An Evaluation of the Implementation of Millennium Development Goals (MDGs) Health Programmes in Nigeria

By

N. A. Shalok¹ and A. O. Ogoh²

Abstract

The relevance of health cannot be over-emphasised. This is because, it has been and continued to remain one of the most priced assets of every country that desires or aspires to join the league of developed countries in the world. The reason being that health, no doubt, contributes immensely to increased productivity and high income growth. In view of this, the paper evaluates the success or otherwise of the implementation of the Millennium Development Goals (MDGs) health-related programmes in Nigeria. The aim of the Millennium Development Goals (MDGs) is to encourage development by improving social, economic and health conditions in the world’s poorest countries. Nigeria, interestingly, was an enthusiastic signatory to the Millennium Development Goals (MDGs) and has claimed to pursue them vigorously since then, though with varying degrees of success. The information used in this evaluation was gathered through the secondary method of data collection. Using the Political System Theory, also known as the Input-Output Approach, the paper argues that Nigeria has not achieved any of the health-related MDGs because the outputs from the system are not favourable. Therefore, they will be channelled back into the system as inputs for further action by the government. As a result, the paper concludes that Nigeria has performed poorly in meeting the health-related MDGs targets. To this end, the paper recommends home-grown policies and strategies that will drive development in the country’s health sector in particular and the country in general. Increased budgetary allocation to the health section is also recommended.

Key Words: Millennium Development Goals, Health, Nigeria,

Introduction

It is pertinent to say that the relevance and importance of keeping and maintaining good health cannot be over-emphasised. This is because, a healthy status has continued and will remain the most priced asset of every nation that aspires to make progress. This is often reflected in phrases such as “a healthy nation is a wealthy nation,” and “health is wealth”. In other words, health improvements contribute in no small measure to other development priorities or objectives such as increased productivity and high income growth. Again, the total amount of health time available for people is also determined by health capital. Therefore, the need to maintain a healthy lifestyle is necessary and it is equally pivotal to safeguard our well-being. Importantly, over the past 50 years, the world has actually witnessed unprecedented gains in health as measured in physical terms. For example, life expectancy at birth has increased from 46
years in the 1950s, to 65 years in 1995 (Shut, 2005).

The founders of the World Health Organisation (WHO) over half a century ago defined health as “a state of total or complete physical, mental and social well-being and not simply the absence of disease or infirmity” (WHO, 1948). This view was earlier reinforced by Sigerist (1941) who expresses the view that health is therefore, something positive, a joyful attitude to life, and a cheerful acceptance of the responsibilities that life puts upon the individual, and not merely the absence of disease. That a healthy individual is a man who is well balanced both bodily and mentally, as well as well-adjusted to his physical and social environment. Furthermore, according to Derek (2003) the Constitution of World Health Organisation (WHO) recognised the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being. And that this right to health, as it became expressed in a summarised version in many subsequent documents, includes the right to adequate food, water, clothing, housing, health care, education, security in the event of unemployment, sickness, disability, old age or lack of livelihood in circumstances beyond an individual’s control. In light of the above, this paper seeks to evaluate the implementation of the Millennium Development Goals (MDGs) health programmes in Nigeria.

Theoretical Framework

This paper is anchored on the political system theory or approach which is also known as the input-output approach. It was David Easton (1979) who popularised this theory in political studies. His system theory, which is built on the fact that organisations represent social systems which are a whole comprising of many parts that are interrelated and, can be explained as a two-way traffic. That is, the political system which is made up of an environment with different actors (interest or pressure groups, political parties, students, farmers, market women, and lecturers) takes input from the environment or society comprising of demands (claims for action that individuals and groups make to satisfy their interests and values) for particular policies and expression of support for government, and converts them into output (authoritative policies and decisions) (Shut, 2005 and Okoye, 2015). The outputs then feed-back to the environment so as to affect the next circle of inputs. By outputs, we mean what government actually do or the services it renders. The degree of successes of government policy is tested through feedback, which underscores the relevance of the theory to this paper.

It is therefore, within the above context that this paper evaluates the outputs of the implementation of the Millennium Development Goals (MDGs) health programmes, which are seen as inputs or demands emanating from the environment into the political system to ascertain whether or not they are positive. If the outputs are positive, they will go back into the system as support. But if they are negative, they will go back into the system as inputs.

Understanding Millennium Development Goals (MDGs)

Following the United Nations global conferences of the 1990s, the United Nations Millennium Declaration in the year 2000 marked a global partnership for establishing or creating a conducive environment at both the national and global levels, for the eradication of poverty and the promotion of sustainable human development which paved way for the formation of the Millennium Development Goals (MDGs) (MDGs, 2010). The Millennium Development Goals (MDGs) are commonly or popularly described as a
“roadmap for world development by 2015”. Consequently, they currently serve as invaluable foundation or framework for the transition to the Sustainable Development Goals (SDGs), which was launched in September, 2015, by the United Nations General Assembly (UNGA) (MDGs, 2015). That is to say, they are the link between Nigeria’s MDGs era and the post-MDGs development framework now formally known as the SDGs. The SDGs, otherwise known as the Global Goals, are a universal call to action in order to end poverty, protect the planet and ensure that all people enjoy peace and prosperity (UNDP, 2018). Building on the contentious assumption of “leaving no one behind”, the new Agenda emphasises a holistic approach to achieving sustainable development for all. The year 2016 marks the first year of the implementation of the SDGs. That is, the SDGs came into effect in January 2016 (UNDP, 2018).

From the above, therefore, suffice to say that the MDGs embodied the core content of the current development agenda of “global governance”. They are treated as the current framework of international development cooperation, to which there would allegedly be no alternative. All countries and development agencies have so far proven to comply with this framework, reasoning and operating “inside the box”. The Millennium Development Goals (MDGs) framework over the years has in practice, acquired a politically and morally compelling character (Crossette, 2005).

The Millennium Development Goals are eight (8) international goals that were formally established following the millennium summit of the United Nations (UN) in 2001. The Millennium Development Goals (MDGs) caught the world’s imagination from the very day they were agreed upon by a record of 189 countries and 23 international organisations at the United Nations (UN) General Assembly in September 2000, agreed to achieving those targets (MDGs, 2013).

Importantly, Nigeria was an enthusiastic signatory to the Millennium Development Goals (MDGs) and has claimed to pursue them vigorously since then, though with varying degrees of success. The aim of Millennium Development Goals (MDGs) is to encourage development by improving social, economic and health conditions in the world’s poorest countries. As a result, they inspired a global lobby, the ‘End poverty 2015 Millennium Campaign’, which describes itself as a growing global movement of people who are demanding that their governments honour their commitments to achieve the Millennium Development Goals (MDGs) by 2015 (Crossette, 2005). Thus, the Millennium Development Goals (MDGs) were made to operationalise these ideas by setting targets and indicators for each target (MDGs, 2013).

The eight (8) main targets of the Millennium Development Goals (MDGs), using 1990 as baseline, are:

i. Goal 1: Eradicate Extreme Poverty and Hunger
2015 target: Halve proportion of people living on less than $1 a day, and those suffering hunger.

ii. Goal 2: Achieve Universal Basic Education
2015 target: Achieve universal primary completion.

iii. Goal 3: Promote Gender Equality

iv. Goal 4: Reduce Child Mortality
2015 target: Reduce by two thirds the child mortality rate.
v. Goal 5: Improve Maternal Mortality
2015 target: Reduce by three quarters the proportion of women dying in childbirth.

vi. Goal 6: Combat AIDS, Malaria and Other Diseases
2015 target: Halt and begin to reverse the incidence of HIV/AIDS, malaria and other major diseases.

vii. Goal 7: Ensure Environmental Sustainability
Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.
2015 target. Reduce by half the proportion of people without access to clean drinking water and basic sanitation.
By 2020 achieve a significant improvement in the lives of at least 100 million slum dwellers.

viii. Goal 8: Develop a Global Partnership for Development
These are not measurable. Goal 8 commits North and South to working together to achieve an open, rule-based trading and financial system, more generous aid to countries committed to poverty reduction, and relief for the debt problems of developing countries. It draws attention to the problems of the least developed countries and landlocked countries and small island developing states, which have greater difficulty competing in the global economy (Igbuzor, 2013). The focus of this paper, however, is on goals 4, 5 and 6. That is, the paper appraises or evaluates the attainment of the health programmes of the Millennium Development Goals (MDGs) in Nigeria.

The Specific Health Strategies Advanced for Accelerating the MDGs are As Follows:

i. Goal 4: Reduce Child Mortality – Rapidly implement the integrated maternal, new-born and child health care strategy using the ward Minimum Health Package.

ii. Goal 5: Improve Maternal Health – Strengthen the primary health care system at local level and ensure the implementation of the Safe Motherhood Programme.


Evaluation of the Millennium Development Goals (MDGs) 4, 5 and 6 in Nigeria

It is worthy to note that the larger chunk of the data used below in evaluating the implementation of Millennium Development Goals (MDGs) health-related programmes in Nigeria covers the period between 1990 (baseline) and 2013. However, the MDGs End-Point Report of 2015 has been consulted and effectively utilised in order to fill in the gap

Table A: Health Indicators for Reducing Child Mortality Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>Infant mortality rate (per 1000)</th>
<th>Under 5 mortality rate (per 1000)</th>
<th>Immunisation against measles (% of children ages 12 – 23 months)</th>
<th>Vitamin A supplement (% of children ages 6 – 59 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>126.3</td>
<td>213.2</td>
<td>54</td>
<td>23.0</td>
</tr>
<tr>
<td>1995</td>
<td>123.7</td>
<td>208.5</td>
<td>44</td>
<td>30.0</td>
</tr>
<tr>
<td>2000</td>
<td>112.5</td>
<td>112.5</td>
<td>33</td>
<td>30.0</td>
</tr>
<tr>
<td>2005</td>
<td>97.7</td>
<td>97.1</td>
<td>41</td>
<td>73.0</td>
</tr>
<tr>
<td>2010</td>
<td>81.9</td>
<td>81.9</td>
<td>56</td>
<td>91.5</td>
</tr>
<tr>
<td>2011</td>
<td>79.2</td>
<td>79.2</td>
<td>52</td>
<td>73.0</td>
</tr>
<tr>
<td>2012</td>
<td>76.6</td>
<td>76.2</td>
<td>37</td>
<td>78.0</td>
</tr>
<tr>
<td>2013</td>
<td>74.3</td>
<td>75.1</td>
<td>59</td>
<td>78.0</td>
</tr>
</tbody>
</table>


The performance of the Nigerian government as shown in the data above in reducing the mortality rate of under-five by virtually two-thirds is quite commendable. This is because the reduction in the under-five mortality rate is significant in the country. In 1990, there was a reduction in the under-five mortality rate (U5MR) from 213.2 deaths per 1000 live births to 75.1 deaths per 1000 live births in 2013. This amounted to about 65% reductions in U5MR (Oyeniran and Onokosi-Alliyu, 2015). According to the end-point report of (MDGs, 2015), there has been a remarkable improvement in U5MR with a reduction from 191 deaths per 1000 live births in 2000 to 89 deaths per 1000 live births in 2008 and 2012 respectively (MDGs, 2015). Drawing from the above figures, therefore, suffice to say that in spite of the significant reduction in U5MR, Nigeria has fallen short of the 2015 target of 64 deaths per 1000 live births by approximately 28%.

Furthermore, there was a substantial decrease in infant mortality (under 1) from 126.3 per 1000 live births in 1990 to 74.3 deaths per 1000 live births in 2013 (Oyeniran and Onokosi-Alliyu, 2015). Using 1990 as the baseline, the infant mortality rate (IMR) was approximately put at 91 deaths per 1000 live births. However, there was a reduction from 91 to 75 deaths per 1000 live births in 2008, from 75 to 61 deaths per 1000 live births in 2012 and from 61 to 58 deaths per 1000 live births in 2014 (MDGs, 2015). Even though from the figures above we can confidently say that there was progress in IMR, Nigeria has nevertheless, fallen short of the 2015 target of 30 deaths per 1000 live births.

Again, Nigeria recorded a tremendous increase in the percentage of children receiving Vitamin A supplement in the period under review. Based on the figures above, the percentage increased from 23% in 1990 to approximately 91.5% in 2010. Although the percentage decreased to 78% in 2013, it was still an appreciable progress, using 1990 as the baseline. These milestones were to a large extent due to interventions; example is the Integrated
Management of Childhood Illnesses that reflects the underlying causes of child deaths (UNDP, 2007).

In the area of immunisation coverage, Nigeria has performed below expectation. This is because, there has been fluctuations in the number of children (ages 12 – 23 months) immunised against measles between 1990 and 2013. In 1990, the immunisation coverage which was put at above 54% substantially dropped to 33% in 2000, with a marginal increase to 41% in 2005 and then another decline in 2012 to 37%. The percentage of the immunisation coverage was put at 59% in 2013 (Oyeniran and Onikosi-Alliyu, 2015). Although the End-Point Report of MDGs (2015) says the proportion of children (one-year-old) immunised against measles rose from 46% in 1990 to 61.3% in 2012, and then to 63.0% in 2014, the increase was still negligible to bring about any significant impact. That notwithstanding, Nigeria has performed well in the area of eradicating polio; she celebrated one year of being polio free from July 2014 to July 2015 (MDGs, 2015).

2. Goal 5: Improve Maternal Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Maternal mortality rate per 100,000 live births</th>
<th>Proportion of births attended to by skilled health personnel (% of total)</th>
<th>Adolescent fertility rate (birth per 1000 women ages 15 – 19)</th>
<th>Pregnant women receiving prenatal care (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>1200</td>
<td>30.8</td>
<td>148.01</td>
<td>56.5</td>
</tr>
<tr>
<td>1995</td>
<td>1100</td>
<td>37.2</td>
<td>139.35</td>
<td>60.1</td>
</tr>
<tr>
<td>2000</td>
<td>950</td>
<td>40.1</td>
<td>132.66</td>
<td>61.8</td>
</tr>
<tr>
<td>2005</td>
<td>740</td>
<td>36.2</td>
<td>126.37</td>
<td>58.0</td>
</tr>
<tr>
<td>2010</td>
<td>610</td>
<td>45.3</td>
<td>121.33</td>
<td>64.3</td>
</tr>
<tr>
<td>2011</td>
<td>590</td>
<td>48.7</td>
<td>120.46</td>
<td>65.5</td>
</tr>
<tr>
<td>2012</td>
<td>560</td>
<td>48.9</td>
<td>119.56</td>
<td>66.2</td>
</tr>
<tr>
<td>2013</td>
<td>560</td>
<td>48.7</td>
<td>118.02</td>
<td>66.8</td>
</tr>
</tbody>
</table>


A careful look at Nigeria’s performance in reducing maternal mortality and creating access to reproductive health shows a sluggish progress. With particular reference to universal access to reproductive health, the performance has been slow, and this poses significant challenge to women’s health in the country. Even though there was an appreciable decrease in maternal mortality rate between 1990 and 2013, the level of decrease in maternal mortality which stood at approximately 53% is very much below the set target of 75% decrease or reduction. From the data presented above, maternal mortality rate (MMR) per 100,000 live births dropped from 1,200 per 100,000 live births in 1990 to 560 mortality in 2013 (Oyeniran and Onikosi-Alliyu, 2015). Furthermore, the MDGs End-Point Report (2015), using the baseline figure of 1000 deaths per 100,000 live births in 1990, maintained that MDG 5 has seen improvements in maternal mortality. That MMR consistently dropped over the years to 545 in 2008. The downward movement continued, according to the report to 350 deaths per 100,000 live births in 2012, and to its end-point status of 243 per 100,000.
Inasmuch as I agree that there has been consistent decrease in MMR over the years, it is my contention that the decrease or improvements were marginal or insignificant to make the desired impact in the country, based on the available data.

According to Omowaleola (2013), the poor performance of Nigeria in maternal mortality rate (MMR) and access to reproductive health can be attributed to numerous factors which include among others: poor medical facilities, incessant strike actions by medical personnel and the challenge of relocating midwives to the hinterland or rural areas. However, it is hoped that the innovative Midwives Service Scheme will contribute substantially to on-going shortfalls (UNDP, 2007).

With respect to the number or proportion of births attended to by skilled health workers, marginal increase was recorded between 1990 and 2012. There was increase from 30.8% in 1990 to 48.9% in 2012. In 2014, the figure stood at 58.6% as the end-point status (MDGs, 2015). From a baseline figure of 30.8% in 1990 to an end-point status of 58.6% in 2014, one can say significant improvement has been achieved in this area.

In the area of prenatal or antenatal coverage, appreciable success was recorded. Although the data above reveals that there have been fluctuations in the percentage of pregnant women receiving prenatal care. In 1990, for example, the percentage increased from 56.5% to 61.8% in 2000, and further dropped to 58% in 2005. In 2013, the percentage of prenatal coverage was 66.8%. In 2014, prenatal coverage of at least one visit achieved an end-point status of 68.9%, slightly above that of 2013. And for at least Four visits, the end-point status was 60.6% in 2014 (MDGs, 2015).

3. Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

<table>
<thead>
<tr>
<th>Year</th>
<th>HIV prevalence (% of population 15+)</th>
<th>Incidence of tuberculosis per 100,000 people</th>
<th>Number of children ages 0.14 living with HIV (in thousand)</th>
<th>Tuberculosis case detection rate (% of all forms)</th>
<th>Use of insecticide treated bed nets (% of Under 5 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>53.2</td>
<td>128</td>
<td>160</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>56.1</td>
<td>139</td>
<td>180</td>
<td>8.9</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>57.0</td>
<td>172</td>
<td>210</td>
<td>12.0</td>
<td>1.2</td>
</tr>
<tr>
<td>2005</td>
<td>57.3</td>
<td>175</td>
<td>230</td>
<td>26.0</td>
<td>3.0</td>
</tr>
<tr>
<td>2010</td>
<td>57.4</td>
<td>133</td>
<td>250</td>
<td>40.0</td>
<td>29.1</td>
</tr>
<tr>
<td>2011</td>
<td>57.4</td>
<td>118</td>
<td>280</td>
<td>45.0</td>
<td>16.4</td>
</tr>
<tr>
<td>2012</td>
<td>57.5</td>
<td>108</td>
<td>300</td>
<td>51.0</td>
<td>16.6</td>
</tr>
<tr>
<td>2013</td>
<td>58.0</td>
<td>320</td>
<td>53.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


According to the MDGs end-point report (2015), there has been a steady decline in the prevalence rate of HIV among young pregnant women between the ages of 15 and 24 years – from 5.4% in 2000 to 4.1% in 2010. This decline, however, is very marginal as to make any significant impact. The data displayed above shows that in Nigeria, the prevalence rate of HIV/AIDS still remains high, and on the
increase. The HIV prevalence in pregnant women, between the age of 15 and above, as shown in the data above, grew from 53.2% in 1990 to 58% in 2013. Again, the proportion of children living with HIV grew from 160,000 in 1990 to 320,000 in 2013.

In the area of tuberculosis, Nigeria has grossly underperformed because the incidence of tuberculosis is still quite huge in the country. The incidence of tuberculosis which stood at 128 per 100,000 persons in 1990 significantly skyrocketed to 175 per 100,000 persons in 2005. In 2012, however, the figure decreased to 108 per 100,000 persons. Also, in the period under review, tuberculosis case detection rate increased throughout. The number increased in 1995 from 8.9% to 53% in 2013 (Oyeniran and Onikosi-Alliyu, 2015). It was hoped that with sustained attention and effort, incidence of tuberculosis was expected to be a limited public health challenge or burden by the end of 2015 (UNDP, 2007). However, at the end of 2015, the case is not different. In the past 23 years, according to MDGs end-point report (2015), the value for this indicator fluctuated between 343 in 2005 and 339 in 2012. In 2013, the figure was put at 338 as the end-point status – a figure largely regarded as unacceptable.

As regards malaria, there has been tremendous reduction in its prevalence rate. This success was largely attributed to the massive distribution of about 72 million long-lasting insecticide treated mosquito nets nationwide. It was observed that in its initial stages, the long-lasting insecticide-treated mosquito nets protected twice as many children (10.9 per cent) in 2009, compared to 2008 (5.5 per cent) (UNDP, 2007). Furthermore, the proportion or percentage of children sleeping under the long-lasting insecticide-treated mosquito nets increased appreciably in 2000 from 1.2% to 29.1% in 2010, and later dropped to 16.6% in 2012 (Oyeniran and Onikosi-Alliyu, 2015).

In addition, Nigeria has achieved a cheering and striking success in almost eradicating polio, by reducing the number of cases by almost 98 per cent between 2009 and 2010 (though not captured in Table C) (MDGs, 2010). Interestingly, Nigeria celebrated one year without polio from July 2014 to July 2015 (MDGs, 2015).

Conclusion and Recommendations

Although it is obvious that Nigeria has not achieved any of the health-related Millennium Development Goals (MDGs), the above evaluation shows that there are some positive stories to be told. The country, for example, has done pretty well in terms of reducing under-five mortality rate (U5MR) and almost eradicating polio. That is to say, today, many children are surviving up to their fifth birthday. Consequently, the fears of many mothers have been allayed with respect to given birth, and are almost sure that their children will not yield to polio.

However, the performance of Nigeria in relation to the health-related Millennium Development Goals (MDGs) target is far below expectation. In other words, Nigeria has performed poorly. This is because the statistics shows that health conditions in the country are in comatose, particularly in terms of access to good or quality health facilities. Thus, maternal death or mortality and HIV/AIDS prevalence have both assumed an alarming proportion. This position has been corroborated by Omowaleola (2013), that majority of the pregnant women attended to by skilled health workers are largely found in the urban areas, since most of the medical personnel are unwilling to move to the hinterlands due to absence of social amenities and the deplorable state of health facilities. As a result, most of the pregnant
women in the hinterlands are invariably denied access to the services of medical personnel. Thus, one can conveniently say at this point that a lot remains to be desired from the Nigerian government. Drawing from our theory, therefore, these unfulfilled demands are going back into the system as input in order for them to be processed by the government into a more favourable output for the general good or wellbeing of the Nigerian citizenry. Building on the success story of the near-eradication of polio, the Nigerian government should improve on the unsatisfactory status of routine immunisation in the country in order to reduce to the barest minimum, child mortality rate. Also, if the innovative Midwives Service Scheme is expanded, those in the hinterlands will be covered and it will no doubt contribute substantially to accelerating the progress and achievement of maternal health in the country. This is because many mothers will be covered by pre-natal or ante-natal care. The Rollback Malaria Programme by the Nigerian government aimed at combating malaria in the country should be sustained and built upon.

Again, to reduce the prevalence rate of HIV/AIDS in the country, effective implementation of the National Strategic Frameworks for HIV/AIDS, malaria and tuberculosis control, as well as better awareness campaign against stigmatisation of people living with HIV/AIDS through agencies such as the National Action Committee on Aids (NACA) and its affiliated programme for the Prevention of Maternal to Child Transmission of HIV (PMTCT) must be intensified. Improving access to anti-retroviral therapies will equally go a long way in taming the tide of HIV/AIDS prevalence in the country.

More importantly, it is necessary for the Nigerian government to begin to think ‘outside the box’ by looking for ‘home-grown’ or ‘organic’ policies, strategies and initiatives that will drive development in the health sector. In other words, Nigeria must look beyond both the Millennium Development Goals (MDGs) and the current Sustainable Development Goals (SDGs) for practical or workable solutions to the challenges facing her in the health sector. This is very crucial because, even if all the targets of the MDGs are met, they are still very meagre to bring about substantial turn-around that is desired in Nigeria’s health sector, given her sheer size and population.

Furthermore, there must be an upward review of budgetary allocation to the health sector by the Nigerian government, if any meaning success is to be achieved. No policy, however laudable, can succeed without financial commitment. For instance, challenges such as lack of health infrastructure, hospital equipment and consumables, and general social amenities that will attract health workers to rural areas in the country are all tied down to funding. Thus, the only way the government can demonstrate its willpower or commitment to improving the health conditions of its citizenry is by increasing budgetary allocation to the health sector. According to the World Health Organisation (WHO, 2011), only Rwanda and South Africa have been able to achieve the Abuja Declaration Target by the African Union (AU) in April 2001 of increasing government funding for health to at least 15%. That developing countries (including Nigeria) carry almost 90% of the disease burden in the world, yet they allocate less than 10% of their budget to their health sectors – a situation that is totally unacceptable by all standards.
References


