



# Nigeria's health transitions

## Country data summary

October 2021

Currently, Nigeria is undergoing four key transitions in its health sector—demographic transition, changes in the disease burden, a transition away from development assistance for health, and a shift towards domestic financing. Specifically, despite health gains in previous decades, Nigeria is facing a high burden of communicable diseases and a rapidly increasing burden of non-communicable diseases (NCDs). It is also experiencing high population growth and financial challenges resulting from donor exits. In this profile, we summarize the key transitions that will have an extensive impact on achieving universal health coverage (UHC) in Nigeria.

### 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.<sup>7</sup> 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.

### Domestic finance transition

Only about 5% of Nigerians are covered by health insurance.<sup>18</sup> The domestic general government health expenditure (GGHE-D) as a percent of 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.<sup>4</sup>

### Disease (epidemiological) transition

Nigeria is increasingly facing the problem of a double-disease burden. In 2016, according to the 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.<sup>13</sup> At the same time, deaths from NCDs such as cardiovascular disease have also increased in the last 10 years.

### 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.



Development indicators			Health statistics		
Total population	200,963,599	2019	Life expectancy at birth	54.7	2018
GDP	US\$397.27b	2018	Infant mortality rate per 1,000 live births	75.7	2018
Gross national income (per capita)	US\$1,968	2017	Maternal mortality ratio per 100,000 live births	917	2017
Public health expenditure (% GDP)	0.5	2017	Doctor- population ratio per 100,000 population	38.9	2016
Literacy rate	62.016	2018	Public health expenditure (% GDP)	3.89	2017
Human Development Index	0.534	2019	Total health insurance coverage	5%	2015
Proportion of population living in rural areas	50%	2018	DALYs from NCDs, rate per 100,000 population	14,454	2019
Median age (years)	18.1	2020	DALYs, rate per 100,000 population	54,038	2019
External aid (% of current health expenditure (CHE))	7.86%	2018			

Abbreviations: GDP, gross domestic product; DALYs, disability-adjusted life years

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



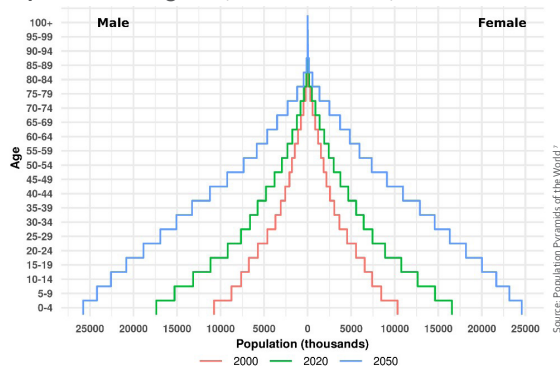
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## Demographic transition

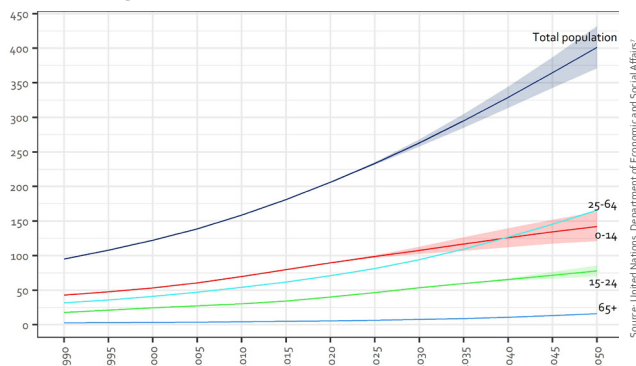
### Key takeaways

- 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 (BHC PF) is implemented in rural areas of Nigeria only.
- By generously allocating money to the BHC PF, some of these challenges can be mitigated, allowing coverage expansion to urban populations.

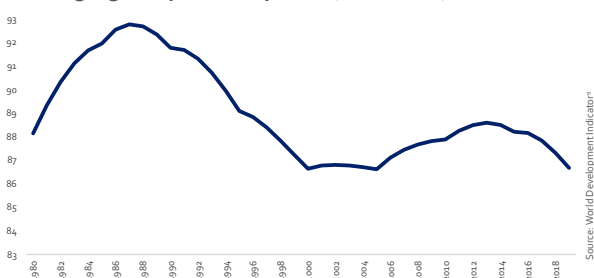
Population of Nigeria (2000, 2020, and 2050)



Population growth (millions)



Working age dependency ratio (% population)



Demographic transition

	2000	2020	2050
Median age (years)	17.9	18.1	22.4
0-4 (% of population)	17.2	16.4	12.5
5-19 (% of population)	37.2	37.6	33
20-64 (% of population)	42.7	43	50.5
>64 (% of population)	2.8	2.7	3.8
Age dependency ratio	86.64	-	-
Rural (% of population)	65	48	30
Total population (millions)	122.2	206.1	401.3

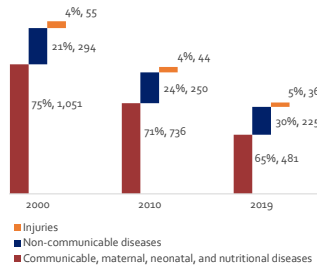
## Disease (epidemiological) transition

### Key takeaways

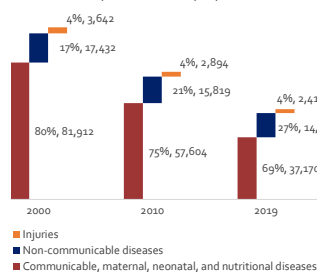
- Communicable (including maternal and neonatal) diseases are the top 5 causes of mortality in Nigeria. But the burden from non-communicable diseases (NCDs) is on the rise as the average annual rate of change between 2000 and 2019 was lower for NCDs (at -1%) than communicable diseases (at -4%).
- Nigeria 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 BHC PF 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.

Main causes of mortality

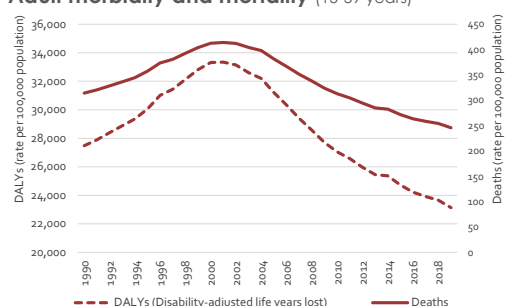
Deaths, rate per 100,000 population



DALYs, rate per 100,000 population



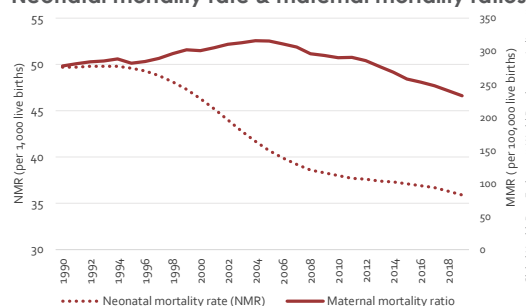
Adult morbidity and mortality (15-59 years)



Top causes of deaths per year (both sexes, all ages, per 100,000 population)

	2000	2010	2019
1	Enteric infections	Enteric infections	Enteric infections
2	RTIs and TB	NTDs & malaria	RTIs and TB
3	NTDs & malaria	RTIs & TB	Maternal & Neonatal
4	Other infections	Maternal & Neonatal	NTDs & malaria
5	Maternal & Neonatal	Cardiovascular diseases	Cardiovascular diseases
6	Cardiovascular diseases	Other infections	HIV/AIDS & STIs
7	HIV/AIDS & STIs	HIV/AIDS & STIs	Other infections
8	Other NCDs	Other NCDs	Neoplasms
9	Digestive diseases	Digestive diseases	Other NCDs
10	Neoplasms	Neoplasms	Digestive diseases

Neonatal mortality rate & maternal mortality ratios



Disease burden (types of disease, both sexes, all ages)

	2000	2010	2019	Ann. ROC*
<b>Deaths</b>				
Communicable, maternal, neonatal, and nutritional diseases	1,051	736	481	-4%
NCDs	294	250	225	-1%
Injuries	55	44	36	-2%
All diseases	1,400	1030	742	-3%
<b>DALYs</b>				
Communicable, maternal, neonatal, and nutritional diseases	81,912	57,604	37,170	-4%
NCDs	17,432	15,819	14,454	-1%
Injuries	3,642	2,894	2,434	-2%
All diseases	102,986	76,317	54,038	-3%

\*From 2000 to 2019, communicable, maternal and neonatal diseases decreased at a faster rate (-4% per year) than non-communicable diseases (-1% per year).

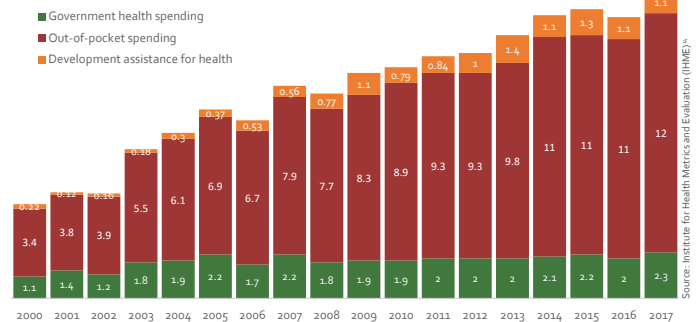
## Domestic finance transition

### Key takeaways

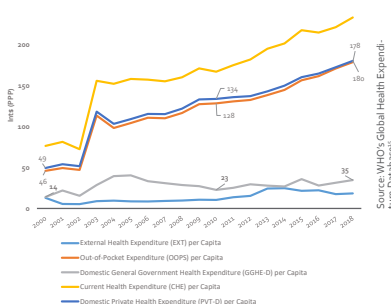
- In 2018, domestic general government health expenditure accounted for only about 15% of current health expenditure (CHE); 76.6% of CHE in the same year was out-of-pocket spending (OOPS). Health insurance coverage and financing from pooled sources hasn't gained traction in Nigeria as only about 5% of 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.

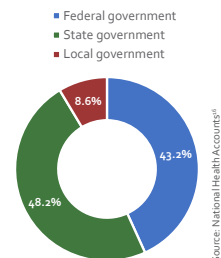
Health expenditure (2019, US\$ billions)



Health expenditure per capita (by sources)



Government source of health financing



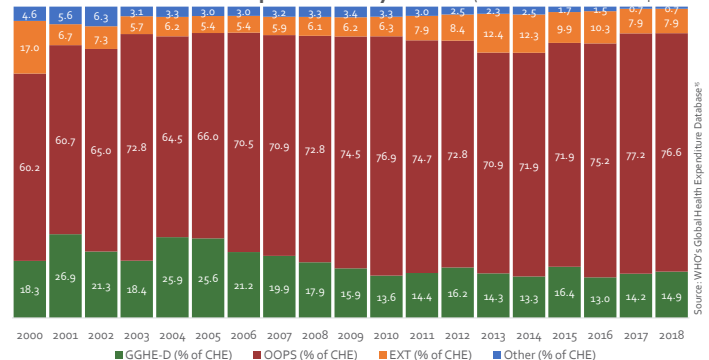
Health expenditure (comparing Nigeria with all low- and middle-income countries)

	Nigeria			Low- and middle-income countries		
	2000	2018	AARC*	2000	2018	AARC*
CHE per capita (US\$)	17.7	83.8	9%	22.9	85.7	7.6%
GGHE-D (% of current health expenditure)	18.3%	14.9%	-1.1%	31.3%	33.2%	0.3%
EXT (% of current health expenditure)	17%	7.9%	-4.2%	3.5%	3.2%	-0.5%
OOPS (% of current health expenditure)	60.2%	76.6%	1.3%	59.2%	55.7%	-0.3%

\*Average annual rate of change

Abbreviations: GGHE-D, domestic general government health expenditure; CHE, current health expenditure; OOPS, out of pocket spending; EXT, external health expenditure.

Breakdown of health expenditure by source (% of current health expenditure)



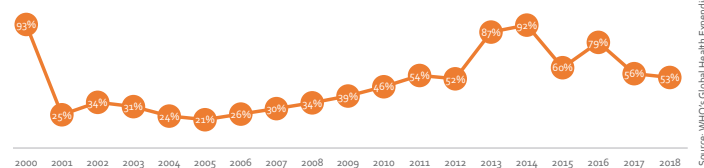
## Donor health aid transition

### Key takeaways<sup>18</sup>

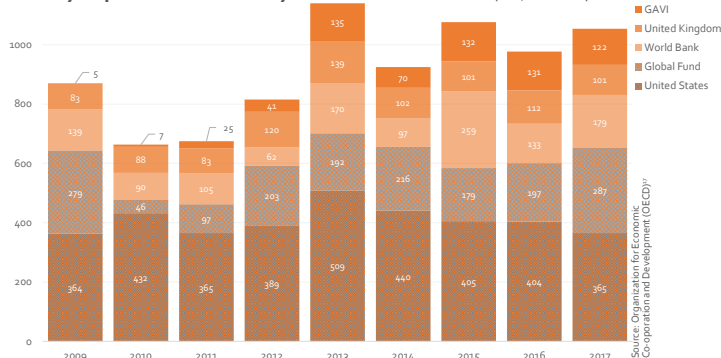
- Gavi, the Vaccine Alliance, the United Kingdom, the World Bank, the Global Fund, and the United States each have criteria for withdrawing support to countries (e.g., reaching a specific per capita income threshold). Nigeria is satisfying some of the exit criteria of many donors. For example, Gavi was 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.

External health expenditure as a percentage of domestic GGHE-D



Aid by top 5 donors each year from 2009-2017 (US\$ millions)



Abbreviations: GGHE-D, domestic general government health expenditure; STD, sexually transmitted disease.

Aid received by health area 2009-2018

Health area	Total flow (US\$ millions)	Percentage of total flow
STD control including HIV/AIDS	3,802.1	41.3%
Malaria control	1,580.6	17.2%
Infectious disease control	987.1	13%
Basic health care	979.9	10%
Reproductive health care	571.7	7%
Health policy & administrative management	348.9	3.8%
Tuberculosis control	304.3	3.3%
Family planning	227.4	2.5%
Basic nutrition	180.7	2.0%
Population policy and administrative management	68.9	0.7%
Personnel development for population and reproductive health	42.7	0.5%
Medical services	42.1	0.5%
Health education	21.0	0.2%
Health personnel development	14.9	0.2%
Medical research	14.9	0.2%
Basic health infrastructure	14.4	0.2%
Medical education/training	7.9	0.1%

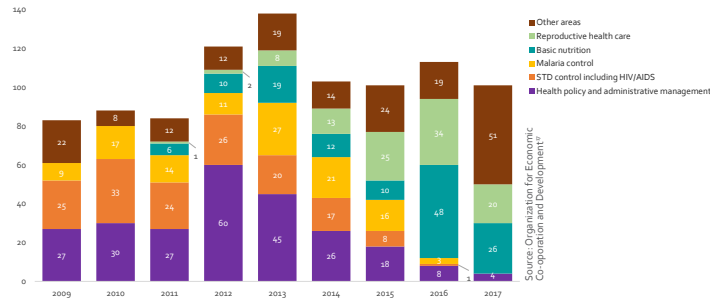
Donor health aid transition (continued)

Top 5 donors (89%, US\$8.2 billion, of all development assistance for health 2009-2017)

Donor	Total	Percentage
United States	3,671.9	40%
Global Fund	1,696.2	18%
World Bank Group	1,233.9	13%
United Kingdom	928.5	10%
Gavi, the Vaccine Alliance	667.2	7%
Other	1,012.0	11%

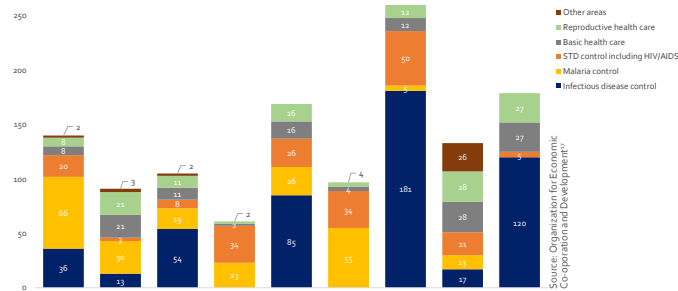
Source: Organization for Economic Co-operation and Development (OECD)

United Kingdom aid to health (US\$ millions)



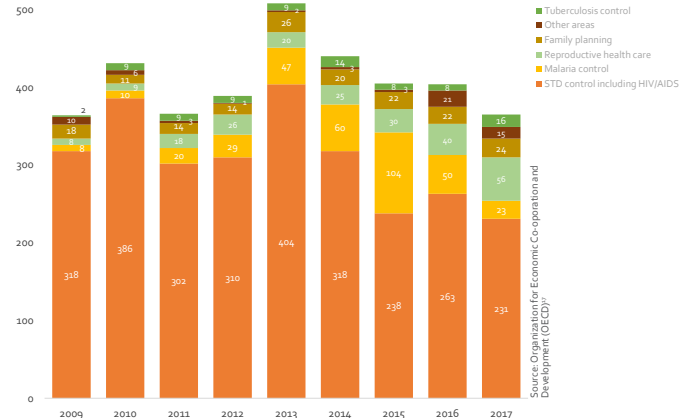
Note: Other areas include basic health care, family planning, infectious disease control, health education, health personnel development, medical research, personnel development for population and reproductive health, and population policy and administrative management

World Bank aid to health (US\$ millions)



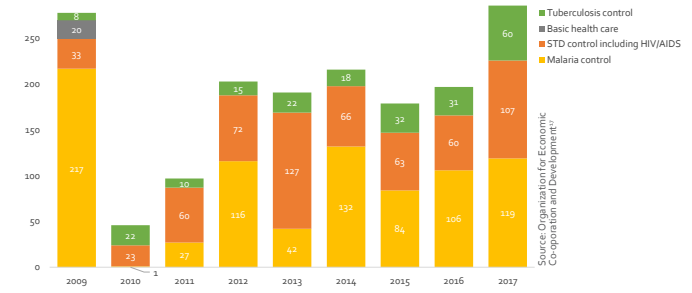
Note: Other areas include basic health care, health policy and administrative management, and family planning

United States aid to health (US\$ millions)

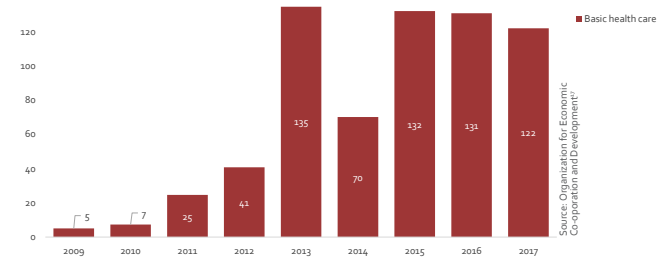


Note: Other areas include basic health care, basic infrastructure, basic nutrition, health personnel development, health policy and administrative management, infectious disease control, medical services, and population policy and administrative management

Global Fund aid to health (US\$ millions)



Gavi, the Vaccine Alliance aid to health (US\$ millions)



Note: Basic health care as related to immunization and system strengthening

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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.'



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