COUNTRY: NIGERIA

An Overview of the Health System in Nigeria and the contributions and role of faith-based health providers in the overall health system.

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FAITH-BASED HEALTH SYSTEMS IN NIGERIA

Nigeria - Introduction

Population

Nigeria is located in the West African sub-region and is bordered by Niger in the north, Chad in the northeast, Cameroon in the east, and the Republic of Benin in the west. The National Population and Housing Census reported Nigeria's population as 140.4 million in 2006 with a growth rate of 2.2% (NPC, 2006). With an estimated population of slightly above 182 million in 2015, the United Nations ranked Nigeria as the seventh most populous country, and one of the fastest-growing populations in the world (UN, 2015). About a quarter (24.9%) of the Nigerian population are women of reproductive age (15-49 years) and 31.7% are young people aged 10-24 years. Nigeria has a young population structure: 62% of the population is in the age range of 0 to 24 years, and the median age is 17.9 years. Life expectancy in Nigeria was 53 years by the end of 2014 (World Bank, 2016). This figure is lower than the average of 59 years for sub-Saharan Africa and 67 years for lower-middle-income countries (World Bank, 2016).

Nigerian Health Systems

All three tiers of government Federal, State, and Local share responsibilities for providing health services and programs in Nigeria. The Federal Government is largely responsible for providing policy guidance, planning, and technical assistance, and coordinating the state-level implementation of the National Health Policy, and establishing health management information systems. The Federal government is responsible for disease surveillance, drug regulation, vaccine management, and training health professionals. The Federal Government is also responsible for the management of teaching, psychiatric and orthopaedic hospitals and also runs some medical centers.

Health facilities in Nigeria are all classified based on their management or the services they render. Under management classification, there are private hospitals and government hospitals. On the other hand, if they are classified by the services rendered, Government Hospitals are classified the same as those in the FBO and private sectors since they all operate under the same regulations and standardizations. The 2014 National Health Act classifications of health services are Primary health care, Secondary health care, and Tertiary health care.

The responsibility for the management of public health facilities and programs is shared by the State Ministries of Health, State Hospital Management Boards, and the Local Government Areas (LGAs). Faith-based and private health facilities play an important role in the provision of health services in Nigeria. The faith-based health response in Nigeria is being implemented at two levels. The first level is at the health facilities involving the direct provision of health and medical services. Here it is estimated that FBO and the private sector contribute up to 70 % of the total health services provision in the rural areas and the hard-to-reach places in Nigeria.

The second level is a non-facility response where the health response focuses mainly on advocacy, community mobilization, prevention, care, and support services. At this level, the impact of FBOs has also been significant. They have been a critical part of the multi-sectoral response to HIV/AIDS through their network of community systems. FBOs are an integral part of the community and their leaders have

strong voices in influencing policies, calling for justice, addressing stigma and discrimination, and mobilizing their members and the community at large to take up testing, prevention, and treatment services.

Faith-Based Health Facilities

The exact number and classification of health facilities in Nigeria is not known. Different sources have different figures. For example, the 2019 Nigerian health facility register, produced by the federal Ministry of Health (MOH) put the total number of health facilities in Nigeria at 40,821. This is broken down into: 34,675 primary health care facilities: 5,780 secondary care facilities; and 166 tertiary care facilities. Regarding classifications, health facilities considered to be managed under the Islamic religious principle are classified as private due to the nature of their ownership and management. In many databases and analyses of health facilities in Nigeria, faith-based health facilities and other nongovernment health facilities are normally lumped together as "private" health facilities.

Number of Health Facilities by Ownership and Category

	Ownership Category	**Health Facility Category**			**Total**
		Primary	**Secondary**	**Tertiary**	
1	MOH/Public facilities	28,448	1,232	105	29,785
2	Faith Based Facilities (CHAN)	432	194	15	641
3	Other FBOs and Private /Islamic Health Facilities	5,795	4,354	46	10,195
	National Total	34,672	5,780	166	40,621

Source: Triangulated from several sources including Nigerian Health Facility Register FMOH (2019)

Christian Health Association of Nigeria (CHAN)

CHAN is a coordinating body for health services carried out by various church denominations in Nigeria. Its member institutions are the longest serving in Nigeria. Presently, CHAN has about 685 registered member institutions (MIs), including medical and health training institutions. CHAN provides a variety of services to strengthen MI capacity. CHAN also manages six functional medical supplies depots located across the country. As of 2020, available records from CHAN indicate that 641 health facilities are managed by CHAN members. The 641 health facilities are divided into 432 Primary Health Care, 194 Secondary, and 15 tertiary health care services levels.

Although the MOH is the leading provider of health services in Nigeria, the private / faith-based health facilities play an important role in increasing access to health care service delivery through their networks that reach even the most remote communities. They also provide a significant percentage of all health care provision in Nigeria. In terms of the actual service delivery, the private/ faith-based health care system contributes over 65%[1] of health services delivery despite owning only 27% of health

[1] It was based on an WHO Report that says; 'Moreover, both private and public sectors provide the orthodox health services, with the private sector made up mostly of Faith-Based contributing 30-70% of services (WHO

facilities in Nigeria. This is mainly because 89% of the p rivate/FBO facilities are located in rural and hard-to-reach communities where 70% of the Nigeria population resides according to the 2006 Nigerian Census. Furthermore, the first medical centers in Nigeria were established in the rural areas by Christian missionaries (Onokerhoraye,1982).

The medical centers established by the missionaries were largely concentrated in rural areas because of the goal of evangelism. These medical centers, however, were merely mobile clinics and at most community dispensary out-posts to treat primary health problems, snake bites and minor injuries. It was in the later years when the British rule had been well established that the administrators promoted the creation of medical centers in the real sense of hospitals to take care of epidemics, such as sleeping sickness, smallpox, malaria and other primary health concerns (Onibonoje, 1985; Aluko- Arowolo, 2006).

The Islamic Medical Association of Nigeria

The Islamic Medical Association of Nigeria (IMAN) was founded in the Holy City of Makkah in the year 1989. The objective was to bring into closer union all Nigerian Muslim health care professionals, to render greater services to humanity. The Islamic faith in Nigeria has a slightly different formation, ownership, and control of Islamic faith-based health care institutions compared to the Christians. The facilities are privately owned but operated under Islamic religious principles. That is why they are classified as private health facilities.

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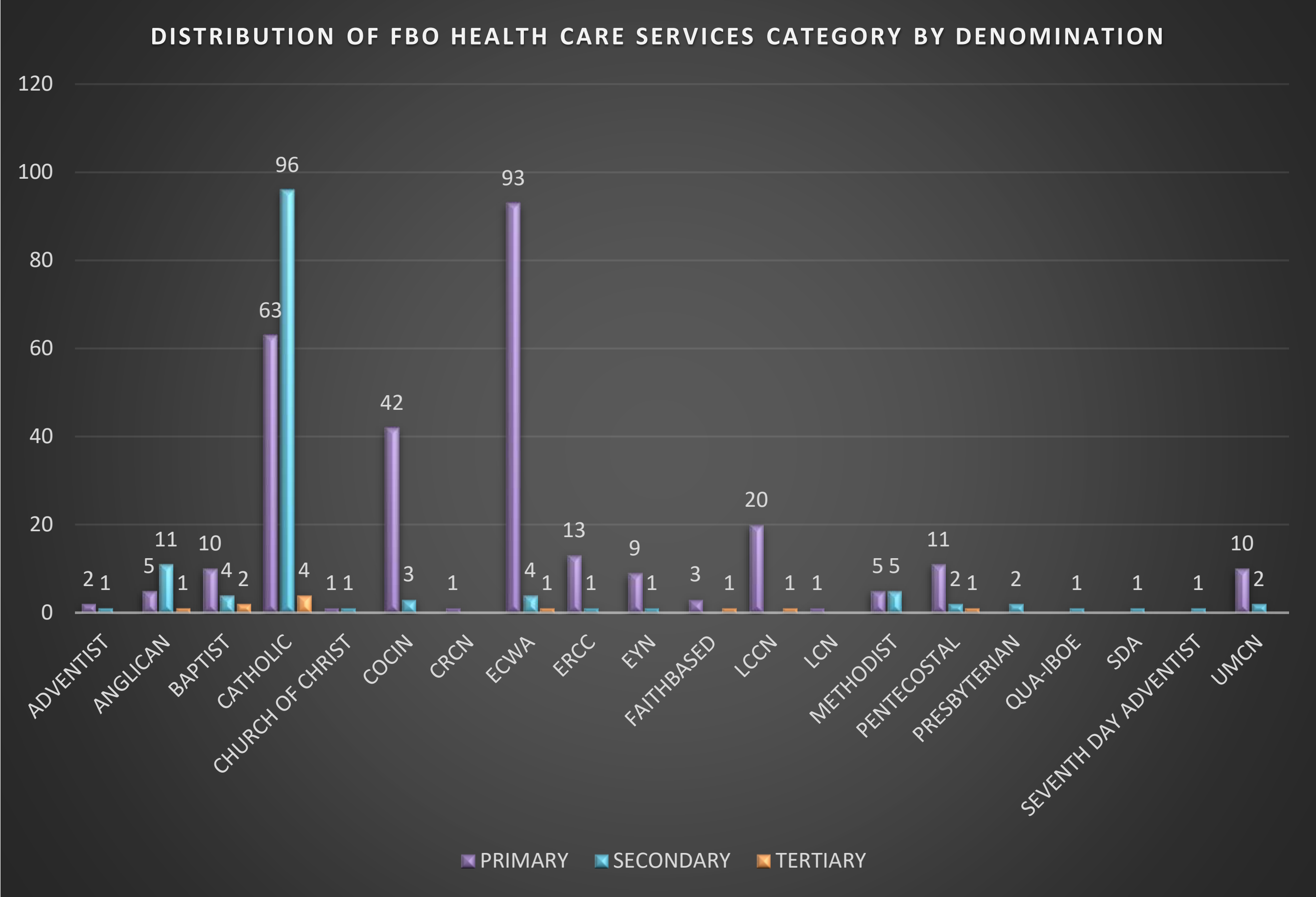
https://www.capacityplan.org/files/resources/issue-brief4FBOs) despite owning only 27% of health facilities. FBO Health Facilities also provide services to 4 out of 10 Nigerian (page 1, CHAN Advocacy Brief for Legislators)



Governance and Management of Faith-Based Health Facilities

The management and governance structure of faith-based health care facilities in Nigeria varies among different denominations. For the Catholics, Anglicans, Methodists, the constitution of the governing council, and management board of a health care facility are largely under the Bishop's office with a reporting line to the National Secretariat of the Church. Tenure and other matters are handled at the Bishop levels. On the other hand, other congregations like the ECWA (Evangelical Church Winning All), NKST ("Nongu u Kristu u ken Sudan hen Tiv" which is interpreted "Church of Christ in Sudan among the Tiv"), COCIN (The Church of Christ in Nations (COCIN), formerly Church of Christ in Nigeria, and Christ Apostolic Church, etc., the governing councils and the management boards are constituted and managed directly by the Health Secretariat of the Church.

Health Care Services Financing

The federal government, the state government, and the local governments respectively are responsible for all financial aspects, including personnel costs, consumables, running costs, and capital investment in the public health sector. The federal and state governments are under obligation to allocate not less than 15% of the state budget to health services. This has however not happened since 2001. The government has not been able to even meet the 6% mark. High priority is given to primary health care services with particular focus to the fewer privileged areas and groups. Community and financial sector resources are mobilized in the spirit of self-help and self- reliance.

Unlike the public health systems with regular funding streams, financing of the faith-based health care sector in Nigeria is primarily 70% from service charges, 20% from church donations and offerings through the health departments while 10% comes from philanthropists, government or other donors. Donations from the government to faith-based health facilities are common in the Nigeria Middle belt, South West and South East regions where there are large groups of inhabitants from a particular faith. Government support comes in the form of ambulances, construction of patient wards, laboratory or road construction, drug donations, hospital equipment, or even joint ventures between the Government and the facility.

In Nigeria, public funding accounts for about 25% of total health spending while the private sector (largely faith-based) provides 75% of the funding, with household out-of-pocket expenditure accounting for 95% of the private sector expenditure. Another existing major health financing mechanism in Nigeria is the Formal Sector Health Insurance Programme (FSSHIP), which is run by the National Health Insurance Scheme (NHIS). It is a mandatory scheme for employees in the formal sector. Most private/FBO health facilities run the NHIS program in Nigeria for both government and private sector workforce. The NHIS contracts private, for-profit Health Maintenance Organizations (HMOs) to administer the purchasing system and channel resources to providers. Healthcare providers receive capitation payments for primary healthcare services and fee-for-service for secondary services.

Availability of Human Resources for Health

The exact number of health workers in the Nigerian health system is not well documented, especially those working in the faith-based sector. There is currently no consolidated database of faith-based health care workers, although CHAN is working on developing one. However, Nigeria has the largest human resource for health in Africa. As of 2007, there were 52,408 registered medical practitioners in Nigeria but only 14,000 applied for registration to practice. There were also 128,918 nurses, and 90,489 midwives registered, which translates into about 35 doctors and 86 nurses per 100,000 population respectively. As is found in most African countries, many qualified medical practitioners work in or are located mostly in urban areas. About 60 % of the states in Nigeria provide incentives to health workers that volunteer to serve in rural areas, while others make rural service a condition for certain promotions

Training Health and Medical Workers

Health workers receive training in designated health /medical training institutions. Presently, these institutions are poorly distributed in favor of the southern parts of the country. Furthermore, nursing and midwifery schools have limited the enrollment of new students to 50 per annum to ensure that standards are maintained.

Health workers are trained at various professional levels including certificate, diploma, graduate, and postgraduate. A major constraint on the number of trained health workers is the acute shortage of intern posts for doctors, dentists, pharmacists, and laboratory scientists as well as a shortage of residency posts for doctors and dentists. There is also no school of public health in Nigeria, although most medical schools have small departments of community health, mainly for undergraduate training. The lack of public health schools focused on postgraduate professional education, leadership, and research severely limits the professional health workforce. Also, the lack of bachelors and masters-level public health programs, and service management training, results in a weak capacity to promote public health programs and to lead health services and systems more effectively.

Some of the problems of the health workforce in Nigeria include low salaries, health worker shortages, particularly in rural and remote areas, skill-mix imbalances characterized by a curative care bias, poor distribution of specialists, poor working environment, a weak evidence base, the challenge of HIV/AIDS, out-migration, and inadequate investment in the health sector.

Distribution of FBO Healthcare Training Institutions by Denominations

Denomination	**College of Health Technology**	**Schools of Medical Laboratory**	**Medicine**	**Nursing**	**Midwifery**	**Total**
ANGLICAN				4		4
ERCC	1	-	-	-	-	1
ADVENTIST (SDA)			1	-	-	1
BAPTIST		1		3	2	6
CATHOLIC		8		10	12	30
ECWA	1		1	1	1	4
NKST	1			1	1	3
TOTAL	3	9	2	19	16	49

**** The numbers and details of public health care training institutions data were not available in the Federal Ministry of Health Data Repository.*

Many graduates of Nigerian faith-based health care training institutions are working in the United Kingdom, and the United States and for Nigerian government facilities.

Health Commodities and Drug Supply Chains

Although there is no unified system of medicine procurement/supply chain under the federal and state governments, the procurement arrangement of medicines and related consumables are health program based. Procurement processes vary from state to state and from health facility to health facility, although CHAN-Medipharm is an exception .

CHAN Medi-Pharm, is the drug supply and logistic arm of CHAN which is responsible for procurement, manufacturing, warehousing, and distribution of drugs and other health supplies across the country. CHAN[2] operates a decentralized system of administration to ensure effective service delivery. Zonal offices have been established in four locations: Jos, Owerri, Ibadan, and Numan Zones and state committees, comprised of MIs in those regions, contribute to decision-making processes at the local level.

[2] It is a member of the Africa Christian Health Association Platform (ACHAP), Christian Connections for International Health (CCIH), Ecumenical Pharmaceutical Network (EPN), and the Faith-Based Organization Network-Nigeria.

CHAN Medi-Pharm works with over 600 faith-based health facilities in Nigeria and is in partnership with Christian Connections for International Health (CCIH) and Ecumenical Pharmaceutical Network (EPN). The partnership endeavours to ensure the supply of quality medicines and other medical supplies that ordinarily would not have been possible for the individual faith-based health care facilities. Recently, DFID; PATH2 Project appointed CHAN Medi-Pharm to manage the program's multi-disease essential drug supply to both public and private facilities in Benue, Nasarawa, Taraba, and Kogi States. CHAN's link to the government has been largely program based with little or no standout commitment to a sole agency for government medicine and related consumables procurement.

Health / Medical Information System

In Nigeria also, there is no institutionalized structure for submission of data by the faith-based hospital to the national health information management systems. The HMIS exists primarily for the government health facilities and institutions. Many faith-based health facilities, including hospitals, do not provide HMIS data to the Federal Ministry of Health for informed decision making. However, at the state levels and particularly at the local government levels, they work closely with some mission hospitals to collect data on immunization and other related information as they supply the immunization material and other related items.

FBO Partnership with Government

In Nigeria, partnership by the faith-based institutions and the government is basically in the secondment of government healthcare staff to the faith-based health care facilities. This can be found in states like Kogi, Taraba, Anambra, Benue, Imo, Edo, and the Cross-River States in Nigeria. However, for intervention programs especially, Global Fund and PEPFAR, CHAN Medi-Pharm provides warehousing and logistics for medical supplies. The federal government has not supported CHAN who has a direct relationship with medical supplies producers prequalified by the World Health Organization. CHAN Medi-Pharm supplies government health facilities for specific programs especially on immunization where either public or private/faith-based facilities are involved. Another partnership worthy of mention here is the secondment of doctors from the University of Jos Teaching Hospital to Vom Hospital, O.L.A, Bigham, and Seventh Day Adventist Hospital Gindiri.

Conclusion

In Nigeria, the contributions and strength of the FBO health sector have remained inadequately documented and harnessed. Understanding the contribution of faith-based organizations in health care will help encourage resources to help FBOs increase their efforts and realize their potential to provide even more care in the country.

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