



HEALTH WORKFORCE COUNTRY PROFILE FOR NIGERIA

FIRST EDITION

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ACRONYMS

ACOSHED	African Council for Sustainable Health Development
AIDS	Acquire Immune Deficiency Syndrome
CHAN	Christian Health Association of Nigeria
CHEW	Community Health Extension Worker
CHO	Community Health officer
CIDA	Canadian International Development Agency
CMR	Crude Mortality Rate
CSM	Cerebro-Spinal Meningitis
FCT	Federal Capital Territory
FMC	Federal Medical Centre
GCE	General Certificate of Education
GDP	Gross Domestic Product
HH	Household
HIV	Human Immuno-deficiency Virus
HRH	Human resources for health
IMR	Infant Mortality Rate
LGA	Local Government Area
MOH	Medical Officer of Health
NDHS	National Demographic and Health Survey
NFS	National Fertility Survey
NHA	National Health Accounts
NGO	Non Governmental Organisation
NNMR	Neo-Natal Mortality Rate
NYSC	National Youth Service Corps
PATHS	Partnership for Transforming Health Systems
PNNMR	Post Neo-Natal Mortality Rate
TB	Tuberculosis
THE	Total Health Expenditure
THE	Total Government Health Expenditure
TPHE	Total Private Health Expenditure
U5MR	Under-5 Mortality rate
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASCE	West African School Certificate Examination
WHO	World Health Organisation

EXECUTIVE SUMMARY

Nigeria is the most populous African country with a population of approximately 140,003,542. It is located at the eastern edge of the West African sub-region.

Since the restoration of civilian governance in May 1999 there has been a general reform in the country for improved and focussed development including re-engineering of the economy, which has translated into economic growth. The country has a predominantly young population (45%), with the disease profile of both the developed (non-communicable) and a developing country (communicable).

Health System

Nigerian health system includes orthodox, alternative and traditional systems of health care delivery. The Government recognises and regulates these three systems. There are three levels of health care delivery: primary, secondary and tertiary. These are managed by Local, State and Federal Governments respectively. The formal health sector is operated with primary health care as the cornerstone of the National health policy. In 2004, a health sector reform was introduced to address the apparent lack of accountability in the running of the health system. There is appreciable commitment of resources to ensure the attainment of the Millennium Development Goals (MDGs) to alleviate poverty and improve the health status of the citizens. There is a demonstrable improvement in political commitment to health issues as exemplified by the commitment to address health workforce issues.

Nigerian health status indicators are very poor with very slow improvement in key health indicators. Today Nigeria ranks among the countries with highest child and maternal mortality rates. The health sector is characterised by wide regional disparities in health status, service delivery, and resource availability. More health services are located in the southern states than in the north. The formal health information system is at the early stage of implementation. However reliable health indicators are available through by the Federal and State Ministries of Health, the National Population, and Federal Bureau of Statistics with significant support of the partners.

Data on health workforce

There are 52,408 Nigerian Doctors on the medical register as at December 2007, however only 14,000 doctors paid the annual practicing licensing fee for that year. It should be noted that the medical and indeed the nursing register has never been pruned of those Doctors that died or have migrated out of the profession or into foreign countries. There are 128,918 nurses and 90,489 midwives on the register, but only a fraction of these pay the required practicing licensing fee. Nurses in Nigeria are required to pay their licensing fees once in 3 years. There are 13,199 pharmacists, 840 radiographers, 1,473 physiotherapists, 12,703 medical laboratory scientists, and 19,268 Community Health Officers. All these health workers are required to pay annual practicing licensing fees.

The main sources of data are the Health Professional Regulatory Agencies. These agencies collect data on State-by-State distribution of health workers, the age and gender distribution, the state of employment, the type of employment, proxy data on Nigerian health workers in the Diaspora, and the distribution of health training institutions. Additional information is obtained from Professional Qualifying agencies like the National Postgraduate Medical College of Nigeria, and the West African Health Examination Board. Data could not be obtained from the West African Postgraduate

Medical College, which produces specialists in Medicine and Dental Surgery, as the data from that body has not been disaggregated for candidates' country of origin. The National Universities Commission provided data on enrollment of students in tertiary health training institutions, and production of health workers by these institutions.

Distribution of health workforce

Nigeria has one of the largest stocks of health workers in Africa comparable to Egypt and South Africa but it should be noted that the figures for Nursing and Midwifery and the Medical and Dental Councils have never been audited for deaths, retirements, migrations and so on. Indeed a definite survey is required to obtain the precise numbers and location of Nigerian health workers. This may require registration of health workers using the Internet, as this will be able to capture Nigerian health workers in the Diaspora.

The health workers are poorly distributed and in favour of urban, southern, tertiary health care services delivery, and curative care. For some cadres of health workers more than 50% work in the South Western part of the country with the majority living in the commercial city of Lagos. Efforts have been made to make health workers available in the rural areas. About 60% of the states in Nigeria, provide rural incentives to health workers that volunteer to serve in the rural areas, while others make rural service a condition for some critical promotion. There is the National Youth Service Corps (NYSC) that is mandatory for all new university and polytechnic graduates in Nigeria. Hitherto, nurses and midwives did not participate in the one-year service, because their training was not university based. However to ensure that nursing and midwifery services are available in all villages and towns in the country, nurses and midwives will now have to participate in the one year National service. This is a recommendation of the Committee that was established to reduce the Maternal Mortality Rate. Nurses and midwives now serve in the National Youth Service.

Health workforce production

Health workers are produced in designated health training institutions. There is poor distribution of these training institutions in favour of southern parts of the country. Workers are produced at various educational levels including certificate, diploma, graduate, and postgraduate. Minimum qualifications for registration as health workers are graduate level training.

In Nigeria, there are 26 accredited medical schools, 86 approved schools of nursing, 77 approved school of midwifery, 12 medical laboratory schools, 6 schools of physiotherapy, 5 schools of radiography, 9 schools of pharmacy, 19 schools of pharmacy technology, 40 schools of health records, 13 schools of community health officers, 43 schools of community health extension workers, 4 schools of dental technology, 6 schools of dental therapy, 3 schools of optometry.

Presently there is inadequate production of radiotherapists in particular. This is due to the discontinuation of the training of diploma radiotherapists. However there is excess production of Community Health practitioners as reflected in the poor absorptive capacity of many states in the Southern parts of the country for this category of health workers. Another dimension to health worker production is the acute shortage of internship posts for doctors, dentists, pharmacist and medical laboratory scientists. There is shortage of posts for residency (postgraduate training) for doctors and dentists. Nursing and midwifery school has limited the enrolment of new students to 50 in order to ensure that standards are maintained.

Health workforce utilisation

Health workers are employed both in public and private sector. In the private sector, though there is optimal utilization of workers, however, salaries and wages are far below those of their contemporaries in the public sector. Private sector workers used to earn more than public sector workers before 1990, however in the public sector, there had been regular salary increases over the years. This has resulted from negotiations prompted by health workers associations, that have been influencing the salary of health workers in the public sector. The Nigerian Medical Association (NMA) is particularly articulate and powerful. Indeed another negotiation is presently in progress, which is expected to result in significant increase in remuneration of health workers in the public sector. It should be noted that this increase would affect Federal health workers (Health is on the concurrent list in Nigeria, that is each level of government determines what it spends on health). State governments and Local governments would make some salary increases for their health workers at a later date. However predictably those increases would fall short of the increase for workers at the Federal level. However even Federal health workers do not earn what their contemporaries working for international agencies, corporations and oil companies earn. In the public sector, health workers are not utilized as efficiently as those in the private sector. This becomes evident during the nights and weekends when there is poorer provision of workers in public health facilities. Currently, the health workforce is top heavy due to freeze on employment in the past; junior workers deliver the crucial weekend and night duties. The conventional duty roster deploys workers in three shifts of morning, afternoon and nights. However some states like Lagos States have only two shifts namely morning (8.00 a.m. to 4.00 p.m.), and night (4.00 p.m. to 8.00 a.m.). The night shift is therefore for a period of 16 hours. In a 7-day cycle the worker does 2 mornings, 2 nights and 3 off days. There is however no change in remuneration.

Governance of HRH

There are 774 Local Government Authorities (LGAs) and all these provide primary health care services. Each LGA is headed by a political head designated the Chairman of the LGA. Most LGAs in the Southern parts of the country and in some states in the North are headed by The Medical Officer of Health.

There are 36 states in Nigeria and these have Governors as their political heads. State Commissioners for Health are also political heads of the Ministries of Health, and Directors in the State Ministries of Health are the professional heads. Of interest is the State Council of Health arrangement whereby all stakeholders on health in the State including Chairmen of the LGAs are brought together to discuss health issues and make recommendations. At the Federal level, the President of the country is the political head of the country, and the Minister of Health is the political head of the Federal Ministry of Health. At various times there is also appointed a Minister of State for Health. The professional heads are the Directors of the various Departments of the Ministry. The National Council on Health (NCH) is the meeting of the Minister of Health and the Commissioners of Health of the 36 States and the Federal Capital Territory whereby consensus on health issues are obtained at the National level. The NCH is the highest policy making body on health in the country. Nigeria has an approved policy document for Human Resources for Health; the document was approved at the 50th National Council of Health meeting in Abuja in January 2007. The Strategic plan of action to implement the Human Resources for Health policy has been drafted. The Strategic plan is about 90% completed; the outstanding issue is the Workforce Projection for Nigeria. Presently the human resources for health programme is poorly funded.

Health workers remunerations are slightly higher than those of non-health workers, mainly because of the call duties health workers perform. Health workers are however dissatisfied with their current

remunerations. Efforts to singly increase the remuneration of medical doctors are resisted by the other health professional groups.

Health workforce issues are being closely addressed in the country because of the hope of the country to attain the Millennium Development Goals. However more resources need to be allocated to the Human Resources for Health programmes all over the country to make significant progress.

INTRODUCTION

The Human Resources for Health (HRH) profile for Nigeria is a collaborative product of the Ministry of Health Nigeria and the Africa Health Workforce Observatory, which is hosted at the World Health Organization Regional Office for Africa in Congo Brazzaville.

The HRH profile is designed to be a live document, which will be updated at least biannually. It aims to serve as a tool for providing a comprehensive picture of the health workforce situation in the country. The HRH profile seeks to strengthen the human resources information system in the country by establishing baselines and trends, facilitate information sharing and cross-country comparisons, and contribute towards producing regional HRH profiles, and overall evidence to inform decisions and policies.

The HRH profile can be used:

- to describe the HRH policies and management situation in a comparable way;
- to highlight challenges and areas that require more in-depth analysis
- to aide in monitoring the HRH stock and trends in the country, and
- to communicate with and between policy-makers and stakeholders in the country.

The HRH profile is prepared by country experts in collaboration with the staff of the Africa Health Workforce Observatory. In order to facilitate comparisons between countries and over time the profile is based on a template, prepared by the secretariat of Africa Health Workforce Observatory through consultations. The template provides the detailed guidance needed to complete the HRH profile.

Preparing the HRH profile posed a number of challenges. There is very little information on health workforce particularly their distribution, policies related to motivation and incentives, regulation. Due to lack of a single data source, multiple sources have been used to collect information on HRH.

The HRH profile for Nigeria begins with a brief overview of the geography, history and the political context of Nigeria. It then describes the current health care situation in the country, elaborating on health care financing and health information system. Section 3 provides information on health workers stock and distribution by category and geographical distribution. Section 4 and 5 describes Human Resource production and utilization. It discusses the migration of health care workers from Nigeria. The profile ends up with information on governance for HRH, and a discussion on policies and regulations. Data and tables are used in each section to support the findings.

1. COUNTRY OVERVIEW

1.1 Geography and demography

Nigeria came into existence as a nation-state in 1914 through the amalgamation of the North and South protectorates. Before 1994, there were various separate cultural, ethnic, and linguistic groups, such as the Oyo, Benin, Nupe, Jukun, Kanem-Bornu, and Hausa-Fulani empires. These peoples lived in kingdoms and emirates with traditional but sophisticated systems of government. There were also other relatively small but strong—and indeed resistant—ethnic groups (e.g., Ibo, Ibibio, and Tiv). The British established a crown colony type of government after the amalgamation. The administration was managed by the British until 1942, when a few Nigerians became involved in the administration of the country.

In the early 1950s, Nigeria achieved partial self-government with a legislature in which the majority of the Nigerians were elected into an executive council. In 1954, Nigeria became a federation of three regions and remained so until its independence in October 1960, with the Lagos as the Federal Capital Territory. Three years later, on October 1, 1963, Nigeria became a republic.

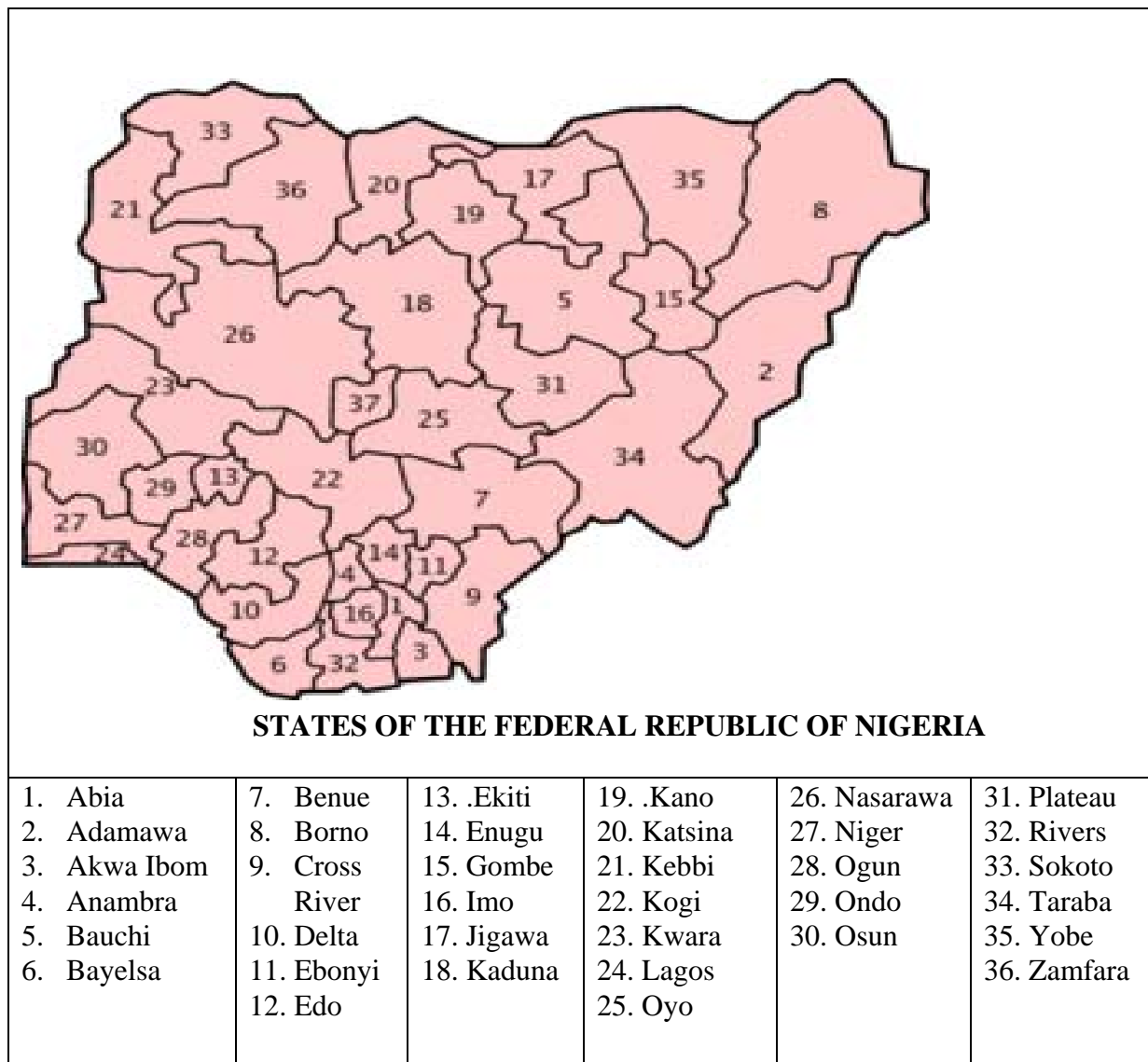
Nigeria has many social groups with distinct cultural traits, which are reflected in the diverse behavior of the people. There are about 374 identifiable ethnic groups; the Igbo, Hausa, and Yoruba are the major groups.

Nigeria lies between 4°16' and 13°53' north latitude and between 2°40' and 14°41' east longitude. The country is in the West African sub region and borders Niger in the north, Chad in the northeast, Cameroon in the east, and Benin in the west. To the south, Nigeria is bordered by approximately 800 kilometers of the Atlantic Ocean, stretching from Badagry in the west to the Rio del Rey in the east. With a total land area of 923,768 square kilometers, the country is the fourth largest in Africa.



<http://www.nigeria-law.org/WorldMap.jpg>

Presently, Nigeria is made up of 36 states and a Federal Capital Territory (FCT), which are grouped into six geopolitical regions: North Central, North East, North West, South East, South, and South West. There are also 774 constitutionally recognized Local Government Areas (LGAs) in the country.



Nigeria is diverse climatically and topographically. It exhibits a great variety of relief features, encompassing uplands of 600 meters above sea level to 1,300 meters on the North Central and the east highlands and lowlands of less than 20 metres in the coastal areas. The lowlands extend from the Sokoto plains to the Borno plains in the North, the coastal lowlands of Western Nigeria, and the Cross River basin in the east. The highland includes the Jos Plateau, the Adamawa highlands in the North, extending to the Obudu Plateau and Oban Hills in the South East. Other topographic features include the Niger-Benue Trough and Chad Basin.

Nigeria has a tropical climate with wet and dry seasons associated with the movement of the Inter tropical Convergence Zone north and south of the equator. The dry season occurs from October to March with a spell of cool and dry, dusty winds in the north in December and January. The wet season occurs from April to September. The temperature oscillates between 22° and 40°C, while rainfall ranges from 2,650 millimeters in the southeast to less than 600 millimeters in some parts of the north, mainly on the fringes of the Sahara Desert. The vegetation that results from these climatic

differences consists of mangrove swamp forest in the Niger Delta and Sahel grassland in the north. Within a wide range of climatic, vegetation, and soil conditions, Nigeria possesses potential for a wide range of agricultural production.

The population of Nigeria as reported by the 2006 census was 140,003,542. It is predominantly rural; approximately one-third live in urban areas. The current projections are that the population of Nigeria will be 152,229,398 by 2009. 45% of the population is under 15 years of age. Nigeria has an annual population growth rate is 2.83% and the male female ratio is 105%. The growth rate and the male sex ratio has been constant from 2003- 2006 (table 1.1).

Table 1.1 Population distributions by Sex

Year	Total	Male	Female	Male/Female (%)	Growth rate (%)
2003	128,450,450	67,436,486	61,013,964	105%	2.83%
2004	132,191,469	69,400,521	62,790,948	105%	2.83%
2003	136,041,442	71,421,757	64,619,685	105%	2.83%
2006	140,003,542	71,709,859	68,293,083	105%	2.83%

Source: National Population Commission, 1991, 2006 (Estimates based on 2.83% Growth Rate and working back from 2006 census)

The 1981-1982 Nigeria Fertility Survey (NFS) was the first nationally representative survey on fertility, family planning, contraceptive use, and related topics. The first Nigeria Demographic and Health Survey (NDHS) was conducted in 1990. In addition to the topics covered by the NFS, the 1990 NDHS collected information on maternal and child health. In 1994, the first sentinel survey was conducted to serve as a baseline study to monitor the various projects designed to achieve the objectives of the National Population Policy, followed by another in 2000. In 1999, and 2003, NDHS were repeated. The Total Fertility Rate by the 2003 NDHS is 5.7, the neo-natal mortality rate is 48 per 1000 live births, the infant mortality rate is 100 per 1,000 live births, and under-5 mortality rate is 201 per 1000 live births.

1.2. Economic context.

Nigeria's economic history and development have been closely tied to its agricultural sector. Before the discovery of oil, the country depended almost entirely on agriculture for food and on agro industrial raw materials for foreign exchange earnings through commodity trade. Agriculture provided gainful employment to over 75 percent of the country's labour force and satisfactory livelihood to over 90 percent of the population at the time of the country's independence. Over the years, the dominant role of agriculture in the economy, especially in terms of the country's foreign exchange earnings, gave way to petroleum.

Since 1980, oil production has accounted for more than two-thirds of the gross domestic product (GDP) and more than 80 percent of total government revenue. The country is the 12th largest producer of petroleum in the world and the 8th largest exporter, and has the 10th largest proven reserves and is also a founding member of Organization of Petroleum Exporting Countries. To date, the government has largely controlled vast industrial and commercial enterprises; however, there is now a vigorous drive to privatization. There are also large, multinational companies, as well as organized small-scale enterprises.

Economic policies have become more favorable to investment since 1999. Consequently, there has been an improvement in the performance of the domestic economy. Nigeria's GDP was estimated at 2.7 percent in 1999, 2.8 percent in 2000, and 3.8 percent in 2001. The GDP in 2003, 2004, 2005, 2006 and 2007 are 3, 7.1, 6.2, 6.9 and 5.3% respectively.

The civilian administration in Nigeria has recognized the importance of privatization in the restructuring of its economy. The country embarked on a broader economic reform and liberalization programme designed to restore macroeconomic stability, achieve faster sustainable growth, raise living standards, and reduce poverty. The reform programme aimed at promoting greater private sector participation in economic activity, and it included the maintenance of sound macroeconomic policies, as well as deregulation, with emphasis on power, telecommunications, and downstream petroleum sectors. It is too early to determine the impact of privatization and liberalization on the Nigerian economy. It is expected that these economic policy reforms, combined with investments in human resources and physical infrastructure, as well as the establishment of macroeconomic stability and good governance, are essential to achieve a high rate of self-sustaining, long-term economic growth.

Table 1.2 Economic indicators

Indicators	2005	2006	2007	Source & year
GDP (real growth)	6.2%	6.9%	5.3%	National Bureau of Statistics
National Debt	\$22.5 billion	\$2.07 billion	\$3.39 billion	Debt Mngt office, Nigeria 2007, World Bank 2007
Economic Aid	\$5.85 billion	\$6.4 billion	\$6.437 billion	Central Bank of Nigeria 2007
Proportion of budget spent on health	-	-	4.3%	NHA Report 2003, WHO 2006
Proportion of population living below poverty line	56.8%	58%	60%	National Bureau of Statistics,
Unemployment rate	-	-	5.8%	2006 estimates
Inflation rate	12.3%	10.1%	8.2%	Central Bank of Nigeria 2007

Sources: Central bank of Nigeria, National Bureau of Statistics, Debt management office of Nigeria, National Health Account Report,

1.3 Political context

In the Nigerian Constitution of 1963, health is on the concurrent list of responsibilities with the exception of international health, quarantine and the control of drugs and poisons which is exclusively the responsibility of the Federal Government. The Constitution assigned specific responsibilities to the State and Local Governments.

The Nigerian Constitution of 1999, which is the operative document, is almost silent on health care delivery except the vague reference made on Local Governments' responsibility for health. In section 45 the constitution has made provision for the overriding of individual rights, if it is in the interest of, among other things, public health. There is at present no National Health Policy stating the roles and responsibilities of each tier of government.

1.4 Health status

With a population of more than 140 million (National Population Commission, 2007), Nigeria is the most populous country in Africa. The latest estimates (NPC 2007) put life expectancy in Nigeria at 44 years. 72% urban population and 49% of rural population have access to safe drinking water.

Improvements in key health indicators have been slow and today Nigeria ranks among the countries with the highest child and maternal mortality: the Under-five mortality rate is 201 per 1,000 live births, and the maternal mortality ratio is estimated at 800 per 100,000 live births.

Table 1. 3 Health indicators

Indicators	Both sex	Source and Year
Life expectancy	44 Years	National Population commission 2007
Crude Birth Rate	43 per 1000 live births	National Population commission 2007
Crude Mortality rate	14.7 %	National Population commission 2007
Under-5 mortality rate	201/1000 live births	National Bureau of Statistics, 2007
Maternal mortality ratio	800/100,000 live births	National Bureau of Statistics, 2007
HIV/AIDS prevalence rate	3.9%	NACA, 2007
% Safe water access	72% Urban/49% rural	2006 estimates

The major contributors to the disease burden of the country are malaria, tuberculosis (TB), and HIV/AIDS. Malaria is a major health and developmental problem in Nigeria, with a prevalence of 919 per 100,000 populations. It is by far the most important cause of morbidity and mortality in infants and young children: about 75 percent of malaria deaths occur in children under five, and one in ten maternal deaths is due to malaria.

The HIV/AIDS epidemic has unfolded on a large scale in Nigeria: adult prevalence is 3.9 percent and nearly 2.9 million people are living with the virus. In 2005 alone, there were about 220,000 HIV/AIDS related deaths in Nigeria.

Table 1.4 : Main causes of morbidity and mortality

Main causes of morbidity		Value (%)	Main causes of mortality		Value (%)
1.	Malaria	70.5	1.	Malaria	53.9
2.	Diarrhoea	14.2	2.	Diarrhoea	17.1
3.	Dysentery	5.50	3.	Pneumonia	7.40
4.	Pneumonia	4.76	4.	Dysentery	4.90
5.	Sexually Trans Dis.	1.96	5.	AIDS	3.30
6.	Tuberculosis	0.60	6.	CSM	3.25
7.	Measles	0.37	7.	Cholera	3.20
8.	AIDS	0.37	8.	Measles	1.80
9.	Cholera	0.36	9.	Neo-Natal Tetanus	1.40
10.	Pertussis	0.30	10.	Tuberculosis	1.30

Source: Department of Public Health, Epidemiological Division, Federal Ministry of Health, 2006

Tuberculosis cases have increased dramatically with the onset of HIV/AIDS in the country, with an estimated prevalence of 546 cases per 100,000 population in 2004. About 27 percent of adults with TB are also infected with HIV.

There are great disparities in health status and access to health care among different population groups in Nigeria. For example, the Under-five mortality rate in rural areas is estimated at 243 per 1,000 live births, compared to 153 per 1,000 in urban areas. 59% of women in urban areas deliver with a doctor, nurse, or midwife, in contrast to 26 % of women in rural areas. Unlike most of Sub-Saharan Africa, rural areas in Nigeria have a higher HIV/AIDS prevalence than urban areas.

Furthermore, there are wide variations in health status and access to care among the six geo-political regions of the country. Indicators are generally worse in the North than in the South. The south-south zone consisting of the oil-rich Niger-Delta has the poorest indices in the South. For example the Infant Mortality Rate for North-central, Northeast, North-west, Southeast, South-south and south-west was 103, 125, 114, 66, 120 and 69 per 1,000 live births respectively.

The current priorities in the health sector are 1) reduction of disease burden from HIV/ AIDS, 2) reduction of maternal mortality, 3) child survival (with emphasis on routine immunization), 4) control of malaria and tuberculosis, and 5) increasing private sector participation in service delivery.

2. COUNTRY HEALTH SYSTEM

2.1 Governance of health system

The national health care system is built on the basis of the three-tier responsibilities of the Federal, State and Local Governments. Schedules of responsibilities to be assigned to the Federal, State and Local Governments respectively are prepared in consultation with all tiers of government and approved by the Federal Ministry of Health.

The health system can be divided into orthodox, alternative and traditional systems of health care delivery. The Government recognises and regulates these three systems. However comprehensive data is available only on the orthodox health care service providers only. It is expected that data will be available on traditional health practitioners after the appointment of a Registrar to regulate the activities of traditional health practitioners.

The national health policy regards primary health care as the framework to improve health services for the population. Primary health care services include health education; adequate nutrition; safe water and sanitation; reproductive health, including family planning; immunization against major infectious diseases; provision of essential drugs; disease control, mental and dental care. The policy document requires that a comprehensive health care system delivered through the primary health centers should include maternal, newborn and child health care, including family planning services.

The Chairman of the Local Government administers health at the local government level. He is assisted by an officer designated to head the health department of the local government. Some local government authorities have a Medical Officer of Health, who is usually a medical doctor with public health training. Local Government Areas (LGAs) are mandated by the National Health Policy to finance and manage primary health care.

A parastatal of the Federal Ministry of Health called the National Primary Health Care Development Agency (NPHCDA) is established to provide strategic support for the development and delivery of primary health care. The Agency is responsible for developing guidelines on implementation of primary health care, and for enforcing such guidelines.

At the state level, the state ministry of health administers health. The state ministry of health has a political head, who is designated a state commissioner of health. Some states have a health management board to manage health facilities in the state. To obtain consensus on issues of health, most states periodically organize a state council of health meeting. This meeting is between the State commissioner of health and the local government chairman.

At the Federal level, the political head of the Federal Ministry of health is the Minister of health. To obtain consensus on health there are periodic meetings with the Minister of health and the State commissioners of health. This comprises the National Council on Health. The National Council on Health advises the Government of the Federation on the development of national guidelines for Health, the development, implementation and administration of the National Health Policy, and on the organization, delivery, and distribution of health services.

2.2 Service provision

Nigeria is a federation with three tiers of government - federal, state, and local – and responsibility for health service provision in the public sector is based on these three tiers. The levels of care in the public sector are:

Primary: Facilities at this level serve as the entry point of the community into the health care delivery system. These facilities include health centers, clinics, dispensaries, and health posts. They provide general preventive, curative, promotive, and pre-referral care to the population. Primary facilities are staffed by nurses, community health officers, community health extension workers (CHEWs), junior CHEWs, and environmental health officers. Most private sector practitioners also provide health care at this level.

Secondary; Secondary care facilities, including general hospitals. They provide general medical and laboratory services, as well as specialized health services, such as surgery, pediatrics, obstetrics and gynecology to patients referred from the primary health care level. Medical officers, nurses, midwives, laboratory and pharmacists, and community health officers typically staff general hospitals. Primary and secondary care is also provided by the largely unregulated private health sector, which includes a wide range of providers such as physician practices, clinics, and hospitals.

Tertiary: Tertiary level facilities form the highest level of health care in the country. Tertiary health care, consist of highly specialized services, care for specific disease conditions or specific group of patients. These include specialist and teaching hospitals and federal medical centers (FMCs). They manage patients referred from the primary and secondary levels and have special expertise and full-fledged technological capacity that enable them to serve as resource centers for knowledge generation and diffusion. Each state has at least one tertiary health facility. Selected centers are encouraged to develop special expertise in the advanced modern technology thereby serving as a resource for evaluating and adapting these new developments in the context of local needs and opportunities.

Current efforts to supply modern hospital equipment to health facilities are limited to federal tertiary hospitals. There are 14 Federal Teaching Hospitals. Currently 8 hospitals are equipped and efforts are on way to equip the other 6 hospitals. This is under what is the VAMED project. This is a medical equipment initiative, and modern state of the earth equipment have been supplied and installed, and most are in use. There was an initial problem of shortage of workers to operate these equipment, especially in radiography and radiotherapy. However efforts have been made to solve this problem. However some six hospitals are yet to be similarly equipped, and these are hospitals located at Benin, Calabar, Ile-Ife, Kano, Nnewi and Sokoto. These hospitals will however be equipped this financial year.

Health service provision in Nigeria includes a wide range of providers in both the public and private sectors, such as public facilities managed by federal, state, and local governments, private for-profit providers, NGOs, community-based and faith-based organizations, religious and traditional care givers. Pharmacies provide health care service in the form of drugs and supplies.

The health sector is characterized by wide regional disparities in status, service delivery, and resource availability. More health services are located in the southern states than in the north.

2.3 Health care financing

In the Nigerian Constitution, health is on the concurrent list. This means that each level of Government budgets for its own responsibility of health care service delivery. The Federal

Government handles tertiary health care services, the State Governments handle secondary health care services, and the Local Governments handle primary health care services delivery.

Nominally, per capita health expenditure consistently increased from 1,445.95 Nigeria naira in 1998 to 2,565.77 Nigerian Naira in 2002. In general expenditure on health is less than \$8 per capita, compared to the \$34 recommended by the Commission of Microeconomics and Health. Private expenditures are estimated to be over 70% of total expenditure with most of it coming from out of pocket expenses, in spite of the endemic nature of poverty.

The National Health Account Study, in 1998, revealed the Total Health Expenditure (THE) as 157.1 billion or 5.45% of GDP, the Total Government Health Expenditure (TGHE) was 23.5 billion or 0.82% of GDP or 15% of THE (with FG: 10%; SG: 4%; & LG: 1%). Donor health expenditure was 20.5 billion (13% of total health expenditure). However Total Private Health Expenditure (TPHE) was 113.0 billion. This represents 72% of Total Health Expenditure. Household share of Total Health Expenditure was 108 billion or 69.21%. (Soyibo A, 2002).

According to the 2001 estimates, private facilities provided maximum health care services and goods worth 81.37 billion, (29.19% of THE); the Government facilities provided goods worth 39.78 billion (14.27% of THE). Health care services/ goods worth 37.52 billion (13.46% of THE) were provided by Chemists and Pharmacies, mission/NGO facilities contributed 26.26 billion (9.42% of THE) Traditional health care providers represented 11.25 billion (4.03% of THE). 82.55 billion (29.62% of THE) are accounted by other sources (such as self-treatment/home care, administration of health, research or education and training).

Financing agents include the Federal and its parastatals, State and Local Governments, and insurance companies. Funding for health care service delivery also come from companies, households and partners. The contribution of health insurance looks negligible, but it is gradually growing. It grew from the least proportion of 1.79% in 1998, rising to 2.38% in 1999, 3.45% in 2000, and 4.47% in 2000 and to the highest value of 4.96% in 2002. In Nigeria, National Health Insurance is currently for the formal sector, both public and private. However, the coverage has not been expanded to insure the poor, unemployed, rural dwellers, yet.

Health care functions which are funded include curative, preventive, and rehabilitative services. Others include occupational health and capital formation (education and training, health personnel, and research and development in health. The 2001 National Health Accounts estimate reveal that curative care dominates the type of health service spending, accounting for 175.5 billion or 68.49% of Total Health Expenditure.

Preventive care is in second position with 2.2 billion, and this is 0.9% of total health expenditure. Capital formation takes the rear with less than 0.31%. About 29.93% are lumped as others.

2.4 Health information system

Nigeria has a formal health information system (HIS) that is nationwide in its coverage. A policy document had been approved for implementation in all the states of the country. However earlier efforts at implementing the policy did not succeed because of the ambitious efforts to collect all the health possible data using one format.

A revised Health Management Information System is now in practice with the guiding principle to keep things simple, practicable and sustainable. The data collection format consists of fewer of summary forms for communities, health facility, LGA, and states including Federal capital Territory,

and health facility register, which serves as tally sheets. Health data is also collected from the private sector.

HIS system in Nigeria is managed by the Health Records Officers (Health Information Officers), with assistance from supervising statisticians in some states. The HIS in most states is computerized. Presently the system does not collect data on human resources for health.

3. HEALTH WORKERS

3.1 Health workers: stock and trends

Nigeria includes a wide range of health care workers in both the public and private sectors, such as public facilities managed by federal, state, and local governments, private for-profit providers, NGOs, community-based and faith-based organizations, religious and traditional care givers.

Nigeria has one of the largest stocks of human resources for health in Africa comparable only to Egypt and South Africa. In 2005, there were about 39,210 doctors and 124,629 nurses registered in the country, which translates into about 39 doctors and 124 nurses per 100,000 populations (Table 3.1) as compared to the Sub-Saharan African average of 15 doctors and 72 nurses per 100,000 populations (WHO 2006).

The figures presented in Table 3.1 are for some health professional categories registered by Nigeria's professional medical/health regulatory bodies as in 2006. They include health workers in both the private and public health sectors, and, very likely, health professionals who are not practicing in the country or may not be practicing health care at all. Comparing the data of 2005 with 2006, there is very little change in the total number of health workers/1000 population.

Doctors and dentists include 2,968 and 215 expatriates respectively. This suggests that there are considerable numbers of expatriates providing medical care support in the country.

Table 3.1: Health worker Population ratios at national level

Health Occupational categories	2005		2006		2007	
	Number	HW/ 10000 Pop	Number	HW/ 10000 Pop	Number	HW/ 10000 Pop
Physicians	39210	3.0	49612	3,54	52408	3,70
Physicians (aliens)	-	-	-	-	2968	0,21
Prof/Registered Nurses	124629	10.0	125292	8,95	128918	9,10
Registered Midwives	88796	6.8	88996	6,36	90489	6,39
Dentists	2113	2	2241	0,16	2356	0,17
Dentists (aliens)	-	-	-	-	215	0,02
Dentist technologist & Therapists	-	-	-	-	1517	0,11
Pharmacists	12072	1	12503	0,89	13199	0,93
Pharmacy technician	-	-	-	-	5483	0,39
Lab scientist	-	1.2	-	-	12703	0,90
Laboratory technician	-	-	-	-	2936	0,21
Laboratory assistant	-	-	-	-	7044	0,50
Physiotherapist	1473	-	-	-	1473	0,10
Occupational therapists	17	-	19	0	29	0
Speech therapists	27	-	30	0	26	0
Radiographers	729	-	-	-	840	0,06
Optometrists	-	-	-	-	1415	0,10
Chartered chemists	-	-	-	-	1503	1,06
Public analysts	-	-	-	-	500	0,04
Environment & public health workers	3441	-	-	-	4280	0,3
Health management workers / Health Records	820	0.66	935	0,07	1187	0,08
Other health support staff/ community health officers	19268	-	-	-	19268	1,36

Source: National Professional medical/health regulatory bodies 2005, 2006, 2007

3.2 Distribution profile of the workers by category/cadre

3.2.1. Gender distribution by health occupation/cadre

Females are predominantly nurses, midwives, occupational therapists, speech therapists/audiologists, dental therapists, and community health officers (this is probably because public health nurses may require community health qualification for significant promotion in some states of the country)

Males are predominantly doctors, dentists, pharmacists, radiographers, physiotherapists, health records, environmental health officers and medical laboratory scientists.

Available data shows that 20% physicians and dentists across the country are women, while 99.9% of midwives and 72.2% of occupational therapists are women.

Table 3.2.1 Gender distribution by health occupation 2007

Health Occupational categories	Total	% Female
Physicians (Nigerians)	52 408	22,0%
Physicians (Aliens)	2 968	28,7%
Nurses	128 918	94,6%
Midwives	90 489	100,0%
Dentists (Nigerians)	2 356	40,8%
Dentists (Aliens)	215	42,3%
Dental technologist/ Assistant	1 517	44,1%
Pharmacists	13 199	30,5%
Pharmacists Technicians	5 483	-
Medical Lab scientists	12 703	14,3%
Medical Lab Technicians	2 936	-
Medical Lab Assistants	7 044	-
Physiotherapists	1 473	40,7%
Occupational therapists	29	44,8%
Speech therapists	26	65,4%
Radiographers	840	32,3%
Optometrists	1 415	53,0%
Chartered chemists	1 503	31,7%
Environment & public health workers	4 280	33,8%
Public analysis	500	24,6%
Health management workers/Health Records	1 187	47,3%
Other health support staff/ community health officers	19 268	59,4%

Source and year Professional Regulatory Agencies, 2008

3.2.2 Age distribution by health occupation/cadre

The retirement age for civil servants in the country is 60 years. Health workers in academic posts retire at the age of 65 years. For those professional categories for whom data is available, the age of most of the staff is below 50 years, except for occupational therapists, most of who are above 50 years old. Health workers under 30 years are in the minority, in all cadres.

3.2.3 Geographical distribution by health occupation/cadre

There is mal-distribution of health workers in Nigeria. Health workers are in abundance in the Southern parts of the country. For specialists Doctors, more than half work in the Southwestern zone of Nigeria. There is shortage of workers in the Northern parts of Nigeria, generally, but in the northern States of Niger, Jigawa, Zamfara and Taraba the shortages are acute. Bayelsa in the Niger Delta (in the South south zone) also has shortage of health workers. There are several reasons for this uneven distribution the most important being financial and social, differences among the zones. Some states in the north with acute shortages do not give pensionable appointment to workers from other parts of the country, thus making it unattractive for non-indigenes to seek employment there in addition to socio-economic and geographical difficulties of those regions.

Table 3.2.3 Regional distribution of health workers (2007)

Health worker categories	Total Number	North central %	North east %	North west %	South east %	South south %	South west %
Doctors	52408	9.73	4.06	8.35	19.59	14.37	43.9
Nurses	128,918	16.4	11.65	13.52	15.29	27.75	15.35
Radiographers	840	14.3	3.66	5.97	15.0	18.3	43
Pharmacist	13,199	19.94	3.8	7.79	11.74	12.39	44
Physiotherapists	1,473	10.8	2.73	8.32	8.58	7.93	62
Medical Laboratory Scientists	12,703	6.82	1.72	3.6	35.26	23.89	29
Environment & Pub HW	4,280	9.39	11.27	18.94	12.36	15.69	32.08
Health Records Officers	1,187	13.34	4.85	11.6	14.64	29.9	26
Dental Technologists	505	14.08	5.92	5.92	12.96	16.62	44.5
Dental Therapists	1,102	13.19	10.29	21.88	10.19	12.99	31.5
Pharmacy Technician	5,483	6.17	9.12	18	8.58	11.8	46

Source: Professional Regulatory Agencies 2008

The geographical distribution of health workers in Nigeria is very uneven, with fewer staff per person in less developed areas. There is concentration of health workers in urban areas, tertiary health care, curative and the southern parts of the country. The uneven distribution of health workers is greater in some category of workers; like physician specialist being the most unevenly distributed. Community health workers are well distributed in the rural areas.

All health workers that qualify from University have to participate in the mandatory one year National Youth service. It is now a requirement that nurses and midwives participate in the National Youth service, whatever the types of basic qualification they possess. This is a new requirement, and it emanated from the Committee that was constituted to proffer recommendations to reduce the Maternal Mortality Rate in Nigeria. This was a major recommendation of the committee, and it was applied immediately in the health system delivery. So nurses and midwives, though not university graduates have to participate in the National Youth Service. During the service year, Youth Corpsers are posted to states other than their own. Health workers serving in the National Youth service are usually deployed to the rural areas.

Table 3.2.4. Doctor Population Density in Relation to Some Health Indices in the Geo-Political Zones

Zones	Doctors/ Million pop	NNMR	PNNMR	IMR	CMR	U5MR
N/Central	101.0	53	49	103	70	165
N/East	35.5	61	65	125	154	260
N/West	24.0	55	59	114	176	269
S/East	142.7	34	32	66	40	103
S/South	89.2	53	68	120	63	176
S/West	211.7	39	30	69	47	113

Adapted from the NDHS Report (2003)

3.2.4 Sectoral distribution by health occupation/cadre

There is not precise information about the percentage of Health workers (medical doctors, nurses and midwives) working in public (government), private for profit, and private for non profit (faith based organization). Available information shows that dental assistants, pharmacist and radiographers operate both in public and private.

4. HRH PRODUCTION

4.1 Pre-service education of health workforce

There are 306 health training institutions available in Nigeria. These institutions are well distributed across the country (table 4.1). There are 18 medical schools. The curriculum for the degree of Bachelor of Medicine, Bachelor of Surgery (MBBS) normally extends over a period of six academic years. The examination for the degree of M.B.BS is in four parts. Part I, training include Anatomy, Biochemistry, Physiology, Biostatistics, Psychology and Community Health. Part II, training cover Pathology (and Microbiology), Pharmacology and Community Health. In Part III the subjects are Paediatrics and Obstetrics and Gynecology, and for Part IV the subjects are Medicine, Surgery, and Community Health including Social Medicine. A significant part of the training is devoted to clinical training. Students must pass written, clinical and oral examinations to get the degree.

The entrance requirements for MBBS are: graduates of Universities recognized by the Senate for the purpose, candidates holding the General Certificate of Education in Chemistry, Physics and Zoology, plus GCE O Level in English, Mathematics. Candidates with the West African Senior Secondary School Certificate Examinations (WASSCE) with passes in core Mathematics, English, Chemistry, Physics and Biology. Candidates with GCE ordinary level in Mathematics, English can complete qualification at the one year preliminary course in Sciences and then advance to the Part I of the M.B B.S. The candidate must pass Chemistry, Biology, Physics, Mathematics and other prescribed University courses like general studies.

Entry requirements for dental surgeons are similar to those for MBBS candidates. Dental course extends for a period of six years. In Part I, courses taken are in Physiology, Oral Physiology, Psychology, Biochemistry and Statistics. The courses taken in Part IIA are Prosthetics, Operative Techniques and Science of Dental Materials. For Part IIB, the courses are Pathology and Pharmacology. For Part IIIA, the courses are Medicine and Paediatrics, and Surgery (including Anaesthesia). For Part IIIB, the courses are Oral Maxillofacial Surgery, Oral Pathology and Medicine, Preventive Dentistry, and Restorative Dentistry.

There are 71 nurses school in the country. Nurses are awarded degree as B.S. The course of study extend over four academic years. In the first year, students take courses in science. From the second academic year, students take professional courses in nursing. The professional course is in 3 parts, each part extending over one year period each. In Part I, students take courses in Anatomy and physiology, Nutrition, Sociology, Political Science and Perspective in Nursing. In Part II, the courses are Sociology, Psychology, Public Health Science, Principles of Teaching and Administration, Psychiatric Nursing, Community Health Nursing. In Part III, the courses are Clinical Nursing, Nursing Research, Nursing Education or Nursing Administration. Candidates are required to pass practical, written and oral examination.

The entry requirements for nurses are: candidates should have 5 five credits in the West African School Certificate examinations, or its equivalent including English Language and at least one science subject.

There are 71 schools of midwifery distributed across the country. 19 schools provide training in medical laboratory. There are 6 institutions that provide training in radiology and rehabilitation. 10 institutions are available for training in pharmacology and 19 for pharmacology technicians.

Table 4.1.1. Number of health training schools by geographical distribution

Institutions	Total	S/East zone	S/South zone	S/West zone	N/Central zone	N/East zone	N/West zone
Acc.Med. Sch	26	7	7	6	2	1	3
App. Sch.of Nursing	76	19	18	20	10	7	2
App. Sch.of Midwifery	77	17	17	17	10	6	10
Med Lab.Sch	12	4	5	1	0	1	1
Rehab. Therapist	06	1	0	4	0	0	1
Sch. Of Radiogr	05	2	1	1	0	1	0
Sch of Pharm	9	1	2	4	1	0	1
Sch. of Pharm Tech	19	2	3	4	4	0	6
Sch. Of Record Off	40	3	10	10	7	2	8
CHOs Sch	13	1	3	3	2	1	3
CHEWs Sch	43	6	5	7	9	6	10
Dental technician	4	2	0	2	0	0	0
Dental therapy	6	1	1	2	0	1	1
Optometry	3	2	1	0	0	0	0
Total	339	68	73	81	45	26	46

Source: Health professional regulatory agencies, 2008

Describe the number of the annual enrolments in the Health Training Institutions and of the number of health workers who have been produced in different institutions of the country as indicated in table 4.2 and table 4. 3.

Table 4.1. 2 Training inputs in the Health Training Institutions from 2004 to 2007

Cadre being trained	Actual Annual Inputs				Total Input
	2004	2005	2006	2007	
Physicians	-	-	-	-	-
Nurses	4483	4078	1888	3494	13943
Midwives	3089	2960	1189	2042	9280
Pharmacists	-	-	-	-	-
Health Records Officers	762	924	2144	1698	5528
Dental Therapists	36	32	46	47	161
Optometrists	364	445	306	-	1115

Source : National Universities Commission, Professional regulatory Agencies 2008

Table 4.1.3 : Annual student enrollment into professional health programmes 2002 to 2007

Year	Medicine	Pharmacy	Nurses	Midwives	Radio-Graphers	Health Records Officers	Dent. Tech	Dental Therapists	Optometrists
2002	26,360	5,727	5075	2138	77	564	-	38	137
2003	22,088	-	4913	2355	90	-	-	40	369
2004	-	-	4483	3089	90	762	-	36	364
2005	-	-	4078	2960	-	924	-	32	445
2006	-	-	1880	1189	-	2144	-	46	306
2007	-	-	3494	2042	-	1698	100	47	-

Source: National Universities Commission, 2008, Professional regulatory Agencies, 2008

Student enrollment figures are presented in the above table. The intake for medicine and medicine related sciences are not disaggregated. So there are no figures available for students that would like to read medicine. Indeed all these are classified as medical students.

Table 4.1. 4: Training outputs in the Health Training Institutions from the year 2002 to 2005

Cadre being trained	Actual Annual Outputs				Total output
	2002	2003	2004	2005	
Physicians	2300	2300	2300	2300	9200
Nurses and midwives	3138	3199	3419	3272	13028
Pharmacists	517	242	249	717	1225
Radiographers	8	23	15	18	64
Health records officers	27	NA	123	94	244
Community health practitioners	9322	7112	6382	6624	29440
Total	15312	12876	12488	13025	53201

Source: National Universities Commission, Professional Regulatory Agencies, 2007

4.2 Post-service and continuing education

Medical graduates training in Nigeria is coordinated by the National Postgraduate Medical College of Nigeria. Candidates have the option of taking the examinations of the West African Postgraduate Medical College. The National Postgraduate Medical College is divided into various faculties like Anaesthesia, Surgery, Internal Medicine, Pathology and Public Health. The length of study is at least four years after the medical or dental degree, and after internship. In this country, a one year National service is mandatory. The course is in 3 parts, namely Primary, Part and Part II finals. The primary examinations cover review of the basic medical course, taken during the first degree. Part I, is taken two years after passing the primary. It covers specialist training that is relevant to the specialty. The examination consists of written and oral examination, clinical and practical tests and presentation of cases in workbooks. The Part II final is based mainly on dissertation, but students are still examined in all aspects of the course.

Post graduation in pathology and surgery is most favoured while general medical practice, anaesthesia and ENT are not much sought after specialization as seen in the statistics from 1991-2005 in table 4.5.

Table 4.1.5 Statistics of graduate of National Postgraduate Medical College of Nigeria

FACULTY	91- 95	96-2000	2001-2005	2006	2007	TOTAL
Anaesthesia	14	9	11	7	11	52
Dental Surgery	15	16	30	9	7	77
Gen. Med. Practice	6	3	5	1	0	15
Gen Dental Practice	33	16	24	3	6	82
Ob-Gyn	25	26	64	13	34	162
Ophthalmology	28	30	38	3	14	114
Paediatrics	39	32	45	14	13	143
Pathology	33	58	67	16	28	202
Internal Medicine	35	35	49	32	31	182
Psychiatry	7	14	15	6	14	56
Public Health	26	38	55	13	13	145
Radiology	26	14	36	16	12	104
Surgery	53	46	50	9	14	172
Oto-Rhino-Laryngology	4	20	14	4	5	47
Total	344	357	360	503	203	1533

Source: National Post graduate medical college of Nigeria 2008

Table 4.1.6. Statistics of Nurses with general and post basic training (December 2007)

Category	Total	Female	Male
General Nurses	128918	121929	6989
General Midwives	90489	90470	19
Mental Health Nurses	6005	5186	819
Public Health Nurses	4308	4219	89
Public Health Nurses Educators	162	150	12
Nurse Educators	2102	1806	296
Midwife Educators	716	716	0
Nurse Administrators	1228	1107	121
Orthopaedic Nurses	721	406	315
Nurse Anaesthetics	517	215	302
Peri-Operative Nurses	1794	1031	763
Ophthalmic Nurses	418	256	162
Accident And Emergency Nurses	656	412	244
Paediatric Nurses	226	213	13

Source: Nursing and midwifery council of Nigeria, 2008

Graduates have a binding arrangement linked to education. Students are required to serve a year of National Youth Service in a state other than his or her state of origin. The certificate of completion of that service is required for employment in Nigeria. Privately sponsored students are subjected to any other binding arrangement. State sponsored candidates are required to serve the state for a pre-arranged number of years. The Nigerian National Universities Commission has the responsibility of

maintaining the education standards, regulations and accreditation of education institutions. It also ensures that standards are maintained in aspects of quality of the lectures, the academic standard of the lecturers, and the lecture environment.

Continuing education is a must for all health workers. This comes in various forms. Some health workers are required to take annual examinations. Some are required to take regular courses. Some are required to attend regular conferences. It is proposed that these continuing education activities would be mandatory for annual re-registration.

The teaching staff in Nigeria is predominately males. There are currently 286 male professors/associates of medicines in compared to 29 females. The table below presents the level of Universities lecturers in medicine and pharmacy by gender as at 1999/ 2000 academic year.

Table 4.1.7. Teaching stock: Level lecturers in medicine and pharmacy at the of federal universities 1999/ 2000

Level	MEDICINE		PHARMACY	
	Total	% Females	Total	% Females
Professors, Associate Professors, Readers	315	9,2%	45	6,7%
Senior lecturers, Senior Research Fellows	451	20,0%	83	26,5%
Lecturers, and Research Fellows	649	21,4%	107	16,8%
Associate Lecturers, Junior Lecturers	151	22,5%	68	20,6%
Others (Tutors, Instructors e.t.c.)	86	17,4%	30	10,0%

Source: National Universities Commission, 2006

4.3 Health workforce requirements

There are currently no projections on the number required for the 5 next years of health workforce by occupational category/cadre. This has been included in the workplan for 2009. The activity involves inviting an expert in the field of workforce planning from outside the country. This activity will complete the drafting of the Human resources for Health Strategic Document which is 90% completed.

5. HRH UTILIZATION: PRIORITY AND PRACTICE

5.1 Recruitment

The Federal and State Civil Service commissions recruit health workers, into the public service. Tertiary hospitals have management boards, and these are empowered to employ health workers, on the directive of the Minister of Health. The same is true of state hospitals, where the State health management board handles the employment.

At the local government level, the local government service commission handles the employment of health workers.

Recruitment capacities are established for each category of health worker, depending on the capacity of the health institution. In general it is easier to fill vacant posts of non-skilled staff.

5.2 Deployment and distribution mechanisms,

Deployment and distribution of staff is done locally. There is at present no agency that deploys health workers at the national level. A federal agency, Tertiary Hospital Services Commission, ensures that standards are kept in staffing and equipment situation of tertiary hospitals. A study is planned for the year 2008 to document the job description of officers in some health departments.

5.3. Job description

There is a deliberate effort to formalize the writing of job descriptions, so that health workers could be made accountable for their service outcomes. Presently detailed job descriptions are not commonly available, but efforts are ongoing at the Federal level and in some states to create detailed job descriptions.

On placement preparations, a formal orientation for new employees is usually arranged. During the orientation, peculiarities of the organization are explained to the new workers.

5. 4. Work environment

There are some incentives are given to health workers in Nigeria like owner-occupier housing, provision of loans to purchase vehicles, study leave, study grants, and so on. All Federal health workers enjoy the National Health Insurance Scheme. The other levels of health care will soon be introduced in the Scheme.

Pensions for all Government health workers had been poorly managed in the past. However, the pension arrangement has been streamlined, and most health workers have a more positive attitude. The arrangement is contributory (employer and employees contribute 71/2 % of the monthly salary. The fund is invested on the Stock market.

There are other incentives operating in some States. It is likely that all States will eventually be offering similar incentives, to prevent poaching of health workers by neighboring States.

1. Rural area incentive of 25% of salary. Unique to health workers.
2. Salaries paid regularly

3. Owner-occupier scheme available for civil servants
4. Retirement benefits paid within 3 months of leaving the service
5. Medical Pharmacy students paid salaries up to the end of their training
6. All circulars issued from Federal government pertaining to salaries are implemented in the state
7. Shares from different companies bought by government and sold to all civil servants at a 50% discount
8. Loans- furniture, vehicle refurbishing, agricultural available to civil servants.
9. 40% salary allowance paid to family before the payment of death gratuity, on the death of a worker.
10. Staff quarters are allocated to health workers in the state in all primary and secondary health care facilities.

A disincentive to health workers was noted in a State recently. The salary of Doctors in the State is small compared to that paid by the Federal health institution in the State, so virtually no doctor take up the posts offered. As a result doctors from Asia are employed. On arrival those Doctors were given brand new cars, lodged in hotels, and of course paid in local and foreign currencies though some language difficulties are experienced.

The staff turnover appears to be higher in the private sector than in the public sector. However, there is no systematic collection of data on this.

Staff attrition is seen due to retirement, voluntary resignation, and migration. The retirement age in Nigeria is 60 years generally, and it is 65 years for academic staff.

In 2006, major increase in health workforce is seen in the category of doctors (16.50%), the attrition rate of doctors was 2.34%. The lowest increase in health workforce number is of nurses and midwives (1.14%) while the attrition rate was 1.43%. For other category of health workers see table 5.1.

Table 5.4.1 HRH Stock Increase from New Graduates and Attrition Rates in the Public Sector

Staff Category	Increase from New Graduates (%)	Attrition Rate (%)
Doctors	16.50	2.34
Nurses and Midwives	1.14	1.43
Laboratory Staff	3.42	1.26
Pharmacists and technicians	3.56	2.16
CHO/CHEWs	3.25	1.44

Source: National AIDS Control Agency, 2006

Migration of health staff out of the country is an important issue. Highly qualified nurses and specialist doctors have been mainly involved in migration to other countries. Research into migration of health workers is ongoing with funding and technical support from partners. In the year 2005, 2600 0 nurses migrated to UK, 2050 migrated to USA. Other countries of importance to migration are Ireland, Australia, and Canada. Some nurses have migrated to other parts of Africa. (Table 5. 2).

Data from nursing and Midwifery council shows that they received a request from 3194 nurses in 2008 for seeking employment outside Nigeria.

Table 5.4.2 Nurses Seeking Employment outside Nigeria from 2004-2006

Country	2004	2005	2006 *	2007
United Kingdom	2500	2600	750	94
USA	2100	2050	650	1233
Ireland	750	855	450	510
Australia	55	60	75	-
Canada	50	60	12	130
British Columbia	10	11	3	-
New Zealand	20	21	5	-
South Africa	15	16	6	-
Ghana	8	10	7	-
Botswana	4	5	10	-
African Boards*	-	-	-	87
Other Boards**	-	-	-	1140
Prince Ward Island	5	7	9	-
Total	5517	5695	1977	3194

* African Boards (An addition of figures for Ghana, Botswana, South Africa, and other African countries. This new classification was started by the Nursing Council from the 2006 data generation year)

** Other Boards (An addition of figures for Australia, New Zealand, British Columbia, and Prince ward Islands.)

A large number of medical doctors have migrated to UK, USA, Ireland, Denmark, Australia. The trend of migration is more towards USA, UK, then other parts of Europe. It is difficult to have a total number of actual migrants, however using proxy data like requests for certificate of good standing it appears that 2,989 Nigerian doctors migrated in the year 2006 and 2,341 migrated in 2005. In 2007 the number of doctors migrated increased to 3,567 (table 5.3)

Table 5.4.3 Nigerian Doctors who requested for certificate of good standing and their destinations countries for the years 2005-2007

Country	2005	2006	2007
United Kingdom	979	1236	1,236
Ireland	714	851	851
U.S.A	122	189	189
Denmark	9	16	16
Israel	-	-	4
South Africa	-	-	538
West Indies	304	384	384
Canada	136	176	176
United Arab Emirates	5	5	5
Singapore	6	6	10
Australia	49	86	86
Germany	7	12	12
Poland	1	3	3
Italy	2	6	6
Netherlands	5	11	11
Malaysia	2	4	4
Guyana	-	-	6
New Zealand	-	-	3
Nepal	-	-	2
Ghana	-	-	8
Russia	-	-	4
Libya	-	-	2
Ukraine	-	-	7
Liberia	-	-	2
Total	2341	2985	3,567

Source: Medical and Dental Council of Nigeria, 2008

Data from American Medical Association revealed that in 2003, 2855 Nigerian Doctors were registered with the American Medical Association out of which 44% of were specialist in internal medicine (table 5.4.).

Table 5.4. 4. Nigerian Doctors Registered with the American Medical Association 2003

Specialty	Number	Percentage
Internal Medicine and sub specialties	1269	44
Surgery and surgical sub specialties	332	12
Family/General Practice	281	10
Pediatrics	427	15
Psychiatry	187	7
Obstetrics and Gynecology	161	6
Pathology/Oncology	90	3
Radiology	35	1
Preventive Medicine	32	1
Others	41	1
Total	2855	100

Source: American Medical Association, 2003

Absenteeism is not a major problem at the country level. It is however of concern in some states in the Southeastern zone of the country and would benefit by a research study. In some health facilities in the rural areas, the full staff complement is employed, but on inspection less than 50% are actually on duty. Reasons for absence include delay in payment of staff salaries (sometimes for as much as 9 months), lack of drugs to give to patients and poor supervision.

5.5 Remuneration mechanisms

Health workers are paid on a monthly basis. They are entitled to a variety of allowances: transport, housing, furniture, leave, hazard, call duty allowance, and so on. However at the Federal level, all these allowances are consolidated. This obliterates any financial edge that health workers had over other non-health workers and has become a source of discontent among health workers.

Table 5.5 Total monthly salary for State Employees (entry point and bar) by professional category as at September 2008

Category	Entry point ₦	Bar ₦
Doctors/Dentists	101,107.64	266,775.54
Nurses/Midwives	39,977.15	123,278.48
Pharmacists	67,024.55	266,775.54
Pharmacy Technicians	31,931.19	123,278.48
CHOs	39,977.15	123,278.48
CHEWs	31,931.19	123,278.48
Scientists/Technologists	52,456.66	147,814.40
Radiographers	31,931.19	123,278.48
Environmental Health Officers	39,977.15	123,278.48
Health Records Officers	31,931.19	123,278.48
Dental Technologists	30,450.70	123,278.48
Dental Therapists	30,450.70	123,278.48
Dental Surgery Assistants	26,981.08	85,799.11

\$1 = 117 Nigerian Naira (as as October 2008)

Exchange rate \$1 = N 11 at most commercial banks as at 8 October 2008.

Local government employees earn significantly less than their counterparts at the State level. Federal Government employees are the best-paid public health workers in Nigeria. Most private employers pay less than the Governments.

In Nigeria health is on the concurrent list of the Federal Constitution. Each level of Government employs and pays its own health staff. Thus a Local Government Authority employs her own staff and pays them. The National Salaries and Wages Commission fix the level of salaries and allowance paid by all the three types of Governments. However the entry points are different for Local Government staff compared to State and Federal employed staff. Hence it is possible that similarly qualified and experienced nurses may earn different amount just because they work for different governments. The Local Government Authorities pay the least, and the Federal Government pays the most.

5.6 Supervision Systems and mechanisms

The Professional Regulatory Agencies are parastatals of the Federal Ministry of Health, and they are mandated to regulate, monitor and standardize the training and practice of the various health professions in the country. In case of professional misconduct by health workers, these Agencies decide on disciplinary actions to be taken. These agencies employ the services of lawyers in the performance of this duty.

An agency called the Federal Hospital Services Commission, is recently established in Nigeria for evaluation of health workers and hence health facility performance. This would be possible through the National Council on health with meetings between the Minister of Health and the States' Commissioners of Health. Eventually the 36 States and the Federal Capital Territory will establish corresponding Commissions, to complement the one at the Federal Level. Hitherto systematic and comprehensive evaluation of health workers performance has not been formalized in the country.

5.7 Disciplinary action-decisions

Non-patient related misconducts are handled by the Departments of Personnel Managements of various health facilities. In some cases the coordinating Ministry of Health may be involved. However if a misconduct require dismissal from the service, the Civil Service Commission is be required to be involved in such a decision.

5.8 Evaluation of health workers performance

There are mechanisms of evaluation of health performance, however, particularly in teaching hospitals. A study titled "Peer Participatory Rapid Health Appraisal for Action (PPRHAA)" sponsored by a partner demonstrated that a lot would be gained by institutionalizing health workers performance. The Country is currently going through reform in the health sector, most of which is administrative in nature. The next logical step is the institutionalization of clinical and public health reforms.

Supervision is carried out by more experienced health workers. If a rural health facility is to be visited, usually multi-disciplinary team carries out such a visit. Of importance is the fact that assessments are done using pre-arranged criteria.

6. Governance for HRH

6.1 HRH policies and plans

Following an extensive consultation process, a HRH strategic plan of action was developed and approved by The national Council on Health in 2007. This document was written based on evidence. A rapid assessment of human resources for health was carried out, in two states of each of the geo-political zone of the country. Human resources for health stakeholders were consulted at the zonal and national levels.

6.2 Policy development, planning and managing for HRH

The Human resources for health branch is placed in the Department of Health Planning, Research and Statistics of the Federal Ministry of Health. It is located in Phase 3 of the Federal Secretariat, Maitama, Abuja. The branch is in the Policy and Planning division of the Department.

A Director heads the Department of Health Planning, Research and Statistics, while a Deputy Director heads the Policy and Planning Division. An Assistant Director heads the Human resources for health branch. There are 2 sections in the branch namely H.R.H Policy and plan, H.R.H Management, and Collaborating Centres / Flagship courses section. The unit is supported by 4 committees namely,

1. Intra-sectoral Committee: Members are drawn from all the departments and agencies of the Federal Ministry of Health. The professional regulatory agencies are in this Committee.
2. Inter-sectoral Committee: Members are drawn from the Ministries of Education, Science and Technology, Information, Finance and Federal Civil Service Commission
3. Inter-governmental Committee: Members are drawn from all the states of the Federation
4. Partners' Committee: Membership drawn from partner agencies with interest in Human resources for health issues. The main agencies interested so far in the Nigerian Human resources for health programme are World Health Organization, PATHS, an arm of Department for International Development (DFID), and CIDA.

6.3 Regulations

All human resources for health in Nigeria are regulated through the agency of professional regulatory agencies. Each health care cadre of worker is taken care of by a professional regulatory agency. These professional regulatory agency are headed by registrar.

The regulatory agency accredits health-training institutions according to certain defined criteria. Some of these criteria include the number and quality of teachers, the equipment situation, availability and quality of clinical and practical training. Regulatory agencies, is responsible for registering new health workers, ensuring that these health workers have the minimum qualification that is needed for enrolling. The regulatory agency disciplines erring health workers. Though there are many regulatory bodies, most of these agencies do not have sufficient funds to perform their functions especially prosecute erring members and facilities that operate in rural areas. These agencies are:

- Medical & Dental Council of Nigeria,
- Pharmacy Council of Nigeria,
- Nursing & Midwifery Council of Nigeria,
- Radiographers Registration Board of Nigeria,
- Medical Rehabilitation Therapists Registration Board,
- Environmental Health Officers Registration Council,
- Dental Technologists Registration Board of Nigeria,
- Dental Therapists Registration Board of Nigeria,
- Institute of Public Analysts of Nigeria,
- Health Records Officers Registration Board of Nigeria,
- Institute of Chartered Chemists of Nigeria,
- Medical Laboratory Science Council of Nigeria,
- Optometrists Registration Board of Nigeria, and
- Community Health Practitioners Registration Board of Nigeria

6.4 HRH information

Presently various bodies are housing information on health workers. These include the federal and state civil service commissions, offices of the head of civil service of the Federation, the various ministries of health and of local government, the ministries of finance, health training institutions, professional regulatory agencies and so on.

As information is collected at various sources, reported and analyzed separately, HRIS is fragmented. Often there exists discrepancy in the number tallied from register and obtained from Professional regulatory bodies.

6.5 HRH research

Currently there are very few HRH- specific research programmes. There is very little fund available for such research. Efforts are on way to process funds to carry out research on human resources for health. Some of the research issues include the migration of health workers, motivation of health workers and so on.

6.6 Stakeholders in HRH

There are many identified stakeholders for HRH in Nigeria. These are the following:

1. Human resources for health Programme: Director (Health Planning and Research & Statistics), Deputy Director (Planning), Assistant Director (Human resources for health), Secretariat
2. Academic Institutions: Universities, Teaching Hospitals, Professional training schools, Research institutions
3. Qualifying and examination bodies
 - National Postgraduate Medical College of Nigeria,
 - West African Health Examinations Board,
4. Regulatory bodies:
 - Medical & Dental Council of Nigeria,
 - Pharmacy Council of Nigeria,
 - Nursing & Midwifery Council of Nigeria,
 - Radiographers Registration Board of Nigeria,

- Medical Rehabilitation Therapists Registration Board,
 - Environmental Health Officers Registration Council,
 - Dental Technologists Registration Board of Nigeria,
 - Dental Therapists Registration Board of Nigeria,
 - Institute of Public Analysts of Nigeria,
 - Health Records Officers Registration Board of Nigeria,
 - Institute of Chartered Chemists of Nigeria,
 - Medical Laboratory Science Council of Nigeria,
 - Optometrists Registration Board of Nigeria, and
 - Community Health Practitioners Registration Board of Nigeria
5. Inter-ministerial Committee;
 - The Presidency
 - National Assembly, Health Committee
 - Federal Ministry of Education
 - National Universities Commission
 - Ministry of Defense
 - Federal Civil Service Commission
 - National Manpower Board
 - Federal Ministry of Finance

 6. Intra-ministerial Committee
 - Department of Public Health
 - Department of Health Planning, Research and Statistics
 - Department of Personnel Management
 - Department of Finance and supplies
 - Department of Hospital Services
 - Department of Food and Drugs Services
 - National Primary Health Care Development Agency
 - National Agency for Food and Drugs Administration and Control
 - National Health Insurance Scheme
 - National Tertiary Hospitals Services Commission

 7. Inter-Governmental Committee
 - State Ministries of Health H.R.H Units
 - Local Government Human resources for health Units

 8. Professional Health Associations in Nigeria
 - Nigerian Medical association
 - National Association of Nurses and Midwives
 - Pharmaceutical Society of Nigeria

 9. Partners:
 - World Health Organisation
 - W.H.O. AFRO (African Region)
 - World Health Organisation Nigeria
 - West African Health Organisation
 - Department for International Development (PATHS)
 - CIDA
 - USAID
 - UNDP
 - UNICEF
 - World Bank

10. Civil Societies and NGOs

- ACOSHED
- CHAN
- Red Cross
- Red Crescent

ANNEX 1 : HEALTH WORKFORCE IN NIGERIA-DEC 2007

Source: Federal Ministry of Health, 2008. Adapted from data collected from professional regulatory agencies and fixed as December 2007

STATISTICS OF PROFESSIONAL HEALTH WORKERS AS AT DECEMBER 2007

S/N	TYPE	TOTAL NO	IN GOOD STANDING*	PUBLIC	PRIVATE	UNEMPLOYED	ABROAD	FEMALE	MALE
1	DOCTORS (NIGERIANS)	52,408	14,000	Na	Na	Na	na	11,546	40,862
2	DENTISTS (NIGERIAN)	2,356		na	na	na	na	962	1,596
3	DOCTORS (ALIENS)	2,968	2,968	na	na	na	na	853	2,115
4	DENTISTS (ALIENS)	215	215	na	na	na	na	91	124
5	ALTERNATIVE MEDICINE PRACTITIONERS	10	10	0	10	0	0	1	9
6	NURSES	128,918	na	na	na	na	na	121929	6989
7	MIDWIVES	90,489	na	na	na	na	na	87164	7
8	PHARMACISTS	13,199	6,744	na	na	0	296	4,327	9,872
9	RADIO-GRAPHERS	840	600	na	na	0	47	271	528
10	PHYSIO-THERAPISTS	1,473	1,276	433	86	746	363	599	901
11	OCCUPATIONAL THERAPISTS	29	18	10	0	4	7	13	5
12	SPEECH THERAPISTS/AUDIOLOGISTS	26	26	17	0	4	5	17	9
13	HEALTH RECORDS	1,187	367	845	342	0	5	562	625
14	DENTAL TECHNOLOGISTS	505	350	382	41	38	17	92	370
15	DENTAL THERAPISTS	1012	936	720	249	11	76	577	425
16	PHARM. TECH	5483		na	na	na	na	na	na
17	ENVIRONMENTAL HEALTH OFFICERS	4280	1,500	na	na	na	na	1447	2833
18	COMMUNITY HEALTH OFFICERS	19268	na	18494	279	495	0	11437	7831
19	MEDICAL LABORATORY SCIENTISTS	12703	5548	na	na	na	na	1813	3735

20	MEDICAL LABORATORY ASSISTANTS	7,044	na	na	na	na	na	na	na
21	MEDICAL LABORATORY TECHNICIANS	2936	na	na	na	na	na	na	na
22	CHARTERED CHEMISTS	1503	1503	na	na	0	0	476	1027
23	PUBLIC ANALYSTS	500	313	na	na	0	12	123	377
24	OPTOMETRISTS	1415	205	1120	na	na	na	750	665
	* RENEWED ANNUAL PRACTISING LICENSE								
	** AS AT DEC 2005								

	Cadre	Total number	Female	Male	
1	Physicians (Nigerians)	52,408	11,546	40,862	
3	Physicians (Aliens)	2,968	853	2,115	
2	Dentists (Nigerians)	2,356	962	1,596	
4	Dentists (Aliens)	215	91	124	
6	Nurses	128,918	121929	6989	
7	Midwives	90,489	87164	7	
8	Pharmacists	13,199	4,327	9,872	
9	Radiographers	840	271	528	
10	Physiotherapists	1,473	599	901	
11	Occupational therapists	29	13	5	
12	Speech therapists	26	17	9	
13	Health records	1,187	562	625	
14	Dental technologist	505	92	370	
15	Dental therapists	1012	577	425	
16	Pharm. Technicians	5483	-	-	
17	Environmental Health Off	4280	1447	2833	
18	Community Health Off.	19268	11437	7831	
19	Medical Lab scientists	12703	1813	3735	
20	Medical Lab Assistants	7,044	-	-	
21	Medical Lab Technicians	2936	-	-	
22	Chartered chemists	1503	476	1027	
23	Public analysis	500	123	377	
24	Optometrists	1415	750	665	

ANNEX 2 : Contributing Agencies

The following organizations contributed to the preparation of the country profile through sharing their experiences and documents:

- Professional regulatory agencies
- Medical & Dental Council of Nigeria,
- Pharmacy Council of Nigeria,
- Nursing & Midwifery Council of Nigeria,
- Radiographers Registration Board of Nigeria,
- Medical Rehabilitation Therapists Registration Board,
- Environmental Health Officers Registration Council,
- Dental Technologists Registration Board of Nigeria,
- Dental Therapists Registration Board of Nigeria,
- Institute of Public Analysts of Nigeria,
- Health Records Officers Registration Board of Nigeria,
- Institute of Chartered Chemists of Nigeria,
- Medical Laboratory Science Council of Nigeria,
- Optometrists Registration Board of Nigeria, and
- Community Health Practitioners Registration Board of Nigeria
- Professional qualifying agencies
- National Postgraduate Medical College of Nigeria
- West African Health Examinations Board
- The National Universities Commission
- National Population Commission
- National Bureau of Statistics
- Central Bank of Nigeria
- Federal Ministry of Finance
- Debt Management Office, Nigeria
- The World Bank Group
- Department of Public Health, Federal Ministry of Health
- Department of Health Planning, Research and Statistics, Federal Ministry of Health
- Department of Personnel Management, Federal Ministry of Health
- Department of Finance and Supplies, Federal Ministry of Health
- NHMIS Division, Department of Planning Research and Statistics, Federal Ministry of Health
- National Agency for Control of AIDS (NACA)

ANNEX 3:**MEMBERS INVOLVED IN THE WORKING GROUP**

Name	Position/Title	Organization
Dr. Adetunji Labiran	Assistant Director (Human resources for health)	Dept of Health Planning, Research and Statistics, Federal Ministry of Health, Abuja
Professor Eyitayo Lambo	Former Honourable Minister of Health	International Management and Health Consultants, Abuja
Dr. Margaret Mafe	Head of Department	Dept of Public Health, Nigerian Institute of Medical Research, Yaba, Lagos
Dr. Bayo Onajole	Head of Department	Department of Community Health, College of Medicine, University of Lagos