

Country Profile: Nigeria

Demographic Context

The population progressively increased from 193M to 218M between 2017 to 2022, the highest population within this cohort of countries as shown in **figure 1**. Infants aged below 12 months and those below the age of 5 years accounted for less than 7% and 17% of the entire population respectively.

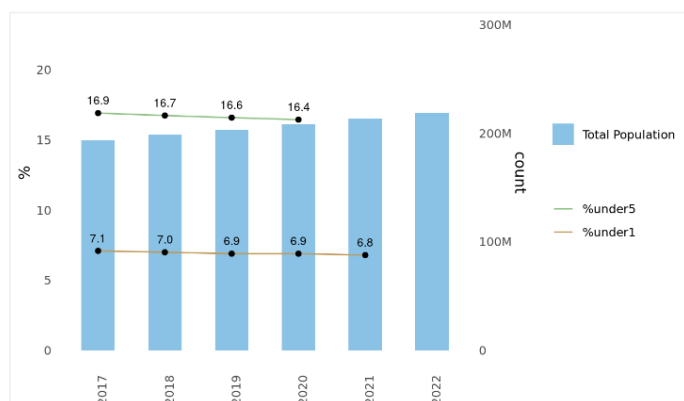


Figure 1: Population Trends in Nigeria

During the same period, the Human Development Index remained at 0.5, an average performance on individual longevity, education and income capabilities (**Figure 2**). The Human Capital Index increased from 0.3 to 0.4, which was below average in terms of the expected productivity of future generations owing to deprivations related to health and education. This implied that children born during the period would attain only 40% of their productivity potential. The life expectancy at birth remained between 52 and 53 years, the lowest within this cohort of countries.

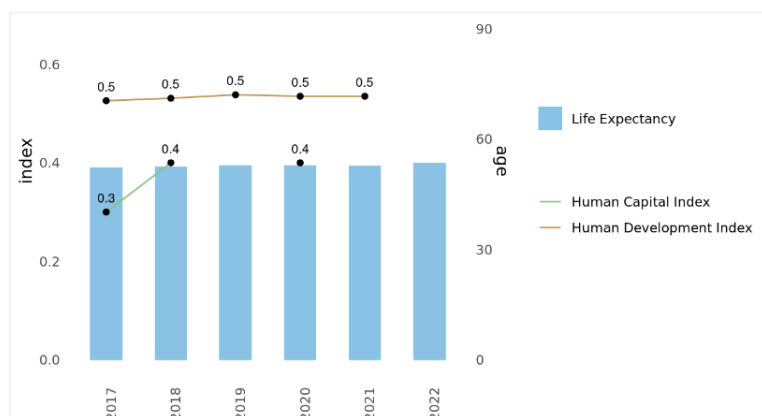


Figure 2: Development and Productivity Potential in Nigeria

Economic Context

The Gross National Income Per Capita increased from USD 1880 to USD 2105 during the period of analysis (**Figure 3**). This matches the accelerated transition phase for GAVI eligibility¹. The Tax to GDP ratio was below 6% between 2017 and 2022, one of the lowest within this cohort of countries despite being the wealthiest. It thus did not meet the regional 15% threshold for adequacy of financing public services.

The Debt to GDP ratio spanned between 25% and 38% during the period of interest hence well within the LMIC threshold of 64% for debt sustainability and adequacy of financing public services beyond debt repayment.

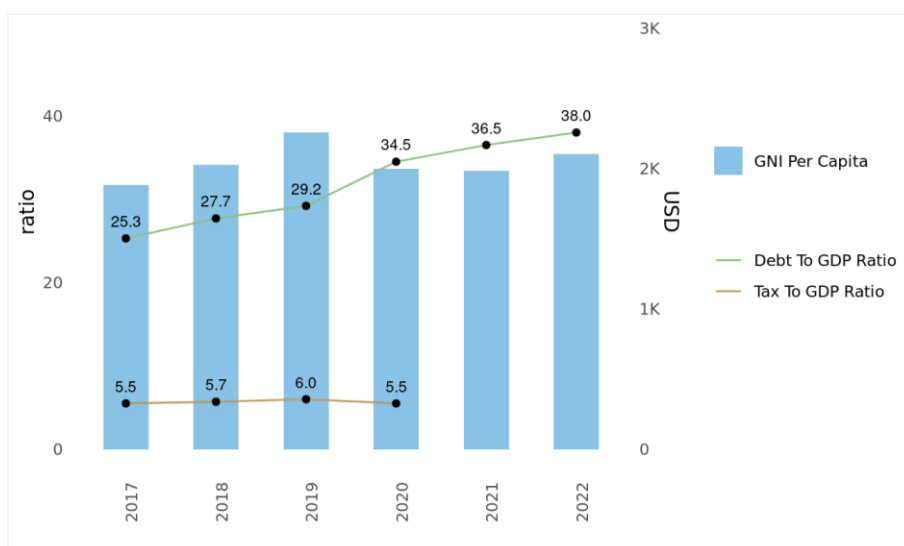


Figure 3: Economic Performance in Nigeria

Highlight

The low debt levels in Nigeria highlights potential for expansion of the fiscal space for health and immunization. This is however negated by the significantly low tax revenues implying weak tax administration within Nigeria.

A strengthened tax administration in Nigeria would help mobilize more resources for public goods such as health and immunization.

Health System Context

The top 3 causes of death in the general population were neonatal conditions, lower respiratory tract infections and diarrheal diseases. Preterm birth complications, birth trauma, congenital anomalies, malaria, pneumonia and diarrhea were the main causes of under 5 mortalities.

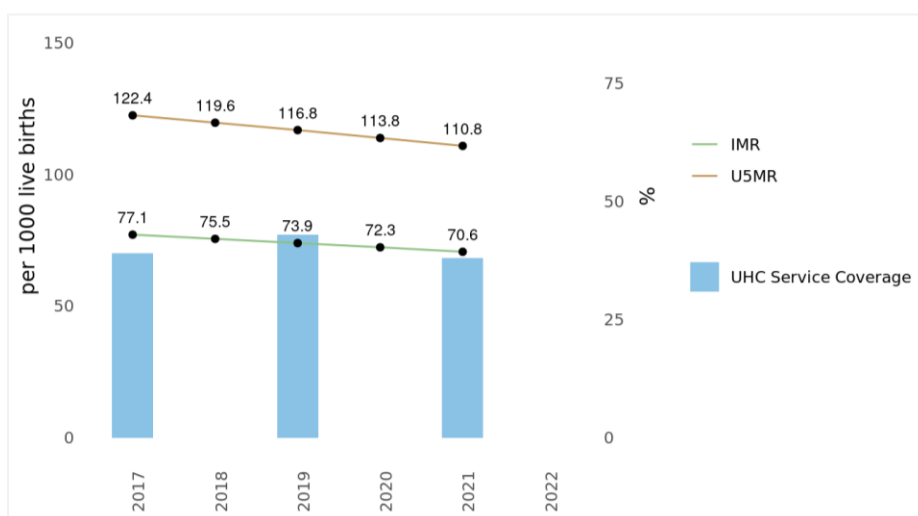


Figure 4: Health System Performance in Nigeria

While Nigeria had the highest U5MR in this cohort of countries, there was a steady decline in both the Infant and Under Five Mortality Rates over the period of analysis. The Infant Mortality Rate (IMR) declined from 77 to

71 deaths per 1000 live births, while the Under Five Mortality Rate declined from 122 to 110 deaths per 1000 live births as shown in **figure 4**.

The UHC Service Coverage Index in 2021 was 38% implying that just a third of the population in Nigeria had access to quality essential services including reproductive, maternal, newborn and child health, infectious diseases, and non-communicable disease services.

Health Financing Context

Government spending on health was below 1% of the GDP which was markedly below the minimum of 5% recommended for progression towards UHC2. The per capita spending on health was between USD 66 and USD 73 across the years, which was below the recommended per capita target of USD 862. Further, the government expenditure on health relative to other sectors was at 4%, which was below the 15% Abuja target, and the lowest within this cohort of countries (**Figure 5**).

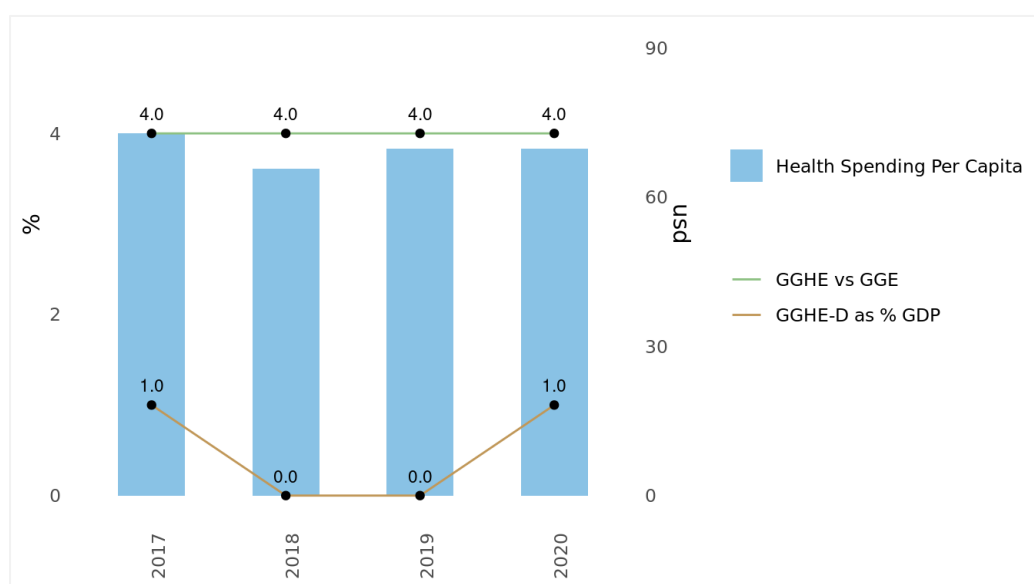


Figure 5: Health Financing Trends in Nigeria

Out of Pocket (OOP) spending was the most significant source of funding for health in Nigeria. OOP spending accounted for three quarters of all health financing, while donor funding and government funding each accounted for less than 15% of all health funding during the period of analysis (**Figure 6**).

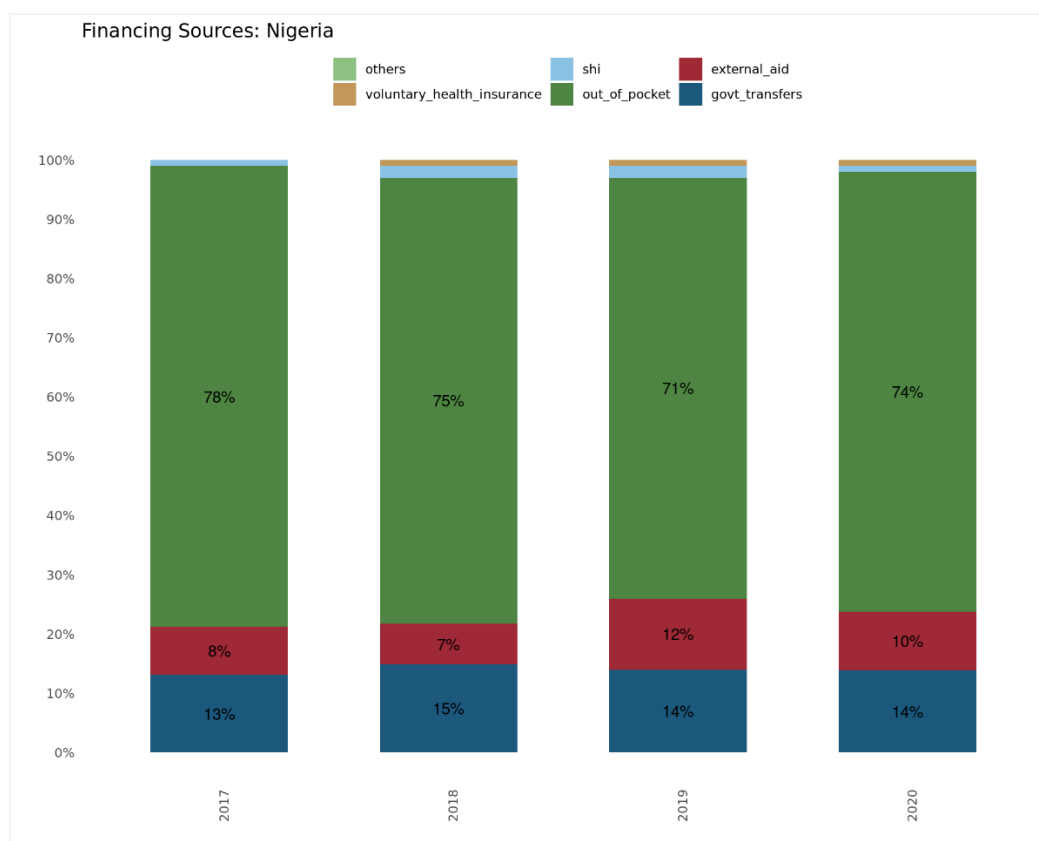


Figure 6: Health Financing Sources in Nigeria

Highlight

The significantly low UHC service coverage index highlights the need for system wide improvements to facilitate access to quality essential healthcare in Nigeria.

The high dependence on OOP payments poses a significant risk of financial hardship among the population as they seek for care. Strengthening pooling mechanisms in Nigeria would help reduce OOPs. Increased government allocations are essential to guarantee sustainability of health services, including immunization services.

Immunization Coverage

Overall, Nigeria had among the lowest immunization coverage rates (below 80%) the national immunization coverage rates showed a positive trend in performance between 2017-2022 (**Figure 7**). However, measles 2 coverage remained low and stagnated at 38% in 2020. There was no data available for measles 2 coverage in 2021 and 2022.

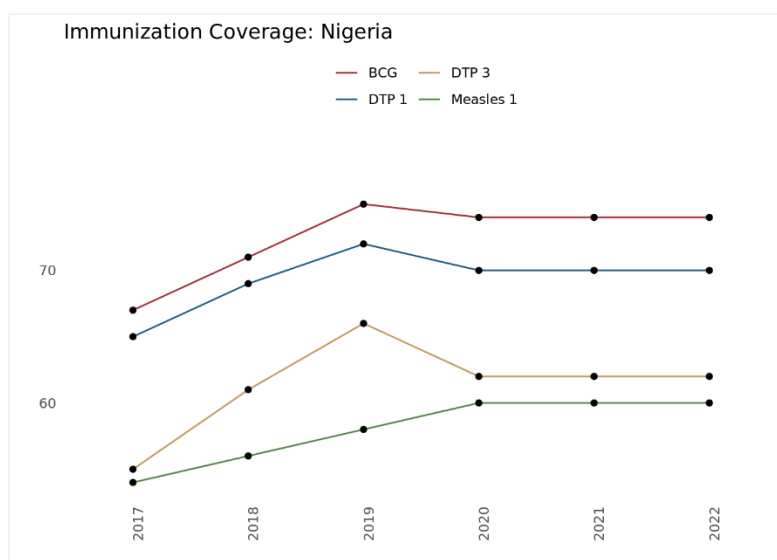


Figure 7: Immunization Coverage in Nigeria

Overall, lower income groups had significantly higher under five mortality rates, higher zero dose children and higher immunization coverage (**Figure 8**). There was a gap of more than 100 deaths per 1000 live births among the under-fives between the wealthiest and poorest income groups. Similarly, there was a gap of about 60% more Zero dose children among the poor income groups.

The coverage for DTP3 and MCV2 was generally low in Nigeria. The coverage gap across the income groups was approximately 10 percentage points in favor of the poorest income groups.

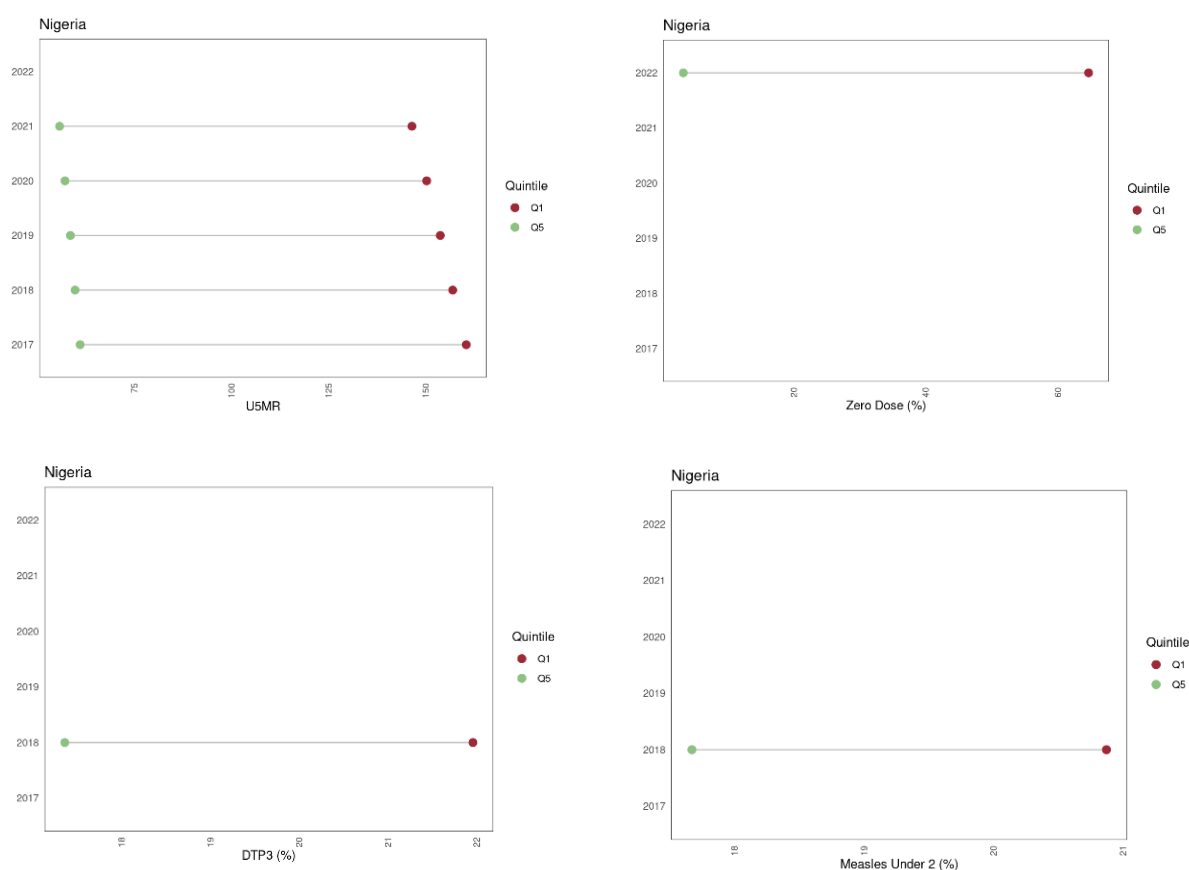


Figure 8: Equity Analysis of U5MR and Immunization Coverage in Nigeria

Immunization Financing

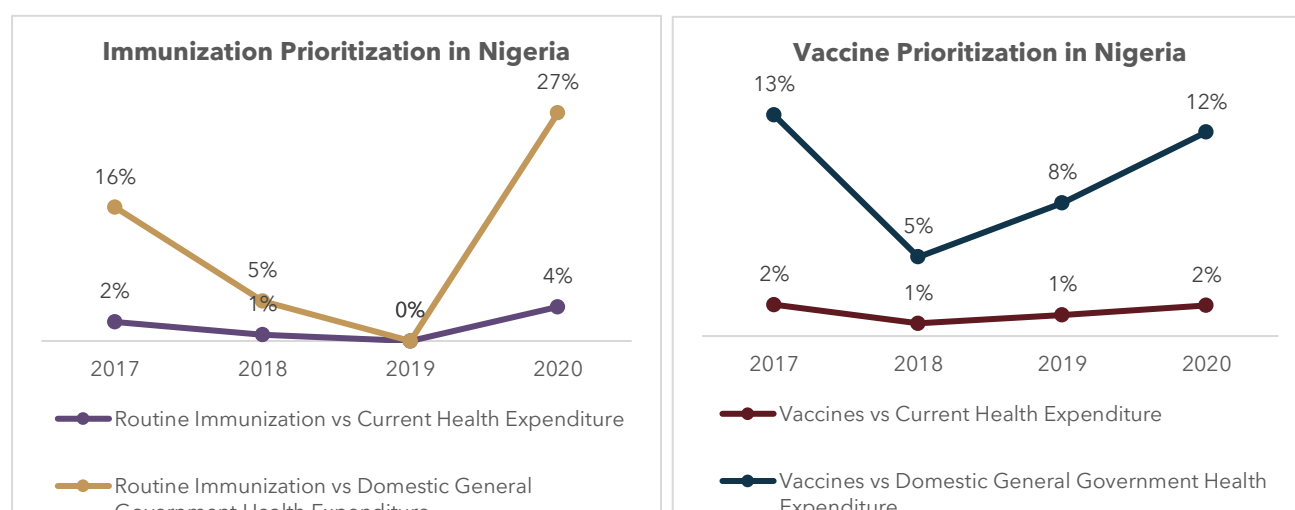


Figure 9: Prioritization of Immunization and Vaccines in Nigeria

Expenditures on Routine Immunization in Nigeria declined between 2018 and 2019. Routine immunization accounted for between less than 1% and 4% of the Current Health Expenditure; and between 5% and 27% of the Domestic General Government Health Expenditures between 2017 and 2020 (**Figure 9**). Vaccine related expenditures accounted for less than 2% of the CHE, and between 5% to 13% of the Domestic General Government Expenditures.

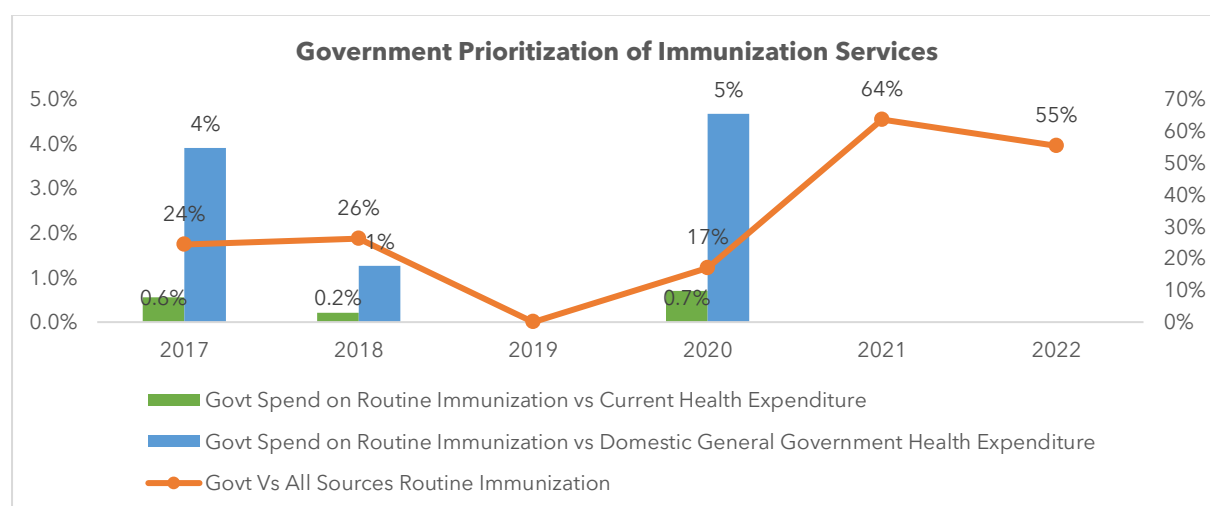


Figure 10: Government Prioritization of Immunization in Nigeria

Government funding as a source of immunization financing fluctuated between 17% to 64% between 2017 and 2022. This accounted for less than 1% of Current Health Expenditures and less than 5% of the Domestic General Government Health Expenditure (**Figure 10**).

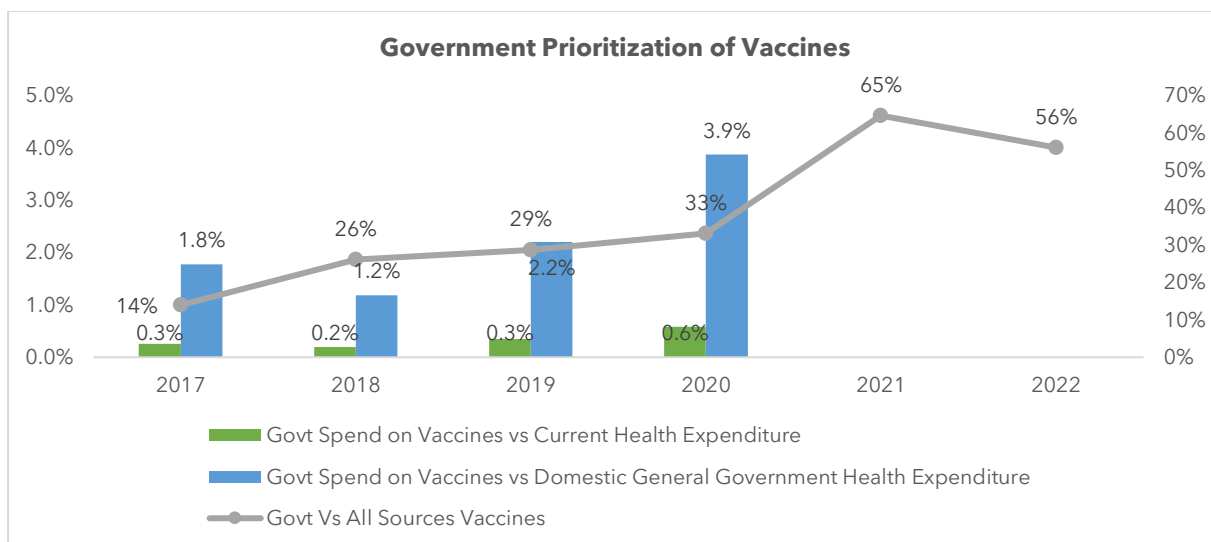


Figure 11: Government prioritization of Vaccines in Nigeria

Government funding as a source of vaccination financing progressively increased from 14% to 65% between 2017 and 2022. This accounted for less than 1% of Current Health Expenditures and below 5% of the Domestic General Government Health Expenditure (**Figure 11**).

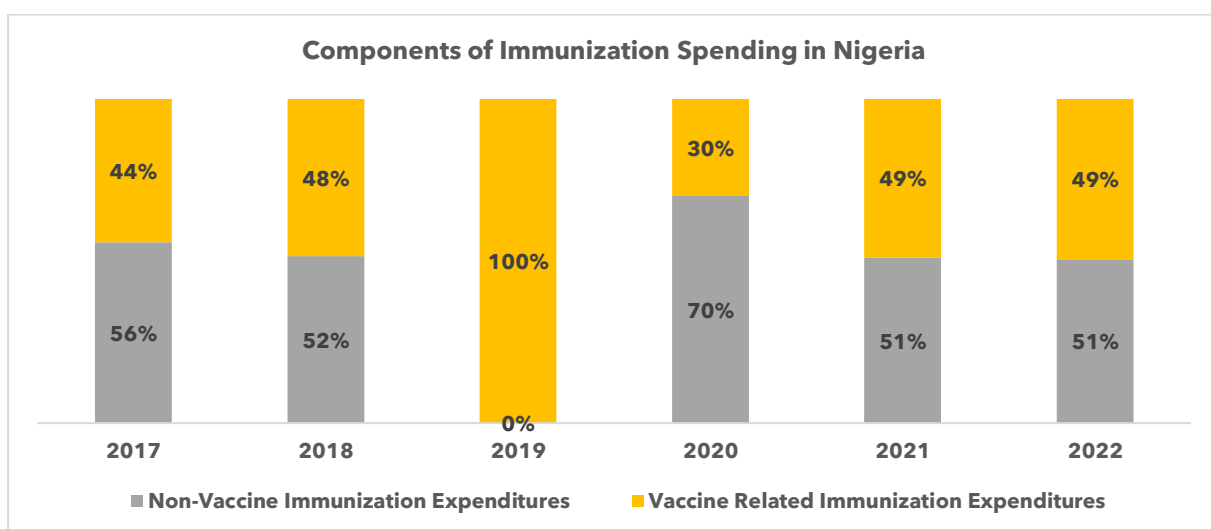


Figure 12: Components of Immunization Financing in Nigeria

Procurement of vaccines accounted for just about half of the immunization expenditures between 2017 and 2022 in Nigeria (**Figure 12**).

Highlight

There is some donor dependence for immunization financing in Nigeria. This threatens sustainability of immunization services. Progressive increments in government financing of health and immunization will help mitigate against donor dependence and financial hardship among households as they seek for immunization services.

The generally low coverage rates highlight the need for vaccination campaigns targeted also to the higher income groups.

Recommendations towards improving immunization services in Nigeria.

1. **Vaccine Supply and Cold Chain Management:** Increase vaccine production and distribution, improve cold chain infrastructure, and implement effective waste management mechanisms.
2. **Access and Geographic Barriers:** Establish mobile immunization clinics, increase the number of healthcare workers, and improve transportation infrastructure.
3. **Vaccine Hesitancy:** Increase public awareness through targeted campaigns, engage with community leaders, and provide accurate information about vaccines.
4. **Healthcare Workforce Shortages:** Increase the number of trained healthcare workers, provide adequate training and supervision, and incentivize healthcare workers to work in rural areas.
5. **Socioeconomic Factors:** Increase public awareness through targeted campaigns, provide free or subsidized vaccines, and improve access to education and healthcare.
6. **Security Challenges:** Increase security in conflict-prone areas, provide adequate protection for healthcare workers, and establish contingency plans for immunization services.
7. **Data Management and Monitoring:** Improve data collection and management systems, establish a centralized database for immunization data, and provide training for healthcare workers on data management.
8. **Cultural and Religious Factors:** Engage with religious and community leaders, provide accurate information about vaccines, and address cultural and religious beliefs that discourage vaccination while developing culturally appropriate immunization programs.
9. **Inadequate Government Funding:** Increase government funding for immunization programs, establish a predictable funding mechanism, and reduce dependence on external donors.
10. **Health System Weaknesses:** Improve healthcare infrastructure, establish efficient logistics and supply chain management, and strengthen health system governance.

Recommendations towards improving immunization financing in Nigeria.

1. **Inadequate Government Funding:** Increase budget allocation for immunization programs, prioritize immunization spending, and improve budget transparency.
2. **Dependency on Donor Funding:** Diversify funding sources, establish predictable long-term partnerships with donors and private sector, and develop contingency plans for funding fluctuations.
3. **Financial Mismanagement:** Improve financial management systems, establish accountability mechanisms, and increase transparency in financial reporting.
4. **High Cost of Vaccines:** Negotiate favorable vaccine prices with manufacturers, explore alternative negotiated procurement mechanisms, prioritize vaccines based on cost-effectiveness, and incentivize domestic manufacturing of vaccines.
5. **Supply Chain Costs:** Increase budget allocation for supply chain logistics, improve cold chain infrastructure, and establish effective waste management mechanisms.
6. **Human Resource Costs:** Increase incentives for healthcare workers involved in immunization delivery, provide adequate training and supervision, and incentivize healthcare workers to work in rural areas.
7. **Healthcare Infrastructure Costs:** Increase budget allocation for healthcare infrastructure, prioritize infrastructure development in underserved areas, and establish public-private partnerships for infrastructure development.
8. **Health Insurance Coverage:** Expand health insurance programs to cover immunization costs, establish public-private partnerships for health insurance, and increase awareness of health insurance benefits.
9. **Economic Challenges:** Strengthen Public Finance Management systems, establish contingency plans for economic fluctuations, prioritize immunization spending during recessions, and increase public-private partnerships for immunization financing.
10. **Advocacy & Awareness:** Increase public and political awareness of the importance of immunization, engage with community leaders and stakeholders, and establish advocacy campaigns for immunization financing.
11. **Coordination & Accountability:** Strengthen central and decentralized immunization coordination among government agencies, donors, and implementing partners, with stronger accountability mechanisms to ensure funds are used effectively.

- 12. Data and Monitoring:** Increase funding for data collection, monitoring, and evaluation of immunization programs, strengthen the centralized database for immunization data, and provide training for healthcare workers on data management.

References

- GAVI. (2022). *Gavi Alliance Eligibility and Transition Policy Version 4*. <https://www.gavi.org/types-support/sustainability/eligibility>
- McIntyre, D., Meheus, F., & Rottingen, J. A. (2017). What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Economics, Policy and Law*, 12(2), 125-137. <https://doi.org/10.1017/S1744133116000414>