, a population growth rate of 2.57% (2019), and more people living in urban than rural areas.
- During the last decade of the 20th century, Nigeria had a dependency ratio of >90%. After a slight decline between 2000 and 2004, the dependency ratio increased reaching 89% in 2013. Currently, Nigeria has a high age dependency ratio of 87% (2019).
- Between now and 2050, Nigeria's population structure will rapidly grow, urbanize, and age, creating profound challenges for the healthcare system.
- At this time, the Basic Health Care Provision Fund (BHCPF) is implemented in rural areas of Nigeria only.
- By generously allocating money to the BHCPF, some of these challenges can be mitigated, allowing coverage expansion to urban populations.



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Disease (epidemiological) transition

Challenge: The unfinished agenda of infections and reproductive, maternal, newborn, and child health (RMNCH) conditions

Nigeria has a high burden of mortality from communicable, maternal and neonatal diseases, which accounted for about 63% deaths in 2016.⁵ Such diseases were in the top five causes of deaths between 2000 and 2017 (Table 2).

One of the major impediments in reducing the high burden of RMNCH conditions is the regional and zonal disparities in access to RMNCH services. There are stark differences in coverage of healthcare services in rural versus urban areas as well as between northern and southern zones. For ex-

ample, in 2016-17 only 56.8% of women received antenatal care (ANC) from a skilled provider in rural areas compared with 87.4% in urban areas.³ In urban areas, 61% of deliveries are in a health facility, whereas in rural areas only 27.6% are facility-based. Only around one third (32.2 %) of rural women aged 15-49 were fully vaccinated in comparison to 63.1% in urban areas. The low coverage of essential maternal and child health interventions is reflected in the high infant mortality rate (IMR) and under five mortality rate (U5MR) of 77 and 138 per 1,000 live births, respectively, in rural areas in 2016-17 (Table 3).³

Similar differences in healthcare coverage can be seen between northern and southern geopolitical zones of the country. For example, the proportion of women receiving ANC from skilled providers was 62.5%, 67%, and 53.6% in north-central, north-east, and north-west zones, respectively, whereas service coverage in south-east, south-south, and south-west zones was 91.3%, 81%, and 89.5%, respectively.³ Similar regional differences in coverage are seen for other health care services like deliveries in health facilities and vaccination. The coverage of these healthcare services is always higher in southern zones of Nigeria than the northern zones. This disparity is again reflected in the lower IMR and U5MR in the southern zones when compared to the northern zones (Table 3).

Although health service coverage is higher in urban areas,

Table 2. Ranking of deaths due to various disease in 2000 and 2017

2000	2017
1. Respiratory infections & TB	1. Respiratory infections & TB
2. Enteric infections	2. Maternal & neonatal
3. NTDs & malaria	3. HIV/AIDS & STIs
4. Maternal & neonatal	4. NTDs & malaria
5. HIV/AIDS & STIs	5. Enteric infections
6. Other infectious	6. Cardiovascular diseases
7. Cardiovascular diseases	7. Other infectious
8. Digestive diseases	8. Neoplasms
9. Neoplasms	9. Digestive diseases
10. Other non-communicable	10. Other non-communicable

Source: Authors' creation using data from Institute for Health Metrics and Evaluation²³

Table 3. Coverage of selected maternal and child health interventions, by region in 2016-2017

	Women age 15-49 (percentage)					Children	
	Receiving ANC from skilled provider (1)	Delivering in a health facility	Delivered by skilled provider (1)	With PNC within 2 days after birth	% Fully vaccinated (2)	IMR per 1,000 live births	U5M per 1,000 live births
Residence							
Urban	87.4	61	67.1	58.9	63.1	53	78
Rural	56.8	27.6	32.9	27.8	32.1	77	138
Zone							
North Central	62.5	44.4	50.3	46.6	26.2	72	103
North East	67.0	25.8	34.0	24.5	17.5	62	115
North West	53.6	17.8	23.6	19.0	7.9	87	162
South East	91.3	87.5	90.7	66.1	36.5	46	67
South South	81.0	66.8	64.0	69.1	38.2	39	59
South West	89.5	76.6	82.7	76.1	47.9	52	67

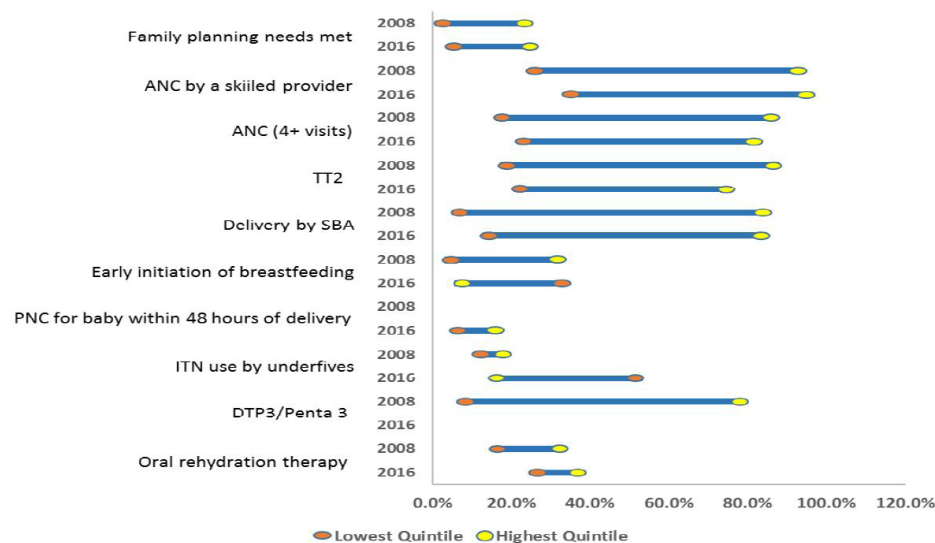
Note: **ANC**, antenatal care; **PNC**, post-natal checkup; (1) annotates skilled provider includes doctor, nurse, midwife, and auxiliary nurse/midwife; (2) includes BCG, polio3, PENTA3/DPT3, measles and yellow fever as per the vaccination schedule in Nigeria.

Source: The World Bank³



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Figure 5. Access to RMNCH services by wealth quintile prior to the launch of BHCPF

Source: Federal Government of Nigeria¹

a large majority of the urban population is still outside the coverage of many essential health services. The urban population will not get any benefit from the recently instituted Basic Health Care Provision Fund (BHCPF) as it will only be implemented in rural areas for the first 5 years. Moreover, Figure 5 shows that the wealthier population is more likely to access RMNCH services than the poor. So, the rapidly increasing urban population will require an expansion in health care services in such settings, and the absence of any insurance coverage will severely limit the urban poor's access to RMNCH services.

Challenge: Rising burden of NCDs

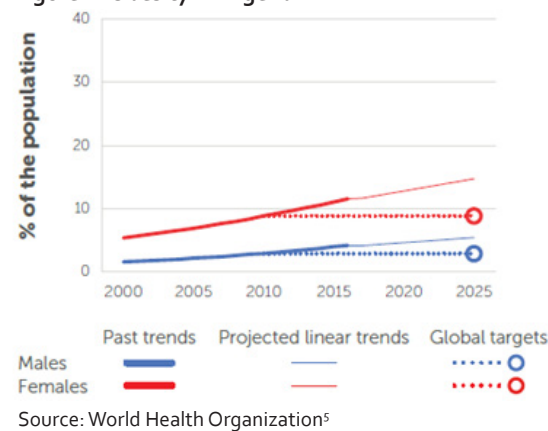
Nigeria faces a double burden of communicable diseases and non-communicable diseases (NCDs). Although infections and RMNCH conditions still comprise almost two thirds (63%) of the burden of disease, the number of annual deaths due to NCDs like cardiovascular disease, cancer, and diabetes increased between 2000 and 2017, and is projected to rise in the near future (Table 2).

The proportion of total deaths from NCDs in Nigeria is on an upward trajectory, increasing from 24% in 2012 to 29% in 2016.^{4,5} The prevalence of obesity in both men and women is rising. The current obesity prevalence in the Nigerian population is well above the global average, and the WHO predicts that Nigeria's prevalence will continue to increase in the near-term (Figure 6).⁵ Obesity is an important risk factor for many NCDs, and an increase in the population is a precursor to increasing rates of NCDs.

Challenge: Unavailability of equipment and drugs to treat NCDs at primary health centers

A 2018 report by the WHO found that in 2017 no primary health center (PHC) reported offering cardiovascular disease (CVD) risk stratification, no facility reported having CVD guidelines, only three out of 10 facilities had essential medicines, and only two out of six facilities reported that they had equipment and basic technologies to treat NCDs that were sometimes available.⁵ The increasing burden of NCDs and unavailability of necessary drugs and equipment at PHCs is one reason why patients in Nigeria seek care from private health facilities, where they incur high OOPes that can be impoverishing. Moreover, the recently instituted BMPHS also does not include many NCD services

Figure 6. Obesity in Nigeria

Source: World Health Organization⁵

related to diseases like cancer, ischemic heart disease, and many others. Therefore, even though the BMPHS is hailed as an important step in achieving UHC in Nigeria, it still does not do much to reduce OOPes on NCDs.

Challenge: Expansion of insurance net to improve the uptake of disease prevention and treatment services

A study by Brals et al. that measured the effect of health insurance and health facility upgrades on hospital deliveries in rural Nigeria found that when insurance coverage was increased from 0% to 70% in the treatment area, the increase in the number of hospital deliveries in the treatment area was 29.3% greater than the change in the control area.²⁴ Another study sponsored by USAID discovered that health insurance coverage improved access to family planning services by women in Nigeria. Using household survey data, the study found that the modern contraceptive prevalence rate among married women in Nigeria was about 25%, whereas among uninsured women it was less than 10%.²⁵ A systematic review by Comfort, Peterson, and Hatt of the impact of health insurance on the use of maternal health services and on maternal and neonatal health outcome in low-and middle-income countries included Nigeria as one of the countries in the analysis.²⁷ The authors found a positive relation-

ship between health insurance and the usage of maternal health services. Given the overwhelming evidence of the strong relationship between health insurance coverage and uptake of health services, the Nigerian government will need to expand the insurance net if it intends to tackle the double burden of communicable diseases and NCDs.

Domestic financing transition

Challenge: Low public health expenditure and high OOPes

The GGHE-D as a percentage of GDP in Nigeria has been well below the average for low- and middle-income countries (LMICs), and it has been even below the average across Sub-Saharan African (SSA) countries. The government public health expenditure as a percentage of GDP in Nigeria has been falling since 2004, and has remained almost constant since 2010, whereas average government spending in LMICs has increased. This has resulted in a widening of the expenditure gap between Nigeria, countries in SSA and LMICs (Figure 7).

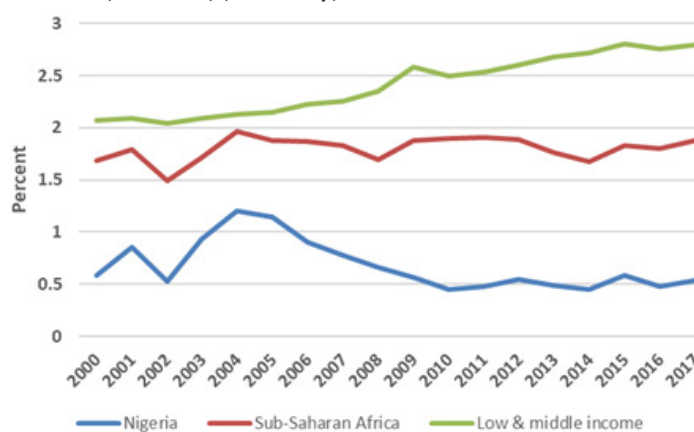
The situation is similar for GGHE-D as a percentage of CHE; this percentage has mostly hovered at around 20% or below in the last two decades. In the last 10 years, GGHE-D has rarely risen above 15% of CHE. This low percentage has resulted in OOPe becoming the main source of health spending in Nigeria. In 2017, OOPe accounted for about 77% of CHE (Figure 8). Around 25% of households spent more than 10% of their household consumption on health, leading to the catastrophic health expenditure.³

The National Health Insurance Scheme (NHIS) was established in 1999 to provide health insurance cover to all

Disease (epidemiological) transition takeaways

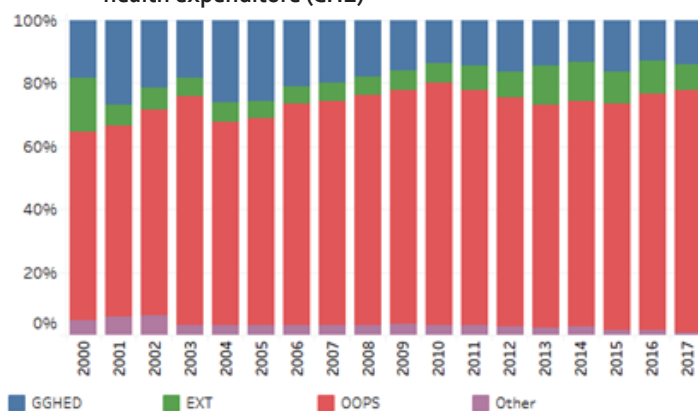
- Communicable (including maternal and neonatal) diseases are the top 5 causes of mortality in Nigeria. But the burden from non-communicable diseases (NCDs) is on the rise as the average annual rate of change between 2000 and 2019 was lower for NCDs (at -1%) than communicable diseases (at -4%),
- Nigeria will increasingly face the challenge of a double burden of disease in coming years—NCDs plus communicable, maternal, and neonatal diseases.
- Given this increase in NCD burden and the high mortality from communicable and maternal and neonatal diseases, Nigeria's healthcare system will need to quickly adapt.
- The basic minimum package of health services (BMPHS) of the BHCPF currently includes four interventions for maternal health, regular immunization, and two interventions for NCDs. The package needs to expand to include more interventions in order to address these disease transition challenges.

Figure 7. Domestic general government health expenditure (% of GDP) (2000-2017)



Source: Authors' creation using data from the World Bank Indicator⁶

Figure 8. GGHE-D, EXT (External), OOPS, other as % of current health expenditure (CHE)

Source: World Health Organization Global Health Expenditure Database¹⁷

Nigerians. However, by 2017 only 4.2 % of Nigerians had been covered by the NHIS, and most of the insured are civil servants.³ In 2015, less than 5% of Nigerians had any kind of health insurance coverage; most enrollees in health insurance schemes are from the formal sector. The informal sector has a very poor enrollment rate in the health insurance schemes.²⁷ The continuous public underfunding of health has caused high OOP expenditures on health. Even though Nigeria has a fast-increasing population, most people remain outside health insurance coverage.

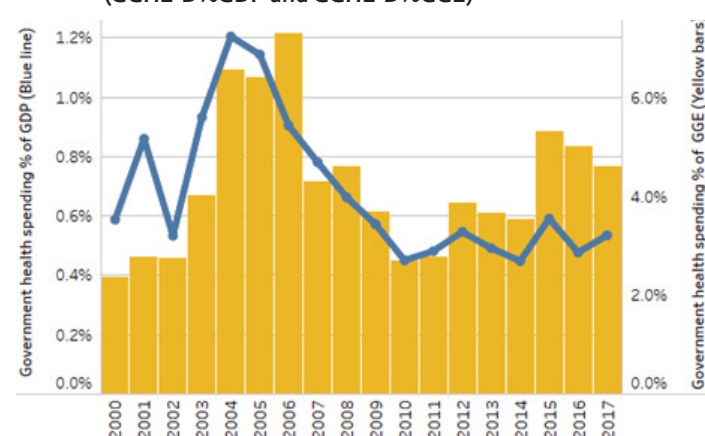
The 2010 World Health Report showed that spending 5-6% of GDP on health will limit catastrophic health spending, and is the minimum spending required if a country aspires to achieve UHC.⁷ However, total government health spending in Nigeria as a percentage of GDP has been mostly below 1% (Figure 9). Therefore, if Nigeria plans to move towards UHC then it will have to increase government health spending significantly.

Challenge: Weak domestic revenue mobilization (DRM), and challenging macroeconomic outlook

Nigeria has a low level of DRM at 4.8% of GDP, and a small tax base of 14 million people out of a total workforce of 103 million (i.e., only around 14% of people are in the tax net).³ Some of the reasons for the low revenue collection are weak tax administration, a large informal sector, poor performance of state generated revenues, and high reliance on oil revenues.

Nigeria is heavily dependent on oil revenues to finance its expenditures. According to Nigeria's second National Stra-

Figure 9. Domestic government expenditure and health prioritization (GGHE-D%GDP and GGHE-D%GGE)

Source: World Health Organization Global Health Expenditure Database¹⁷

tegic Health Development Plan (2018-2022), in 2016 oil accounted for more than 90% of exports and 75% of government revenues.¹ Federal government revenues from oil have always been higher than non-oil revenues which have included corporate tax, value-added tax, customs and excise duties (Figure 10).

According to IMF's 2019 Article IV, Nigeria was hit hard by recession in 2016. It made a partial recovery after the rebound in oil prices and from the tight monetary policies followed by the Government of Nigeria. However, the article projected a subdued economic outlook and expected the country's economic growth to hover around 2.5%.²⁸ However, this was the outlook before the COVID-19 pandemic and the collapse of oil prices in 2020. The current macroeconomic situation has worsened, and the IMF expects a contraction in the economy. Furthermore, the World Bank

Figure 10. Oil and non-oil revenues (% of GDP)

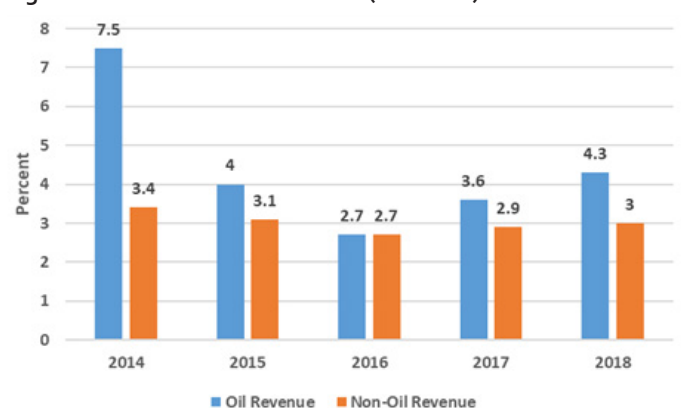
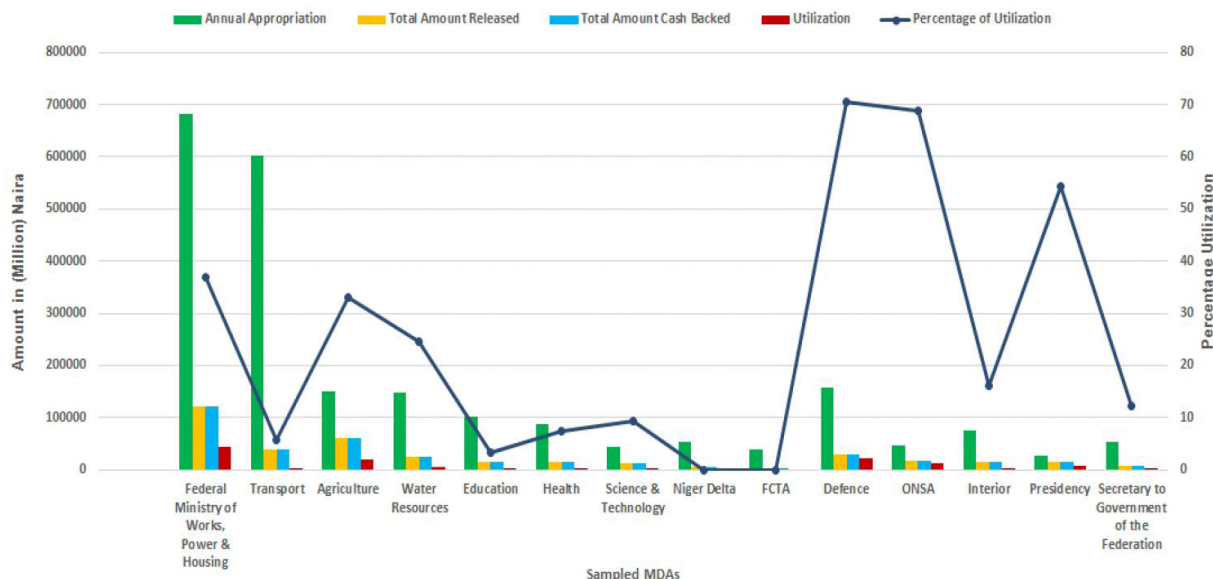
Source: Central Bank of Nigeria⁸

Figure 11. Capital budget implementation across selected Ministries, Departments and Agencies (MDAs) (2018 Third Quarter)



Source: Nigeria Ministry of Budget and National Planning³⁰

predicts that the pandemic will cause a recession across sub-Saharan Africa for the first time in 25 years.²⁹ This will further exacerbate the already gloomy economic outlook for Nigeria.

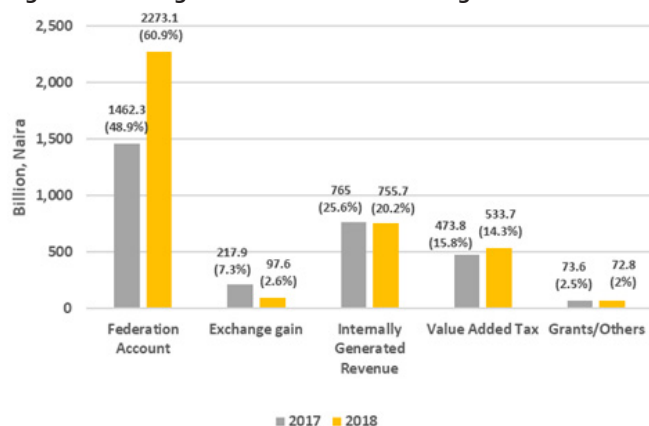
Therefore, the weak revenue mobilization in the country will further be worsened due to the challenging short- and medium-term macroeconomic outlook for Nigeria. This will reduce the limited revenues available for sectors like health. Even prior to these challenges, health already had the lowest amount of budget released by the government,

and also had the least budget utilization when compared to other sectors like transport, agriculture, education, and power as reported in the Third Quarter 2018 Budget Implementation Report (Figure 11). A substantial decrease in overall revenue generation will severely impact the already low resources available for the healthcare sector.

Challenge: Weak sub-national public funding of UHC and over-reliance on the federal government

The weak sub-national public funding of primary health was shown by the 2016 national health facility survey. The sur-

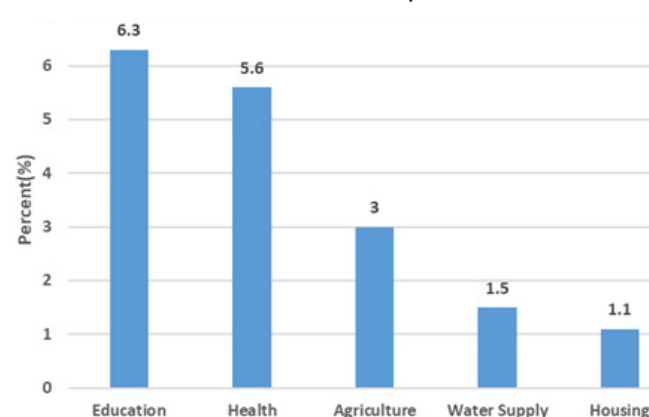
Figure 12. State governments' revenue in Nigeria



Note: The height of bars corresponds to the actual naira amount and not the percentage values

Source: Authors' calculation using data from Central Bank of Nigeria⁸

Figure 13. State governments' expenditure in key primary welfare sectors in 2018 (% of total expenditure) rate



Source: Authors' calculation using data from Central Bank of Nigeria⁸

vey found that only about one-third of PHCs received cash grants from the government for their operational expenses and so user fees were their major source of revenues. Some PHCs also received in-kind support from donors and some local governments (mostly drugs and vaccines). The survey also found that most PHCs lacked essential medicines, basic amenities such as power, water, and sanitation, and diagnostic capacity for pregnancies, malaria, HIV, diabetes, and hypertension.³

Nigeria is a decentralized country where the state and local government can also raise revenues through different avenues. Therefore, in addition to revenue transfers from the federal governments, state and local governments also generate some internal revenues. The total revenues of state governments were 2,992 billion naira in 2017 (US\$7.27 billion) and 3,773 billion naira (US\$9.17 billion) in 2018 (1 Naira = 0.0024 dollars, 19 July 2021). However, as shown in Figure 12, the increase in revenues can mostly be attributed to the transfers from the federal account which increased from 49% in 2017 to 60% in 2018. On the other hand, the share of internally generated revenues decreased to 20.2% in 2018 from 25.6% in 2017. Thus, state governments are highly dependent on federal revenue allocations to manage their expenditures. Any changes in the federal government's revenues, which themselves rely heavily on oil, will have cascading effect on the monies available to the states and local governments in Nigeria.

Healthcare is the second most important primary welfare sector into which the states invest, and it accounted for 5.6% of state expenditures in 2018 (Figure 13). When there

is a slump in oil prices, federal government revenues will get suppressed and will badly impact state revenues, which are highly dependent on federal transfers. This in turn will affect the allocation of funds for healthcare not only at the federal level but also in the states.

Challenge: Fragmentation of funding pools in Nigeria

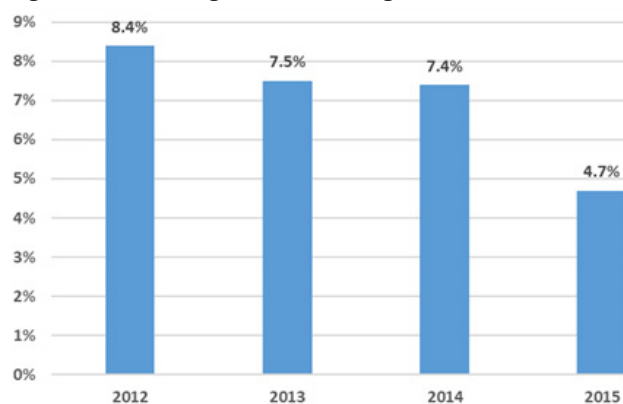
However, Nigeria has a fragmented health funding pool. For example, the federal NHIS has a separate pool for federal civil servants, each of the 36 states and the Federal Capital Territory's (FCT) state health insurance scheme (SHIS) have separate pools for their civil servants, and the private sector uses one of several Health Maintenance Organizations (HMOs) to insure their staff.³¹ Each pool provides different levels of benefits to its enrollees leading to (i) different quality of care for similar diseases, (ii) different quality of care for people from different socioeconomic status, and (iii) lost opportunities for economies of scale and scope. Pooling of these multiple schemes will be very important so that unpredictable individual financial risks are minimized and financial resources are distributed among all members of the pool. Integrated risk pooling is one of the main components for achieving successful UHC in any country. Such integration means that the health and young cross-subsidize the old and unhealthy.

Challenge: Poor condition of healthcare facilities, and low availability of health personnel's

The Sustainable Development Goal (SDG) Index thresholds suggest a minimum density of 4.45 doctors, nurses, and midwives per 1000 population (i.e., 44.5 per 10,000 population) in a country.³² But, according to the WHO, in 2018 Nigeria only had 3.81 medical doctors (per 10,000 population), and 9.26 nurses/midwives (per 10,000 population).³³ Furthermore, 88% of practicing doctors work in hospitals, and most of those (74%) work in private hospitals. Only about 12% of practicing doctors work at PHCs. National Strategic Health Development Plan II (2018-2022) also notes that PHCs comprise 80% of all health facilities, and of these, around 80% lack running water, electricity, equipment and essential medicines, or the building requires maintenance.^{1,3}

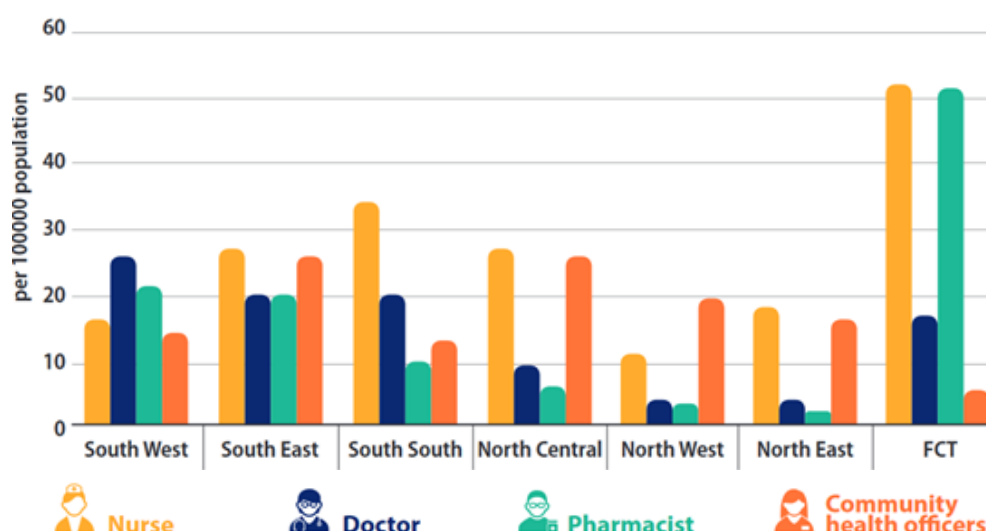
Currently, PHCs receive little to no operating budget. The providers working at PHCs often receive salaries with two to three months delay.³ Furthermore, the federal budget

Figure 14. Percentage of federal budget for PHC activities



Source: Authors' creation using data from The Alliance for Health Policy and Systems Research³⁴

Figure 15. Zonal distribution of human resources for health



Source: Authors' creation using data from The Alliance for Health Policy and Systems Research³⁴

for PHCs has experienced continuous decline. For example, the percentage of the budget for PHCs was 8.4% of total spending in the health sector in 2012, which fell to 7.4% in 2014 and then 4.7% of total spending in the health sector

in 2015 (Figure 14).

There are also zonal disparities in the distribution of health professionals. The South East, South West, and South South zones have more doctors, nurses and pharmacists per 100,000 than the North East, North West and North central zones of the country (Figure 15).

Challenge: Funding and sustainability of the BHCPF

As noted earlier, the funds available for the BHCPF make up 1% of the total consolidated revenues. Therefore, the monies required for the fund vary with the revenue collected by the federal government. Hence, an unfavorable macroeconomic situation and weak revenue generation impacts the funds available for the BHCPF. For example, 55 billion naira (US\$1.13 billion) were allocated to the BHCPF in 2018 but only 35 billion naira (US\$0.85 billion; 1 Naira = 0.0024 dollars, 19 July 2021) in 2021, which shows that the sustainability of BHCPF relies heavily on the government's revenue base.

Donor health aid transition

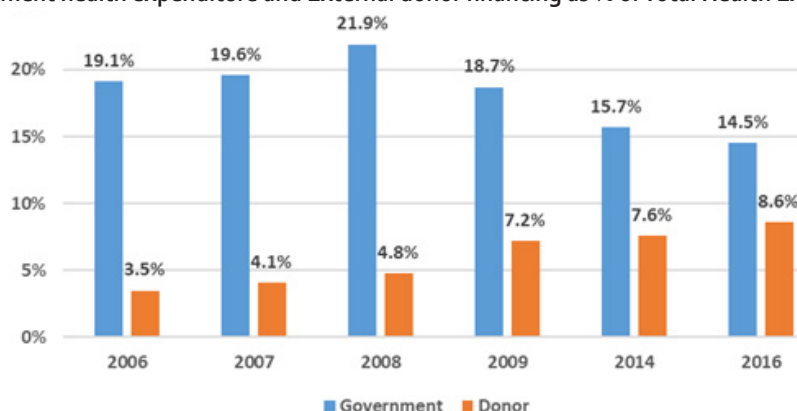
Challenge: Heavy dependence on donor financing for health

In 2016, the GGHE was about US\$2.2 billion, which was around 0.6% of GDP. In the same year, external donor financing of health amounted to US\$1 billion, a little under half of what the Nigerian government spent on healthcare.³ The GGHE as a percentage of total health expenditure (THE) in Nigeria has mostly been below 20%, and it has

Domestic finance transition takeaways

- In 2018, domestic general government health expenditure accounted for only about 15% of current health expenditure (CHE); 76.6% of CHE in the same year was out-of-pocket spending (OOPS). Health insurance coverage and financing from pooled sources hasn't gained traction in Nigeria as only about 5% of Nigerians have any kind of health insurance.
- OOPS, external health expenditure (EXT), and CHE per capita went up in 2002 before falling by a small amount in 2003. Since then these expenditures have mostly been on the rise.
- Challenges related to demographic, disease, and donor transition will be exacerbated if the situation remains the same and Nigeria does not increase public expenditure on healthcare.
- Nigeria's National Health Act provides protected funding for UHC through the BHCPF. By providing continuous funding for the BHCPF—and thus an increase in public expenditure on healthcare—the government will be ensuring improvements in healthcare.

Figure 16. General government health expenditure and External donor financing as % of Total Health Expenditure (THE) in Nigeria



Source: Authors' calculation using data from the World Bank, the Nigeria Federal Ministry of Health, and the Global Burden of Disease Health Financing Collaborator Network^{9,10}

been on a decline from 19.1% 2006 to 14.5% in 2016 (though it did increase for one year, in 2008, to 21.9% before falling again). In contrast, donor financing of health as a percentage of THE has continuously increased from 3.5% in 2006 to 8.6% in 2016. The remaining share of health expenditure is borne by private and OOPes (Figure 16).

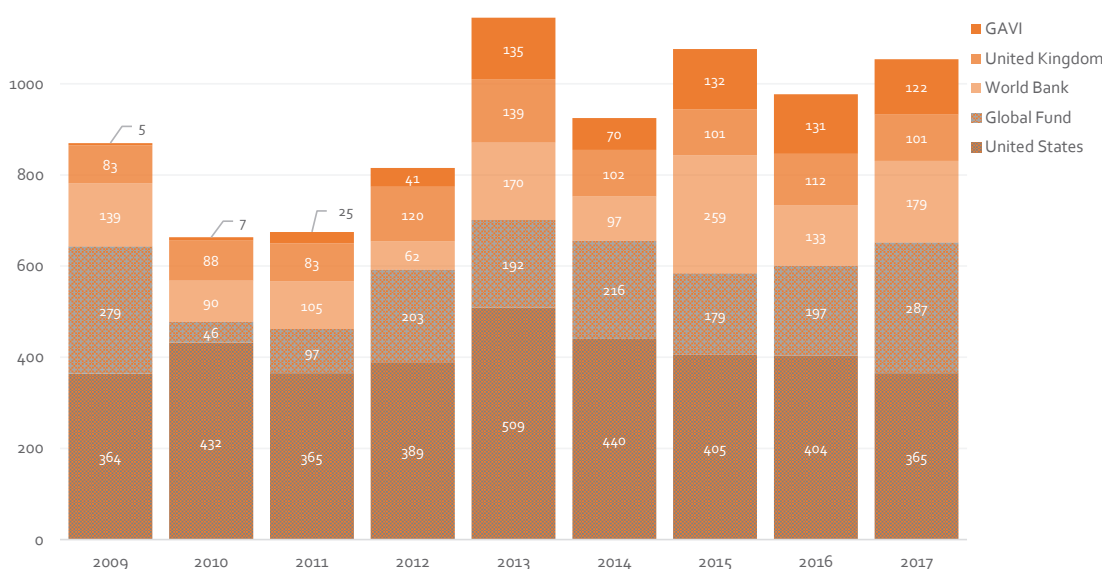
Donor financing has become a crucial source of funding healthcare in Nigeria (Figure 17). Therefore, any decrease in donor funding without a substantial corresponding increase in government health financing is likely to have adverse impacts on the healthcare landscape of Nigeria.

The top five donors to healthcare in Nigeria are the US, the Global Fund, The World Bank, the UK, and Gavi. The total investments in different years by different donors are shown in Figure 17.

Challenge: Potential impacts of donor exits on health-care services

Many of the multilateral donors are in the process of transitioning out of Nigeria now that the country meets some of their exit criteria, such as reaching a particular per capita income eligibility threshold. For example, Gavi, which is a major funder of vaccination programs, had planned to

Figure 17. Development assistance for health (DAH) by top 5 donors to Nigeria (US\$ millions)



Source: Authors' calculations using Organization for Economic Co-operation and Development³⁵

transition from Nigeria in 2021, but due to a request from the Nigerian government it has extended its exit from 2021 to 2028. Nigeria will need to increase its domestic funding of vaccine programs to maintain vaccination coverage after Gavi exits. Similarly, Nigeria is a World Bank International Development Association (IDA) blend country, which limits its ability to access concessional financing. The GPEI has also started to reduce its support.³

Gavi, the Global Fund, IDA, and other donors transition not only fund disease control programs, but also provide non-financial resources such as technical knowledge. The departure of these donors will seriously impact the quality and quantity of healthcare services available in Nigeria unless there is a commensurate rise in domestic health financing.

Furthermore, Nigeria depends heavily on imports of essential medicines as local manufacturing only provides 5% of the medicines required.³⁶ The exit of major donors from Nigeria will create a substantial funding gap in health sector. This could cause an increase in the cost of providing healthcare services and medicines, and if the government is unable to absorb the funding gap, the OOPes will increase further. The poor in both urban and rural areas are at highest risk of being affected by increased OOPes.

Challenge: Inadequate transition preparedness

This paper argues that Nigeria is undergoing four key transitions—rapidly changing demography, changing disease patterns, a changing pattern of domestic financing, and donor transition leading to reduction in the DAH. These transitions become even more stark when one considers the high dependence of Nigeria on donors to finance Routine Immunization (Gavi, BMGF-polio), and diseases like HIV/AIDS (PEPFAR, Global Fund). Donors will inevitably exit a country when it grows economically, and thus every country currently dependent on aid needs to be prepared for this eventual exit. However, Nigeria's health system is not equipped to tackle the ongoing transitions in the face of donor exits. Nigeria under invests in its health system, particularly in comparison to average investments across LMICs and across sub-Saharan African countries (see the domestic financing transition section). There is rapid population growth and urbanization (see the demographic transition section), yet the BHCPF will be implemented in rural areas for the first five years. The health infrastructure and human resources are both inadequate to meet health sector demands and there are regional inequities in health

Development assistance transition takeaways

- Gavi, the Vaccine Alliance, the United Kingdom, the World Bank, the Global Fund, and the United States each have criteria for withdrawing support to countries (e.g., reaching a specific per capita income threshold). Nigeria is satisfying some of the exit criteria of many donors. For example, Gavi was to transition support out of Nigeria in 2021, but due to a request from the Nigerian government it has extended its aid to 2028. Nigeria is a World Bank International Development Association (IDA) blend country, which limits its ability to access concessional financing.
- The high dependence on external finance is a key challenge for healthcare in Nigeria. Nigeria needs to prepare for the impending donor exits and the reduction in development assistance for health (DAH).
- The Nigerian government needs to find domestic resources to finance healthcare to reduce its dependence on donors. Continuous funding of the BHCPF will go a long way in addressing transition challenges Nigeria is undergoing.

service provision (see the disease transition and domestic financing transition sections). Therefore, most of the health system building blocks in Nigeria are inadequately prepared to successfully manage the 4Ds of transition.

Policy options, opportunities and gaps

Policy options

The Basic Health Care Provision Fund (BHCPF)

The government of Nigeria recognized the importance of improving healthcare and introduced the BHCPF as a pathway to achieve UHC in the National Health Act 2014. The BHCPF was to provide all Nigerians with access to a BMPHS. The fund is a non-contributory scheme (i.e., beneficiaries do not need to contribute) and it is a tax-financed scheme. The fund will be only implemented in rural areas for the initial few years. The BHCPF is earmarked funding for primary healthcare.

BHCPF is to be financed through following channels³⁷:

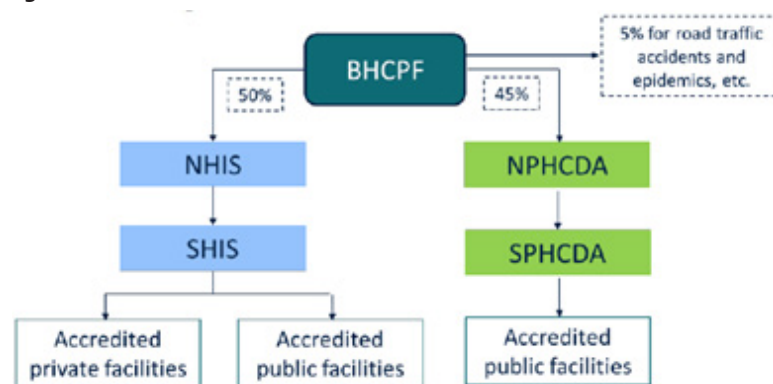
- A federal government annual grant of no less than 1% of its consolidated revenue fund.
- Grants from international donor partners
- Funds from other sources.

The fund breakdown is as follows:

- Half of the BHCPF will be used to provide a basic package of services in PHCs through the NHIS



Figure 18. Schematics of the BHCPF

Source: The World Bank³

- 45% of the fund will be disbursed by the National Primary Healthcare Development Agency for essential drugs, maintaining PHC facilities, equipment and transportation, and strengthening human resource capacity
- The remaining 5% of the fund will be used by the Federal Ministry of Health to respond to health emergencies and epidemics (Figure 18).³

As per the BHCPF guideline document (2016), the BMPHS will consist of nine interventions³⁸:

- Four maternal health interventions: ANC, labor and delivery care, emergency obstetric and neonatal care, and clinically-indicated elective cesarean section
- Care for illness in children under five: malaria, diarrhea, pneumonia, and vaccine preventable diseases
- Interventions for two NCDs: diabetes (urinalysis screening test) and cardiovascular disease (blood pressure screening)
- Routine immunization
- Emergency treatment of road traffic injuries.

In 2021, the Nigeria Government appropriated 1% of the Consolidated Revenue Fund, 35 billion naira, which is lower than the 55 billion naira that the government allocated in 2018.³⁹ In September 2019, the federal government released 15 billion naira to the NHIS from BHCPF, and of this amount 6.5 billion naira was transferred to 15 states and FCT which fulfilled the criteria of having a SHIS through NHIS gateway.⁴³ By December 2020, funds were disbursed to 36 states, including the FCT and, 1,300 facilities across five states have started implementation of the fund.⁴⁰

Opportunities and gaps

The four transitions mentioned in this paper will have a profound impact on health care in Nigeria, and will need to be

managed effectively if Nigeria wants to achieve UHC. Nigeria has taken the first step to managing these transitions with the enactment of BHCPF in 2014. However, the country needs to follow through on the commitments made. The government needs to make sure that it puts money into the fund each year from the budget. Funding alone, however, will not be enough to successfully tackle some of the challenges of transition. NPHCDA is responsible for disbursement of funds to PHCs, and a strong public financial management component has been incorporated in the NPHCDA gateway for BHCPF. But, the government will need to establish, from the start, public and social accountability in the usage BHCPF by enforcing the publication of financial reports showing the usage of the funds, and monitoring and evaluation of the programs using the fund. This will help set precedents accountability and transparency for other programs that will be implemented in future.³

Below are some of the opportunities that can help tackle the impact of the 4Ds of transition in Nigeria:

- *Implementation of BHCPF through PHCs*
The BHCPF will be used to provide a basic package of health services through PHCs, especially to the poor and vulnerable in rural areas. It will also provide much needed funds for PHCs which will improve the infrastructure and the services that they deliver. However, the urban poor will be left out of the coverage because BHCPF will mainly focus on rural areas for the first few years of its initiation.⁴¹
- *Basic minimum package of health services (BMPHS) offered under BHCPF*
The BMPHS, under the BHCPF, will cover interventions for two NCDs (cardiovascular disease and diabetes), four interventions for maternal health, and care of

childhood illnesses. However, the minimum package will leave out other major NCDs such as cancers and respiratory disease, even though mortality from cancer and respiratory diseases are 4% and 2%, respectively, of the total deaths in Nigeria, and are gradually increasing.^{4,5} Moreover, the BMPHS for the two NCDs will only include two basic tests (urinalysis, blood pressure). So, while the BMPHS is an important step, it does not provide adequate risk protection, and an increasingly broader range of services for NCDs will need to be included in the package.

- In August 2019, Nigeria launched the first National Multisectoral Action Plan (NNMSAP) for the Prevention and Control of NCDs. Many key ministries, departments, civil society organizations, research institutes and academics were involved in the preparation of the report. The plan is an important step and the fulfillment of an important commitment that Nigeria made at the UN high level meeting on NCDs in 2018. The plan provides a framework to tackle its increasing NCD burden. It also includes activities to collect nationally representative data on the current prevalence of NCD risk in the country. This is an important opportunity for Nigeria to start collecting data and planning interventions to address the increasing risk of NCDs in the country.^{4,2}

Table 4 summarizes the key challenges, opportunities and gaps for Nigeria in its march towards providing UHC to its population.

Conclusion

Nigeria is facing four main transitions—in demography, disease patterns, domestic finance, and DAH—that could affect the country's ability to successfully provide health-care service to its rapidly increasing and youthful population. Low investment by the government of Nigeria in healthcare has affected the national health system and has also limited the country's ability to expand healthcare provision to the poor. The country is facing an unfinished agenda of infections and RMNCH conditions and a rising burden of NCDs. Many donors, who have been one of the main sources of funding for healthcare in Nigeria, are in the process of exiting the country or planning their exit in the near future. Nigeria will need to find additional resources to fund its response to the changing disease landscape.

The National Health Act 2014 enacted the BHCPF which earmarked funds to provide guaranteed delivery of an essential package of health services to all Nigerians. This is an important step to manage some of these transitions and help the country move towards UHC. However, the government needs to implement the fund as envisioned in the health act, and gradually increase its funding. In addition, greater accountability, and a gradual expansion in essential services will have to be incorporated in the essential package for the BHCPF to become a successful instrument in managing the 4Ds of transition and help Nigeria achieve UHC.

Table 4. Key challenges, opportunities, and gaps

	Key challenges	Opportunities	Gaps
Demographic transition	<ul style="list-style-type: none"> • Rapidly increasing and urbanizing population • Change in population age structure—a large young and working age population 	<ul style="list-style-type: none"> • Implementation of the basic minimum package of health services (BMPHS) through PHCs • Interventions covered by the basic minimum package of health services • Nigeria's National Multisectoral Action Plan (NNMSAP) for the prevention and control of non-communicable diseases 	<ul style="list-style-type: none"> • BHCPF will mainly focus on rural areas during early years • Only 2 NCDs in interventions covered under BMPHS • Inadequate transition preparedness
Disease (epidemiological) transition	<ul style="list-style-type: none"> • The unfinished agenda of infections and reproductive, maternal, newborn, and child (RMNCH) conditions • Rising burden of non-communicable diseases (NCDs) 		
Domestic financing transition	<ul style="list-style-type: none"> • Low public health expenditure and high out-of-pocket expenditures (OOPEs) • Weak domestic revenue mobilization (DRM), and challenging macroeconomic outlook • Weak sub-national public funding of UHC and over-reliance on the federal government • Poor condition of healthcare facilities and low availability of health personnel 		
Donor health aid transition	<ul style="list-style-type: none"> • High dependence on donor financing for health • Impact on quantity and quality of healthcare services due to important donor exits from Nigeria 		



Resources

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Methods

Our research included a desk-based review of websites, strategy documents, grey literature reports, and academic literature. This project was screened for exemption by the Duke University Institutional Review Board as part of the study 'Driving health progress during disease, demographic, domestic finance and donor transitions (the "4Ds"): policy analysis and engagement with transitioning countries.'



This is one in a series of profiles focusing on middle-income countries that are transitioning out of official development assistance for health. The profiles are part of a broader study, *Driving health progress during disease, demographic, domestic finance, and donor transitions*, led by the [Center for Policy Impact in Global Health](#).