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# HealthNet Nigeria

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## Nigeria at a Glance: Health Statistics

compiled March, 1999

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|---|---|
| Total Population | 118,369,000 |
| People per Physician | 4,496 (World Almanac, 1998) |
| Per capita GNP ($US) | 260 |
| Total national health expenditure as a % of GNP | 2.7 (World Bank, 1990) |
| % of national health expenditure devoted to local health care | 14 (WHO, 1989-90) |
| Total government health expenditure as a % of GNP | 1.2 (World Bank, 1990) |
| Life Expectancy at birth (in years) | Total population: 52 |
| Total Fertility Rate (children born/woman) | 6.0 |
| Infant Mortality Rate (deaths per 1,000 live births) | 78 |
| Probability of dying before 5th birthday (both sexes) | 14.1% |
| Maternal Mortality Rate (deaths per 100,000 live births) | 1,000 (UNICEF, 1998) |
| Child Malnutrition (% of children under age 5) | 35 (World Bank, 1997) |
| Immunization:<br>% of infants reaching their first birthday and have been fully immunized against: | |
| diphtheria, tetanus, pertussis | 24 |
| poliomyelitis | 26 |
| measles | 38 |
| tuberculosis | 43 |
| % of women that have been immunized with tetanus toxoid (TT) | 34 |

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| during pregnancy | |
| Access to safe drinking water (% of population) | Total: 50, Urban: 80, Rural: 39 (UNICEF, 1998) |
| Access to sanitation (adequate excreta disposal facilities) | Total: 38, Urban: 63, Rural: 23 (WHO, 1994) |
| Adult literacy rate (% of population age 15+ who can read and write) | Total: 57.1 |
| Main Telephone Lines | Source: Tam Tam to Internet<br><br>Total: 405,100<br>Per 100 inhabitants: 0.4<br><br>Households: 21,190,000<br>Residential main lines: 200,100<br><br>Per 100 households: 1.0<br>Main lines per 100 inhabitants: 0.4<br><br>Total payphones: 500<br>Payphones per 1,000 inhabitants: 0.0<br><br>Waiting list for telephones: 98,100<br>Waiting time: 3.5 years |

**NOTE:** All statistics are from *The World Health Report 1998*, published by the World Health Organization (WHO) unless otherwise noted.

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**Section 1 of 1**

# Nigeria

## History of Modern Medical Services

Western medicine was not formally introduced into Nigeria until the 1860s, when the Sacred Heart Hospital was established by Roman Catholic missionaries in Abeokuta. Throughout the ensuing colonial period, the religious missions played a major role in the supply of modern health care facilities in Nigeria. The Roman Catholic missions predominanted, accounting for about 40 percent of the total number of mission-based hospital beds by 1960. By that time, mission hospitals somewhat exceeded government hospitals in number: 118 mission hospitals, compared with 101 government hospitals.

Mission-based facilities were concentrated in certain areas, depending on the religious and other activities of the missions. Roman Catholic hospitals in particular were concentrated in the southeastern and midwestern areas. By 1954 almost all the hospitals in the midwestern part of the country were operated by Roman Catholic missions. The next largest sponsors of mission hospitals were, respectively, the Sudan United Mission, which concentrated on middle belt areas, and the Sudan Interior Mission, which worked in the Islamic north. Together they operated twenty-five hospitals or other facilities in the northern half of the country. Many of the mission hospitals remained important components of the health care network in the north in 1990.

The missions also played an important role in medical training and education, providing training for nurses and paramedical personnel and sponsoring basic education as well as advanced medical training, often in Europe, for many of the first generation of Western-educated Nigerian doctors. In addition, the general education provided by the missions for many Nigerians helped to lay the groundwork for a wider distribution and acceptance of modern medical care.

The British colonial government began providing formal medical services with the construction of several clinics and hospitals in Lagos, Calabar, and other coastal trading centers in the 1870s. Unlike the missionary facilities, these were, at least initially, solely for the use of Europeans. Services were later extended to African employees of European concerns. Government hospitals and clinics expanded to other areas of the country as European activity increased there. The hospital in Jos, for example, was founded in 1912 after the initiation there of tin mining.

World War I had a strong detrimental effect on medical services in Nigeria because of the large number of medical personnel, both European and African, who were pulled out to serve in Europe. After the war, medical facilities were expanded substantially, and a number of government-sponsored schools for the training of Nigerian medical assistants were established. Nigerian physicians, even if trained in Europe, were, however, generally prohibited from practicing in government hospitals unless they were serving African patients. This practice led to protests and to frequent involvement by doctors and other medical personnel in the nationalist movements of the period.

After World War II, partly in response to nationalist agitation, the colonial government tried to extend modern health and education facilities to much of the Nigerian population. A ten-year health development plan was announced in 1946. The University of Ibadan was founded in 1948; it included the country's first full faculty of medicine and university hospital, still known as University College Hospital. A number of nursing schools were established, as were two schools of pharmacy; by 1960 there were sixty-five government nursing or midwifery training schools. The 1946 health plan established the Ministry of Health to coordinate health services throughout the country,

including those provided by the government, by private companies, and by the missions. The plan also budgeted funds for hospitals and clinics, most of which were concentrated in the main cities; little funding was allocated for rural health centers. There was also a strong imbalance between the appropriation of facilities to southern areas, compared with those in the north.

By 1979 there were 562 general hospitals, supplemented by 16 maternity and/or pediatric hospitals, 11 armed forces hospitals, 6 teaching hospitals, and 3 prison hospitals. Altogether they accounted for about 44,600 hospital beds. In addition, general health centers were estimated to total slightly less than 600; general clinics 2,740; maternity homes 930; and maternal health centers 1,240.

Ownership of health establishments was divided among federal, state, and local governments, and there were privately owned facilities. Whereas the great majority of health establishments were government owned, there was a growing number of private institutions through the 1980s. By 1985 there were 84 health establishments owned by the federal government (accounting for 13 percent of hospital beds); 3,023 owned by state governments (47 percent of hospital beds); 6,331 owned by local governments (11 percent of hospital beds); and 1,436 privately owned establishments (providing 14 percent of hospital beds see; table 6, Appendix).

The problems of geographic maldistribution of medical facilities among the regions and of the inadequacy of rural facilities persisted. By 1980 the ratios were an estimated 3,800 people per hospital bed in the north (Borno, Kaduna, Kano, Niger, and Sokoto states); 2,200 per bed in the middle belt (Bauchi, Benue, Gongola, Kwara, and Plateau states); 1,300 per bed in the southeast (Anambra, Cross River, Imo, and Rivers states); and 800 per bed in the southwest (Bendel, Lagos, Ogun, Ondo, and Oyo states). There were also significant disparities within each of the regions. For example, in 1980 there were an estimated 2,600 people per physician in Lagos State, compared with 38,000 per physician in the much more rural Ondo State.

In a comparison of the distribution of hospitals between urban and rural areas in 1980, Dennis Ityavyar found that whereas approximately 80 percent of the population of those states lived in rural regions, only 42 percent of hospitals were located in those areas. The maldistribution of physicians was even more marked because few trained doctors who had a choice wanted to live in rural areas. Many of the doctors who did work in rural areas were there as part of their required service in the National Youth Service Corps, established in 1973. Few, however, remained in remote areas beyond their required term.

Hospitals were divided into general wards, which provided both outpatient and inpatient care for a small fee, and amenity wards, which charged higher fees but provided better conditions. The general wards were usually very crowded, and there were long waits for registration as well as for treatment. Patients frequently did not see a doctor, but only a nurse or other practitioner. Many types of drugs were not available at the hospital pharmacy; those that were available were usually dispensed without containers, meaning the patients had to provide their own. The inpatient wards were extremely crowded; beds were in corridors and even consisted of mattresses on floors. Food was free for very poor patients who had no one to provide for them. Most, however, had relatives or friends present, who prepared or brought food and often stayed in the hospital with the patient. By contrast, in the amenity wards available to wealthier or elite patients, food and better care were provided, and drug availability was greater. The highest level of the Nigerian elite frequently traveled abroad for medical care, particularly when a serious medical problem existed.

In the early 1980s, because of shortages of fuel and spare parts, much expensive medical equipment could not be operated. Currency devaluation and structural adjustment beginning in 1986 exacerbated these conditions. Imported goods of all types doubled or tripled in price, and government and public health care facilities were severely affected by rising costs, government budget cuts, and materials shortages of the late 1980s. Partly as a result of these problems, privately owned health care facilities became increasingly important in the late 1980s. The demand for modern medical care far outstripped its availability. Medical personnel, drugs, and equipment were increasingly diverted to the private sector as government hospitals deteriorated.

Government health policies increasingly had become an issue of policy debate and public contention in the late 1980s. The issue emerged during the Constituent Assembly held in 1989 to draft a proposed constitution. The original draft reported by the assembly included a clause specifying that free and adequate health care was to be available as a matter of right to all Nigerians within certain

categories. The categories included all children younger than eighteen; all people sixty-five and older; and all those physically disabled or handicapped. This provision was, however, deleted by the president and the governing council when they reviewed the draft constitution.

*Data as of June 1991*


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