Chapter

7

Service delivery

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Abbreviations

ANC ..... antenatal care
BHCPF..... Basic Health Care Provision Fund
BMPHS..... basic minimum package of health services
CHEW..... community health extension worker
CHIPS..... Community Health Influencers, Promoters and Services
CHO..... community health officer
CHW ..... community health worker
CORP ..... community resource person
CRI ..... Critical Rescue International
DOTS ..... directly observed treatment, short-course
DQA..... data quality assessment
DSNO ..... disease surveillance and notification officer
EMS..... emergency medical services
ERA ..... Emergency Response Africa
FCT..... Federal Capital Territory
FMC ..... federal medical centre
FMOH..... Federal Ministry of Health
FRSC ..... Federal Road Safety Commission
ICT ..... information and communications technology
IDSR..... Integrated Disease Surveillance and Response
ISS..... integrated supportive supervision
JCHEW..... junior community health extension worker
LGA..... local government area
MCH ..... maternal and child health
NAFDAC..... National Agency for Food and Drug Administration and Control
NEMA ..... National Emergency Management Agency
NEMSAS..... National Emergency Medical Service and Ambulance System
NGO ..... nongovernmental organization
NHA ..... National Health Act
NHIA..... National Health Insurance Authority

NPHCDA ..... National Primary Health Care Development Agency
NSHDP II ..... National Strategic Health Development Plan II (2018–2022)
PHC..... primary health care
PNC..... postnatal care
PPMV..... patent and proprietary medicine vendor
SERVICOM..... Service Compact with All Nigerians
SHC..... secondary health care
SMoH ..... state ministry of health
SWAp..... sector-wide approach
TB..... tuberculosis
UHC ..... universal health coverage
VDC..... village development committee
VHC..... village health committee
WASH ..... water, sanitation and hygiene
WDC ..... ward development committee
WHO..... World Health Organization
WMHCP ..... ward minimum health care package

Chapter 7 key messages

- Essential health service coverage is very limited, contributing to Nigeria's poor performance against health indicators. Primary health care (PHC) is the weakest level of health care delivery, although facilities with the capacity to deliver the basic package of essential health services are lacking at the primacy, secondary and tertiary levels.
- The regional distribution of tertiary health care facilities is uneven, with a greater concentration in major urban centres and more developed regions than in rural and less developed areas.
- Emphasis remains on curative care, and challenges persist in prioritizing and funding public health interventions. Limited funding, inadequate infrastructure and health care workforce shortages constrain the effectiveness and reach of existing screening programmes.
- Strong community-level structures exist, but have not translated into the scaled-up delivery of essential health services at the primary health level.
- Specialist and emergency services are insufficient. Specialist services are confined primarily to urban areas and are often dictated by funding sources. Emergency medical care exists, but many communities lack ambulance services and prehospital care, and hospital units are ill-equipped to resuscitate critically ill patients.
- Referral systems are suboptimal, and many patients bypass lower levels of care to access higher levels.
- The coexistence of traditional and contemporary medicine poses possible risks, emphasizing the necessity of regulating and incorporating traditional medicine practices into the health care system.
- Service delivery reforms will improve basic package provision, but implementation challenges remain. Recent reforms to allocate at least 1% of the Consolidated Revenue Fund to the Basic Health Care Provision Fund will improve service delivery, providing for one functional PHC centre per ward and one general hospital per local government area. However, funding limitations, infrastructure constraints, cultural barriers and logistical difficulties continue to constrain implementation.

7.1 Organization and governance of service delivery

Health system governance is devolved to three levels of care (see Chapter 2 for an overview of the organizational structure of the health system). This is mirrored at the operational level, with primary health care (PHC) operating at the local government level, secondary health care (SHC) at the state level and tertiary health care at the federal level. PHC is the cornerstone of health policy and provides the first point of contact with the health system for most Nigerians.

While the federal government provides national laws and policies, states also regulate and provide health care services. Service delivery is mainly through public and private for-profit facilities. In addition, faith-based and voluntary organizations also provide services at different levels. Table 6.2.1 in Chapter 6 outlines the distribution of the various types of health facilities. The tertiary and primary levels have a preponderance of public facilities, while private facilities dominate SHC.

Structures and functions of primary health care at the local government area level

- **Local government areas** (LGAs) are geographical areas with devolved administrative responsibilities defined by the constitution. There are 774 LGAs and 36 states and the Federal Capital Territory in Nigeria. The populations of the LGAs vary: Bakassi LGA in Cross River state has the smallest population, at 48 200, while Alimosho LGA in Lagos state has the largest, at 1 953 500 (NPC and NBS, 2022). Many communities, in both urban and rural areas, have their own administration systems. The LGA is the level of government closest to the community, and is best situated to implement socioeconomic development activities and enable decision-making.
- **Ward health systems** are the smallest administrative unit in which health services are provided by trained personnel. They often revolve around a health facility or a group of health facilities. There are 9565 political wards in Nigeria, which are currently the focus of PHC development. Each ward has a minimum of one health centre.

- **Local government health authorities (LGHAs)** oversee a self-contained segment of the national health system, comprising the population served and the institutions and personnel providing health care, including referral systems.

7.1.1 Service delivery policies and frameworks

Overarching national and subnational health system policies and legal frameworks (e.g. the National Health Act (NHA), National Health Policy, National Strategic Health Development Plan, National Health Insurance Authority Act and state strategic health development plans) are already outlined and discussed in Chapter 2, Section 2.2. Core system- and programme-specific policies are outlined in Table 2.2.1 in Chapter 2.

Additional specific disease and service delivery policies and frameworks are outlined here, in Table 7.1.a.

Table 7.1.a Service delivery policies and frameworks

Policy	Date introduced	Objective
One Health Strategic Plan (FGN, 2019)	2019–2023	To address human–animal ecosystem public health challenges
National Policy and Strategic Plan of Action on the Prevention and Control of Noncommunicable Diseases (FMOH, 2013a)	2013	To develop and ensure the implementation of policies and programmes that will engender and guarantee a healthy lifestyle and good health for all Nigerians
National Strategic Plan for Tuberculosis Control (FMOH, 2021g)	2021–2025	To address the future challenges and priorities in prevention, care and treatment in relation to TB and TB–HIV
National Biosecurity Policy and Action Plan (FGN, 2022b)	2022–2026	To provide a framework for the design and implementation of programmes, to facilitate effective communication, collaboration and coordination of activities in a multisectoral biosecurity environment
National Mental Health Act (FGN, 2021b)	2021	To guide a national response to the delivery of mental health services
National Policy and Strategic Plan for Ear and Hearing Care in Nigeria (FMOH, 2019b)	2019–2023	To present evidence-based interventions to prevent, identify and treat ear diseases and hearing loss through the health system

Table 7.1.a Continued

Policy	Date introduced	Objective
National Policy on Emergency Medical Services and Operational Guidelines for the National Ambulance Scheme (FMOH, 2016d)	2018	To get people safely to the hospital from the site of acute injury or illness
National Oral Health Policy (FMOH, 2012b)	2020	To reduce the rate of oral disease among Nigerians
National Policy and Strategic Plan for Hospital and Palliative Care 2021 (FMOH, 2021f)	2022	To ensure the provision of good-quality and equitable hospice and palliative service

Source: Authors' compilation
Note: TB = tuberculosis.

The minimum standards for PHC referenced in Chapter 2 are described in more detail below in relation to service delivery.

Minimum standards for primary health care

These standards uniformly define the various levels of fixed health facilities and the minimum standards for PHC structures (systems, staffing, equipment and service delivery) at the local government level, to improve access to and the quality of services. They also provide a vital tool for guiding adequate supervision, monitoring and evaluation, and for informing effective planning, development and delivery of PHC services. Minimum standards are defined in the following areas:

- **health infrastructure**: the types/levels of PHC facilities, including recommended infrastructure dimensions, furniture and equipment;
- **human resources for health**: minimum recommended staff number and cadre for each type of health facility;
- **service provision**: recommended minimum PHC services for each facility type, including the minimum requirements for medical equipment and essential drugs (from the Essential Medicines List) required to achieve these services (NPHCDA, 2010).

The regulation of financing practices for both public and private health providers in Nigeria is guided by the National Health Financing Policy and Strategy, which focuses on revenue generation, pooling, allocation and purchasing, to facilitate universal health coverage (UHC). In addition, the NHA 2014 sets a framework for standards and the regulation of health services, encompassing both public and private providers, with an emphasis on cooperation, responsibility and the rights of citizens to access health care services. The actors responsible regulating health service providers are summarised in Table 7.1.1.

Essential service packages

The essential service packages for the primary and secondary levels of care are summarized in Table 7.1.b. The National Primary Health Care Development Agency (NPHCDA) established a ward-level health care minimum package for PHC, while the National Health Insurance Authority (NHIA) promotes, integrates and regulates health insurance schemes, and enforces the basic minimum package of health services (BMPHS) across all health insurance schemes nationwide.

Table 7.1.1 Overview of actors responsible for the regulation of providers

	Legislation	Planning	Licensing/accreditation	Pricing/tariff setting	Quality assurance	Purchasing/ financing
Public providers	• SMoH	• Department of Planning and Administration	• Medical and Dental Council of Nigeria • Nursing and Midwifery Council of Nigeria • Medical Laboratory Science Council of Nigeria • Board of Nursing	• Competition and Consumer Protection Tribunal	• National Health Research Ethics Committee • Pharmacy Council of Nigeria • NAFDAC	NA
Public health services	• SMoH	• Department of Planning and Administration	• Medical and Dental Council of Nigeria	NA	• National Health Research Ethics Committee	NA
Primary care (including community-based providers)	• SMoH • Local government health authority • Community Health Practitioners Registration Board of Nigeria	• Department of Planning Research and Statistics	• SMoH • Community Health Practitioners Registration Board of Nigeria	NA	• State health research ethics committees	NA
Secondary care	• SMoH	• Department of Planning Research and Statistics	• Medical and Dental Council of Nigeria • State health board	NA	State health research ethics committees	NA

Table 7.1.1 Continued

	Legislation	Planning	Licensing/accreditation	Pricing/tariff setting	Quality assurance	Purchasing/ financing
Tertiary care	• FMOH • Pharmacy Council of Nigeria • Medical Laboratory Science Council of Nigeria	• Department of Planning and Administration	• Medical and Dental Council of Nigeria • Nursing and Midwifery Council of Nigeria • Medical Laboratory Science Council of Nigeria • Pharmacy Council of Nigeria • Medical Rehabilitation Therapists (Registration) Board of Nigeria	NA	• Issuance of annual practising licence • Continuing professional development • National Health Research Ethics Committee	Department of Accounts
Traditional medicine providers	• SMoH (state and local government boards)	• FMOH • Traditional, Complementary and Alternative Medicine Council of Nigeria	• Federal Ministry of Innovation, Science and Technology	Does not exist	• NAFDAC (for traditional medicines) • Traditional medicine provider boards and councils	NA
Private providers	• SMoH	• Does not exist	• SMoH (renewable yearly) • Pharmacy Council of Nigeria	Does not exist	• Corporate Affairs Commission • SMoH (Department of Health Services)	NA
Diagnostic and imaging centres	• Corporate Affairs Commission	• Does not exist independently	• Medical Laboratory Science Council of Nigeria • Nigeria Nuclear Regulatory Authority	Does not exist	NA	NA

Source: Authors' compilation

Notes: FMOH = Federal Ministry of Health; NA = data not available; NAFDAC = National Agency for Food and Drug Administration and Control; SMoH = state ministry of health.

Table 7.1.b Essential service packages for the primary and secondary levels of health care

Primary level	Secondary level
• General consultation with prescribed drugs from accredited PHC facilities • Consultation with a health care professional in authorized PHC facilities, together with the provision of necessary medications • Health education and disease prevention • Surgery • Primary eye care • Paediatrics • Internal medicine (adult) • HIV/AIDS and other sexually transmitted diseases • Mental health management • Maternal, neonatal and child health • First aid and emergency services • Basic laboratory investigation	• Consultation with a health care professional in authorized SHC facilities, together with the provision of necessary medications • Emergencies occurring outside the usual residence or accredited health care provider • Hospital admission • Treatment and procedures included in the BMPHS that cannot be handled at the primary level • Surgery • Paediatrics • Internal medicine (adult) • HIV/AIDS (opportunistic infections as defined in the HIV treatment protocol) • Obstetrics and gynaecology • Laboratory investigations • Physiotherapy

Source: Authors' compilation

7.1.2 Health facility management

Primary health care

Local government councils oversee the administration of PHC services through health care centres and health posts (FGN, 1999). The LGA councillor is accountable to the LGA chairperson, with duties that include supervision of service delivery in the LGA. The National Health Policy is based on the PHC system, with linkages to other levels of care through a two-way referral system (FMOH, 2016c). Health facility committees facilitate community representation and enhance accountability, offering a means to address coverage, access and utilization issues.

Secondary health care

SHC is managed and funded by state governments. It includes general hospitals and cottage hospitals. Patients requiring specialist care are usually referred from PHC to SHC.

Tertiary health care

The federal government manages tertiary health care. This is a specialized health care level to which patients are referred from PHC or SHC facilities, although referral routes are frequently bypassed. Tertiary health care includes federal teaching hospitals, federal medical centres (FMCs) and specialty hospitals. The federal government funds tertiary health care. The government has adopted various public–private collaborative strategies to increase health care efficiency. These include public–private partnerships whereby the government builds the medical facilities while the private operator manages them contractually (see section "Partnerships for health" in Chapter 2, Section 2.3). Other strategies have involved the government and a private operator co-investing in setting up and managing a facility, or the government and a private operator co-investing in setting up a medical facility with an independent operator managing the facility. See Chapter 3, Section 3.7, for further details.

7.1.3 Quality assurance, supervision and support processes

The quality of health care services provided by the different levels of care varies. Operationally, the quality of services is ensured through the development of facility accreditation, standard operating procedures, training, provision of work aids, reminders and work supervision provided by the Department of Planning, Research and Statistics and the Department of Hospital Services. These measures are also expected to be replicated at the state level. For example, the Health Facilities Monitoring and Accreditation Agency in Lagos state has the responsibility of monitoring both private and public health facilities to ensure the delivery of high-quality services (HEFAMAA, 2023).

Quality assurance mechanisms

Following accreditation, various bodies and mechanisms are employed to ensure and sustain a high quality of service delivery, primarily through regular supervision, monitoring and evaluation.

The NHIA established quality assurance protocols that include accreditation of health care providers, periodic performance evaluations and adherence to clinical guidelines. These measures have resulted in better compliance with treatment protocols and improved health outcomes for insured patients.

This section describes key regulatory bodies and quality improvement activities.

Key regulatory bodies and their functions

The key regulatory bodies in Nigeria and their functions are shown in Table 7.1.c. This table categorizes the regulatory bodies and programmes into national regulatory bodies, professional regulatory councils, and other regulatory councils and bodies. It also includes regulatory instruments and acts, and international guidelines, and provides a clear overview of their functions and relationships. These bodies collectively ensure the regulation, quality and delivery of health care services; the protection of patient rights; and the maintenance of professional standards in Nigeria.

Each regulatory body has distinct roles that often overlap with others to ensure comprehensive health care regulation. The Service Compact with All Nigerians (SERVICOM) focuses on service quality, the Federal Competition and Consumer Protection Commission on consumer protection, the National Agency for Food and Drug Administration and Control (NAFDAC) on drug and food safety, and various professional councils on maintaining standards in their respective fields. They all operate within the legal frameworks provided by national acts and the constitution, and align with international guidelines as applicable. These interrelationships ensure a robust and integrated regulatory environment for health care in Nigeria.

Table 7.1.c Key regulatory bodies and functions

Category	Regulatory body/ programme	Function
National regulatory bodies	SERVICOM, launched 2004	• Coordinate efforts to develop and implement high-quality service charters service wide • Conduct independent surveys on customer satisfaction with public services • Raise awareness of public demands for satisfactory services from ministries, departments and agencies • Build the skills of public servants to deliver excellent service by promoting best practices in service delivery
	Federal Competition and Consumer Protection Commission, established through the Federal Competition and Consumer Protection Act 2018	• Handle cases of medical negligence • Achieve safe medical practices and consumer satisfaction • Operate with the Competition and Consumer Protection Tribunal
	Patient's Bill of Rights of the Consumer Protection Council, launched in 2018	• Aggregate patients' rights from various instruments, including the 1999 Constitution of Nigeria and several acts • Ensure patients' rights to information, confidentiality and quality of care • Promote access to patient- and fee-related information
	NAFDAC, established through the National Agency for Food and Drug Administration and Control Decree in 1992	• Regulate and control the manufacture, importation, exportation, distribution, advertisement, sale and use of food, drugs, cosmetics, medical devices, packaged water, chemicals and detergents • Maintain laboratories and conduct tests to ensure compliance with standard specifications • Inspect production premises and raw materials for food and drugs • Compile standard specifications, regulations and guidelines • Oversee the Federal Task Force on Counterfeit and Fake Drugs
	National Tertiary Health Institutions Standards Committee, established through the NHA 2014	• Maintain standards of tertiary hospitals through the issuance of certificates of standards and penalties • Advise the government on the financial needs of tertiary health facilities regarding service delivery, training and research
Professional regulatory councils	Medical and Dental Council of Nigeria	• Regulate the practice of medical doctors and dentists • Ensure medical and health standards

Table 7.1.c Continued

Category	Regulatory body/ programme	Function
Professional regulatory councils	Pharmacy Council of Nigeria	• Register and license all pharmacists, pharmaceutical premises (manufacturing, importation, distribution, wholesale, retail and hospital pharmacies), as well as issue permits to pharmacy technicians, and register and license PPMVs • Oversee an investigating panel and disciplinary committee • Statutorily register community pharmacies
	Nursing and Midwifery Council of Nigeria	• Ensure high-quality nursing and midwifery education • Maintain high standards of professional nursing and midwifery practice • Ensure discipline within the profession • Review and regulate the standards of nursing and midwifery practice in Nigeria
	Association of Medical Laboratory Scientists of Nigeria	• Regulate the practice of medical laboratory science in Nigeria • Regulate the training of scientists, technicians and assistants in institutions in Nigeria and give periodic accreditation to institutions • Regulate the production, importation, sales and stocking of diagnostic laboratory reagents and chemicals
Other regulatory councils and bodies	Radiographers Registration Board of Nigeria	Set specialized regulations in the respective health professions
	Health Records Officers Registration Board of Nigeria	Set specialized regulations in the respective health professions
	Community Health Practitioners Registration Board of Nigeria	Set specialized regulations in the respective health professions
	Medical Rehabilitation Therapists (Registration) Board of Nigeria	Set specialized regulations in the respective health professions
	Dental Technologists Registration Board of Nigeria	Set specialized regulations in the respective health professions
	Environmental Health Officers Registration Council of Nigeria	Set specialized regulations in the respective health professions

Table 7.1.c Continued

Category	Regulatory body/ programme	Function
Other regulatory councils and bodies	Optometrists and Dispensing Opticians Registration Board of Nigeria	Set specialized regulations in the respective health professions
	Dental Therapist Registration Board of Nigeria	Set specialized regulations in the respective health professions
Regulatory instruments and acts	1999 Constitution of Nigeria, Chapter II, Section 17(3)(d)	Ensures the right to health and adequate medical and health facilities for all persons
	Consumer Protection Act 2018	Promotes and protects the interest of consumers over all products and services. It is empowered to eliminate hazardous and substandard goods from the market.
	Child Rights Act 2003	Provides and protects the rights of a Nigerian child and other related matters.
	Freedom of Information Act 2011	Makes public records and information more freely available; provides for public access to public records and information; protects public records and information to the extent consistent with the public interest and the protection of personal privacy; protects serving public officers from adverse consequences of disclosing certain kinds of official information without authorization; and establishes procedures for the achievement of those purposes.
	NHA 2014	Provides a legal framework for national health policies and their implementation.
	Medical and Dental Practitioners Act, Cap 221 Laws of the Federal Republic of Nigeria 1990	Provides guidelines for medical and dental practitioners licensing and practice.
International guidelines	WHO guidelines on the integrated management of childhood illness	• Improve the quality of care for children aged under 5 years • Standardize PHC consultations for childhood illnesses • Focus on diagnosing and treating conditions responsible for the majority of child mortality

Source: Authors' compilation

Notes: NAFDAC = National Agency for Food and Drug Administration and Control; PPMV = patent and proprietary medicine vendor; SERVICOM = Service Compact with All Nigerians; WHO = World Health Organization.

Quality improvement activities

While some quality assurance mechanisms have been created, many of them have not yet been effectively adopted or used holistically, notably in the absence of national-level assessments. Recent analyses of the quality of Nigerian health care suggest that regulatory agencies have failed to embed quality as an operating principle and that inadequate budgetary allocation has constrained quality of care assessments; these concerns need to be addressed (FMOH, 2022e). The quality enhancement activities are outlined as follows:

- **Clinical audit** refers to the assessment of practice, for example prescribing, dispensing and laboratory procedures, and documenting of findings to generate appropriate reports to be reviewed and presented to staff for communication and education. Such audits highlight promising practices and areas requiring improvement.

  Example of implementation: clinical audits have proved useful in developing antimicrobial stewardship programmes (Kpokiri et al., 2020).

- **Integrated supportive supervision (ISS)**, conducted by the federal government and its subsidiary organizations, ensures effective resource management and the best delivery possible of health care services in health facilities. It involves inspecting, controlling and supporting health workers to improve their skills and performance and, ultimately, health service delivery.

  Example of implementation: state-level data suggest that ISS has positive effects, including improved infrastructure, health workforce and essential drugs in Katsina state; an increase in family planning acceptance rates in Zamfara and Akwa Ibom states; and an increased uptake of adolescent health services in Ogun, Plateau, Niger and Edo states. However, poor coordination of the various ISS activities in the country has led to the duplication of ISS tools and scarce resources being wasted by health partners and the Federal Ministry of Health (FMOH) (FMOH&SW, 2023). Since the last national ISS survey in 2011, reported by the National Bureau of Statistics, no further information on any holistic ISS at any level has become available. However, the FMOH has addressed this shortcoming

by collaborating with health partners to develop comprehensive national ISS tools at the primary, secondary and tertiary health levels for use by the FMOH and all health partners (FMOH&SW, 2023). This ISS/data quality assessment (DQA) platform contains electronic versions of the updated ISS and DQA tools, to ensure efficient coordination of ISS and DQA in the country and ease data collection and analysis. The DQA tool improves the quality of National Health Management Information System data at all data management levels via better coordination. On the platform, data can be collected across the various levels of health care, stored, analysed and validated. The data can also be visualized on the data analytics page for more in-depth analysis. The platform is accessible to all health partners and provides the FMOH with a bird's-eye view of ISS activities being conducted nationally. The system has been effective, based on data from the dashboard, although not all states and LGAs have uploaded their data (FMOH&SW, 2023).

- **Standard operating procedures** are written instructions describing the step-by-step process for performing a routine procedure. For example, the Medical and Dental Consultants' Association of Nigeria has provided a protocol to ensure easy COVID-19 identification as well as the protection of all health care providers from suspected or confirmed cases of COVID-19 (Anyanwu et al., 2020).

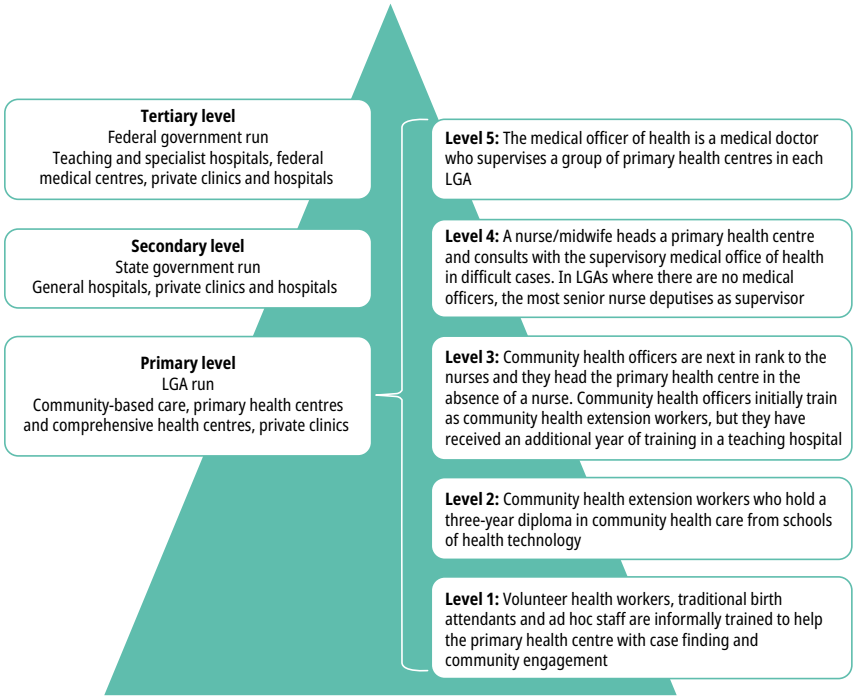
  Example of implementation: while this standard operating procedure applies to all cadres of health workers, there is no information on whether or not it has been adopted by health workers.

7.2 Public health services

This section describes the organization and provision of public health services, as well as specific health promotion and prevention interventions available in Nigeria (Fig. 7.2.a).

Organization and provision of public health services

Figure 7.2.a Organizational structure of the Nigerian health service delivery system



Source: FMOH, 2018b

Primary health care provision

PHC is primarily implemented through primary health centres and home visits. These services align with the minimum service components for PHC outlined in the World Health Organization (WHO)/United Nations Children's Fund Declaration of Alma-Ata of 1978 on PHC and set out in Section 7.1.1. Most services are delivered at the PHC level, meaning that primary health centres have high

potential to have an impact on the health system. The government's proposed health sector renewal programme focuses on patient health outcomes and strengthening prevention through PHC and community health care. It aims to galvanize the Basic Health Care Provision Fund (BHCPF) for PHC and expand service packages (Chinonso, 2023). The lack of health workers and access to health care in primary health centres has led to health care service innovations, to foster more effective and efficient delivery using available health personnel. Most notable has been the introduction of community health workers (CHWs). CHWs use their skills to provide health care to and educate their communities. These functions are facilitated by CHWs' close relationships with community members, bridging the gap between the community and the health care system. There are different types of CHWs, each receiving varying levels of training (see Section 7.4 for details). Community health extension workers (CHEWs) receive two to three years of "health-related training" approved by the Community Health Practitioners Registration Board of Nigeria. This gives CHWs the skills required to provide basic primary care in line with national policy (FMOH, 2014c).

Secondary health care provision

SHC provides specialized services to patients through outpatient and inpatient services at general hospitals under the control of state governments. State ministries of health (SMoHs) provide services through secondary-level health facilities and technical assistance to LGA health departments. Each state has a state PHC management board/agency. The governing body includes individuals representing the interests of their communities, as well as their professional, official or political interests. Governing bodies also have representatives from historically under-represented communities or otherwise excluded groups, such as women and children.

Tertiary health care provision

At the tertiary level, the Directorate of Public Services has divisions of safe motherhood and family planning, health education, disease control, nutrition, the National Programme on Immunization/Diarrhoeal Disease Control Programme, workforce development and training, and PHC monitoring and evaluation. Service delivery challenges include long waiting times, administrative issues due to bureaucratic bottlenecks, bypassing lower-level facilities and lack of space.

Organization of occupational health services

Nigeria's occupational health services are governed through various channels, including government agencies, private sector initiatives and collaborations with international organizations. The Federal Ministry of Labour and Employment manages occupational health and safety rules, laws and programmes. The regulatory framework includes the Factories Act, Labour Act and Employees' Compensation Act, which define obligations and standards for workplace health, safety and welfare (ILO and FGN, 2016). There are challenges related to enforcement, resource allocation and awareness that need to be addressed to ensure effective protection of workers' health and safety. Occupational health professionals, such as physicians, nurses, hygienists and safety officers, are employed by the various organizations, such as the oil and gas industries located in Lagos, Port Harcourt and Abuja.

Public health interventions

Historically, the health care system has been oriented more towards treatment than towards prevention, and has given greater attention and resources to curative services than to public health initiatives such as sanitation, health education or other preventive health care services (Abubakar et al., 2022). As a result, public health campaigns receive less funding than hospitals and clinics. Public health interventions have gained significance in response to diseases such as COVID-19, Lassa fever and Ebola, given that strengthened disease surveillance systems, priority health services for the rural poor and immunization programmes have been implemented to provide basic health services. Despite these efforts, the emphasis remains on curative care, and challenges persist in prioritizing and funding public health interventions.

Disease surveillance

LGAs have mechanisms for disease notification and surveillance of disease outbreaks through their disease surveillance and notification officers (DSNOs). The mechanisms for notification and surveillance of disease outbreaks in Nigeria include the routine Integrated Disease Surveillance and Response (IDSR) and event-based surveillance systems. These are ongoing surveillance activities and are conducted in all states through the Nigeria Centre for Disease Control

and Prevention (NCDC, 2024). At the local government level, the mechanisms for notification and surveillance of disease outbreaks are part of the IDSR framework. DSNOs are responsible for disease surveillance and notification in the LGAs and the IDSR framework is designed to improve early detection and prompt response to acute public health events, including disease outbreaks.

Environmental officers in LGAs have environmental and communicable disease control functions, such as preventing contamination of drinking water, open defecation and refuse dumping; food inspection; and issuance of abatement notices. Details on each programme are provided below.

National screening programmes

Nigeria has several national screening programmes that run in collaboration with international organizations and nongovernmental organizations (NGOs) to address public health challenges. These include screening programmes for cervical cancer, breast cancer, HIV/AIDS, tuberculosis (TB), malaria, diabetes and hypertension, and eye health issues. However, limited funding, inadequate infrastructure and health care workforce shortages constrain the effectiveness and reach of existing screening programmes.

Environmental and communicable disease control functions

Most of the highest-ranked causes of disability-adjusted life years in Nigeria are related to environmental risk factors. These include lower respiratory infection associated with air pollution; chronic respiratory diseases; cardiovascular diseases; enteric infections; diarrhoeal diseases; and communicable, maternal, neonatal and nutritional diseases. The nationwide One Health Strategic Plan (2019–2023) combines environmental, animal and human health management for better health security. The plan, which was jointly developed by the FMOH, the Federal Ministry of Agriculture and Rural Development and the Federal Ministry of Environment, as well as their agencies, reinforces Nigeria's commitment to strengthening multisectoral collaboration for health security. The Nigeria Centre for Disease Control and Prevention is tasked with spearheading communicable disease prevention, detection and control within government. Its functions are to prevent, detect, investigate and control communicable diseases of national and international public health importance.

Public health interventions to address major risk factors

Nigeria has implemented public health interventions to address major risk factors, including smoking and contaminated water, through regulation, health promotion activities and education:

- The country introduced a policy to enact the Framework Convention for Tobacco Control in 2015, and the National Tobacco Control Act to domesticate the convention. Public health campaigns and education programmes raise awareness about smoking risks and encourage cessation. However, challenges include loopholes in the law, corruption, lack of political will and the tobacco industry's influence (Ukwueze et al., 2018).
- Water, sanitation and hygiene (WASH) programmes have been implemented to improve access to clean water, sanitation facilities and hygiene practices, especially in rural areas. In 2018, the WASH sector was declared in a state of emergency, with 60 million Nigerians living without basic drinking water. The government constructed over 2300 water points and 6546 sanitation compartments and hygiene facilities across the country (World Bank, 2021a). NAFDAC regulates packaged water quality and monitors performance against health indicators.

Table 7.2.a sets out further public health interventions by disease type.

Food inspection services

Food safety, defined as the assurance that food will not cause harm to the consumer when it is prepared or eaten according to its intended use, is an integral part of food and nutrition security. Nigeria's NAFDAC and FMOH oversee food inspection services, which ensure that food products meet safety and quality standards. NAFDAC and FMOH conduct regular inspections, monitor imported products, issue licences and conduct sampling and testing. They also enforce compliance through recalling products, imposing sanctions and fines, and taking legal action. Several guidelines and policies are in place to guide these functions (NAFDAC, 2012). Despite these efforts, inadequate funding,

limited capacity, weak enforcement mechanisms and informal food markets limit NAFDAC's inspection capabilities, necessitating continued investment, capacity-building and public collaboration.

Table 7.2.a Public health interventions classified by disease type

Communicable	Noncommunicable	Other
HIV/AIDS • Providing antiretroviral therapy • Offering HIV prevention, treatment, care and support services through a multisectoral approach	**Injuries** • Integrating injury surveillance, detection, management and control into existing national strategies and plans • Promoting strategies for the prevention and management of occupational injuries • Raising awareness of legislation and building capacity to respond to all forms of violence, including gender-based violence and violence against children • Establishing trauma care centres at all levels of care, building the capacity of health systems in support of injury prevention and control • Establishing a national emergency ambulance service	**Pandemic preparedness** • Developing and maintaining the capabilities of stakeholders for regular risk analysis, including vulnerability and risk assessment • Developing and implementing health emergency and disaster preparedness plans and risk-specific contingency plans, including pre-positioned emergency medical stocks and supplies • Implementing strategies to mitigate the health impacts of disasters and environmental health issues • Strengthening health emergency management capacity and emergency coordination mechanisms at all levels • Strengthening the capacity of the surveillance and response systems in line with the International Health Regulations of 2005 • Upgrading health infrastructure and security systems in public health institutions that handle biological agents of public health importance

Table 7.2.a Continued

Communicable	Noncommunicable	Other
Malaria • Implementing an integrated vector management strategy • Implementing prevention and treatment strategies	**Cardiovascular diseases** • Screening for early detection of hypertension, stroke, heart attack and risk factors • Strengthening capacity for the detection and management of cardiovascular diseases • Establishments for the rehabilitation of clients with long-term sequelae of cardiovascular disease	**Water and sanitation** • Promoting the provision of adequate and safe water and appropriate sanitary facilities in urban and rural areas through multisectoral collaboration, public–private partnerships and effective community engagement • Developing and implementing quality standards for safe potable drinking water • Developing and implementing a national framework for water quality monitoring and surveillance strategies • Promoting awareness on the risks linked with the consumption of unwholesome water
TB and leprosy • Implementing prevention and treatment strategies • Providing high-quality integrated services for all people coinfected with TB and HIV	**Diabetes mellitus** • Promoting screening for early detection of diabetes and risk factors • Building capacity in the detection and management of diabetes mellitus • Establishing rehabilitation centres for the management of long-term complications of diabetes mellitus	**Health promotion** • Promoting awareness on the rights and responsibilities of consumers • Mobilizing the potential of mass media for health promotion • Strengthening partnerships and multisectoral collaboration for health promotion • Strengthening capacity in health promotion, including the channelling of resources at all levels • Promoting the inclusion of health promotion in school curricula at all levels • Promoting the inclusion of health promotion in workplace health programmes

Table 7.2.a Continued

Communicable	Noncommunicable	Other
Neglected tropical diseases • Implementing integrated vector management strategies	**Cancers** • Promoting strategies for routine screening and early detection of cancers in relevant age groups • Strengthening the existing cancer treatment centres for the management of patients • Improving the quality of life of cancer patients and providing palliative care • Strengthening cancer registries across the country • Developing innovative financing mechanisms for cancer patient care provision	
Immunization and vaccine-preventable diseases • Ensuring vaccine security for appropriate routine immunization coverage • Setting standards for injection safety and disposal, cold-chain equipment and inventory requirement for immunization service delivery • Promoting equity in access to and the utilization of services across all communities	**Sickle cell** • Providing universal screening and genetic counselling for the general populace • Strengthening the structures and capabilities for the management of sickle cell disease • Promoting research on innovative methods of management of sickle cell disease to improve the quality of life and life expectancy of people with sickle cell disease	

Source: FMOH, 2016c

Health promotion and social marketing

The National Health Promotion Policy revised in 2019 guides best practice for health care providers on health promotion. Each LGA health promotion unit is responsible for managing, implementing and documenting LGA-level activities, including community mobilization and oversight of health promotion

activities at the ward and community levels (FMOH, 2019d). The government has prioritized social marketing, advocacy activities and campaigns through its various institutions and agencies in an effort to change attitudes and address high levels of corruption. A study on the Nigerian perspective of social marketing campaigns using the Ebonyi State Action Committee on AIDS as a case study showed that, with proper message timing and frequency, broadcast media campaigns are likely to influence people's social life, just as appropriate information can alter people's behaviour or attitude. Several health promotion programmes have used social marketing strategies, including a programme that increased the uptake of pap smears among women in an urban slum area of Lagos (Olubodun et al., 2022).

Public health implementation challenges

Nigeria's public health initiatives face challenges such as inadequate funding; poor health infrastructure and inequities in the distribution of service delivery structures; insecurities; inadequate capacity to carry out essential public health functions; the simultaneous challenges of responsiveness and continuity; and disjointed decision-making without necessary data and knowledge. These challenges are exacerbated by weak health care governance. Successful programmes such as the Saving One Million Lives initiative have improved maternal and child health (MCH) through targeted incentives and partnerships; however, scaling up digital health and strengthening PHC facilities remain key priorities, as they are likely to have a substantial impact.

7.3 Referral system and patient pathway

Overview

In principle, Nigeria has processes in place for a two-way referral system, initiated at the primary care level as the first point of contact, with cases beyond the capacity of the primary level referred to the secondary level and then on to the tertiary level, with feedback being provided to the referring facility (FGN, 2022c). Referrals can be external or internal, outside or within the health care level. Referring physicians are mandated to refer a patient promptly, to guarantee efficient, cost-effective, optimal and high-quality care for the patient.

Physicians in the receiving hospital or health care facility are required to refer the patient back after treatment to the facility or physician who initiated the referral, with clear feedback on the findings observed, investigations conducted and treatment given. However, in practice, this has taken various forms, with the most common pathways outlined below:

- **Self-referral**: 60–90% of patients present at any health care system level without a referral, usually bypassing the primary level of care due to perceptions that the facility and services at this level will be of a low quality, and patients' perceptions of the severity of their symptoms (Koce et al., 2019).
- **Physician self-referral**: physicians involved in dual practice (i.e. working in both public health care institutions and private practices) divert or refer patients to a facility outside their primary employer institution for financial reasons, particularly if the physician owns that facility or will receive financial gains from referring a patient to it.
- **e-Referrals**: computerized systems are used in clinical settings for managing and referring patients and for the subsequent electronic transfer of medical records. This system is rudimentary in Nigeria. Plans for the wider implementation of electronic records management include providing a technology learning support centre and a reference library. Providing these services at the electronic records management level will greatly facilitate referrals, thus enhancing service quality. Good examples of systems already in use in Nigeria are SaferMom and MOBicure, two cheap health technologies that can deliver vital health information to nursing mothers and pregnant women through short message service and voice calls. Referral efficiency is increased through the use of eConsult, which streamlines asynchronous clinician-to-clinician interactions through a web-based electronic health record platform. These technologies have led to improved access to specialty care in underserved populations, better care coordination, clinician satisfaction and cost savings (Olayiwola et al., 2020). Access to health information in local languages will increase coverage and ensure the effective communication of public health issues to people in rural areas.

Implementation successes and challenges

The referral system can be seen as a measure of the health system's overall performance, and shows the government's ability to manage all the systems and human resources involved in the referral process. However, in many low- and middle-income settings like Nigeria, referral systems are characterized by inefficiencies (especially poor provision of feedback to the referring physician/facility), with a negative impact on cost, equity and quality of care. In some cases where referral is impossible, patients are retained in care and managed with low-cost but effective interventions. The gatekeeping function of PHC centres needs improvement, as linkages between the different health system tiers are ineffective. This leads to patients accessing health care directly from the secondary and tertiary health levels, which is more expensive, especially for poorer populations (Amedari and Ejidike, 2021).

7.4 Community-based care

Overview and summary of challenges

Nigeria's community health care system is designed to give people, especially those living in underserved and rural regions, easy access to high-quality health care at a reasonable cost. A combination of public and private sector providers, as well as interventions from NGOs and international entities, are involved in the organization and delivery of community health care services. Active community engagement produces a workforce that can manage procedures, maintain openness, build connections and provide both qualitative and quantitative data to support the integration, coordination, adoption and responsiveness of health services. Community-based care services are crucial for improving health care access, promoting health equity and strengthening health care systems. For example, the Integrated Community Case Management programme, community-based health education, community-based rehabilitation programmes and community-based health insurance have all improved life-saving interventions, empowered individuals with disabilities and improved MCH services.

Community-based care reforms

Over the last 10 years, Nigeria has seen several major changes in the delivery of community-based care. Reflecting the government's commitment to improving health and well-being, Nigeria's PHC system has undergone continuous change and reforms to address service delivery challenges (Chinonso, 2023). Efforts have also been made to strengthen PHC and improve health financing and governance. These reforms have been successfully adopted. In addition, community-based health insurance has been promoted as an effective health-financing option for providing access to care for individuals in the informal sector and contributing to attaining UHC.

Implementation of reforms

However, the existence of the structures described above has not translated into the scaled-up delivery of services, and quality assurance reports are not readily available. There are regional variations in the availability of community health services. Family planning services are inconsistent across the country's six regions, with better access in urban areas than in rural areas, and the strongest provision in the north-west. All regions face issues with stock-outs of contraceptives, and postnatal care (PNC) provision also appears uneven, although evidence is sparse on its spatial distribution across regions. Uptake of PNC is higher in the south than in the north, and intraregional variations are also significant, with higher PNC use in Yobe and Bauchi in north-eastern Nigeria than in other states within the region (Ononokpono et al., 2020). Current challenges include addressing diverse disease burdens and inadequate investment in the social determinants of health. Reform plans focus on health investment for prosperity, balancing prevention and care and leveraging human resources (Abubakar et al., 2022).

Community health worker cadres, management and coordination

Cadres

Nigeria has four community health provider cadres that serve as entry points for communities into the PHC system and provide ward minimum health care

package (WMHCP) services. Community health officers (CHOs) are based at health facilities and provide a broad range of PHC services. CHOs oversee CHEWs and junior community health extension workers (JCHEWs), who work at health facilities and in communities. All three cadres are employed by the FMOH (Egan et al., 2017). A fourth cadre, known as community resource persons (CORPs), also operates at the community level. CORP is a broad term that refers to a variety of informal providers, including traditional birth attendants and village health workers, who are often supported by NGOs. While CORPs are not officially part of the government-run PHC system, they refer clients to government health facilities and are typically supervised by JCHEWs. For these reasons, health policies provide basic guidance on CORP roles, supervision and involvement in the health management information system. Ward development committees (WDCs) are the primary management body at the ward level and serve as liaison with the community, identifying health needs and mobilizing the resources needed (see Chapter 2, Section 2.1). They also provide administrative oversight for CHOs, CHEWs, CORPs and JCHEWs. All community health programmes in Nigeria are integrated into the PHC system.

Management and coordination

Health system governance structures at all levels are set out in full in Chapter 2, Section 2.1, but described here in relation to PHC service delivery.

- The FMOH sets policy and supports capacity-building at the state level, while the NPHCDA leads system implementation through advocacy, resource mobilization, partnership development and capacity-building.
- The SMoH provides planning, training, programming, and financial and operational support at the state level. The LGA PHC management committee provides overall direction and manages PHC system services.
- Community-level service delivery is managed and coordinated across the national, state, LGA and ward/village levels. Each level has a distinct role in supporting policy and programme efforts. NGOs provide support and resources at all levels of the health system. They often focus on specific health issues such as HIV/AIDS, malaria, TB or malnutrition, providing resources, training and technical assistance.

- WDCs implement the PHC system at the ward level. Wards with larger populations are divided into villages, each of which has a village development committee (VDC). VDCs/WDCs coordinate and link communities with ward- and village-level health facilities: health posts, primary health clinics and primary health centres. VDCs/WDCs identify health needs and available resources, supervise PHC workplan implementation and monitor progress, mobilize communities to use PHC services, and supervise CHEWs, CHOs, CORPs and JCHEWs. The role and composition of each WDC/VDC can be customized to the local context, but they are generally led by an elected chairperson and include members from religious groups, women's groups/associations, occupational/professional groups, NGOs, community health providers, youth groups, traditional healers and medicine shop owners. WDCs also have a representative from each VDC in the ward.
- CHEWs, CHOs and JCHEWs are salaried providers at the lowest level of service delivery in the PHC system. They work from health posts, primary health clinics and primary health centres, and provide WMHCP services. Of the three, CHOs receive the highest level of training. They are based at health facilities and provide a range of health services, including services related to MCH, family planning, malaria and HIV/AIDS. They also oversee health facility management, including CHEW and JCHEW supervision and oversight. CHEWs provide similar services to CHOs but are more focused on preventive care and health education. They spend 40% of their time working in the community and 60% at the health facility. JCHEWs receive less training than CHEWs and provide a narrower scope of services. They spend 90% of their time in communities and 10% at the health facility. CHEWs supervise JCHEWs.

Community health providers

Roles and responsibilities

Table 7.4.a Community health providers

	CHEW	CHO	CORP	JCHEW
Number in country	• 117 568 CHEWs, CHOs and JCHEWs combined	• 117 568 CHEWs, CHOs and • JCHEWs combined	• Information not available	• 117 568 CHEWs, CHOs and JCHEWs combined
Target number	Information not available	7 740	Information not available	Information not available
Coverage ratios and areas	• 3 CHEWs : 1 primary health centre (10 000–30 000 people) • 2 CHEWs : 1 primary health clinic (2 000–5 000 people) • Operate in urban, rural and peri-urban areas	• 1 CHO : 1 primary health centre (10 000–30 000 people) • Operate in urban, rural and peri-urban areas	• Information not available • Operate in urban, rural and peri-urban areas	• 6 JCHEWs: 1 primary health centre (10 000–30 000 people) • 4 JCHEWs: 1 primary health clinic (2 000–5 000 people) • 1 JCHEW: 1 health post (500 people) • Operate in urban, rural and peri-urban areas
Health system linkage	CHEWs are government employees who are connected to government health facilities and provide WMHCP services	CHOs are government employees who work at government health facilities and provide WMHCP services	CORPs are supported by NGOs but serve as a link between health facilities and the community by referring clients	JCHEWs are government employees who are connected to government health facilities and provide WMHCP services
Supervision	CHEWs are supervised by CHOs, with administrative oversight from VDCs/WDCs	CHOs report to the LGA PHC Management Committee and the medical officer at the health facility. They also receive feedback on their performance from the WDC/VDC	CORPs are supervised by the NGOs they work for and JCHEWs, with administrative oversight from VDCs/WDCs	JCHEWs are supervised by CHEWs, with administrative oversight from VDCs/WDCs

Table 7.4.a Continued

	CHEW	CHO	CORP	JCHEW
Accessing clients	• On foot, bicycle and public transport • Clients travel to them	• Clients travel to them	• On foot and bicycle	• On foot, bicycle and public transport • Clients travel to them
Selection criteria	Selection criteria are not stated in policy, but they must undergo training and therefore be literate	Selection criteria are not stated in policy, but they must undergo training and therefore be literate	Some CORPs are required to be nominated by his/her community, and must be a resident there and have a source of livelihood. Selection criteria differ based on the supporting NGO and the needs of the community	Selection criteria are not stated in policy, but they must undergo training and therefore be literate

Source: Egan et al., 2017
Note: Information reflects data as at 2017.

Table 7.4.a outlines the roles and responsibilities of various community-based health care workers in Nigeria, namely CHEWs, CHOs, CORPs and JCHEWs, and related organizational structures. Key takeaways are outlined below:

- CHEWs and CHOs operate in urban, rural and peri-urban areas, with varying ratios of workers to population sizes for different health care facilities. CHEWs, CHOs and JCHEWs are government employees connected to government health facilities, while CORPs are supported by NGOs and serve as a link between health facilities and the community.
- The data show that Nigeria has 117 568 CHWs (CHEWs, CHOs and JCHEWs combined), but no specific data on the distribution of CHWs among the various categories are available. In 2007, Nigeria had a CHW density of 0.1 per 1000 people, with urban centres having better access to health care and facilities, and rural and remote regions facing challenges due to infrastructure, transport and resource constraints. The north-west and north-east regions have lower CHW densities due to insecurity, poverty and limited infrastructure, while the south-west and south-east regions have

better community health care infrastructure. State-level variations exist within geopolitical zones, with south-west states such as Lagos, Ogun and Oyo having robust CHW programmes, and north-east states such as Borno and Yobe facing challenges. If we assume similar targets proportionately for CHEWs and JCHEWs, 117 568 might still be insufficient given Nigeria's large and growing population (over 200 million people). Effective distribution should prioritize rural areas. The ratios provided suggest a framework for this trend, but evaluating real-world deployment versus need is essential. Rural areas typically suffer from understaffing more than urban centres.

- There are no universal benchmarks for CHW density, but comparisons can be made with countries with successful PHC models. For example, Rwanda maintains a workforce of nearly 45 000 CHWs, which translates to approximately three CHWs per village of about 50 to 150 households. This relatively high CHW density has been recognized as a key driver of Rwanda's early achievement of the Millennium Development Goals (Napier et al., 2020).

Interventions and services

Table 7.4.b Selected MCH interventions, products and services provided by CHWs

Subtopic	Interventions, products and/or services	Information, education and/or counselling	Administration and/or provision	Referral	Follow-up
Family planning	Condoms	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
	Implants	CHEW, CHO, JCHEW	CHEW, CHO	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
	Injectable contraceptives	CHEW, CHO, JCHEW	CHEW, CHO	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
	Intrauterine devices	CHEW, CHO, JCHEW	CHEW, CHO	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
	Oral contraceptive pills	CHEW, CHO, JCHEW	CHEW, CHO, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW

Table 7.4.b Continued

Subtopic	Interventions, products and/or services	Information, education and/or counselling	Administration and/or provision	Referral	Follow-up
Maternal health	Birth preparedness plans	Unspecified	Unspecified	Unspecified	Unspecified
	Iron/folate for pregnant women	CHEW, CHO, CORP, JCHEW	CHEW, CHO, JCHEW	CHEW, CHO, CORP, JCHEW	Unspecified
	Nutrition/dietary practices during pregnancy	CHEW, CHO, CORP, JCHEW		CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
	Recognition of danger signs during and post pregnancy	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
Newborn care	Care seeking based on signs of illness	CHEW, CHO, CORP, JCHEW			CHEW, CHO, CORP, JCHEW
	Chlorhexidine use	Unspecified	Unspecified	Unspecified	Unspecified
	PNC	CHEW, CHO, JCHEW	CHEW, CHO, JCHEW	CHEW, CHO, JCHEW	CHEW, CHO, JCHEW
Child health and nutrition	Community integrated management of childhood illness	CHEW, CHO, JCHEW	CHEW, CHO, JCHEW	CHEW, CHO, JCHEW	CHEW, CHO, JCHEW
	Exclusive breastfeeding for first 6 months	CHEW, CHO, CORP, JCHEW		CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
	Immunization of children	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW

Source: Egan et al., 2017

Table 7.4.c Selected programme interventions, products and services provided by CHWs

Subtopic	Interventions, products and/or services	Information, education and/or counselling	Administration and/or provision	Referral	Follow-up
Malaria	Artemisinin combination therapy	CHEW, CHO, CORP, JCHEW	CHEW, CHO, JCHEW	CHEW, CHO, CORP, JCHEW	Unspecified
	Long-lasting insecticide-treated nets	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
	Rapid diagnostic testing for malaria	CHEW, CHO, CORP, JCHEW	CHEW, CHO	CHEW, CHO, CORP, JCHEW	Unspecified
HIV and TB	Community treatment adherence support, including directly observed treatment short-course therapy	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
	Contact tracing of people suspected of being exposed to TB	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW
	HIV testing and treatment support	CHEW, CHO, CORP, JCHEW	CHEW, CHO	CHEW, CHO, CORP, JCHEW	CHEW, CHO
WASH	Community-led total sanitation	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW		
	Hand washing with soap	CHEW, CHO, CORP, JCHEW			
	Oral rehydration salts	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW	CHEW, CHO, CORP, JCHEW

Source: Egan et al., 2017

Tables 7.4.b and 7.4.c provide details about selected interventions delivered by CHEWs, CHOs, CORPs and JCHEWs across a range of health areas. The data in these tables serve as a valuable resource for guiding activities to enhance health care delivery at the grass-roots level. Key takeaways are outlined below:

- The data suggest that training in clinical procedures, diagnostic tools, community mobilization, health education and referral

processes is needed. JCHEWs should be equipped with clinical support and community health promotion skills. Resource allocation should be optimized by providing essential medical provisions and instructional materials.

- Service delivery can be improved by integrating services across various health domains, and allowing for education, treatment and follow-up. This approach reduces the workload on larger health facilities. Effective communication strategies can be taught to all CHWs. Well-defined supervision structures can be established, with CHEWs supervising JCHEWs, and CHOs supervising CHEWs. Regular feedback and digital tools can monitor health worker activities and assess outcomes.

Additional programmes and related providers are described below.

The Community Health Influencers, Promoters and Services programme

The Community Health Influencers, Promoters and Services (CHIPS) programme was launched by the NPHCDA in 2018. The CHIPS programme aims to expand maternal, child and reproductive health interventions at the community level and strengthen the health service delivery system. The strategy is to harmonize existing community-based programmes, such as the Integrated Community Case Management of Childhood Illnesses, Volunteer Community Mobilizer and Village Health Worker programmes, into the CHIPS programme. This process provides a coordinating platform with one training curriculum, one monitoring and evaluation framework, and one category of community-based health workers, that is, the CHIPS personnel – CHIPS agents and community engagement focal persons.

The CHIPS programme harmonized all training materials and resources of all categories of CHWs, providing a better definition of their roles and coordination. All health workers at the community level – except CHEWs – are now trained for 14 days using nationally approved tools, with supervision from community-empowered personnel and persons in charge of the primary health centres. The government pays monthly stipends to CHIPS agents and their supervisors. Each implementing agency/partner at the community level is expected to upgrade the status of their CHWs to CHIPS agents. At the same time, states and LGAs are encouraged to participate in the programme.

Patent and proprietary medicine vendors and community pharmacists

Patent and proprietary medicine vendors (PPMVs) are medicine shop owners without formal pharmacy training, selling orthodox pharmaceutical products on a retail basis for profit. PPMVs act as the first point of care for many Nigerian populations by providing diarrhoea, pneumonia, malaria and family planning services for all ages. PPMV practice is primarily regulated by the Pharmacy Council of Nigeria. PPMVs are a notable private sector player and are the primary source of medicine for acute conditions (Agha et al., 2022).

Community pharmacists are formally trained, having completed an undergraduate degree in pharmacy from an approved faculty/school of pharmacy in Nigeria or overseas. In 2005, the number of PPMVs in Nigeria was estimated to be 200 000, roughly 100 times greater than the number of registered pharmacists, and nearly four times the number of physicians (Barnes et al., 2008). However, ratios vary geographically: in Lagos state, the ratio of community pharmacists to PPMVs is 1 : 2, while, in Kaduna state, the ratio is 1 : 17 (IntegratE, 2021).

Ward development committee or ward health committee/village health committee

Nigeria adopted the WDC structure in 2000 to facilitate community participation in health care delivery. The National Health Policy 2004 established ward health committees, WDCs and village health committees (VHCs). Every ward in an LGA has a ward health committee whose role is to organize, plan, make budgets and monitor all PHC services that concern residents. In every village, a VHC has been established to prepare the community for health action, find available resources within the community and distribute them appropriately for health development. The VHC also plans for the health and welfare of the community, relates the plans at the health facility level and supervises the implementation of the health plans developed.

Home-based care providers for the home management of HIV/AIDS

Home-based care programmes for HIV patients were initiated to assist family caregivers in providing HIV/AIDS-related care because public health services at the peak of the HIV epidemic could not cope with the increased demand

for treatment and care. Some of these home-based care services focus on providing social and psychological support, with some also providing nutritional support and basic nursing care. Others also dispense antiretrovirals and treat opportunistic infections. These services, whether provided through NGOs, government health clinics or community groups, are essential in supporting people living with HIV and AIDS, as well as people who provide care and support within families. This use of this approach is widespread and primarily operated by community-based organizations (Akeju et al., 2021).

Community-based tuberculosis programmes

Community-based TB activities encompass a wide range of activities aimed at prevention, diagnosis and improving adherence to treatment and care that affect the outcomes of drug-sensitive, drug-resistant and HIV-associated TB. These community-based activities for TB are conducted within community-based structures (e.g. schools, places of worship and congregate settings) and homesteads, and not in health care facilities. They are known to be a more cost-effective approach associated with better compliance to treatment and better patient satisfaction than the health facility-based approach.

Community involvement in TB is part of the Stop TB Partnership Nigeria, a strategy launched in 2006 to enhance the expansion of directly observed treatment short-course (DOTS) therapy programmes and reduce the global burden of TB. Implementation of community TB care in Nigeria commenced in 2007. As of 2012, community TB care was established in 27 out of 36 states, plus the Federal Capital Territory (FCT) (Adejumo et al., 2016). In addition to referral of presumptive TB cases to the DOTS centres, in some models community workers also serve as treatment supporters and help track those lost to follow-up.

The Bamako Initiative

In 1988, Nigeria adopted the Bamako Initiative to strengthen PHC at the community and local government levels. Community participation, the upgrading and reorganization of health centres, the provision of essential drugs, community financing through user fees, and enhanced management were the five main components of the Nigerian initiative (Uzochukwu and Onwujekwe, 2004).

Community engagement strategy for strengthening routine immunization in northern Nigeria

Traditional community architectures in northern Nigeria have been harnessed to coordinate and mobilize local communities. The Global Polio Eradication Initiative has successfully utilized this community architecture in its polio eradication efforts, and the Expanded Programme on Immunization is using this architecture in the form of WDCs and VDCs and the development of micro plans for both routine and supplemental immunization activities. Some northern states have also developed state-specific community engagement strategies, which the leadership of the Northern Traditional Rulers' Council, the Sultanate and some Emirate councils are working to harmonize within a coordinated framework. The routine immunization strategy builds on these models to provide a harmonized approach for increasing community participation in routine immunization.

Community-based health insurance

The community-based health insurance scheme is an initiative aimed at increasing access to high-quality and affordable health care services at the community level (see Chapter 3, Section 3.6). It ensures the availability of drugs, access to certified medical professionals and high-quality MCH care.

Although there is no information on the quality assurance package for community-based health care nationally, looking at a state-level package that is in place in Akwa Ibom state reveals important elements for quality assurance, such as (i) the philosophy, namely that care should be at minimal risk to the client and to the benefit of the client and that clients should demonstrate a moral sense of duty, among other things; (ii) objectives, namely giving consumers adequate information, continuously looking for ways to provide innovative services and safeguarding consumer satisfaction; and (iii) measures for quality assurance, namely providing continuous education for health workers, licensing all health care providers, ensuring close supervision, minimizing unjustified geographical variation in care and reducing access barriers. This package has been recommended for adoption for health care administration at the national level.

Service distribution

Details of the distribution of community-based health care services are set out in Tables 6.2.b and 6.2.c in Chapter 6.

Implementation challenges

Factors that hinder community health service delivery include poor health-seeking behaviour, preference for traditional medicine providers, male dominance in communities, superstitious beliefs, poor attitudes among health facility workers and inadequate financial support. Enabling factors include community members' participation and compassionate attitudes among informal providers. Enhancing factors include synergies between formal and informal providers, support from community-based organizations and government support. Integrating community health service delivery into programme implementation and working with the community health system can improve the overall health system and community health (Ozor et al., 2024).

7.5 Primary health care

Primary care physicians are often a patient's first point of contact with the health care system. For most Nigerians, a PHC facility is the first point of contact, at which point any short-term, uncomplicated health issues should be resolved. It is also the level at which health promotion and education efforts are undertaken, and where patients in need of more specialized services are connected with secondary care. Primary health centres are located at the grass-roots level in the ward health system, with a primary health centre being located in each political ward (of 9560 wards) and run by the local government authority. The NPHCDA provides support for the implementation of the National Health Policy where it relates to PHC. Within the policy, PHC is identified as the "main focus for delivering effective, efficient, quality, accessible and affordable health services to a wider proportion of the population"(Akwaowo et al., 2020). The government's four basic approaches to PHC are to (i) promote community participation in planning, management, monitoring and evaluation; (ii) improve intersectoral collaboration in PHC delivery; (iii) enhance functional integration

at all levels of the health system; and (iv) strengthen managerial processes for health development at all levels.

Primary health care infrastructure: facilities and equipment

PHC facilities have been referred to by various terms, including dispensaries, health clinics, health centres, primary health centres, maternities, health posts and comprehensive health centres. However, the ward health system and NPHCDA manual of minimum standards for PHC recognize three facility types: (i) health post, (ii) primary health clinic and (iii) PHC centre. Table 7.5.a aligns the previous facility nomenclature with these three formally recognized terms.

Table 7.5.a Types of health facilities, management and expected coverage

Previous health facility nomenclature	New health facility nomenclature	Level of management	Current number of facilities
Comprehensive health centre, model PHC centre	Primary health centre	Local government	One per ward, with an average of 10 wards per LGA Total of 7740 is estimated to exist currently
Maternity centre, basic health centre	Primary health clinic	Local government and WDC	One per group of villages/ neighbourhoods of about 2000–5000 persons
Dispensary	Health post	VDC/community development committee	One per village or neighbourhood of about 500 persons

Source: Authors' compilation

These facilities are owned by the government or private for-profit or not-for-profit organizations. Private health facilities are classified according to their structure and the services they provide. The majority are clinics and maternity homes and hospitals, owned by individual professionals or faith-based and other civil society organizations. They provide PHC services, but are not categorized in line with public facilities.

Health posts

Service delivery is primarily at the settlement, neighbourhood and/or village levels. The estimated population coverage is 500 persons. Health posts are headed by at least one JCHEW, who supervises CORPs working within the community. CORPs partner with skilled providers by encouraging women to enrol for essential antenatal care (ANC) and PNC, act as community educators to lend support for accurate maternal and neonatal health messages, identify pregnant women in the community who might need maternity services, distribute commodities/drugs to pregnant women in the community and treat minor ailments. It is expected that 40% of JCHEWs' time will be spent at the health post and 60% in the community (according to the WMHCP)(NPHCDA, 2007). Only outpatient care is offered here.

Primary health clinics

Primary health clinics deliver services to a group of settlements/neighbourhoods, villages or communities. The estimated population coverage is 2000 to 5000. Each facility should provide a 24-hour service. JCHEWs spend 60% of their working time in the health facility and 40% in the community, while CHEWs spend 80% of their working time in the facility and 20% in the community. Only outpatient care is offered at primary health clinics. Health personnel are allocated as shown in Table 7.5.b.

Table 7.5.b Standard staffing for primary health clinics

Standard staffing	Number
Health care staff	
Midwife or nurse midwife	2
CHEW (must follow specific instructions for supporting patient care in emergency situations)	2
JCHEW	4
Support staff	
Health attendant/assistant	2
Security personnel	2

Source: NPHCDA, 2010

Primary health centres

These centres deliver services to the political ward, with an estimated population coverage of 10 000 to 20 000. Centres are open 24 hours a day. Health personnel are allocated as shown in Table 7.5.c.

Table 7.5.c Standard staffing for primary health centres

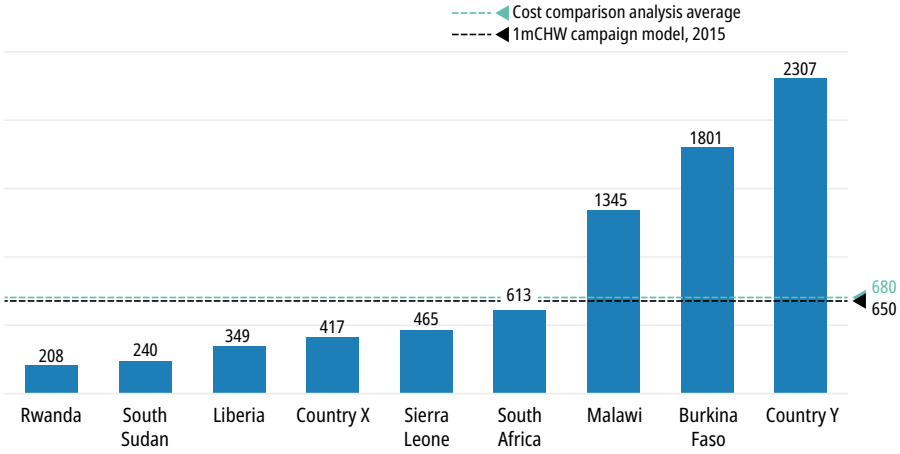
Standard staffing	Number
Health care staff	
Medical officer if available	1
CHO (must follow specific instructions for supporting patient care in emergency situations)	1
Nurse/midwife	4
CHEW (must follow specific instructions for supporting patient care in emergency situations)	3
Pharmacy technician	1
JCHEW (must follow specific instructions for supporting patient care in emergency situations)	6
Environmental officer	1
Medical records officer	1
Laboratory technician	1
Support staff	
Health attendant/assistant	2
Security personnel	2
General maintenance staff	1

Source: NPHCDA, 2010

Both inpatient and outpatient care are offered at this level, especially MCH care services. Of the 30 098 primary health centres nationally, 21 808 are public and 8290 are private. Of both categories, less than 25% are functional (Ibeh, 2023). There are 42 938 senior CHEWs, with the ratio of senior CHEWs to total population being 1 : 28 256, and 28 548 JCHEWs, with the ratio of JCHEWs to total population being 1 : 5914 (FMOH, 2018b). As a comparison, although data for senior CHEWs and JCHEWs are not available for the African region overall,

the average CHW-to-population ratio in sub-Saharan Africa was reported to be 1 : 680 in 2013, and varied widely from 1 : 200 to 1 : 2400 (McCord et al., 2013). In 2014, Kenya recorded about 64 000 CHWs (this number includes CHEWs), and Niger had a total of 7500 CHWs as at 2020 (Stodel et al., 2020). Fig. 7.5.a shows the average CHW-to-population ratio in nine additional countries in sub-Saharan Africa. Table 7.5.d shows the geographical distribution of primary health facilities in Nigeria. See also Chapter 6, Table 6.2.b.

Figure 7.5.a Average CHW-to-population ratios in nine countries in sub-Saharan Africa



Source: Gichaga et al., 2021

Notes: Countries X and Y are masked, awaiting formal government approval to share the data; 1mCHW = One Million Community Health Workers.

Table 7.5.d Distribution of primary health facilities per 100 000 population in Nigeria

Region	Primary health facilities
North-central	23.3
North-east	17.9
North-west	14.0
South-east	17.9
South-south	11.8
South-west	16.9

Source: Makinde et al., 2018

Key challenges at the primary health care level

- The north-central region has the largest number of primary health facilities per capita, followed by the north-east, south-east and south-west regions, respectively.
- At the PHC level, the minimum guidelines also provide for additional services, including mental health in PHC, primary oral/dental health, primary care of the elderly (in geriatric units), care of people with disabilities in PHC, and control of noncommunicable diseases. However, the functionality of these services is not documented.
- The majority of PHC facilities are in a non-functional condition. Structural and infrastructural issues are widely documented, including in a recent review of PHC facilities in five states and the FCT (FMOH, 2018b), and many facilities do not have the required equipment or pharmaceutical products.
- The quality of care provided in primary health centres is not well documented. Individual studies have documented a high proportion of patients being satisfied with various aspects of care at health centres, but others have noted variances in the availability of basic medical equipment and its functionality and gaps in basic drug availability, which compromise service provision and suggest that the majority of facilities surveyed could not meet the minimum standard for PHC service delivery (Oyekale, 2017).

Polices and agencies/committees aimed at improving PHC delivery have been developed, including:

- the NPHCDA and equivalent agencies at the state level (i.e. state PHC development agencies);
- the NHA, which aims to achieve UHC through an efficient PHC system and provides for a BMPHS through the establishment of the BHCPF;
- the National Strategic Health Development Plan II (2018–2022) (NSHDP II);
- the Primary Health Care Under One Roof initiative, which aims to integrate PHC activities;
- WDCs and health facility committees, which aim to create an enabling environment for the participation of communities in PHC;

- through a PHC summit held in 2022 with the theme "Re-imagining Primary Health Care in Nigeria".

See Chapter 2, Section 2.5, for further information on the organization of the health care system and a list of recent reforms.

7.6 Secondary health care

SHC is delivered in both general and private hospitals. General hospitals are run by state governments, with each hospital covering several LGAs. SMoHs are responsible for SHC.

Service provision

The secondary level of care involves preventing, treating and managing a small range of minimally complex cases. SHC facilities include general hospitals, comprehensive health centres, district hospitals and specialist hospitals, which are run by both public and private providers. General hospitals offer both inpatient and outpatient care, provide accident and emergency services, and have diagnostic units. SHC acts as a link between primary care and highly specialized tertiary health care services.

- In addition to offering inpatient and outpatient services, some of the more established secondary care facilities, for example the Lagos Island General Hospital, offer additional services, including general medicine, surgical services, ophthalmology, orthopaedics, physiotherapy, maternal care and ANC, emergency services, pathology, blood bank services, radiology, dental care, chest clinics, medical rehabilitation and pharmaceutical services Extra services such as ophthalmology, orthopaedics and physiotherapy are not routinely offered in the less well-established secondary care facilities.
- Comprehensive health centres offer fundamental medical services, such as preventive care, regular check-ups, immunizations, basic diagnostic testing and treatment for common illnesses and minor accidents. In addition, they provide maternity and child health services and family planning services.

- District hospitals, however, are located in rural or suburban areas and provide intermediate care, that is, between specialized care and primary care. They serve the health care needs of a specific district or LGA even though they may not offer services of the same level of specialization or have the same state-of-the-art medical equipment as general hospitals. They offer a broader range of services than comprehensive health centres.

Public versus private ownership

The 2019 Nigeria Health Facility Register, produced by the FMOH, put the total number of health facilities in Nigeria at 40 621. SHC facilities make up 14.2% of health care facilities (5780 out of 40 621 facilities). Of these, 78.7% are privately owned (including by faith-based organizations) and 21.3% are publicly owned. The large number of secondary private health facilities may point to specialists' preferences for working in private practice over government employment, or to the lack of positions in government-owned SHC facilities.

Regional distribution

Secondary health facilities are unequally distributed across the country, resulting in notable regional differences in the availability and standard of care provided. Secondary facilities are concentrated more in urban centres and in more economically developed regions such as the south-east, where there are 5.4 facilities per 100 000 population. At the other end of the spectrum, more rural areas in the north, such as Sokoto, Zamfara and Yobe, lack the same quantity or calibre of facilities (Ademiluyi and Aluko-Arowolo, 2009); for example, the north-west region has just 0.45 facilities per 100 000 population (Makinde et al., 2018). The disparities in SHC accessibility between urban and rural areas are primarily due to differences in resource distribution and infrastructure investment. Urban areas attract more resources, leading to better-equipped institutions and a larger pool of health care experts. Rural areas often lack adequate roads and transit networks, which affects service availability and quality (Ajala et al., 2005).

Health workers who work in public health care facilities are directly employed by the government, while those who work in private health care facilities are either contracted or own the facilities. Table 7.6.a shows the distribution of health workers by category and their density.

Table 7.6.a Health worker distribution and densities

Health worker category	Number	Health worker-to-population ratio	Ratio required to meet population needs
Doctors	24 600	1 : 8 836	1 : 600
Dentists	1 400	1 : 155 267	1 : 5 000
Nurses	249 566	1 : 1 677	1 : 5

Source: FMOH, 2018b

Service quality

Various studies on patient satisfaction with service quality in secondary health facilities in Nigeria have found that reliability and assurance are the most important elements influencing the satisfaction of users. Patients are generally happy with the quality of care they receive when empathy is exhibited. Private facilities are considered more convenient by patients and to have more empathetic health workers than public facilities. These findings suggest that patients value certain components of care more than others, and that public and private health facilities may differ in these components.

Hospital indicators

Data on hospital indicators for secondary care are very limited. As shown in Table 7.6.1, data on the average length of stay and occupancy rates for hospitals are limited to 2010 and 2021, respectively. The numbers of discharges and admissions have increased, suggesting that access to health care services has improved, which in turn suggests that infrastructure and outreach efforts have improved. Hospital mortality has also increased, however, possibly due to the COVID-19 pandemic. These data are crucial for understanding the efficiency and capacity of secondary hospital care services. Data on these indicators also offer crucial insights into Nigeria's secondary hospital system's performance and the challenges it faces, thus enabling informed decision-making by policymakers and health care providers to enhance public health outcomes.

Table 7.6.1 Hospital indicators related to secondary care (selected years)

	2010	2015	2020	Latest available year	Source
Average length of stay	5 days	NA	NA	NA	Puozaa, 2013
Occupancy rate	NA	NA	NA	53% (2021)	*Punch*, 2019
Total number of hospital discharges	NA	2 078 189	NA	3 215 083 (2023)	DHIS2, 2024 (as at June 2024)
Admission rate per 1 000 population	NA	13%	18.9%	21% (2023)	DHIS2, 2024 (as at June 2024)
Hospital mortality	NA	0.06%	6.86%	0.07% (2023)	DHIS2, 2024 (as at June 2024)

Notes: DHIS2 = District Health Information System 2; NA = data not available.

Role of digital services

Nigerian secondary care is embracing digital services to enhance health care provision. Electronic health records are being used to digitize patient health information. The introduction of digital services has encountered challenges, including inadequate information and communications technology (ICT) equipment, privacy risks, poor internet availability, information overload, low computer proficiency and budget constraints. However, there have also been notable successes. Secondary health facilities in Ondo, Lagos and Yobe states are implementing telemedicine platforms to provide remote health care services, such as teleconsultations, telephone triage and telemonitoring, which have significantly reduced maternal and infant mortality (Egenti et al., 2022). In addition, the use of ICT has had a major impact on the provision of high-quality health care services in Kogi state's SHC facilities; in particular, ICT use has improved patient safety by simplifying medical information when providing online treatment. The administration of SHC institutions should give priority to improving the integration of ICT into their operations (Nafiu et al., 2024).

Implementation challenges

Public secondary health services face several challenges. These include unequal distribution across the country, resulting in notable regional differences in

the availability and standard of care; shifts from clinical service delivery to population-based services; reduced budgets; difficulty in recruiting and retaining staff; and a lack of awareness about the professional training and roles of health educators. In addition, there are challenges related to system fragmentation, limited resources and ineffective delivery of mental health services for young adults (SciSpace, undated).

7.7 Tertiary care

Organization

Tertiary health care is organized and provided via varied settings, organizations and health care providers. Facilities include teaching hospitals, FMCs and specialized medical institutions. Health care providers include doctors, specialists, nurses, pharmacists and laboratory technicians. Support staff contribute to the smooth functioning of facilities. The distribution and composition of the different types of facility are influenced by their roles, functions and specialization areas.

- **Teaching hospitals**, often affiliated with medical schools and universities, consist of a mix of academic staff who are also medical practitioners, nurses or allied health professionals. These hospitals also have specialized departments for various areas of medical practice. Due to their role in medical education and research, teaching hospitals often have a higher concentration of academic and research-oriented staff than other medical institutions.
- **FMCs** offer patients specialized medical services, such as diagnosis and treatment. The workforce is usually composed of physicians, nurses, pharmacists, radiographers, laboratory scientists and administrative personnel as in teaching hospitals, but in smaller numbers. FMCs primarily focus on offering specialized health care services to the general public. The staffing structure in FMCs may vary depending on their size, location and areas of specialization.
- **Specialized medical institutions** focus on specific medical specialties or areas of health care, such as orthopaedic, psychiatric, eye, and ear, nose and throat specialties. These facilities often employ a multidisciplinary team of nurses, technicians, medical specialists and support personnel.

The variety of diagnostic tests available at tertiary hospitals is restricted by a shortage of equipment, supplies and skills.

Service provision

Tertiary facilities offer outpatient care, inpatient care, specialized care, teaching and research. Outpatient care includes consultations, diagnostic testing, minor procedures and the prescription of drugs. Inpatient care includes surgery, observation and rehabilitation. Specialized treatments include advanced surgery, cancer treatment and intricate diagnostic procedures. Medical students, interns, residents and nurses are often trained in these facilities.

Tertiary hospitals are run by the federal government and offer tertiary care and health workforce training in teaching hospitals and FMCs. Nigeria's private tertiary care sector, which is also under the regulation of the FMOH, includes hospitals, clinics and other facilities, and offers specialized consultative health care, including cardiology, cancer, neurology, orthopaedics and other cutting-edge procedures. These facilities have state-of-the-art machinery and skilled medical staff and offer specialty therapies. There is at least one tertiary health institution, in the form of a public teaching hospital or FMC, in each state and in the FCT. The regional distribution of tertiary health care facilities in Nigeria is uneven, with these facilities being more concentrated in major urban centres and more developed regions than in rural and less developed areas. For example, the north-west and north-east regions have the lowest concentration of tertiary health facilities, while the south-west and south-south regions have the highest concentrations (Makinde et al., 2018).

Service quality

The quality of services rendered in these facilities varies from one facility to another. Studies have recorded relatively high levels of patient satisfaction with services in the south-eastern region (Nwoke et al., 2021), while, in other regions, such as the south-south region, patients were dissatisfied (Etim et al., 2023). A long waiting time to be seen on admission, an unfriendly hospital environment, the inability to get all the prescribed drugs from the facility and the poor attitude of health care professionals were reasons cited for dissatisfaction, whereas cleanliness of the hospital environment, friendly

health workers, level of privacy given and cost of treatment were reasons cited for being satisfied.

Nigeria's tertiary hospitals have faced public criticism over substandard services and poor infrastructure (see Table 7.7.1 which sets out hospital indicators related to tertiary care). Challenges include the lack of vital equipment needed for emergency care of acute asthma and obstetric haemorrhage, inadequate electricity supply from the national grid, insufficient government funding and bureaucratic bottlenecks undermining staff recruitment and training. This situation differs from many countries that adopt global best practices for tertiary health care. For example, Egypt, Ghana, Kenya and South Africa have advanced health care systems, with specialized tertiary hospitals and modern facilities. These countries invest in medical infrastructure, research and professional training to enhance their health care systems. Kenya is working to improve infrastructure and expand access to tertiary services. In 2023, South Africa had the highest Health Care Index score, of 63.5 points, in Africa, followed by Kenya with 61.5 points, while Nigeria trails behind with 48 points (Cowling, 2024). The Health Care Index takes into account factors such as the overall quality of the health care system, equipment, cost and number of health care professionals, staff and doctors. The National Tertiary Health Institutions Standards Committee, established by the NHA 2014, is charged with maintaining tertiary hospital standards in line with global best practices. As such, they issue certificates of standards or penalties to substandard hospitals, which may include closure and the criminal prosecution of indicted officials. However, the committee is not functioning optimally and hence the standards are not enforced.

There are national policies and programmes to improve tertiary facility standards and hence quality of care. These include SERVICOM, which was launched in 2004 (SERVICOM, 2019), and the Patients' Bill of Rights of the Consumer Protection Council, launched in 2018 (CPC, 2018). The impact of these policies is not yet clear, but reports suggest that hospitals have not met desired standards (*Punch*, 2019).

Palliative care

Palliative care is relatively new in Nigeria and still at a developmental stage, although specific facilities do exist, for example the Centre for Palliative Care, Nigeria, at University College Hospital Ibadan, established in 2003, and the

Pain and Palliative Care Unit at the Oncology Centre of the University of Nigeria Teaching Hospital Enugu, set up in 2008. Palliative care has yet to be included as an area of specialization for health professionals and integrated into the health care system, contrary to the recommendations of the WHO (Chukwunyere, 2019).

In line with secondary care provision more generally, palliative care provision is unevenly spread. Many cancer treatment centres are located in urban areas, while rural areas have poor access because of distance and poverty. In the facilities that do exist, infrastructure and workforce challenges affect care. Radiotherapy centres lack functional machines and an adequate workforce. Hospitals and cancer care facilities lack physicians to prescribe controlled drugs such as morphine for pain relief (Chukwunyere, 2019).

Table 7.7.1 Hospital indicators related to tertiary care (selected years)

	2010	2015	2020	Latest available year	Source
Average length of stay	10.07 days	9.42 days	8.15 days	16.8 days (range 4–33 days) (2022)	Aloh et al., 2020; Medugu et al., 2022
Occupancy rate	43.16%	28.74%	42.14%	42.14% (2020)	Aloh et al., 2020
Total number of hospital discharges	NA	NA	NA	DAMA 32.3% (2021)	Madubueze et al., 2022
Admission rate per 1 000 population	NA	NA	NA	NA	NA
Hospital mortality	6.5%	4.2%	46.7%	34.1% (2022)	Eya et al., 2022; IB et al., 2022

Notes: DAMA = discharge against medical advice; NA = data not available.

Role of digital services

Tertiary health care institutions are implementing electronic health records to digitize patient health information in the country (Sawyer-George and Friday, 2023). Digital health record preservation is crucial in health care facilities, especially in tertiary hospitals, given that it allows quick access to patient health records for future reference. It is also important because tertiary hospitals in Nigeria generate a significant volume of health records daily, thus requiring substantial storage space, which can be challenging to find.

Nigeria has implemented an electronic health information management system in a few university teaching hospitals that supports patient, clinical, ancillary and financial information management, and enhances the digitalization of medical records. However, federally funded tertiary facilities have a significant way to go to reach telemedicine maturity. Policymakers need to increase health equity and ensure continuity and progress towards statewide deployment. The federal government has also increased e-health services in some teaching hospitals through Galaxy Backbone Ltd, a private enterprise that aims to provide efficient health care, reduce hospital stays and provide quick access to patient records in emergencies (Abari, 2023). Several potential obstacles could prevent tertiary facilities from fully implementing e-health. They include infrastructure issues, and a lack of workforce compliance.

Implementation challenges

Inadequate funding is one of the greatest challenges in tertiary health facilities, especially as these facilities handle complex health problems requiring highly skilled personnel and advanced technology, both of which are capital-intensive. Other challenges include the inadequate condition of medical equipment, inadequate staff training, delayed diagnostics and treatment procedures, and long waiting times for patients.

7.8 Traditional medical practices

Overview

Traditional medicine practitioners are those recognized by the community as competent to provide health care using methods based on practices and beliefs prevalent in that community (WHO, 1996). Traditional medicine in Nigeria comprises herbal medicine, bone setting, circumcision, maternity care, spiritual therapies, psychiatric care, music therapy, homeopathy and aromatherapy, among many other practices.

Nigeria has a long history and culture of traditional medicine, which contribute to the broad appeal of traditional medical practices. The majority of Nigerians (67–82% of adults) utilize traditional medicines, which are generally perceived to be natural with no side-effects (Niggemann and Grüber, 2003).

The first line of treatment for 60% of children with high fever resulting from malaria is the use of herbal medicine (WHO, 2000), and a significant number of hypertensive patients receiving conventional treatment at the tertiary health facility in Lagos have used complementary and alternative medicine therapies (Amira and Okubadejo, 2007). In addition, effective medicinal plants in the management of various diseases have been documented, including those used for the treatment of opportunistic infections associated with HIV/AIDS (Enwereji, 2008).

Widespread acceptability and usage, particularly in rural areas, is based on traditional medicine's perceived efficacy, availability, low cost, accessibility and conformity with patients' culture and religion, safety and dissatisfaction with orthodox health care services, which are considered expensive.

Implementation challenges

In practice, Nigeria runs a dual health care delivery system: the orthodox system and the traditional system. However, Nigerians are exposed to potential hazards from the parallel use of traditional and orthodox medicines, hence the need for regulation. Some orthodox medical practitioners object to traditional medicine practitioners because of the lack of standardization of dosage regimens and treatment failures, mainly due to poor training. NAFDAC grants approval for the public use of traditional medicines, especially those packaged as tablets, capsules and syrups, following laboratory tests. The practice of traditional medicine and traditional medicine practitioners are controlled by designated boards and committees at the state and local government levels, while the National Traditional Medicines Council (NTMC), at the federal level, develops guidelines (NAFDAC, 2012).

7.9 Emergency care

Overview

An estimated 10–15% of Nigeria's 1.6 million annual deaths take place in emergency departments (Adewole et al., 2012), and 75% of Nigerians have experienced a medical emergency in the last five years (Coker, 2019). The emergency medical services (EMS) system aims to provide safe medical care for

various emergencies, including medical and surgical interventions, obstetrics, paediatrics, accidents and disasters. The system includes components at every health system level, from bystander responses to tertiary interventions. The objective is to reach those in need of urgent medical care and treat those presenting conditions from the scene to the point of definitive care, typically in a hospital's emergency department. The system includes a continuum of prehospital, hospital and rehabilitative care, involving emergency personnel, communication systems, infrastructure, ambulance services, equipment and a functional trauma system in the receiving facility. In terms of linkages to existing primary, secondary and tertiary provision, bystanders refer patients outside hospitals to primary health centres for follow-up care for non-urgent cases. Patients are then transferred to secondary facilities if primary health centres are not able to cope, where EMS will provide emergency interventions. From secondary facilities, patients with severe injuries are transferred to tertiary centres, which manage complex medical problems, perform advanced surgery and administer specialized treatments.

EMS in Nigeria vary depending on the location, with urban areas having better accessibility due to better infrastructure, transport networks and proximity to health care institutions. Urban hospitals have the resources to manage various medical diseases, while rural areas face challenges such as inadequate roads, challenging terrain and limited numbers of ambulances and medical supplies. The federal government has implemented initiatives such as the Rural Ambulance and Maternal Transport initiative to reduce maternal mortality in remote areas by offering prehospital services and EMS. In terms of regional variations, insurgency and conflict affect emergency responses in northern Nigeria, with access to well-equipped hospitals being limited, while the south has a more developed infrastructure and better access to health care facilities.

In 2022, in a bid to boost emergency response, the FMOH launched the National Emergency Medical Service and Ambulance System (NEMSAS) to provide urgent health services to Nigerians at the point of distress, with no cost at the point of care, within the first 48 hours. However, there have been no subsequent reports regarding the initiative's activities or progress.

Organization and governance

The Federal Road Safety Commission (FRSC), National Emergency Management Agency (NEMA) and state medical emergency response team oversee emergency care provision. Until recently, however, services were fragmented, and there was no national coordination or governance structure. There was also no effective national three-digit medical emergency number, nor any shared facilities between states or nationwide data.

However, in 2022, the FMOH implemented NEMSAS, which establishes multisectoral partnerships to support the collaborative rolling out of efficient and effective emergency medical provision nationally. Partner organizations include:

- the Nigerian Road Safety Corps, which is an NGO focused on road safety advocacy, education and awareness that works alongside government agencies such as the FRSC but is not a government entity;
- the National Health Insurance Scheme;
- the Association of Nigerian Private Medical Practitioners;
- the Guild of Medical Directors.

The pilot implementation of the programme is ongoing in the FCT. NEMSAS is expected to reduce mortality by 50%. NEMSAS will coordinate all ambulance services and emergency treatment centres in the country. In partnership with the states, NEMSAS will share guidelines, establish state emergency treatment medical committees and set up state EMS and ambulance systems. NEMSAS and state committees will map existing state-level emergency provision and then provide infrastructure, equipment and personnel for the operation of a medical emergency response centre. A functional state social health insurance agency will support claim management. States will contribute 25% as co-funding.

Key emergency medical services stakeholders

Federal Road Safety Commission

Established in 1988, the FRSC is the country's number one agency on road safety administration and management. The agency has a presence in all states of the federation. Its functions include making the highways safe for motorists

and other road users, checking the road worthiness of vehicles, recommending works and infrastructure to minimize accidents on the highways, and educating motorists and members of the public on the importance of road discipline on the highways (Mac et al., 2019). The FRSC has vehicle ambulances equipped with medical gadgets and devices and a call centre with a unique toll-free number.

National Emergency Management Agency

Established in 1999, NEMA manages medical emergencies, including fire outbreaks, disease epidemics, flood disasters and road traffic accidents (Mac et al., 2019). Like the FRSC, it has a presence in all states. It is equipped with helicopter, vehicle and boat ambulances. It has a call centre with a national toll-free emergency number. The agency has beacon services that use tracking transmitters triggered during an emergency to help rescuers find survivors within the first 24 hours of an emergency (Mac et al., 2019).

State medical emergency response services

The EMS evolved from the use of ambulances for moving corpses pre-1990 to the introduction of a Tokaro EMS in Lagos in 1990 and a Niger Delta EMS in 1995 to aid rescue operations for oil company staff. The first statewide EMS system was established in 2001, namely the Lagos State Ambulance Service, but many of the ambulances were non-functional and the road traffic system at the time limited their capacity to reach emergencies (Cannoodt et al., 2012). Lagos and Rivers states made further attempts at running EMS by acquiring well-equipped ambulances in 2001 and 2002, respectively (Jasper et al., 2019). Other states, such as Oyo, Delta and the FCT, have implemented their own EMS with varying standards and levels of oversight (Oyedokun et al., 2023).

Maitama Hospital, Abuja

Located in Maitama District, Abuja, this federal government-owned medical centre is responsible for providing general medicine and specialized services. The hospital has a well-functioning accident and emergency care unit with vehicle ambulances, medical equipment and first aid devices. The accident and emergency unit call centre – known as the "Compound Unit" – operates a 24-hour service. The emergency call number differs from that of other institutions in the country (Mac et al., 2019). Emergency services are free of

charge, but relatives or victims pay for consumables and blood. The cost is between approximately US$ 161 and US$ 428 depending on the nature of the emergency and the organization involved in the rescue mission (Mac et al., 2019).

Private emergency medical services provision

Because of the government's slow pace in initiating nationwide EMS in the country, the private sector has begun to fill the gap.

Critical Rescue International

In 2001, Critical Rescue International (CRI) became the first formal private organization to provide EMS after a botched attempt by Tokaro EMS to do this in 1992. CRI aims to adhere to international standards and ensure that their ambulance personnel's knowledge is always kept up to date at emergency response services training facilities. CRI employs the services of experienced foreign paramedics to teach Nigerian paramedics.

Emergency Response Africa

Emergency Response Africa (ERA) was launched in 2021 to provide comprehensive prehospital care in Nigeria (Chinonso, 2023). It connects patients to a network of medical first responders, emergency vehicles and verified emergency-ready hospitals. A 24-hour command centre coordinates requests from the ERA toll-free number and mobile application. When a case is submitted, a medical first responder or ambulance is dispatched for immediate medical attention and transport to a health facility. ERA first responders are trained paramedics who stabilize patients and then transport them to an emergency-ready hospital. The network includes 82 verified hospitals in Abuja, Lagos state, Ibadan, Port Harcourt, Warri and Enugu. ERA also employs a motorcycle medic unit for faster first aid and emergency response. ERA offers an annual subscription plan for 35 000 Nigerian naira (approximately US $25) per person, and provides access to emergency services, ambulances and an accident insurance product for additional financial protection.

Implementation challenges

Variation in provision and satisfaction levels

- Each ambulance from the FRSC and NEMA has a nurse and three paramedics when on an emergency rescue mission. The Maitama Hospital has a team of one doctor, three nurses and two paramedics (Mac et al., 2019). The (transport) delay time from the point of call to arrival is 15–30 minutes for Maitama Hospital and NEMA, and 35 minutes for the FRSC (Mac et al., 2019).
- The satisfaction levels with the EMS provided were reported as 24% for FRSC, 36% for Maitama and 70% for NEMA services (Mac et al., 2019). Causes of dissatisfaction included time delays before the arrival of the rescue team; lack of supplies and medications; and, despite FRSC and NEMA services being free, individuals being charged for services rendered by Maitama Hospital (Mac et al., 2019).

Poor sustainability

- In addition to the absence of qualified personnel and relevant ambulance equipment, sustainability is an issue. Most government ambulance services collapsed soon after being established when the government could not continue to inject funds into a system that generated no revenue, which has resulted in significant apathy and distrust for EMS nationally. Evidence suggests that only 3% of Nigerians call an ambulance service to get help during an emergency, despite the fact that the government has approved 112 as Nigeria's toll-free emergency number with national reach for fielding and dispatching distress calls. The vast majority (78%) of Nigerians call family and/or friends or otherwise source their own transport to hospital. On reaching a hospital, a significant proportion (44%) of emergency patients are rejected, have treatment delayed or are referred to other facilities without treatment. Dissatisfaction with emergency treatment is therefore high, with 64% of Nigerians indicating significant dissatisfaction (Coker, 2019).

Low levels of public awareness

- Efforts to sensitize and mobilize the general public around EMS have been limited, contributing to public apathy. Even where government-owned EMS exist, surveys suggest that the majority of the public do not know the emergency number to call, what information to relay or the actions they can take to sustain a patient's life while waiting for EMS to arrive.

Possible reforms

- Commentaries published by health care professionals have characterized deficiencies in the Nigerian emergency care system and offered potential solutions. For example, Nigeria needs to revamp and improve education in EMS, including by providing for functional ambulances, specialists and consumables. Promoting unique call numbers and reducing call times can reduce deaths and disabilities. The benefits of prehospital emergency care can be maximized by training community volunteers in vital interventions such as keeping a patient's airways open, controlling external bleeding and immobilizing fractures using local materials and resources.

7.10 Specialized services

Overview

The public and private sectors provide specialized services in Nigeria. Almost all specialized care services are available in urban areas only. Specialized hospitals in the public sector include national neuropsychiatric hospitals, national orthopaedic hospitals, national eye hospitals and national ear, nose and throat hospitals. In addition, specialized health care services are provided by teaching and specialized hospitals owned by federal and various state governments. These specialized services include but are not limited to cancer diagnosis and care (oncology) (see Section 7.6 for further detail on specialist palliative care provision), cardiology, nephrology and assisted reproduction,

among others. In addition, specialized health services such as dentistry and eye care are also provided in both public and private settings.

Mental health services

Mental illness, including depression, anxiety and schizophrenia, affects 20% of Nigerians (Idoko, 2023). However, stigma and limited workforce capacity or expertise to cater to mental disorders at the PHC level hinder seeking help. The scarcity of psychiatrists, with only 250 for a population of 200 million, highlights the urgent need for attention to mental health in the country. Nigeria is addressing mental health discrimination and stigma through advocacy, education and policy change. Public campaigns, educational initiatives, community engagement programmes and school-based programmes aim to raise awareness and reduce stigma. A holistic approach involving cross-disciplinary collaboration, robust mental health education and community-based awareness-raising initiatives is also being implemented.

Dentistry services

Public dentistry services are typically provided by government-run health centres, community health clinics and hospitals, with dentists, dental assistants and dental hygienists providing care. Private dental clinics, often located in state capitals and commercial districts, are independently run and owned by dentists; they offer services similar to public settings but with individualized attention and cosmetic dentistry options. As at 2012, a total of 446 dental clinics and hospitals provided oral health care services across the country (Adeniyi et al., 2012). More than half of the facilities are located in the southern part of the country. About 50% of providers in the southern zones belong to the private sector, and about 50% of private providers are based in Lagos State alone. The majority of skilled personnel for dental care are located in the southern zones of the country, particularly in cosmopolitan cities such as Lagos and Port Harcourt. The management of these facilities is influenced by their funding lines, which may derive from government (federal or state), private, corporate or faith-based bodies. Most dental facilities are in urban areas.

Eye care services

Nigeria has a potential pool of 550 general ophthalmologists, 1500 optometrists and 170 ophthalmic nurses for specialist training in child eye health. However, there is a shortage of anaesthetists, pathologists and plastic surgeons for child eye health orientation. The Nigerian Paediatric Ophthalmology and Strabismus Society has established a one-year modular fellowship programme, accredited by six centres and taught by existing paediatric ophthalmologists. The programme supports faith-based facilities and short courses for other team members. School eye health is virtually synonymous with sporadic school screening, mainly for refractive errors and prescription of glasses, supported by NGOs, including optometric associations (IAPB, 2015). There is marked maldistribution of the specialized eye health workforce between geopolitical zones, which is highest in the south-west and lowest in the north-east. Even within states, there is rural/urban inequity.

Organization of services

NSHDP II provides direction for implementing these specialized services. Other policies relevant to the delivery of specialist care include:

- the National Eye Health Strategic Plan (2014–2019)
- the NPHCDA's Minimum Standards for PHC in Nigeria (2015)
- the Primary Health Care Under One Roof (2016)
- the National Eye Health Policy (2019)
- the National Eye Health Strategic Development Plan (2024–2028)
- the National Oral Health Policy.

There is no official programme to promote oral health in schools and the promotion of dental health is limited.

Non-state provision

Several NGOs have collaborated with many state governments (e.g. Cross River, Kaduna, Kwara and Sokoto states) to establish eye care programmes aiming for eye care services that are accountable, affordable, equitable, integrated and sustainable (Muhammad et al., 2019). In addition, FHI 360's Integrated Health for

Refugees and Vulnerable Populations in Nigeria project offers gender-sensitive health services to refugees in Cross River State. It also provides capacity-building and emergency preparedness training for people with disabilities.

Referral system

The connection between primary, secondary and tertiary care and specialized health services is made easier by defined referral protocols and pathways. A health worker in a health centre will refer a patient to a secondary care facility for additional assessment, diagnostic testing or treatment by specialists if the patient has a condition that that cannot be treated at the primary health centre. Giving the patient a two-way referral letter or form that includes pertinent medical information and the purpose for the referral is one step in the referral process. Although patients may occasionally be referred straight from the health centre if their condition needs rapid specialized attention, secondary care facilities are the usual source of referrals to specialized centres (see Section 7.3 for further details).

Implementation challenges

Challenges of implementing specialized health services such as mental health services, dentistry services and eye care services include the lack of understanding of the root causes of mental illness, lack of financial support to get mental health treatment, lack of social support (family, friends, neighbours), the fear of stigmatization, and the lack of integration of eye and dental care into PHC. In addition, implementation is held back by a communication gap between health facilities that make and receive referrals, a lack of specialist care capacity, challenges convincing patients of the reasons for referrals, and a lack of ambulances and of bed spaces to accommodate patients and caregivers in health facilities receiving referrals.

7.11 Recent reforms

Nigeria's health care system has undergone significant changes and reforms, which aim to improve service delivery, enhance health outcomes, make health care more accessible and address structural issues, as outlined below

(see Chapter 2 for further details on all health-related policies and health system governance more broadly). The reforms introduced aim to address critical aspects of Nigeria's health care system, but challenges such as funding limitations, infrastructure constraints, cultural barriers and logistical difficulties have impacted their full realization. National and international actors play crucial roles in policy development, implementation and support, yet sustained success requires overcoming these obstacles for effective health care delivery nationwide.

National Health Act 2014

The National Health Act 2014 provides a legal framework for the regulation, development and management of Nigeria's health care system. It established the BHCPF to enhance the financing of PHC, health care access and quality of care. The BHCPF reforms provide many operational challenges, bureaucratic roadblocks and insufficient funding. National government agencies, policymakers, health care institutions and international organizations have supported its implementation. The act was intended to reduce medical tourism in Nigeria since illnesses that could be treated in Nigeria would no longer be referred outside the country. Inadequate financial support, bureaucratic hurdles and challenges in coordinating stakeholders have hindered the full realization of its objectives.

National Health Insurance Authority Act 2022

In 2022, the National Health Insurance Scheme Act of 2004 was repealed by the NHIA Act. Through the promotion, regulation and integration of health insurance systems, the act seeks to achieve UHC for all. The act gives the 36 states of Nigeria and the FCT the authority to create and oversee their own contributory plans and health insurance policies, while ensuring that all of their citizens have access to medical care. There is also a provision for enrolment into complementary private health insurance schemes. The NHIA will, in conjunction with the states of the federation, provide a basic minimum health care package to all Nigerians. This act also provides for establishing the Vulnerable Group Fund to subsidize health care services for vulnerable groups (defined as children aged under 5 years, pregnant women, people

aged over 60 years, the physically and mentally challenged, and the poor) (FGN, 2022c). NHIA accredits health maintenance organizations, mutual health associations and third-party administrators, and performs functions defined in the act, including collecting and promptly remitting contributions. The NHIA has developed strategies, roadmaps and operational guidelines to ensure the proper implementation of the act. Advocacy for financing the Vulnerable Group Fund has also been carried out.

Primary Health Care Under One Roof (2016)

To streamline the management and coordination of PHC services for efficiency, Primary Health Care Under One Roof aims at integrating PHC services under one authority at the state level. States have had varying success in integrating services, and there are still issues with consistent implementation, bureaucratic resistance and funding issues.

Nigeria's Health Sector Renewal Investment Initiative (2023)

The Nigeria's Health Sector Renewal Investment Initiative was presented by the federal government as part of its attempts to attain UHC by 2030. To enhance health outcomes, the initiative will use the BHCPF in conjunction with state governments and development partners to implement a sector-wide approach (SWAp) strategy. It is anticipated that the BHCPF, which represents 1% or more of the Consolidated Revenue Fund, will receive a minimum of US$ 2.5 billion in pooled and non-pooled financing between 2024 and 2026 to enhance the country's primary health system. The plans also include significant investments in health infrastructure and equipment for hospitals, the provision of essential commodities, the expansion of health insurance and heightened attention to the welfare of the health workforce. This includes initiatives to provide at least 17 000 operational PHC clinics throughout all 36 states and the FCT, and these PHC clinics will be linked to a comprehensive emergency care system.

To ensure transparent reporting, the federal government will make resource allocation, releases and results transparent to all stakeholders, including government bodies, nongovernmental partners, civil society organizations and citizens. To address the rising prices of pharmaceuticals, the federal government plans to establish a mechanism for the pooled procurement

of critical pharmaceuticals in 2024. This initiative aims to lower costs and guarantee quality, while making life-saving medications more affordable for the poorest Nigerians.

In the medium term, the President's initiative to unlock the health care value chain will see Nigeria manufacturing an increasing share of its generic drugs, medical devices and associated content, such as vaccines, over time. This will reduce the dependency on external suppliers. The comprehensive strategy outlined involves assessing existing facilities, improving infrastructure, ensuring a sufficient health workforce and actively engaging local communities for feedback. A strategy to actualize this initiative was signed in Abuja by governments at all levels and development partners to commemorate the 2023 Universal Health Coverage Day.

Implementation challenges

Political and institutional challenges hindered implementation. Institutionally, horizontal and vertical fragmentation of authority within the sector impeded coordination. Politically, electoral cycles led to frequent turnover of sectoral leadership, while senior politicians did not intervene to support fundamental institutional reforms. Lack of implementation of some of the reforms at the state and local levels limits the formal powers of coordinating bodies such as the National Council on Health and the Governors' Forum. Nigeria's Constitution does not give the FMOH control over SMoHs or LGAs, limiting top-down accountability for health service delivery (Croke and Ogbuoji, 2024).

Chapter summary

Chapter 7 describes and analyses how and where essential health services are organized, delivered and managed in both the public and private sectors. Nigeria's health system is categorized into primary, secondary and tertiary health care. PHC is overseen by local government councils, while state governments and health ministries are responsible for delivering SHC. Tertiary health care is structured into teaching hospitals, FMCs and specialized medical institutions, but the distribution of tertiary health facilities is uneven.

The PHC level is the weakest level of health care delivery. However, facilities that can deliver essential health services are lacking at the primary, secondary

and tertiary levels. Specialist and emergency services exist but are insufficient. Specialized services are confined primarily to urban areas and their provision is often dictated by funding sources. Referral systems are suboptimal, and many patients bypass lower levels of care to access higher levels of care. Emergency medical care exists, but many communities lack ambulance services and prehospital care, and hospital units are ill-equipped to resuscitate critically ill patients. Palliative care is new in Nigeria, with poor access in rural areas and infrastructure challenges indicative of the larger difficulties in ensuring the fair and equal distribution of health care services. Despite the existence of quality assurance mechanisms, they are not being effectively used.

Strong community-level structures exist to provide health care services to people who lack access, utilizing a mix of public and private sector providers. However, these structures have not yet translated into the scaled-up delivery of essential health services at the PHC level. This discrepancy constrains progress towards achieving UHC and the health-related Sustainable Development Goals, especially in relation to MCH and communicable and noncommunicable diseases.

Traditional medicine services are popular due to their perceived efficacy, availability and cultural compatibility. However, the coexistence of traditional and contemporary medicine poses possible risks, emphasizing the need to regulate and incorporate traditional medicine practices into the health system, to guarantee patient safety and advocate for evidence-based health care practices.

Service delivery reforms will improve basic package provision and thus progress towards achieving UHC, but implementation challenges remain. Recent reforms to allocate at least 1% of the Consolidated Revenue Fund to the BHCPF will improve service delivery, by providing one functional PHC centre per ward and one general hospital per LGA. In addition, it is hoped that recent FMOH policy reforms using the SWAp strategy and the gateways of the BHCPF, especially the NPHCDA and emergency transport gateways, will revitalize service delivery and decrease health burdens. The financial autonomy that was recently granted to LGAs should also enable them to offer better support at the PHC level for better service delivery.

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