DES 312: Health and Development

Course Outline

- Module 1: Introduction to Health in Development
- Module 2: Health care Demand and Supply
- Module 3: Challenges of Healthcare delivery in Nigeria
- Module 4: Disease Burden in Development

Module 1: Introduction to Health in Development

Unit 1: Health as Public Good
Unit 2: Social Determinants of Health
Unit 3: Health governance
Unit 4: Distinction between Health and Healthcare and its impact on Development

Unit 1: Health as Public Good

Introduction

This study unit focuses on the concept of health as public good. The classic understanding of health as public good, mean a good that excludes nobody from its use, and its use by others does not diminish its availability to other users. In this regard, the unit introduces learners to the scope of health as a human right, the economics and health, as well as health in Nigeria in the context of development sector.

Objectives

At the end of this unit, you should be able to: - Discuss the scope of health as human right. - Understand economics in the context of health. - Explain the status and nature of health in Nigeria.

Main Content

- Health as a Human Right
- Economics and Health
- Health in Nigeria

Health as a Human Right

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" - Constitution of the World Health Organization, enshrined in 1946

According to the Constitution of the World Health Organization, the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and a number of other organizations– Health is a fundamental human right. Not only is it a human right, but it is a human right that has been enshrined into international law.

Health and human rights are complementary approaches for defining and advancing human well-being. Health as a fundamental human right is indispensable to the enjoyment of other human rights. Every human being is entitled to the enjoyment of the highest attainable of standard and conducive health, for living a dignify life. Therefore, attainment of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, and/or the implementation of health programs, or the adoption of specific legal instruments that promotes health.

Human rights are relevant to addressing several health issues, including prevention and treatment of sexual and reproductive health; infectious diseases, access to clean water and adequate sanitation; medical confidentiality; access to education and information on health; access to drugs; and the health of marginalized and vulnerable groups such as women, ethnic and racial minorities, and people with disabilities. Human rights are also relevant to promoting health in broader contexts, such as in armed conflict, poverty reduction strategies, and international trade.

Indeed, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of raced, religion, political belief, economic or social conditions. Understanding of the linkages between health and human rights, strengthening its role in providing technical, intellectual and political leadership related to health system.

According to the Preamble of the Constitution of the World Health Organization, *Health is a state of complete physical, mental and social well-being, not merely the absence of disease.*

Health as human right is well articulated in the concept of Global Public Goods for Health; the provision of public health is linked to government action and other classic public goods. Thus, the conditions that promote the health of the public are classic public goods, even if increasingly the assertive ownership society that we have may threaten that. Knowledge of technology, policy, and health systems have many properties considered public goods; modern health technologies are "increasingly patented and thus made artificially excludable". This means that people, corporations, and governments are increasingly making health and things that can improvement health, out of reach. In addition, absent or minimal public financing for health systems as made health unaffordable to many people, this endangering their as human right. Many human rights activities work on the intersection between human rights and specific health institutes, often in partnership with other relevant agencies, like academic institutions, and non-governmental organizations; in order to canvas/lobby/agitate for healthcare accessibility as human right.

While health is considered a fundamental right, it is generally, not considered a public good, because low socioeconomic individuals may not afford good health. In fact, for millions of people throughout the world, the full enjoyment of the right to the highest attainable standard of physical and mental health remains a very distant goal. In many cases and places, this goal is increasingly harder to reach. For those in vulnerable situations including, but not limited to:

- Indigenous peoples
- Migrants and refugees
- Internally displaced people
- People affected by extreme poverty
- Minority communities
- People with disabilities
- People who live in residential institutions
- People in detention
- People who use drugs
- LGBT and gender diverse persons

the goal often seems even more distant.

In order to help support and enforce the protection of this human right, the Human Rights council (in 2002) created the mandate of the special Rapporteur on the right of everyone to the highest attainable standards of physical and mental health. These Special Rapporteurs are independent experts appointed by the human rights council, their mandate was created to:

- Gather, request, receive and exchange information on the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;
- Foster dialogue on possible cooperation with relevant actors, including Governments, the UN—and in particular WHO and UNAIDS—NGOs and financial institutions;

- Report on the realization of the right to health throughout the world, including on laws, policies, good practices and obstacles, making recommendations to promote and protect this right and to support States' enhancement of public health; and
- Address specific cases of alleged violations of the right to physical and mental health for everyone.

In July of 2020, the Human Rights Council appointed Dr. Tlaleng Mofokeng as Special Rapporteur on the right to health. Dr Mofokeng is a medical doctor from South Africa, with expertise advocating for universal health access, HIV care, youth friendly services and family planning.

Efforts to introduce universal health coverage in all countries may help to position healthcare closer towards being a public good. The adoption of social insurance systems or other publicly financed health insurance, where all citizens are insured and can utilize healthcare services regardless of whether they can afford it or not, appreciate health as public good. During this course, we will explore some of these issues

Economics and Health

Health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives.

Health impacts economic growth in a number of ways both directly and indirectly.

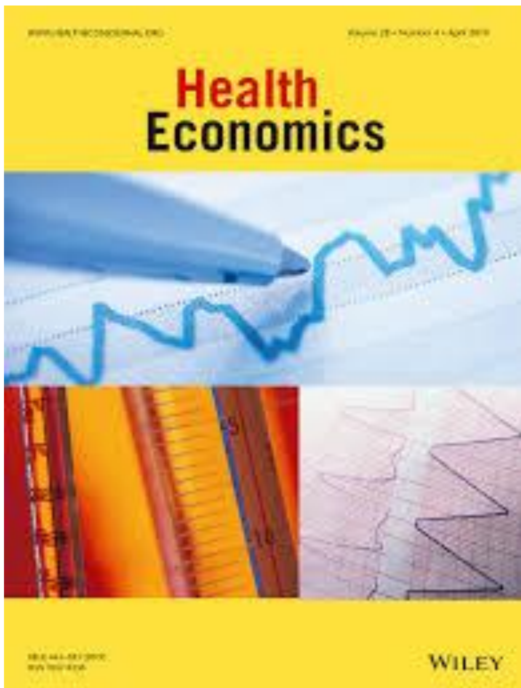
Direct:

- Reduces production losses due to worker illness,

- Increases the productivity of adult as a result of better nutrition, and
- Lowers absenteeism rates and improves learning among school children.
- Allows for the use of natural resources that used to be totally or partially inaccessible due to illnesses.
- Permits the different use of financial resources that might normally be destined for the treatment of ill health.

Indirect:

- The story of Fatima



Health is an asset individuals possess, which has intrinsic value (being healthy is a very important source of well-being), as well as instrumental value.

Economic development is an important determinant of health. Economics is particularly relevant in understanding why healthcare delivery development can and often does inform public health policy formation and implementation. Higher income usually increases demand for the quantity and quality of public and private health services. Economic development guides public investments and expenditure in health. However, health outcomes depend on whether government is responsive to popular demands and whether increased public health spending can improve health.

Economic growth usually has a positive correlational relationship with health and survival chances. However, despite this the net effect of improved economics on health is ambiguous, partly because as those that survive due to higher incomes might have lower levels of health. This can make sense because if you think about it, if you have cancer and the money to pay for treatment, the best doctors, and everything you need. Just because you survive the treatment does not necessarily mean that you are healthy at the end of it. Or that you are particularly fit, the impact on going through the treatment may cause other types of health issues besides the cancer. Whether high economic growth will increase population health might depend on the distribution of wealth in the society. Economics status has a potential health impact on individuals within and between households, depending upon on how the income generated is spent. Income spent on goods and services may or may not impact health, and thus can play a decisive role on the effect that economic growth has on health.

Historically, long-run improvements in health have been tied to economic growth through three broad mechanisms: better nutrition, enhancements in public health infrastructure (such as sanitation and adequate water supply), and more effective medical technology and supplies (such as antibiotics and vaccines). People with higher incomes, experience fewer years of disability and also tend to live longer. Women in higher-income classes have lower rates of anemia, infants born in those classes have higher birth weights, which often result in a healthier and productive population that which promises positive economic development. While there are other factors that come into play (which we will discuss in later units), income will and its impact on health will be a recurring theme.

While higher incomes are broadly good for health, booming economies can increase mortality. At first this fact may not make sense, but when we stop and think about it, we realize that both things can be true if the people who experience higher mortality during a robust economy are generally not the same people who enjoy the financial gains. For example, if more businesses come into an community (yay jobs), more construction jobs will be needed to build that infrastructure. Construction work can be very dangerous- individuals can easily get hurt and lose their limbs or lives. These construction workers will need to eat while they working which will cause more people that provide food to flock the the area, if we assume that many of these construction workers are away from their families, this will also cause an influx of transactional sex workers to move into the same area. We can go on and on about how more companies moving into an area impact the dynamics of a community. However that does not get to the point of the example, think of how this move impacts the health of the community. How does the sex worker, construction worker, and food provider's health get impacted? What options do they have if something goes wrong, compared to the CEO of the company building the company, or the workers that will work in the building/facility once its built. Often times, it is not the local people who are directly employed by the company, and thus it is not the local people that are then directly impacted by whatever health policies the company has in place. However the influx of more people with more income will impact the cost of basic goods in the community, particularly, the cost of food, housing, transportation, and to a degree healthcare.

Story of Fatima

In another example, lets take the example of Fatima. Fatima is a girl child (lets say around 7 years old). When her family is healthy, both her mother and father are making a decent income, she can eat regularly and her parents can afford to send her and her siblings to school. Fatima when she is healthy and well-nourished will perform better in school which will positively impact her future income, and her likelihood of reaching adulthood.

If we change aspects of Fatima's life, for example one of her parent's passes away, there is less money for food or school fees. So the quality of education that she receives will decrease, (if she is able to still go), which means that her potential income, quality of life, and contribution to the countries GDP will also likely decrease. How a situation like Fatima's may change does not only depend on her direct family situation, but also the culture in which she's living. Think for example how this situation could change her life if she's in different parts of Nigeria, whether her remaining parent is supported by family or not, if she loses the remaining parent, if a parent gets remarried. All of these factors (social determinants which will be covered in another unit), have an impact on Fatima's health and her feature economic role.

Leaving both of our examples, economic related changes in a community affects health care coverage and delivery systems like health insurance coverage, health care utilization, costs, and health outcomes; overtime and across different populations these interrelated factors change and reflect the in and out-of-pocket expenditure and how people can finance the totality of their health.

Economic growth in many ways can be seen as widening gap between rich and poor people. While health is considered a fundamental human right and the achievement of economic development thrives on the highest possible level of healthy population, it is important to recognize this disconnect, especially since these are some of the most important social goals globally. The relationship between health and economics is reciprocal, where poor health can have a significant economic impact on any households and poor economy can limit health access. Poor economy can make individuals within households exhausted, indebted, and reduce their essential consumption;

often people of poor economic status not only have productivity challenges and income losses, but also are limited in the available healthcare services that are easily accessible.

Understanding the full impact of failing to make economic changes that can enhance health care coverage, delivery systems, and living standards is important in the creation of effective programs, policies, and business ventures. Failing to address the widening gap between the rich and poor can lead to a decreased consequential effect of economy on population health.

Student Assessment Exercise

i. Explain the impact of economy on health.
ii. Brainstorm the ways that health can impact the economy

Health in Nigeria

Low densities of nurses, midwives and doctors that are still too low to effectively deliver essential health services

-1.95 health professionals per 1,000 people, and health professionals are primarily located in urban centers

Three forms of healthcare

- Orthodox,
- Alternative, and
- Traditional

Three tiers of healthcare

- Primary
- Secondary
- Tertiary

The Health and Healthcare in Nigeria is particularly interesting, or frustrating, considering that during the 70s and early 80s, the healthcare quality was comparable to the rest of the world. At one point the healthcare system was actually one of the best in the world, with reports that the King of Saudi Arabia used to get treated at the University College Hospital in Ibadan.

Since that time not only has the healthcare system declined, but also the general health of Nigerians. While Nigeria has one of the largest stocks of human resources for health (HRH) in Africa, similar to

the other 57 HRH crisis countries, it has a density of nurses, midwives and doctors that is too low to effectively deliver essential health services. There are an estimated 4 physicians per 10,000 people and 16.1 nurses or midwives per 10,000 people. The population of Nigeria means that is needs significantly more human resources for health than it has.

The Nigerian health care system is multifaceted health care sphere. Several health facilities personnel, and medical equipment are in use in the country, and various reforms have been put forward by the Nigerian government to address the wide ranging issues in the health care system. Three tiers of healthcare services sectors were involve in the implementation of health services at the national, state and local government area levels, thus; Primary, Secondary, and Tertiary services providers.

Health is an important element of public welfare and national security. Before independence in 1960, a 10-year developmental plan (1946–1956) was introduced to enhance health care delivery. Along those lines, several institutions, medical and health schools were developed in accordance to various national health reforms and plans. By the 1980s (and continuing to today), there had been great development in terms of health care delivery facilities. The creation of teaching, specialist and general hospitals including several primary health centers (over 10,000) had been introduced (more on this later). There have been efforts made by the federal government to revitalize the state of health systems, the Nigerian health insurance scheme (NHIS) was established in 2005 by Decree 35 of 1999. Other health reforms include: National Immunisation Coverage Scheme (NICS), Midwives Service Scheme (MSS) and Nigerian Pay for Performance scheme (P4P).

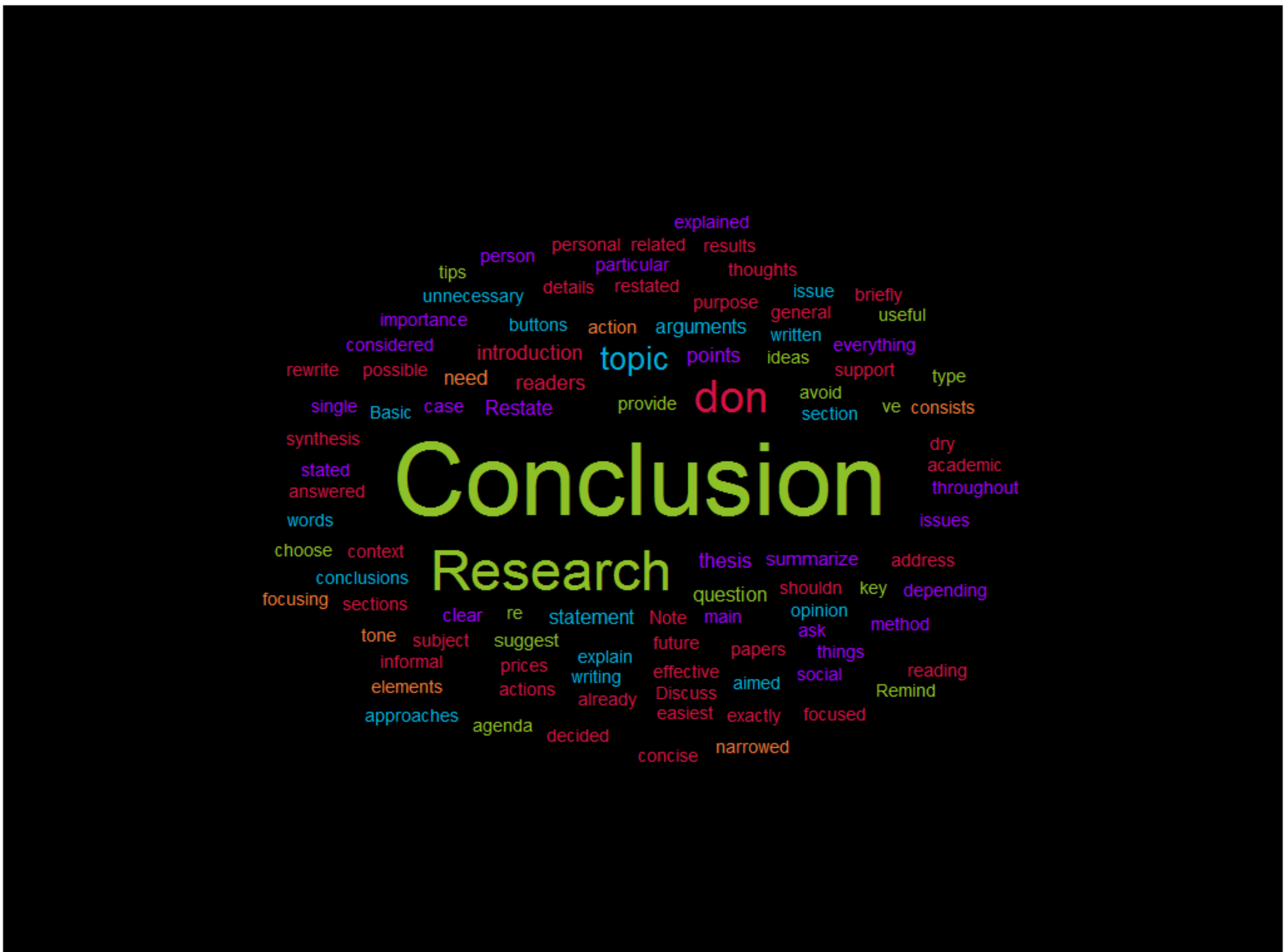
Despite these efforts and the potential dynamicness of the system, the Nigerian health care system remains weak. There are many reports that there is a(n): lack of coordination, fragmentation of services, dearth of resources, including drug and supplies inadequacy and decaying infrastructure, inequity in resource distribution, and access to care and very deplorable quality of care. Lack of clarity in roles and responsibilities among the different governance sectors, compounded the situation. In order to address some of the issues and create more social and financial risk protection for poor and vulnerable populations many countries are moving towards universal health coverage (UHC). It is seen as a means of ensuring access to quality health care services without individual, especially the most vulnerable, suffering financial hardship in Nigeria.

Social and financial risk protection schemes for poor and vulnerable populations helps to promote health as human right. This the provision of social health protection schemes targeting vulnerable groups in Nigeria should not be over looked, failure to provide the needed health care services will not help in towards the realization of the 2030 health and well-being agenda.

Student Assessment Exercise

i. Identify and discuss popular health reforms in Nigeria.
ii. Discuss health challenges confronting health services delivery in Nigeria.

Conclusion



The module highlight public health as public goods and the essentially for a healthy workforce and healthy consumers who can propel the production and consumption of healthcare productions as human right. Economic development policies that promotes healthy population. Economics status has a potential health issue in both within and between households, depending upon how income is spent. It also, highlights that Nigerian health care system was based on three tiers of healthcare services sectors are involved in the implementation of health services delivery at the national, state and local government area levels, thus; Primary, Secondary, and Tertiary services providers.

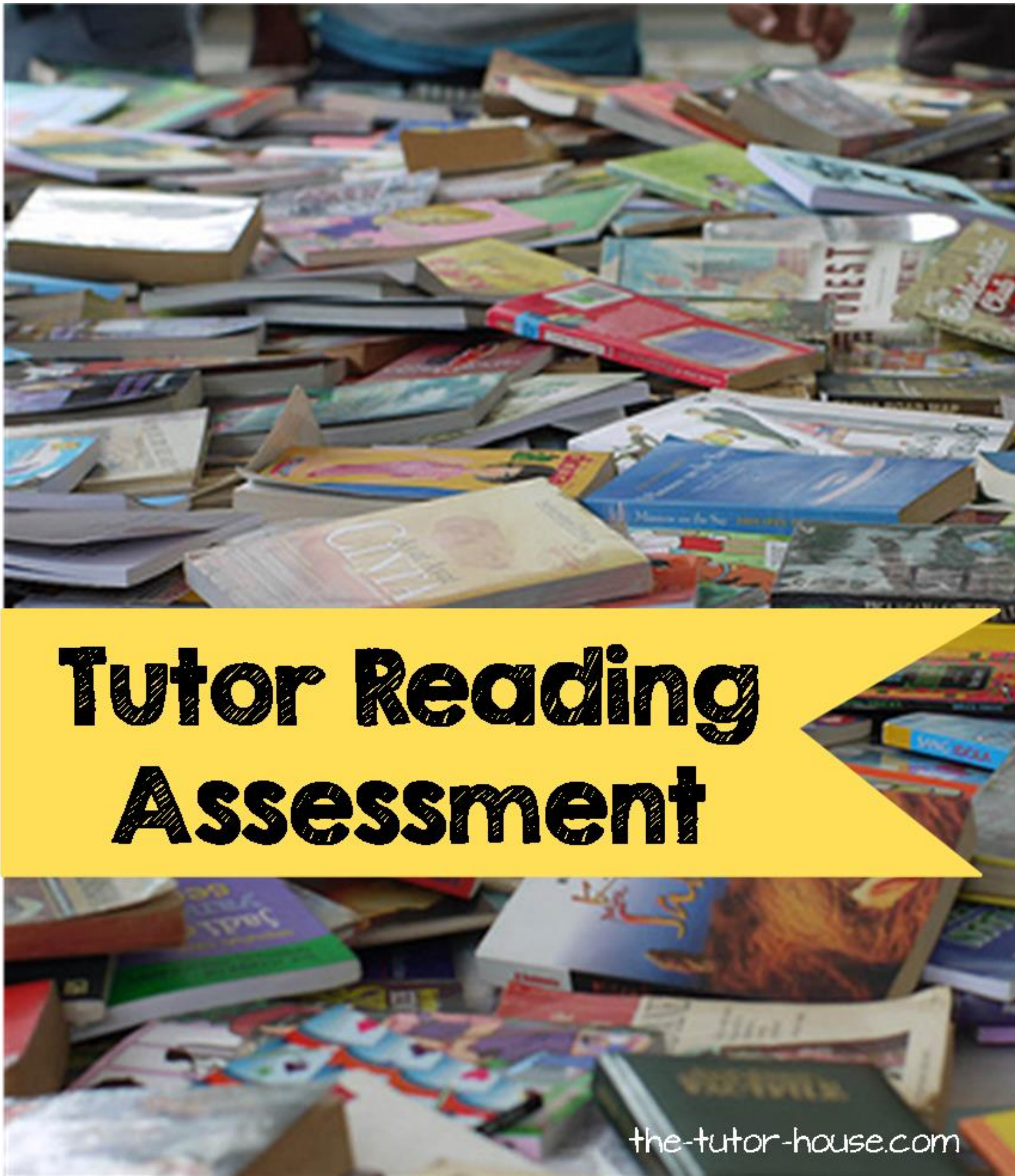
Summary

- Health as public good, was explained as a good that excluded nobody from its use, and its use by others does not diminish its availability to other users
- Health as human right denotes the fact that every human being is entitled to the enjoyment of the highest attainable of standard and conducive health
- Health and economics, showed the relationship between health outcomes and the economic viability now and in the future
- Health in Nigeria, we began to understand some of the unique challenges that the health care system in Nigeria faces

In this module, health as public good, was explained as a good that excluded nobody from its use, and its use by others does not diminish its availability to other users. But, health generally is not considered a public good, because non-paying individuals may be derived of it. Also, health as human right denotes the fact that every human being is entitled to the enjoyment of the highest attainable of standard and conducive health. Moreover, economic development depend on responsive population health at national, states and Local Government Areas.

Tutor Marked Assignment

i. Explain the linkages between health and human right
ii. Examine the impact of economy on population health.
iii. What are the popular health reforms in Nigeria? Discuss
iv. Identify health challenges confronting health systems in Nigeria.



References and Further Readings

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1. Bolaji Aregbeshola. Health care in Nigeria: Challenges and recommendations | socialprotection.org. 2019. https://socialprotection.org/discover/blog/health-care-nigeria-challenges-and-recommendations. Accessed March 4, 2021.

2. Frakt AB. How the economy affects health. 2018;319:1187-1188. doi:10.1001/jama.2018.1739

3. WHO. Human rights and health. https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health. Accessed March 4, 2021.

4. Lange S, Vollmer S. The effect of economic development on population health: A review of the empirical evidence. 2017;121:47-60. doi:10.1093/bmb/ldw052

5. OHCHR. OHCHR and the right to health. https://www.ohchr.org/EN/Issues/ESCR/Pages/Health.aspx. Accessed March 4, 2021.

6. OHCHR. Special Rapporteur on the right to physical and mental health. https://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx. Accessed March 4, 2021.

7. Onyedinefu G. Ratio of Nigerian doctors to population is 1: 2753 - FG - Businessday NG. March 2020. https://businessday.ng/uncategorized/article/ratio-of-nigerian-doctors-to-population-is-1-2753-fg/. Accessed March 4, 2021.

8. Paul Hunt. Human Rights and Health (Introduction). In: 2004:1.

9. Saudi Arabian royal family used to visit Nigeria for treatment – Health minister – Punch Newspapers. https://punchng.com/saudi-arabian-royal-family-used-to-come-to-nigeria-for-treatment-health-minister/. Accessed March 4, 2021.

10. Thoa NTM, Thanh NX, Chuc NTK, Lindholm L. The impact of economic growth on health care utilization: A longitudinal study in rural Vietnam. International Journal for Equity in Health. 2013;12(1):19. doi:10.1186/1475-9276-12-19

11. The Right to Health.

12. Welcome MO. The Nigerian health care system: Need for integrating adequate medical intelligence and surveillance systems. In: Journal of Pharmacy and Bioallied Sciences. Vol 3. Wolters Kluwer – Medknow Publications; 2011:470-478. doi:10.4103/0975-7406.90100

13. Right to Health – WMA – The World Medical Association. https://www.wma.net/what-we-do/human-rights/right-to-health/. Accessed March 4, 2021.

Unit 2: Social Determinants of Health

Introduction

Social Determinants of Health

This study unit examines the conditions in which people are born, grow, live, work and age that shape health, also known as social determinant of health. We examine these social determinants through reflections on personal characteristics and behaviors, mainstreaming physical environment, and the relevance of social and economic environments and health equity.

Why is it important to consider social determinants? We know that individuals do not live in isolation – we live in families in neighborhoods and communities; we interact with others in workplaces and social environments and places of worship; we interact with institutions and agencies and organizations. In order to fully understand why some people get sick while others stay healthy, we need to understand the impact of those environments and interactions as well as what is going on inside the individual. It is widely thought that environments influence disease processes at least in part because they place constraints on individual choices and other social factors can either create vulnerability or susceptibility or both. In order words, understanding social determinants of health is important for reducing longstanding disparities in health and health care as well as how to improve it.

Objectives

At the end of this unit, you should be able to:

- Discuss personal characteristics and behaviors.
- Discuss the physical environment.
- Explain social and economic environments and health equity.

Main Content

- Personal Characteristic and Behaviors
- Physical Environment
- Social and Economic Environments
- Health Equity

Personal Characteristics and Behaviors

- Genetics
- Personal factors
- Health behaviors

Examples include: - Balanced eating - Keeping active - Smoking and drinking - How the person deals with life stresses

Individual health thrives on personal characteristics and behaviors. The choices make by people affect life quality. Some of the most significant personal health behaviors include smoking, physical activity, and eating behavior. All the three behaviors mentioned constitutes a person's risk for developing diabetes, cardiovascular disease, cancer, obesity, and other chronic illnesses. Health behaviors are personal choices, which someone's environment encourages or discourages; thought another way behaviors that an environment either facilitates or creates barriers for.

Health behaviors are a complex mix of behavioral, environmental, and genetic factors. The social health determinants include the following factors: early childhood development, education level, employment ability and type, food security, access to and quality of health care, living conditions and housing, income, discrimination, and social support. Biological factors including genetics, sex, and age impact health behavior. Health choices such as alcohol use, smoking, drug use, sexual activity, etc., also interact to influence health behaviors. Social characteristics, social environment, physical environment, and access to quality health care all contribute to health behaviors.

The term 'behavioral' refers psychological processes such as cognition, emotion, temperament, and motivation; and to bio-behavioral interactions. Behavior occurs within a particular context and is influenced by factors interacting in complex 'Systems thinking' that sufficiently inform how to change and maintain the change. A clear map of the system within which change inform decisions about where and how to intervene strategies occurs. This approach had yielded dividends that support targeted personal behavior change. In this light, policy-makers' need to understand health-related behaviors by promoting changes in personal behaviors that can help avoid errors in determining what interventions works in promoting healthy behaviors.

People's health to a large extent determined individual characteristics such as educational status, income, life security and pleasant living environment, and opportunities for social interactions and other related activities that advanced population health. Human behavior creates enabling social environment through which the population can flourish, and also help in adopting the culture that promotes health.

Personal characteristics are an important social and economic determinant of health. They guide an understanding in both overall health and healthcare. Distinctive human behavior, drawing on the full gamut of theories and evidence based methodologies can improve population health. Population-wide behavioral change interventions are essential to attaining development. However health behavior is notoriously difficult to change, for example you constantly see people complain about losing weight. However while the equation to lose weight is simple- expend more energy than you

consume, obesity rates in develop countries are alarming high and rates are on the rise in developing countries.

An essential aspect of an individual's personal characteristics are their genetic factors. Genetics can have marked influence on health and health behaviors. These factors serve to contribute to to create either a lesser or a greater risk for certain health outcomes as opposed to causing certain health outcomes. There are several links between genetic factors and behavior. Studies of twins that were separated at birth, help to show the impact of genetics, these twins show a high concordance rate of alcoholism, schizophrenia, and affective disorders. This means in laymen terms, that despite being raised in different environments the genetic predisposition towards certain behaviors and health outcomes occurred anyways. Social and environmental factors may interact with genetic factors to influence health behaviors.

Another personal factor that has a significant impact on behavior is an individual's knowledge and skills. For example, knowledge about a disease, helps an individual understand more about it. In particular:

- It helps to inform them about how susceptible they are;
- How serious the disease will be if they get it; and
- Overall threat.

HOWEVER, knowledge alone is not enough to behavior, knowledge alone is not enough to change attitudes most of the time- but it *helps a great deal and is the first step*. It helps by influencing key attitudes and the decisions individuals make. Behavior change communication are buried in information campaigns. Often, poorly done (non-evidence based) public health announcements provide advice without considering many other potential and powerful behavior drivers and analysis of what is likely to be most effective.

Effective information sharing make people become more aware of the dangers of their behavior, meaning that improves their knowledge. Behavior is more likely to change if there are clear pathways that support change. Increase in use of communication gadgets influence behavior change. Accessing services and regulatory frameworks and social policy interventions through technologies are wide spread. There is debate about the value and efficacy of health-based technology interventions that target individual behavior and those that focus on community development. For example, there is a strong case for community-led participatory health program, especially those that empowered communities to reduce inequalities in health. Considering the challenges confronting sustained behavior change; tackling acute and chronic health issues through committed strategies that focus, especially on evaluations of interventions addressing these issues, at large change population behavior are needed to ensure healthy activity at all levels across development sector.

Physical Determinants of Health

- Natural Environment
  - Plants
  - Weather
  - CLIMATE
- Built Environment
  - Buildings
  - Transportation
  - Work-site

- School
- Safe homes
- Safe communities and roads
- Harmful substances
  - Air Pollution
  - Proximity to toxic sites (the focus of classic environmental epidemiology);
- Access* to various health-related resources
  - Healthy or unhealthy foods,
  - Recreational resources,
  - Medical care
  - Safe water

*Access means proximity AND affordability

Physical environment encompasses the natural and built environments. Public transportation systems, building structures and public resources, like school, work, and home environments have a direct effect on population health and also influence health related behaviors. For example, access to sidewalks, parks and playgrounds offer opportunities for physical activity, while exposure to pollution or unsafe drinking water contributes to health conditions like asthma and waterborne illness. Environmental factors like air quality, water quality, safe housing, among others contribute to health and well-being. The environmental factors with influence on health can be positive or negative, range from global to national to regional issues, and be based on the local built environment or social environment.

Physical environment is essential for human health and well-being. Local environment is a source of stress. For example, air pollution, noise, and hazardous chemicals among others, negatively affect population health. Population health is also adversely affected by environmental threats caused by climate change like heat waves, floods and vector-borne diseases. At a broader level, climate change includes a loss of biodiversity and land degradation which impacts human health and well-being through threatening the existence of ecosystem services, i.e access to freshwater and food production.

Policies and practices connected to physical environments influence population health and well-being. For example, the availability and accessibility to public transportation affects access to employment, affordable healthy foods, healthcare, and other important drivers of health and wellness. Nutrition enhanced programs such as farms in school and community gardens, through

policies can promote health in low socioeconomic societies. As with everything, there is only so much time, money, and resources that government officials have, thus many of these environmental determinants are competing with each other and other policy priorities seeking to address broader environment and development agendas.

Two thirds of deaths in developing countries are related to the physical environment factors. For example, indoor smoke from solid fuels, urban air pollution generated by vehicles, industries and energy production kills due to respiratory diseases. Traffic injuries are responsible for several deaths in low- and middle-income countries, while degradation of the built urban and rural environment, particularly for pedestrians and cyclists, has been cited as a key risk factor that leads to more death exposure. Climate change related factors like extreme weather events, changed patterns of disease and effects on agricultural production are estimated to cause several deaths as well.

Looked at another way, the physical environment can be a tool to enhance sustainable development. Efforts that improve sustainable development can enhance the coordination of economic, social and environmental development by making the best use of existing knowledge that portray a good environment and health policy as an essential feature of sound development processes. Delivering vital knowledge and evidence based environmental health potential solutions remains a formidable political, organizational and logistical challenge. Addressing it required policy-makers to focus on better utilizing assessment tools that improve the application of environmental knowledge for resilient development decision-making.

Social and Economic Environments

- Culture
- Tribe
- Socio-Economics

"Social and economic determinants include measures of individual and family socioeconomic position, neighbor conditions, sociocultural factors that may influence health like education, social support networks, and culture."

The term 'social' encompasses sociocultural, socioeconomic, and socio-demographic status; to bio-social interactions; and to the various concepts of social context from small groups to complex cultural systems, with explicit focus on the understanding of social processes, with influence on health outcomes or health risk factors. Personal, economic, social, and environmental elements serve to either enhance or to compromise health. Policy-making takes place at the local, state, and federal levels, and impacts individuals and entire communities and populations.

Some researchers believe that social factors are likely the fundamental causes of disease. They embody access to important resources. They are not disease- specific, but rather they affect multiple disease outcomes in various ways. The mechanism of action may and likely does differ by disease and help to explain how people come to experience exposures that are important to disease occurrence. This is important because, if we do not understand the process leading to exposure, our efforts to reduce risk may be ineffective or at least less effective than it needs to be.

The social and economic environments determine access to a quality education, job opportunities, safe neighborhoods, social support, and healthy foods. All of these factors influence health. In fact, a person's education and income status are some of the greatest predictors of your health. Individuals with higher levels of education and income tend to live longer, healthier lives. This relationship exists at both the individual and community level, and it is a theme you will see repeatedly during this course. People who live in wealthy, highly-educated communities are more likely to be in better health, live longer, and have a better quality of life than those who do not.

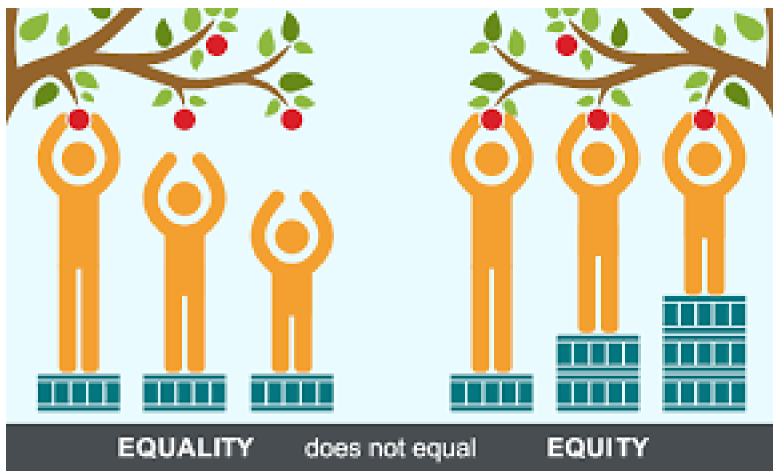
There are many factors that affect the health of individuals and the communities in which they live. The health of people is determined by numerous interrelated factors including lifestyle, circumstances, and environment. The importance of social support adds resources to an individuals' ability to cope with environment and social changes that foster good health. The array of social values and environmental norms of a society influence, in varying degrees, the health and well-being of both individuals and populations.

Social support is a source of emotional reassurance. Greater support from families, friends, and communities is linked to better health for individuals, and a safe place for a personal problem discussion, which can help in coping with adversity. Social networks provide information and practical support that can assist in times of need. The health impact of social factors is supported by the strong and widely observed associations between a wide range of health indicators and measures of individuals' socioeconomic resources or social position (i.e. income [told you, you would hear it frequently], educational attainment, or rank in an occupational hierarchy). Widespread and persistent use of socioeconomic status as an important factor, adds to the evidence that social factors are important influences on health. Strong links between poverty and health have been observed for centuries, and is part of the focus that many organization, governments, and international bodies have in reducing extreme poverty.

Higher income and social status are linked to improved health status, in fact, later in the course we will further focus in on this relationship because it is so significant. These two factors may be the most important determinants of health. The greater the gap between the richest and the poorest people in an area, the greater the disparities in their health. More and more, healthcare leaders position their organizations to assume the social and moral imperative of reducing health inequity by focusing on the social determinants of health. Through creative partnerships, new care delivery models, and population health assessment, and innovation that improve health and life quality.

Health Equity

- *"To reduce health equity gap through action on the determinants of health"*



Health equity refers to the absence of unfair and avoidable or remediable differences in health within a given social groups, defined socially, economically, demographically or geographically. Equity in health is an ethical value, grounded in the ethical principle of distributive justice and consonant with human rights principles (We will talk about ethical principles later in the course). Like most concepts, equity in health cannot be directly measured, but can be operationalized based on meaningful and measurable criteria.

In operational terms and for measurement, equity in health can be defined as the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage and disadvantage. Health inequities systematically put populations who are already socially disadvantaged (for example, by virtue of being poor, female, or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health.

Health equity is a core element of public health; it present the opportunity for all to live in conditions that promote health, minimizing inter-group health differences. This is synchronous with a conception of public goods whereby access to a positive resource is not limited by individual circumstance. Public health is then both a good and an opportunity for access to other goods that contribute to the perhaps mythical, but nearly universally aspirational, a "level playing field."

The understanding social determinants of health are an important way to gauge health inequities, and can help to illuminate the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health. The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality.

While life expectancy and healthy life expectancy have increased, it has increased unequally. There remain persistent and widening gaps between those with the best and worst health and well-being. Poorer populations systematically experience worse health than richer populations. Such trends seen within and between countries are unfair, unjust and most importantly avoidable. Many of these health differences are caused by the decision-making processes, policies, social norms and structures which exist at all levels in society. Inequities in health are socially determined, preventing poorer populations from moving up in society and making the most of their potential.

Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions. Action requires not only equitable access to healthcare but also means working outside the healthcare system to address broader social well-being and development (notice that there is a difference between health and healthcare). While equity and equality are distinct, the concept of equality is indispensable in operationalizing and measuring health. There is an increase in recognizing that improving health and achieving health equity requires broader approaches that must address social, economic, and environmental factors influencing health.

Awareness of the need for greater clarity about the definition of health equity has arisen in the context of a recently proposed approach to the measurement of health inequalities that does not reflect how health is distributed across different social groups. Not all health inequalities necessarily reflect inequity in health, implies unfair processes in the distribution of resources and other conditions. Assessing health equity requires comparing health and its social determinants among more and less advantaged social groups. Without that information, policies and programs leading toward or away from greater social justice in health will be difficult to assess.

In the WHO African Region, these health inequities and inequalities exist between and within countries, and contribute disproportionately to high incidences of preventable illness, disability and premature deaths across population groups particularly the poor, women, children, elderly and displaced populations. As these determinants of health exist outside the domains typically labeled as the “health domain”, multisectoral and interdisciplinary approaches are required.

Equity in health and access to health care are central themes in health system stewardship. Addressing inequity requires a comprehensive approach and action on wider social determinants on health. Health inequities are increasingly becoming a major performance issue for ministries of health and governments and feature more prominently in the policy and political discourse in Member States in the African Region. Economic benefits and scientific advances have increased the length and quality of life for many, still close to 50% of people living i the African Region are living in poverty.

Harsh economic and social conditions have nurtured the growth of both communicable and non-communicable diseases. Health inequities have increased, particularly within countries. Patterns of differential health opportunity between population groups affect both middle and lower income countries alike, not only because of poverty. These differences in health follow a strong social gradient, which reflect an individual or population group’s position in society and different access to and security of resources such as education, employment and housing, as well as different levels of participation in civic society and control over life.

Addressing inequity requires a comprehensive approach and action on wider social determinants of health, with the goal of reducing the overall gap in health opportunity in a country, and tackling the social gradient in health across the whole population. Work has to continue to address the underlying

social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.

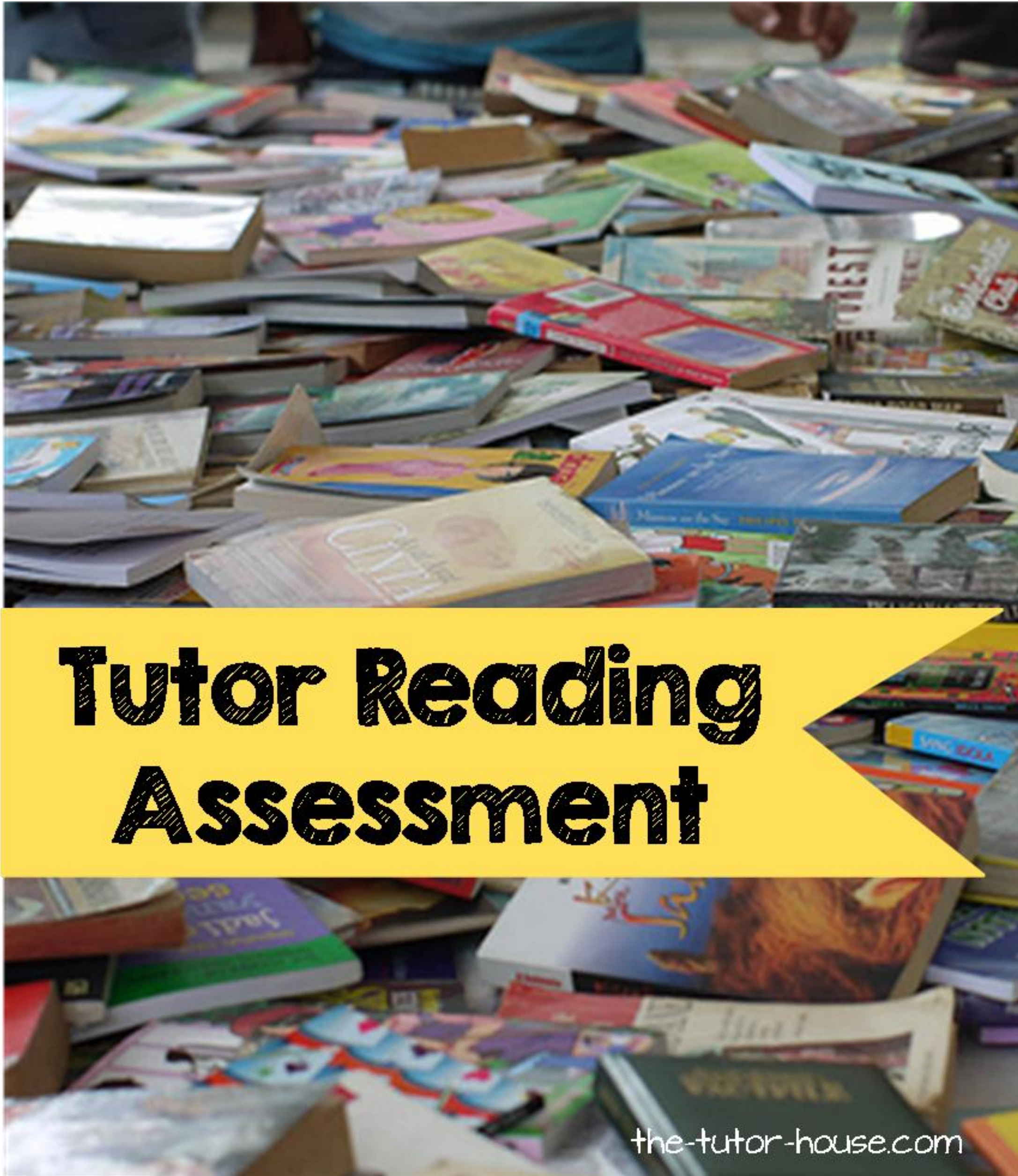
Conclusion

This unit concludes that addressing social determinants of health require working across sectors, for interventions that improve health outcomes of the socially disadvantaged populations. Quality improvement activities includes evaluation of personal characteristics as important social and economic determinants of health. The physical environment is essential for the attainment of human health and well-being. The social and economic environments enable access to quality education, job opportunities, safe neighborhoods, social support, and healthy foods, as health determinant. Equity in health means absence of disparities in health and in its key social determinants. Finally, key resources for local, state, and national policy makers on the issues of health equity are the social, economic and environmental issues that impact health.

Summary

This study unit highlights social factors influence on health, which help in understanding the significance of social determinants of health and how reducing longstanding disparities in health and healthcare appear effective and efficient population health strategies. The social and economic conditions in which people are born, grow, live, work and age shaped their health. Reflection on personal characteristics and behaviors, physical environment mainstreaming, and the relevance of social and economic environments and health equity was done.

Tutor Marked Assignment



- What are the personal characteristics and behaviors that impact human health
- We often hear that we must sensitize a community to be around of an issue. Explain why sensitization is not enough to change behavior.
  - Think of a disease or issue,
  - Think of a community
  - How would you go about sensitizing them to the disease?
  - What steps would you take after the sensitization to change behavior?
  - How would you know when you have reached your goal?
- Explain the relevance of physical environment to population health.
- Discuss the significance of social, economic and environment factors as health determinants
- Discuss the concept of health equity in improving population health

References and Further Readings

14–18

Artiga, S. and Elizabeth Hinton, E. (2018). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Issue Brief

Braveman, P. and Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. Public Health Rep.; 129(Suppl 2): 19–31.

Braveman, P. and Gruskin, S. (2003). Defining equity in health. Epidemiology Community Health; 57:254-258

Melton, C. (2018). The Drivers of Health: Four Factors that Influence Individual and Population Health. Policy Brief. The Sycamore Institute

United Nations Environment Programme (2004). Health & Environment Tools for Effective Decision-Making. The WHO-UNEP Health and Environment Linkages Initiative (HELI)

From a crisis response to institutional capacity building: Experiences from Zimbabwe on cholera outbreak.

Integrating social determinants of health in all public policies: The case of health development in Botswana.

Rio Political Declaration on Social Determinants of Health.; 2011.

World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health - Final report of the commission on social determinants of health.; 2008. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1.

(US) NRC, (US) I of M, Woolf SH, Aron L. Physical and Social Environmental Factors. 2013. https://www.ncbi.nlm.nih.gov/books/NBK154491/.

Unit 3: Health governance

Introduction

This study unit examines the history of health governance, highlights the local, federal and international policies; describes the structures and mechanisms of global health initiatives, and the global fund, GAVI - the Vaccine Alliance arenas.

Objectives

At the end of this unit, you should be able to:

- Discuss the history of health governance.
- Discuss the local, federal and international policies.
- Explain global health initiatives, the global fund, GAVI, the Vaccine Alliance.

Main Content

- History of Health Governance
- Local and Federal Governance
- International Polices
- Global Health Initiatives

History of Health Governance

- Globalization versus Global Health Governance

(1) Governance of the health system and strengthening of the health systems, which is referred to as health governance; and

(2) The joint actions of health and non-health sectors, within the public and private sectors and the citizens to achieve a common interest.

Health governance compose of five key attributes: (1) Accountability; (2) Transparency; (3) Participation of affected interests; (4) Integrity; (5) Policy capacity

- Time Periods of Global Health Governance

1. The nineteenth century and the first international sanitary conferences;
2. The interwar period, with the establishment of international organisations, such as the League of Nations (LN) and the rise of the American foundations;
3. The immediate post-war era, dominated by the history of the World Health Organisation (WHO);

4. The more recent period since the 1970s with the proliferation of new players at the international level.
5. Post COVID-19 Era (?) ::::::::::::: {.columns}

Health governance study in the 21st century focus on governance innovations. It relates the emergence of joint action of the health sector and non-health sectors, of both public and private actors to address health system challenges in 21st century. The governance approach include new understanding of health and well-being as key features of what constitutes a successful society and vibrant economy and the higher value placed on sustainable development. Health governance' denotes the procedures adopted in execution of a program and accountability in health sector; involving management of health institutes, rules and assets for improved health systems.

It is important, especially when working in Health Development to understand 1) you are not working from a "blank" slate and 2) we are not were we are in terms of capacity, resources etc. by accident. Understanding this, will help to contextualize the scope of the problems we grapple with and thus the scope of the solutions required.

Governance is the structure of decision-making and policy implementation in a system. It is characterized by its pattern and re-utilization rather than dependence on charisma or leadership, and it is 'sticky'. Decisions about governance shape and constrain future decisions about substance. Health and its determinants were governed in two ways, thus;

1. Governance of the health system and strengthening of the health systems, which is referred to as health governance; and
2. The joint actions of health and non-health sectors, within the public and private sectors and the citizens to achieve a common interest.

Before we can get too far into discussing global health governance, we must first discuss globalization.

Globalization has been described as the *'widening, deepening and speeding up of the world interconnectedness in all aspects of contemporary life'*, and *the world is rapidly being moulded into a shared social space by economic and technological forces…[and]… developments in one region of the world can have profound consequences for the life chances of individuals or communities on the other side of the globe*. For many, globalization is also associated with a sense of political fatalism and chronic insecurity in that the sheer scale of contemporary social and economic change appears to outstrip the capacity of national governments or citizens to control, contest or resist that change.

Global health governance arises because globalization is seen to have specific health consequences that cannot be addressed by existing forms of health governance. Issues such as climate change, COVID-19, the role of international corporations, challenges the existing forms of international

governance (IHG) defined by national borders. These global issues, are not the responsibility of any single government nor the effects localized to any single one.

Health governance refers to, 'the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population', on the surface it sounds good, but it is difficult to operationalize. Health governance compose of five key attributes:

1. Accountability;
2. Transparency;
3. Participation of affected interests;
4. Integrity;
5. Policy capacity

Good governance, emphasizes the need for governance mechanisms and organisations that are appropriate, representative, accountable and transparent. Governance problems can be traced to one or more of these attributes, which can mean too much, too little, or the wrong kind of them, reflective of the multifaceted arena. The diffusion of health governance functions is a collaborative one, through which governance is co-produced by a wide range of actors, both state and non state who perform or have health governance roles.

Succinctly, there are three categories of health governance actors. The first is the state actors, which includes politicians, policymakers and other public officials; performed their health function through health ministry; the second set of actors constitutes health service providers, which includes organizations that support service provision: insurance agencies, health maintenance organizations, the pharmaceutical industry and equipment manufacturers and suppliers, and the third set of actors constitutes the clients/citizens: service consumers, the general public and organized civil society. However, other public sector actors beyond those usually associated with the health system have roles as well. As such, presence of multiple actors in health governance enhance accountability an increasingly sophisticated input that improve health governance performance.

Health governance have conceptual and practical directions. Ideally, functional health governance make certain that assets committed to health services produce a desired outcome, through effective, diligent and equitable health services delivery. However, weaknesses in the health governance arena hinder the understanding of the processes that ensure the attainment of the intended health outcome, due to the inability to supply the needed technical investment in the sector. Additionally, health governance focuses on the multiplicity of the societal actors in health systems, it brings together wide composite of stakeholders, not only within traditional health boundaries but beyond to include plethora of actors, at all levels of development, for policy formulation and implementation.

These ideals of how health governance should be and how it is structured are based on the concept of a liberal democracy and often associated with the development of European nation states. The development of international co-operation in health can be considered over four periods.

(1) The nineteenth century and the first international sanitary conferences;
(2) The interwar period, with the establishment of international organisations, such as the League of Nations (LN) and the rise of the American foundations;
(3) The immediate post-war era, dominated by the history of the World Health Organisation (WHO);
(4) The more recent period since the 1970s with the proliferation of new players at the international level.

Given the impact of COVID-19 and its unprecedented impact on the world, we have added a 5th time period.

1. The International Sanitary Conferences, from 1851-1903. The beginning of international health co-operation i.e. the co-operation of two or more states, is traditionally located in the series of international sanitary conferences held between 1851 and 1903. Prior to this time, quarantine was used for objectives other than public health- the spread of epidemic diseases, especially cholera and yellow fever was an important motivation to change the use of quarantine.

The two cholera pandemics that engulfed Europe between 1830 and 1847 were facilitated by the increased movement of goods and people between East and West, accompanying developments in international commerce: steamships, rail and later the construction of the Suez Canal. The long established response to epidemic disease such as the plague was to close ports and impose quarantine, but that proved difficult to sustain in the age of international commerce, as we have also seen in the COVID era. Quarantine measures and disruption to shipping served to undermine the maritime economies of nations like Britain and France, whereas the speed of steam ships meant that people and goods would have disembarked before a disease declared itself. The international sanitary conferences emerged as a mechanism for responding to the political and economic threat which a new epidemic disease like cholera posed to the *European powers*.

2. The interwar period was characterized by two interrelated developments, the rise of a new style of international corporate philanthropy, such as that developed by the Rockefeller Foundation and the establishment of permanent international organizations in particular the League of Nations. The League of Nations Health Organisation (LNHO) drew between 1/3 and 1/2 of its budget from the Rockefeller Foundation. The relationship between government and the private sector, can be tied to the creation of an elite group of bio-medical and health specialists at the center of worldwide bio-medical/public health knowledge. The level of involvement by private corporations, specifically American private corporations and the creation of an international cadre of public health expertise is subject to on-going debate. Especially given that during that time the US was political practicing isolationism, many question if this private sector involvement was benign philanthropy or American imperialism by private means.

The years between 1901 and 1913 saw the creation of a new form of philanthropy, characterized by largely American institutions, which developed a research oriented view of social improvement and introduced a wider, international dimension to research and sponsorship activities, especially in the area of science and medicine. The scale of private sector financial input into the international public health institutions of the day, has been seen by some as central agent of bio-medical imperialism – exporting a US model of public health across the world. Through its focus on training and institution building the Rockefeller Foundation was fundamental in creating an international network of public health experts. Drawing on the universalism of science, the Rockefeller Foundation emphasized technology transfer and the exchange of trained personnel. During the interwar period, instruments developed in America to measure community health performance were transferred to Europe via the Rockefeller Foundation.

3. The history of international health in the second half of the twentieth century represents the largest and most organizationally complex era of developments in this field. The key difference in the postwar context is one of scale, mainly the scale of participation i.e. a significant rise in the number of states, the number of intergovernmental organizations and specialized agencies and the number of NGOs. This rise in scale and complexity has been intimately related to fundamental shifts in geo-political structures, such as the dismantling of nineteenth century

colonial empires and the rise and fall of the Soviet Union. Other significant developments specifically related to health and medicine, have also marked the postwar decades. such as the rise of the pharmaceutical and biotechnology sectors, and new health threats like atmospheric pollution, emerging and re-emerging infectious diseases such as HIV and TB. The most significant and well documented event in the organisation of postwar international health was the creation of the World Health Organisation (WHO) as a specialized agency of the United Nations (UN) in 1948.

The regional structure of WHO is largely an historical legacy, in that pre-existing regional organisations were absorbed into the new specialized health agency. The six regions (Eastern Mediterranean, Western Pacific, Europe, Americas, Africa, South East Asia) developed from earlier regional structures like the Pan American Sanitary Organisation. At the foundation of WHO there was no discussion of potential problems, such as the peculiar delineation of compact geographical boundaries, or the possibility that regional organisations would come under the influence of regional blocs, i.e. Pakistan chose to be in the Eastern Mediterranean rather than in SE Asia with India and Afghanistan.

Independence movements and the political nature of regional alliances have been fundamental forces operating in the UN system and its agencies since their inception.In 1948, the WHO had 48 full members by 1993, they had 183 full and two associate members. Although the action of political blocs was not new (for example, the mass withdrawal of socialist states in 1949-50), the structural and political inability of WHO to absorb the newly emerging post-colonial nations meant that new formations, based on differences in wealth, joined established Cold War distinctions of ideology. In response to what was seen as a disparity between voting strength and financial contribution between rich and poor nations the 1960s and the 1970s saw emergence of blocs, such as the Geneva Group (made up of states that contributed the majority of funds to UN/WHO) and the Group of 77 (an international interest group representing developing countries). North-South (donor/recipient of aid) became a new axis of political and ideological conflict in postwar international health.

4. This axis structured debates around the 'politicization' of WHO in the 1970s and 1980s- the alignment of developed – developing countries was clear. A broad based philosophy of health, which was more sensitive to local requirements and distinctions, and was anchored around the provision of primary health care gained ground at WHO in the 1970s. In the 1930s and in the 1970s international health organisations began to emphasize primary health care and an understanding of the economic underpinnings of health. Economic crisis formed the backdrop to developments in both decades, although the new postwar axis of North-South and the greater representation of poor nations in the machinery of international government led developing countries to demand a New International Economic Order.

One of the engines behind primary health care movement was the evidence of successful, low technology community health care provided by China's 'barefoot doctors'. The examples of China and Cuba, which were successfully mobilized by the Soviet Union, challenged the prevailing ideology of the WHO rooted in bio-medicine. This challenge also encouraged a renewed interest in traditional medical practices and personnel, representatives from a range of developing countries began speaking of their traditional medicine as a positive affirmation of their native cultures. Renewed interest in horizontal programmes (health concerns as a whole, rather disease specific) and the emphasis on appropriateness and community involvement pointed to a more inclusive disciplinary mix in international health.

Selective primary care, supported by UNICEF, Rockefeller and heavily influenced by the US, began to replace the more inclusive versions. The primacy now accorded to NGOs developed in the 1980s and during a period when major donor countries pursued anti-static policies in their domestic health sector. The emphasis on NGOs arose in a climate where public sector health provision was often characterized as inefficient, centralized and unaccountable. In this context there was a growing awareness of the financial capacity of NGOs and their experience in funding systems at a local level. NGOs also attracted the attention of donors in relation to concepts of good governance and plurality. Industrialized donor countries began to criticize not only the efficiency of recipient states, but also their legitimacy, on the grounds of a lack of democratic process or accountability.

WHO had refashion itself in order to survive the growing influence of new and powerful actors such as the World Bank . Its essential drugs programme in the 1980s had incurred the opposition of the US and American pharmaceutical companies. In the 1990s it set itself up as co-coordinator, strategic planner and leader of global health initiatives working in partnerships with the new players. In part this was in response to the Children's Vaccine Initiative, seen in the organisation as an attempt by UNICEF, the World Bank , the UN Development programme and other players to wrest control of vaccine development. New mechanisms, institutions and targets emerged with the new actors. New 'hybrid' institutional actors appeared bringing together different combinations of state, market and civil society actors in innovative institutional arrangements.

Local and Federal Policy

Selected Polices; - Western and traditional health care integration, - Basic Health Social Scheme (BHSS), - Primary Health Care (PHC), - the National Health Insurance Scheme (NHIS), - National Action Committee on Aids (NACA) among others.

Objectives; - Every Nigerian has access to good health care services; - Equitable distribution of health care facilities within the federation and at all levels of government; - Maintain high standards of health care delivery; - Limit the rise in the cost of health care services, - Improve and harness private sector participation in the provision of health care services, and - All health care providers conform to laid down rules and regulations guiding healthcare operations.

While it is impossible to cover all of the local and federal policies that are in a given country. It is important to know that these policies exist. I strongly encourage you to explore the National Health Promotion Policy and the website to understand what is being done on the federal level. Also look at one of the state level ministries of health and examine how the federal policies are (or are not) domesticated.

At both local and national levels policies direct health services implementation. Healthcare policy refers to the various rules, regulations and guidelines made by the government to operate, finance and shape health care delivery. It covers a range of health-related issues including the financing of health care; public health, preventive health care, chronic illness and disability, and long-term care and mental health. Health care policy is an action taken by governments at national, state and/or local levels. Health policy is formed and implemented to advance public health. Health policies deal with coordination, organizations, financing and of health systems. This includes training of health professionals, overseeing the safety of drugs and medical services, administering programs and regulating public and private stakeholders in health system strengthening.

Health decision makers make use of a wide range of innovative policy instruments to improve health and well-being. In the health sector, investment in employee and community health and services is being recognized as a new policy model that improve health system. Forming of health policy at local and national level depends on health policy priorities. Local health policies are reflected in the myriad of health decisions reached across a range of local health projects, and service implementation. The implemented decisions were in turned influenced by national health governance processes and the extent to which they enhance effective stewardship across a local public health system. The health system policies are sometimes complex, its elements are not always aligned with the prioritized need across different health related agencies. These challenges need to be addressed if public health governance is to form an integral part not only of governance arrangements, across different institutions at local and regional levels.

Policies can positively or negatively change impacts health determinants: Health in All Policies (HiAP) is a horizontal, policy-related strategy with a high potential for contributing to improved population health. It is complementary to the more commonly known approaches of public health and health care services at national levels. The HiAP approach is to take into account the health impacts of other policies when planning policies, deciding between various policy options and implementing policies in other sectors. The ultimate aim is to create evidence-based policy-making, by assessing and discussion of health impacts of existing policies as well as proposal of policy alternatives.

Goal of national health policy is to bring about comprehensive health system. Nigeria as a nation has a health care policy which seeks to provide health for all. In this regard, various programs are designed to address the issue of health system problems and that of the populace. As such, health system based on primary, secondary and tertiary health care that is protective, preventive and rehabilitative to every citizen of the country within the available resources is needed. If done, individuals and communities will be assured of productivity, and enjoyment of good living, needed for health and well-being.

Health system policies have gone a long way in Nigeria. Initially, the traditional health practitioners dominated the health system in the country, but change with advent of colonial administration, which led to the commencement of orthodox medicine. The colonial government installed western health care system over the traditional methods. After independence, the Federal Government introduced different measures to improve the existing methods through the integration of western and traditional medicine. Despite the efforts, healthcare policies in Nigeria are still confronted with multiple problems.

Health Policies implementation is often bedeviled with challenges. There are various problems that have hitherto constituted barriers to the effective health care services since the country attained independence in October 1960 are examined. The challenges includes People’s attachment to

customs, traditions, myths and legend, high level of corruption, ignorance, poverty and lack of needed commitment by the stakeholders constitute one form of problem or the other. Despite the myriads of the challenges faced by health policies in both local and national levels, some achievements have been recorded within some of the health policy arena, in Nigeria. However, at the global level, the place of health in the development of any nation is primordial. Undoubtedly, the significance of health to national life has made successive governments in many nation of the world, both developed and developing to design and/or formulate certain fundamental policies in order to regulate, control and guide the operations of health care services.

While there are formal laws, in different parts of the country- you also have traditional/religious norms that directly interact with the laws on the books and thus can cause issues with domesticating and **enforcing** them at the local level. One such example of this are the laws trying to regulate child marriage. While on the surface, people agree that child marriage is not something that should happen- different communities have different definitions of what a child is. In this situation, you have the interaction of federal, local, cultural, and religious understanding interacting.

- Pick a (health) issue, what laws are there about this one the federal level? on the state level? How can culture and religion interact with this? What are the potential solutions that can help to address the issue you picked?
- Examine the 2016 federal ministry of health budget, how does the way that money is allocated tell you about the health priorities for that year?

International Policies

International health policy are formulated;

- To identify intra government's response to health threat.
- To address cross border health challenges
- To improve trans-border health services implementation
- To guide prevention and treatment of health challenges and
- To stimulate a productive healthy population, especially in developing countries.

Countries that have a "stake" in Nigeria

- Japan
- The United States of America
- The United Kingdom
- Germany
- China
- Taiwan
- Canada
- The United Nations

There are many countries and organizations that have a hand in Nigeria. These organizations are shaped by their countries' policies as well as international best practice.

Policy is a notoriously slippery term. It may be associated with a set of principles, the exercise of legitimate authority through law and regulation, or processes for ensuring accountability and managing risk within institutions. It may also be apply to the systematic application of processes and procedures. Policy analysis means different things to different people. To some people, policy analysis mainly concerns policy content, while others argue it is more concerned with policy context and process.

As we've already established, International health policy is associated with colonialism. For several decades, the colonial government in several countries encourage the spread and expansion of western healthcare system. For years orthodox medicine served only about 30%, leaving about 70% of the population utilized traditional medicine. Gradually, several developing countries adopted western health policies to combat their health challenges. The success recorded in countries like India, China, Indonesia and Singapore among others, motivates several countries to seek the integration of these contemporary health systems policies. The impact and success in some of these countries led to the campaign for international recognition and general acceptability of the integration of their health system policies. In these regard, the World Health Organization (WHO) in 1976 endorsed and approved the acceptability of the two integrated policies (traditional and modern) as internationally reorganized healthcare services. Indeed, upon the recognition of the infidelity of either western or traditional medicine, the modern healthcare system policy making was repackaged for analysis and possible acceptability.

Approach to policy analysis is policy content related. Health policy making is value oriented – since it analyses how policy implementation diffused the complex relationships across related local, national and international policies. Also, policy making takes into consideration the co-existence, between different types of policies, commonly characterized by markets orientation, hierarchy of need, and/or the policy issue in contention, so as to independently provide sustainable solutions. Generally, international health policies suffer from various weaknesses such as those of sovereignty and as such do not offer appropriate solutions to many health problems in accordance with the comprehensive principles of international health paradigms.

Most international health policies sought to address infectious diseases. Some of the health policy model aims at solving behavioral and environmental health problems such as HIV/AIDS, cancer, diabetes, (road traffic) accidents and drug addiction. The model help in putting in place policy that can comprehensively addressed public health challenges in accordance with the international health

practice principles. Policy making involves decisions that address cross border infectious diseases, made on sequential phases that includes problem identification, definition, alternative approaches to solving the problem, and solution implementation. Furthermore, policy analysis and coordination among decision-making actors, at all levels should ensure that agreed strategies are implemented simultaneously.

International health policy analysis was done base on the contextual factors. Factors like political, economic, socio-cultural and demographic among others that directly or indirectly impact health policy process and outcomes, are taken into consideration, when analyzing policies. International health policy analysis contributes to understanding of how policy makers set healthcare priorities and plan actions that addresses the increasing health problems. It also analyzes important stages of the international health policy process – such as agenda building, planning and policy formulation, implementation, monitoring and evaluation - to determine which factors and actors affect the processes. International health policy analysis can also help in understanding the role of actors and interest groups involved in global health policy arena.

Global health thrives on international policy formation and implementation. International policy have focus on existing institutional arrangements beyond national boundaries, to deal with the health challenges confronting the rapidly changing world. Addressing the increasingly globalized determinants of human health is a complex task requiring collective policy action. The determinants of many important problems affecting human health are increasingly globalized in need of international policy. The possibility of using similar strategies in addressing global health issues pave ways for to the implementation of international policies to solve global health challenges.

Global Health Initiatives

- Gender Based Violence
- HIV/AIDS
- Maternal mortality
- High Parity
- Vaccine Alliance
- Malaria

Challenges to Global Health Effectiveness

- Problem definition
- Positioning
- Coalition- building
- Governance

TheGlobalFund

"Global health" is often used as shorthand to refer to international health cooperation. Defining global health in this way suggests that the governance issues would consider the broader set of health issues of global importance. Such approach would include in its scope the health of all individuals and populations, regardless of whether they live in richer or poorer countries. Global health are not without challenges. Global health networks face four challenges to their effectiveness: problem definition, positioning, coalition-building, and governance. A probable scenario is that public actors at the international, regional, national, and sub-national level together with private actors will design and implement policy actions for attaining Sustainable Development Goal number 3, which we will cover in Module 2. The simultaneous existence of a range of policy actions by multiple actors at different scales corresponds to the definition of global health.

Moreover, global health governance is characterized by processes that take place at the same time, but perhaps at different governance scales, and topics in global governance such as climate change. Yet it seems that global health governance can benefit from embracing concept of partnerships for a conventional preoccupations with formal institutional and inter-state interactions and takes into account how globalization has affected the health policy landscape and restructured the distribution of economic and political power not only among countries, but also within them.

The difference is growing. The threat posed to global health has been widely discussed internationally. Global health initiatives, appears to be a way forward in addressing not only social determinants of health but also the political and environmental determinants as a response to global concerns suffusing the international health discourse. Understanding how human activities impacts their health at both local and international scale calls for integral.

Global Health Initiatives (GHI) as a concept is inevitably large and complex. Global health encapsulate all activities that relate to health, including political, social, and economic processes. From that perspectives, the international community established certain initiatives in order to deal with them more efficiently across national borders. This has especially blossomed after international commitment towards the Sustainable Development Goals in 2015, which represents one of the largest pledges to tackle global health issues in recent times. This leads to the emergence of GHIs and their mode of operation, based on partnership between public and private sector organizations in form of Public Private Partnerships.

Towards the end of the 20th century new global organization of health emerged. The organization is known as GHI, its focus its efforts on partnerships between health actors globally. The scope and operation of the organization much attention has been given to this phenomenon of transnational partnerships in health. The complex landscape of these global health partnerships emphasizes the global characteristic of multi-actor collaboration on issues that require cross-border attention: "the use of formal and informal institutions, rules, and processes by states, intergovernmental organization, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively".

The scope of GHIs largely concentrates on four main areas; research and development (for the development of medicine and vaccines), technical assistance and service support (towards defining the policies directed to the access of drugs), advocacy (developing the response capacity towards combating specific diseases), and financial support (allocation of resources for specific programs). Initiatives such as these have been successful and important in terms of stimulating Research & Development on diseases that have not been prioritized, such as neglected tropical diseases. Ideas of equity and access is thus very important within the GHI framework, but these are accomplished through mobilization of funding towards projects and programs directed at specific diseases.

The emergence of GHIs has been largely ascribed to the global health challenges. GHIs have become a tool for implementing 'fast-track' solutions to pressing health problems that are causing inequities in health, which means that GHIs are distinctly concentrated to the Global South. This fact is challenging if one considers the issue of power within global health, in terms of hegemonic power where some actors hold power over others. In both African continent and South-East Asia GHIs have had positive impact in many areas; an example in this regard is how the Global Fund to Fight AIDS, TB and Malaria Global Fund to Fight HIV, TB and Malaria (GFAM) and Global Alliance for Vaccine and Immunizations (GAVI), have provided assistance with funds, drugs and vaccines free-of-charge, or at a heavily reduced cost to alleviate inequities in health.

Conclusion

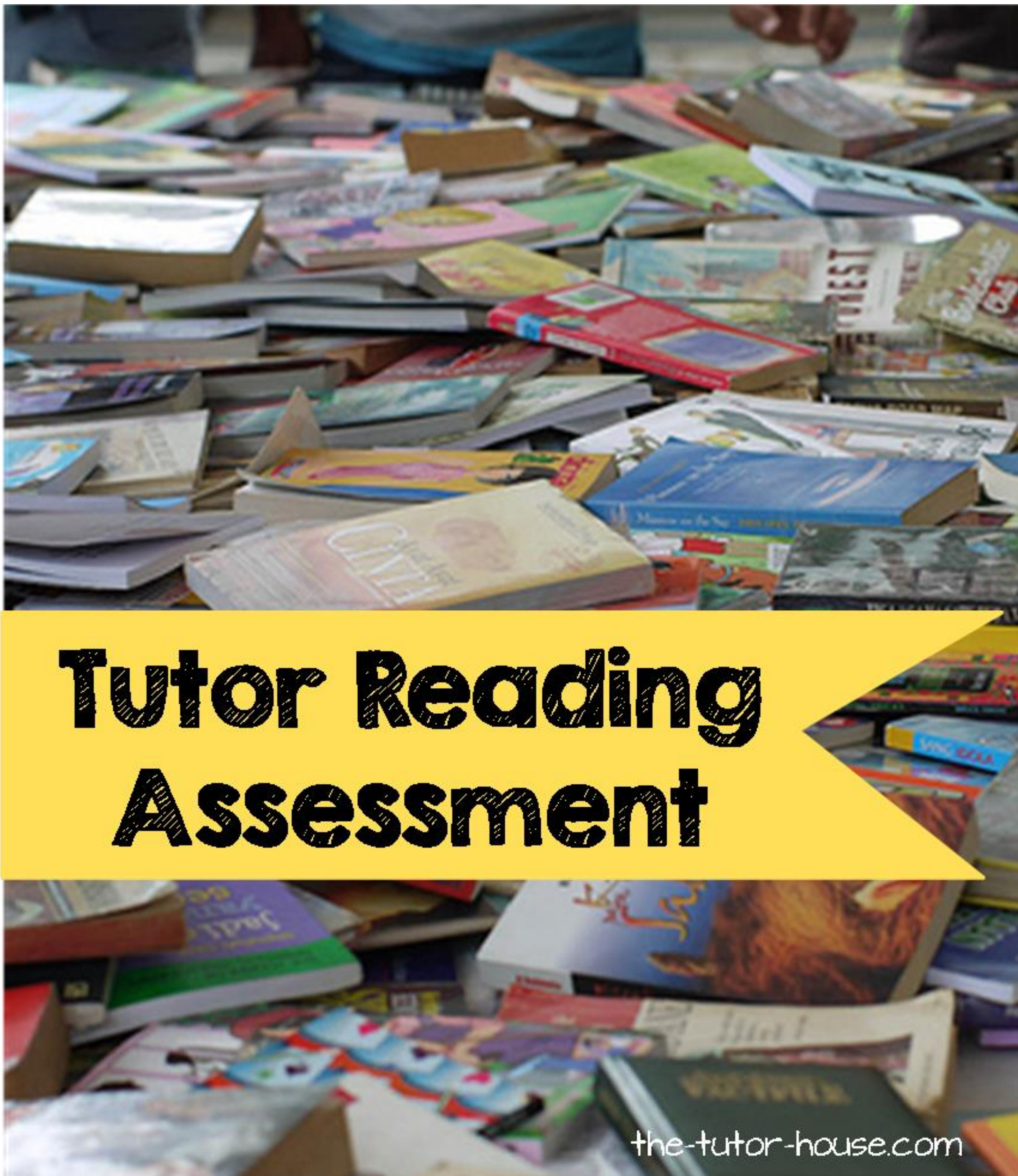
This unit highlighted health governance in relation to policy formation at the local, national and international levels. It also introduced global health initiatives with global fund and GAVI-the vaccine alliance as examples of partnerships that address the looming challenges confronting international communities. Health governance enables collaboration, coordinated by health ministries and other health related agencies in policy formation and implementation through joint action among the actors in health sector and as well as in non-health sectors, involving public and private actors, and citizens for sustainable health system.

Summary

The study describes the history of health governance, health policy, and international collaboration for health at the local, national, and international levels. It also introduced global health initiatives, the types, structures and mechanisms that enable collaboration and roles of public sector (health ministries) private sector and civil societies. The study further explained means of policy identification, prioritization, planning, formulation, implementation, monitoring and evaluation, and analysis.

Tutor Marked Assignment

1. What are the key elements of health governance?
2. Describe health governance in your own word, citing example of the sectors involve.
3. Briefly explain the relationships between national and international health policies
4. Discuss how various factors and processes influence health policy process.
5. What role should foundations play in both formal and informal governance processes?
6. Briefly discuss the roles of Global Fund and GAVI in addressing international health challenges.



References and Further Readings

19–27

Kickbusch, I. and Gleicher, D. (2012). Governance for health in the 21st century World Health Organization Regional Office for Europe.

Pever, N.U., Mson, E., and Kor, F.A. (2016). Health care policies in Nigeria since independence: issues, challenges and prospects. kamjournal.org/2016/06/26/health-care-policies-in-nigeria-since-independence-issues-challenges-and-prospects/

Berridge V, Loughlin K, Herring R. HISTORICAL DIMENSIONS OF GLOBAL HEALTH GOVERNANCE.; 2009.

Brinkerhoff DW, Fort C, Stratton S, Governance G, Progress A, Rwanda I. Good Governance and Health: Assessing Progress in Rwanda TWUBAKANE Decentralization and Health Program Rwanda.; 2009.

Cheld Policy Team. Mental Health Law in Nigeria. https://cheld.org/wp-content/uploads/2021/01/Mental-Health-Policy-Brief-CHELD-1.pdf. Accessed March 8, 2021.

Gavi. About our Alliance. https://www.gavi.org/our-alliance/about. Accessed March 11, 2021.

HEALTH CARE POLICIES IN NIGERIA SINCE INDEPENDENCE: ISSUES, CHALLENGES AND PROSPECTS – Katsina-Ala Multi-disciplinary Journal. https://kamjournal.org/2016/06/26/health-care-policies-in-nigeria-since-independence-issues-challenges-and-prospects/. Accessed March 11, 2021.

Kirigia JM, Kirigia DG. The essence of governance in health development. International Archives of Medicine. 2011;4(1). doi:10.1186/1755-7682-4-11

Nigeria. http://www.healthpolicyplus.com/nigeria.cfm. Accessed March 8, 2021.

Ruger JP. Shared health governance. American Journal of Bioethics. 2011;11(7):32-45. doi:10.1080/15265161.2011.568577

UNAIDS. Health and development | UNAIDS. https://www.unaids.org/en/keywords/health-and-development. Accessed March 8, 2021.

Unit 4: Distinction between Health and Healthcare and its Impact on Development

Introduction

::: notes

Good health is central to improved economy and productive live, stress handling and also improved economy is needed to attain and maintain a good health. In this unit, the meaning of health, healthcare and distinction between the two and health impact on development is discussed.

Objectives

At the end of this unit, you should be able to

- Explain the meaning of health and health systems
- Describe healthcare and its distinction with health
- Discuss the concept and scope of health in development

Main Content

- Health
- Healthcare
- Health in Development

Health

1. the state of being free from illness or injury.
2. a state that allows the individual to adequately cope with all demands of daily life (implying also the absence of disease and impairment).
3. a state of balance, an equilibrium that an individual has established within himself and between himself and his social and physical environment.

There are three primary ways to define health, these definitions are important in understanding the way that health is promoted and approached within a country.

The first definition- health is the absence of any disease or impairment. If health is defined as the absence of disease, then the medical profession is the only one that can declare an individual to be healthy. With the medical progression, people who are declared healthy today may be unhealthy tomorrow because more advanced methods come to light, and they are able to find a disease that was not diagnosable earlier. How a person feels about their state is not relevant in this lens of health. How others judge the behavior and appearance of a person is only relevant if their observations align with the standards of the medical profession. This lens while simpler, is extremely limiting. It's similar in the view that in order to understand the health of the population, you would need to count the number of people who show signs of illness compared to the people who do not.

The second is that health is a state that allows the individual to adequately cope with all demands of daily life, implying the absence of disease and impairment. While this definition is similar to the first and therefore has the same type of limitations- it specifically adds the management of stress and daily life. There are individuals who have abnormalities that can be counted as symptoms of a disease but do not feel ill. There are others whose body tissues do not demonstrate changes but who feel ill and do not function well. There are people who hear voices and might therefore be candidates for psychiatric examination and possibly treatment – but live well in their community and do not ask for nor receive medical care. There is a significant number of people who have ulcers and other diseases, experience no problems, do not know that they have a disease and do not seek treatment for it. Some of these individuals will also escape the second type of definition of health because they function as well as expected in their age and gender group of the general population.

These simple definition of health, i.e. the absence of disease, leads to a definition of the promotion of health as an effort to remove diseases and diminish the numbers of individuals who suffer from them. Health promotion would then only be the process by which the capacity of individuals to cope will be enhanced and strengthened, for example by regular physical exercise. Both of these definitions lead to recommendations to improve the treatment of diseases, and to remove risks factors that might lead to them – such as sedentary life style, smoking, bad eating habits and insufficient application of hygienic measures such as washing one's hands before meals.

The third definition, is that health is a state of balance, an equilibrium that an individual has established within themselves and between themselves, and both their social and physical environments. This makes health depend on whether a person has established a state of balance

within oneself and with the environment. Meaning that those with a disease or impairment will be considered healthy to a level defined by their ability to establish an internal equilibrium, in laymen terms, this means that a person can get the most they can from their life despite the presence of the disease. Health becomes a dimension of human existence that remains regardless of the presence of diseases, like the sky always being there whether are are clouds, stars, moon, or sunlight. What is in the sky changes, but the sky itself is constant. Likewise, diseases do not replace a persons' health: it may affect their ability to maintain balance more or less severely. The person who suffers from a disease (and their doctors) remain aware of the need to work simultaneously on two tasks – one, to address the disease and two to establish a state of balance, within oneself and with their environment.

In fighting stigmatization, that often accompanies many diseases, – especially such as mental health, chronic, or acute disorders – the definition is useful because it encourages us to speak and think about people as individuals who are defined by different dimensions (including health) and who, at a point, suffer from a disease. For example, with this lens you would say "a person with schizophrenia" rather than "a schizophrenic," or a "person who has diabetes" rather than a "diabetic" and a "person with leprosy" rather than a "leper." With this definition, it is not enough to have the medical results, doctors also must doctor must explore how individuals who have a disease feel about it, how the disease influences their lives, how they propose to fight their disease or live with it. It other words it is necessary to view the disease in the context of the person who has it in order to make a judgment about his or her level of health.

This more complex definition, involves health promotion in a more complex manner. It involves the people whose health is to be promoted in an active way: it would have to address the scales of values of individuals and communities to ensure that health is placed higher on those scales. High value placed on health (not only on the absence of disease) would make people undertake whatever is necessary to enhance health: participating in preventive action and seeking treatment would become a normal expression of the need to behave in harmony with one's own and one's community values. Changing the place of health on the scale of values, however, is not possible if left to the health sector alone: values are shaped throughout life under the influence of parents, friends, schools, the media, laws, and one's own life course and experience. Thus, changing values – for example to give health a higher value, to promote health – has to be a task for all of those involved in shaping values and placing them on a scale rather than for the health system alone.

Said another way, you could not approach health from only the health sector. It would have to be kept in mind across all sectors, think of the spokes of a wheel. If health is in the center, the more connection or the more sectors of the government that keeps health in mind, the strong the health and well being of the population will be. Via this definition, because health cuts across everything as a fundamental part of being alive, efforts to support health would likewise cut across everything.

Healthcare

Healthcare = the maintenance and improvement of physical and mental health, especially through the provision of medical services.

Healthcare- means to an end… health- that end

'There are three rules for designing a healthcare system. Unfortunately, no one knows what they are.'
- Somerset Maughan

Most of the time when people think of health, they don't think of any of the definitions that we discussed previously- they think of hospitals, doctors, and nurses. In other words, they think of healthcare or more specifically sick care. They think of paying someone to return them to a state of "normalcy". It's particularly interesting when you realize that healthcare contributes about 10% to an individual's total health, the other 90% comes from social determinants such as education, sanitation, housing, access to healthy foods, poverty, transportation, etc. However healthcare out of all the total is the "sexy" one, its the item that is flashy, innovative, and obvious. When someone builds a hospital, they can name the hospital after themselves and point to the hospital and say "look! I build that!" however when someone reduces the costs of fruits and veggies in a community, reduces poverty, provides safer communities , etc. it becomes a lot less obvious what was done and how. It does not always translate into media coverage or votes to get politicians re elected. However in resource poor environments or really any environment. Each decision made also comes with opportunity costs, so every kobo that is spent going to one thing, is a kobo not spent going towards something else.

Improving health clearly requires health system investment. Increased investment in health requires public action and mobilization of resources for the implementation of health policies. Investment in health is a key element that link health and economic development, because attainment of population health thrives on economic development and vice verse in similar way the economic development depends on good health. For example, health and demography can affect income through their impact on employment status, income savings ability, physical and human capital, among others. Income can also affect health and demography by improving the ability to obtain food, hygiene, housing, and education among other factors that sustained health systems.

Health system comprises the organizations, institutions and citizens whose aims is to improve health. The main purpose of a health system is to protect and improve population health through stakeholders. The stakeholders in health system includes patients, families, and communities, Ministries of Health, health providers, health services organizations, pharmaceutical companies, health financing bodies, and other organizations play important roles, such as oversight, health service provision, financing and resource management. Health systems improvement and economic development are inseparable. Development institutions that aim to improve health relies on sound economic related opportunities, influenced by the liberty to participate in the development discourse for effective health systems strengthening (HSS). HSS is monitored through the WHO six Health System Building Blocks (HSBB):

1. Service Delivery
2. Health Workforce

3. Health Information
4. Medical Products, Vaccines and Technologies
5. Health Financing
6. Leadership and Governance

Health systems are the foundation to the achievement of Sustainable Development Goal number three and all mother health related targets of the 17 goals, through the;

- Promotion and improvement of individuals and groups health
- Avoiding dangers to health.
- Protect people against consequential effects of ill health
- Provide equitable access to health care
- Enable participatory health decisions making

Health care is the total societal effort, organized or not, whether private or public, that attempts to guarantee, provide, finance, and promote health. Healthcare consists of measures, activities and procedures for maintaining and improvement of health and living and working environment, rights and obligations acquired from the health providers and/or financiers, including measures, activities and procedures which are undertaken in the field of health care for maintaining and improvement of people's health, prevention and control of the diseases, injuries and other disorders of the health.

Effective healthcare services encourage early detection of diseases and treatment. Detection of disease conditions, timely and efficient treatment and rehabilitation, through the effective application of professional medical measures, activities and procedures. Delivery of health care services involves public or private providers' efforts that assist individuals in regaining health, and prevention of disease and disability. Healthcare delivery services to patients occurs in a different service delivery settings classified by ownership and profit motive. In addition, they can be classified by whether the patient is admitted as an inpatient or outpatient and, for an inpatient, by the average length of stay.

Historically, hospitals and nursing homes are the most common health services delivery points. They remain prominent in the contemporary healthcare systems, but other health services such as outpatient clinics, imaging centers, free-standing emergency care and surgical centers, large group practices, and home health agencies also deliver healthcare services. Healthcare industry is a multi-institutional systems, both vertically and horizontally integrated, thus; health maintenance organizations, sickness funds, prepaid provider organizations, and managed care systems and others. These healthcare institutions face a wide range of external pressures, such as new rules and technologies, changed demography and ageing, accountability to multiple constituents, and resource constraints.

Nigeria as a nation operates a pluralistic healthcare delivery system. Orthodox and traditional health care delivery systems - orthodox health care services are provided by private and public sectors, but, the provision of health care in the country remains the functions of the three tiers of government: the federal, state, and local government. The primary health care system is managed by the 774 local government areas (LGAs), with support from their respective state ministries of health as well as private medical practitioners. The secondary health care system is managed by the ministry of health at the state level. The tertiary primary health care is provided by teaching hospitals and specialist hospitals. The secondary and tertiary levels, also work with voluntary and nongovernmental organizations, as well as private practitioners.

The WHO recommend secondary and tertiary care to support primary care, concentrating on those functions that cannot be performed effectively in the primary healthcare settings. Typically, healthcare delivery systems performed these functions: - Health services delivery that includes environmental protection, health promotion, prevention and treatment of diseases and injuries, primary care, specialist medicine, hospital services, services for specific groups, and self-help medical services. - Healthcare financing, through funds mobilization, and finance allocation. - Provision of health resources through the construction and maintenance of health facilities, procurement and distribution of drugs, acquisition, allocation and management of equipment and instruments. - Education and capacity building of health personnel at both undergraduate postgraduate levels. - Research and development focusing on healthcare research, technology development, assessment and quality assurance. - Management of local state, and national health systems by looking at issues like healthcare policy and strategy development and action plan implementation by action plans, information, coordination with other sectors, regulation of activities and utilization of health manpower, physical resources and environmental health services).

The main objectives of national healthcare system include, but not limited to:

1. Accessibility to a broad range of healthcare services;
2. Promotion of national healthcare goals;
3. Improvement of healthcare delivery indicators;
4. Equity in regional accessibility to quality of care;
5. Financial adequacy and efficient use of resources;
6. Consumer satisfaction and choice of primary care provider;
7. Provider satisfaction and choice of referral services;
8. Portability of benefits when changing employer or residence;
9. Public administration and/or regulation;
10. Promotion of high quality of service;
11. Comprehensive in primary, secondary, and tertiary levels of care;
12. Well maintained information and monitoring and evaluation systems;
13. Policy continuing and review
14. Promotion of standards of professional practice;
15. Governmental and private provision of healthcare services;
16. Decentralized management and community participation.

Healthcare services is a permanent countrywide system that aims to address various health needs and demands of the population through provision of quality healthcare for individuals and the community including a broad spectrum of preventive and curative activities, and utilizing, to a large extent, multipurpose healthcare professional.

Health in Development

- Interconnectedness
- Actors

The advent of COVID-19 demonstrated better than anything else the importance of health in development. Good health is essential for the stability of countries, regions, and the world. Pandemics transcend borders, can have severe social and economic impacts on families and communities, and can put increased pressure on health systems. We are all interconnected, thus ensuring the health and well-being of all is essential to maintaining the health and well being of all. Health development efforts help to address poverty eradication, achieve sustainable development, contribute to economic growth and prosperous communities.

Aside from the fact that good health allows people to reach their full potential, children to be better able to learn, workers to be more productive and parents to care for their children better; it is also a key indicator of a country's progress. A nation with a healthy population is more likely to experience sustained growth. While global health has improved significantly in recent decades, this benefit has not been shared evenly within and among nations. Several hundred million people across the globe continue to go without basic health services, especially in rural areas and in the most impoverished communities. Health development actors strive to support efforts to address immediate health challenges while building the capacity necessary to sustain and achieve long-term results.

Health is a central ingredient in development sector. It can be seen as an investment in human capital, which plays an important role in both endogenous growth models and neoclassical theories as applied to health. More fundamentally, health is a precious tool for improving the economic and social future of a population by improving not only individuals' aspirations but also their capacities. At the same time, health contributes to the well-being of individuals, which has been reflected in the inclusion of life expectancy in calculating the human development index. Finally, sources of deficiency in the healthcare market mean that the social optimum is not achieved and that intervention in the healthcare market becomes necessary. The necessity of implementing public policies in the healthcare field is a justification in itself for the significant weight given to support health in development aid policies. Health system in the development sector is position to deliver health care services that meet the health needs of the target populations, in partnerships with the participants, governments, trade unions, charities, religious institute, and other coordinated bodies that deliver healthcare services at the three tiers of the government (federal, state and local government).

The necessity of implementing

Health policies implementation support development. Health policies in itself carried a significant weight that support health development policies. The barriers to healthcare accessibility are due to;

i. External factors,

ii. A shortage in high-quality information for the targeted audience
iii. Uncertainty in the coherence of temporal terms,
iv. Demand and supply of the needed services

In reality, primary healthcare services are the one mostly accessible by the poor, especially in Africa, where a large rural population has no access to healthcare services.

Health is an important tool for improving the economic status of a population. The relationship between the health of a population and the state of development of a society is complex and varies over time. Throughout history, improved health has been one of the main benefits of development. This benefit results partly from an increase in income and partly from scientific progress in the fight against disease and disability. Reciprocally, health could be expected to have a favorable effect on development, although this effect is more difficult to detect. Nevertheless, health can be considered part of a society's capital stock, as long as the essential differences between this type of capital and physical capital are recognized. These differences, in turn, provide an insight into the health services market and, in particular, into the tendency to spend more and more resources on health. It is necessary to respect the intrinsic value of human capital, rather than focusing strictly on the economic productivity that may be derived from it, in order to prevent discrimination against children, the elderly, the poor, or the disabled.

Aid for health has increased significantly in absolute terms since the beginning of the 21st century. This is explained in part, by a recovery in publicly funded development aid over the past decade, but first and foremost by the increase in the proportion of development aid allocated to health. Moreover, it is important not to ignore the increasing contribution made by private-sector aid, funded primarily through large private foundations. The proactive approach of a number of major donors, and the philanthropy of the main foundations, have thus contributed to a significant improvement in the volume of aid allocated to health.

Vulnerable and socially disadvantaged people have no access to health resources. Poor people got sicker and die earlier than other people in the privileged social positions. These unfair gaps are growing in spite of an era of unprecedented global wealth, knowledge and health awareness. Health is central to the global 2030 agenda in particular, to the Sustainable Development Goals. Weak and inequitable health systems–especially those that are confronted by severe human resources shortages or lack of means for sustainable financing–represent a key obstacle to scaling up the disease prevention and control programmes. To meet the health objectives outlined in the 17 SDGs aims at reducing child and maternal mortality and the burden of HIV/AIDS, tuberculosis and malaria and providing access to affordable essential drugs in developing countries.

It is vital that countries ensure that health is prioritized within overall development and economic policies. Inversely, social, political and economic initiatives can improve health system functioning if they make these systems a priority. In lieu of this, the World Health Organization (WHO) identified three basic objectives of a healthcare system, include:

1. Good health (improvement and protection of the health of the populace)
2. Fair financial contribution (receiving the services paid for)
3. Responsiveness of the healthcare providers (living up to the people's expectation)

Achievement of these goals is dependent on how the healthcare systems carryout the following functions:

4. Rendering of efficient health services
5. Resources generation such as healthcare financing (raising, pooling and allocating)
6. Health investment such as material resources
7. Stewardship such as human resources.

Other dimensions for the evaluation of health systems include quality, efficiency, acceptability, and equity. They have also been described as "the five C's": Cost, Coverage, Consistency, Complexity, and Chronic Illness. Also, identified the following among others as the factors affecting the overall performance of the Nigerian healthcare system:

- Inadequate health facilities/structure
- Shortage of essential drugs and supplies
- Inadequate supervision of the healthcare system
- Poor human resources, management, remuneration and motivation
- Lack of fair and sustainable health care financing with very low per capita health spending
- Unequal economic and political relations
- The neo-liberal economic policies of the Nigerian state and corruption
- High out-of-pocket expenditure in health by citizens
- Absence of community-based integrated system for disease prevention, surveillance and treatment It became very necessary to brainstorm and come up with plans and strategies that will checkmate the aforementioned factors that militate against effective health care system in the country. Strategies among others which will help in tackling the health sector challenges in the country as follow:
- Improved access to primary healthcare
- Strategic and purposeful leadership in health delivery services
- Increase fund to manage the health sector

Conclusion

The unit concludes by describing health care delivery system as the organized response of a society to the health problems and needs of the population. The quality of healthcare system is expressed through coverage, access, equity, and also, to meet the challenges of healthcare delivery confronting poor and the vulnerable population, the health system must be strengthened. It is vital that countries ensure that health is prioritized within overall development and economic context. Inversely, social, political and economic initiatives that can improve health system should be scaled up to sustain and expand health gains.

Summary

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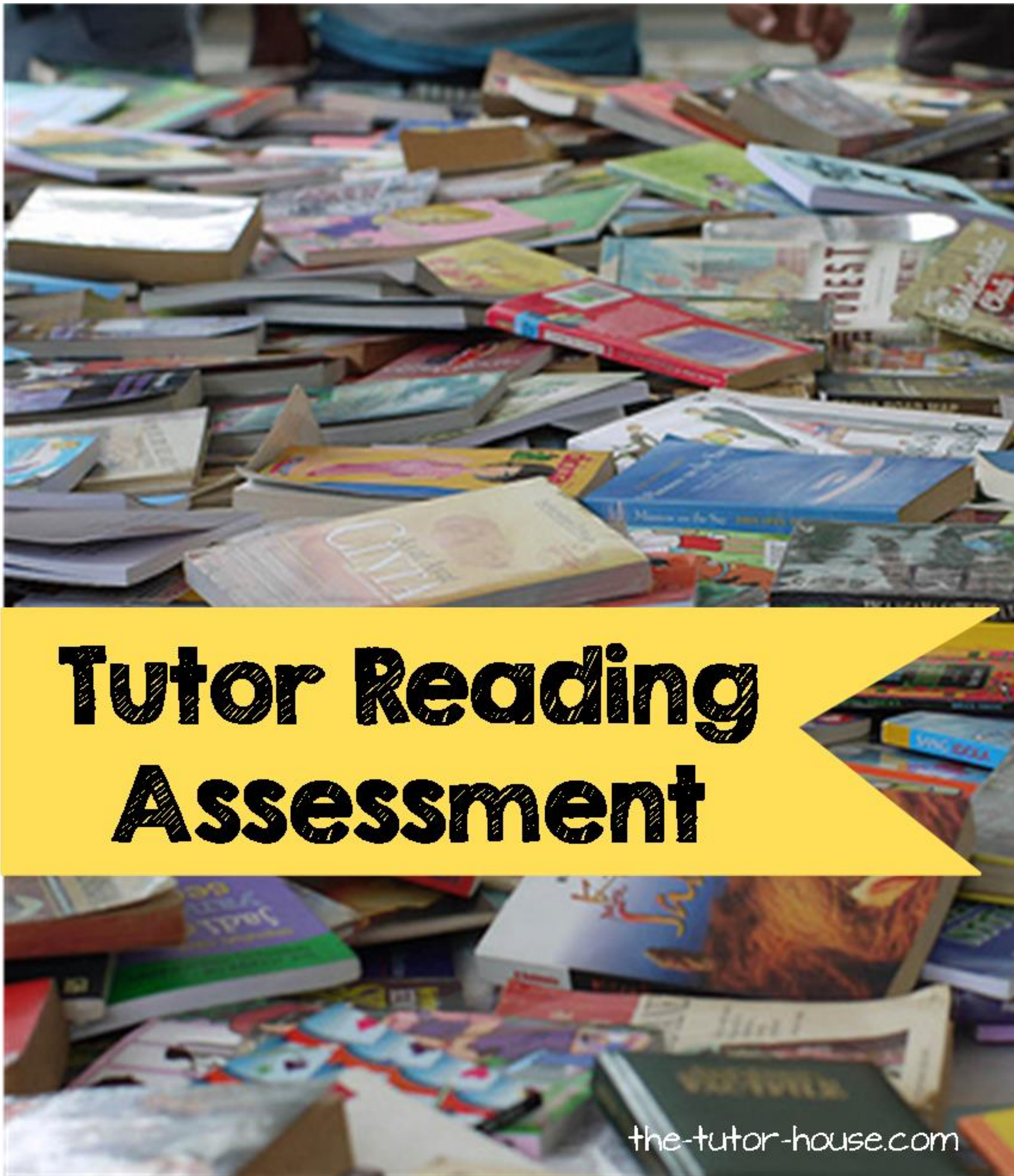
Attainment of health from the development perspectives, improved economy is a requirement and productive live, stress handling and also improved economy is needed to attain and maintain a good health. The meaning of health from the WHO perspective, as the presence of physical, mental and social well-being was presented; healthcare the concept and scope of health and its impact on Development was discussed.

Tutor Marked Assignment

- What is health?
- Explain the World Health Organizations health systems strengthening blocks
- What are the organizational roles in Nigeria's healthcare system?
- What are the different Healthcare Systems found in Nigeria? Discuss
- Describe health care system in Nigeria.
- Discuss health impact on development



References and Further Readings

28–31

Brüssow, H. (2013). What is health? Microbial Biotechnology 6(4), 341–348

Musgrove P. (1993) Relations between health and development]. Bol Oficina Sanit Panam. 114(2):115-29. Spanish. Ruger, J.F (2014). Health and development. Lancet; 362(9385): 678.

Ruger JP, Jamison DT, and Bloom DE. (2001). Health and the economy. In: Merson MH, Black RE, Mills AJ, eds. International public health: disease, programs, systems, and policies. New York: Aspen Publisher

Oyibocha, E.O., Irinoye, O., Sagua, E.O., Ogungide – Essien, O.T., Edeki, J.E. and Okome, O.L. (2014). Sustainable Healthcare System in Nigeria: Vision, Strategies and Challenges. IOSR Journal of Economics and Finance (IOSR-JEF). Volume 5, Issue 2, PP 28-39

Braveman P, Gottlieb L. The social determinants of health: It's time to consider the causes of the causes. Public Health Reports. 2014;129(SUPPL. 2):19-31. doi:10.1177/00333549141291s206

Laura McGovern. The Relative Contribution of Multiple Determinants to Health.; 2014. doi:10.1377/hpb20140821.404487

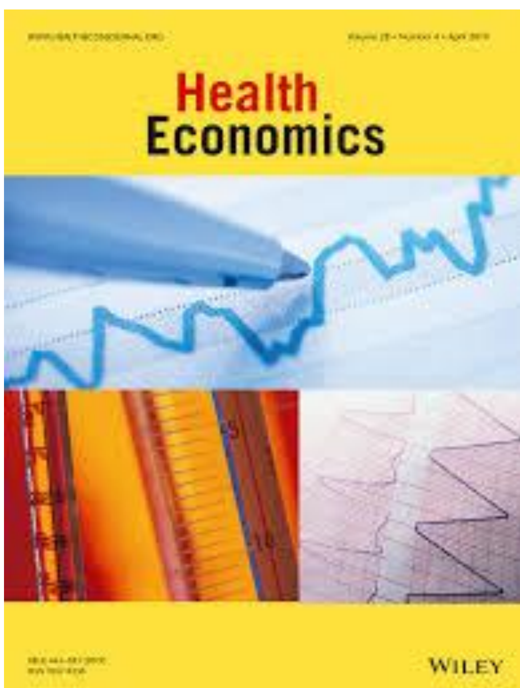
Sartorius N. The meanings of health and its promotion. 2006;47:662-664. www.cmj.hr.

World Health Organization. Helsinki Statement Framework for Country Action.; 2014. www.who.int.

Module 2: Health care Demand and Supply

Unit 1: The theory of health care demand and Supply Unit 2: Healthcare and Government intervention Unit 3: Health care delivery in Nigeria Unit 4: Ethics in Development

Unit 1: The theory of health care demand and Supply



Introduction

Healthcare demand is responsible for having more expensive health system than in another place. Why is the price of health care higher in one place than another? To understand this, the unit examine the factors determining the price and quality of health care, factors determining healthcare services demand, health as investment and health care supply.

Objectives

At the end of this unit, you should be able to:

- Examine the factors determine the price and quality of health care.
- Describe the factors determining healthcare services demand.
- Discuss health as investment and health care supply.

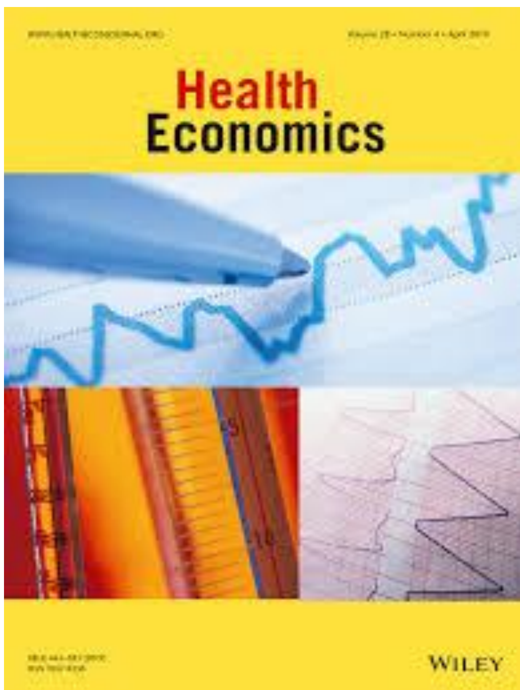
Main Content

- Factors determining the price and quality of healthcare
- Factors determining healthcare services demanded
- Health as investment
- Health care supply

Factors determining the price and quality of health care

Five factors are the main drivers of healthcare pricing:

- Demand
- Supply
- How compensation is determined
- Cost shifting
- Pricing opaqueness



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The five primary factors in determining health care costs are[32]:

Demand - If you add, say, 10 million people to the health rolls, especially the less healthy, demand for services and drugs has got to increase. Unless there is slack in the system, prices would be expected to rise. Supply - T his upward price pressure can be lessened by increasing supply through, say, increasing the number of hospital beds or practitioners (doctors or other). Supply can also be increased relatively by reducing the number of hospital days required for specific events, or by inventing drugs or less invasive methods of treatment.

How compensation is determined- Much compensation is based on “fee-for-service”, which creates reverse incentives for providers, who are paid for procedures, not for outcomes. Cost shifting - Hospitals and providers do not have to charge everyone the same for the same services. This creates a system where some customers, like the Federal government or insurers (where it is not the government), enjoy pricing that is often unprofitable, and others are charged more to make up the difference. Pricing Opaqueness - Most providers, especially hospitals and surgical centers, do not quote prices in advance, even for routine procedures. This makes it impossible for even the best informed consumers to make rational choices.

Health-care prices are not necessarily *the* determinant of healthcare quality. Healthcare prices exert a significant influence on healthcare products. Prices are sometimes determined by bargaining powers between hospitals and drug companies rather than by quality care supply. With people health-care services, needs is likely to be inelastic rather than demand. Inelastic demand is not in itself a problem for a competitive market, but demand by consumers who lack supplies information.

Quality health-care services can be achieved through investment in:

- Various trained professionals, such as General Practices, specialists, nurses, medical technicians, pharmacists, and many others
- Procedures and testing, such as magnetic resonance imaging (MRI) scans and laboratory analyses of blood samples
- Hospital and nursing care services
- Emergency services such as ambulances
- Pharmaceutical products

The supply of quality healthcare can also be a problem. Some health-care suppliers have significant market power, with insights from supply-and-demand view point. But it is trickier to compare the price of health care across countries because differences in market power need to be considered. A bigger problem is that some health-care suppliers, such as hospitals, are either government-controlled or not-for-profit institutions. The standard economic approach presumes that firms seek to make as much profit as possible, but government or not-for-profit hospitals may not have profit maximization as their goal. Also, there are various healthcare supply features. Each supplier has its own peculiarities, the presence of market power, information problems public good characteristics.

Quality of care improving is a continuous process. A robust definition of the quality of healthcare is insufficient if care is to be accomplish as the goal of continuous improvement.

Important notes[33]:

- Due to informational problems for households, market power by suppliers, and government intervention, the market for health care cannot be analyzed by using standard supply-and-demand curves.
- Spending on health care today has an effect on your health status in the future. In that sense, this spending is an investment.
- The demand for health services, like other goods, depends on your income and the price of the services. Unlike your demand for many other goods, your demand for health services is influenced by the costs of health insurance. Also, unlike the case for many other goods, consumers who demand health services are relatively uninformed about the service they are buying.

- The production function for health takes inputs, such as doctors, nurses, and machines, and produces health-care services.

Patient satisfaction is a multi- dimensional healthcare construct affected by many variables[34]. Healthcare quality affects patient satisfaction, which in turn influences positive patient behaviors such as loyalty. Patient satisfaction and healthcare service quality, though difficult to measure, can be operationalized using a multi- disciplinary approach that combines patient inputs as well as expert judgement.

Quality in healthcare is a production of cooperation between the patient and the healthcare provider in a supportive environment[35]. Personal factors of the provider and the patient, and factors pertaining to the healthcare organisation, healthcare system, and the broader environment affect healthcare service quality. Healthcare quality can be improved by supportive visionary leadership, proper planning, education and training, availability of resources, effective management of resources, employees and processes, and collaboration and cooperation among providers.

Factors determining healthcare services demand

As stated earlier, quality consists of the degree to which health services for individuals and populations increase the likelihood of desired health outcomes, are consistent with current professional knowledge (practitioner skill), and meet the expectations of healthcare consumers (the marketplace). Successful healthcare organizations —- be they hospitals, physicians' offices, pharmacies, nursing homes, or ambulatory centers—will have understood, identified, and put into practice all of the following essential principles:

1. Leadership.
2. Measurement.
3. Reliability.
4. Practitioner skills.
5. The marketplace.

Supply and demand interacts to determine the price of care. Recognizing that firms with market power set prices, but unfortunately, healthcare market differs. It is much harder to get information about prices, but cannot simply walk in off the street and purchase an operation. One can in fact find out the hospital procedures and prices. For example, some website allows access to information on

hospital charges for different types of surgeries. Knowing the charges do not necessarily reveal the true price to a consumer because they may not include all the costs of other inputs.

A key characteristic of health care is that demand is relatively inelastic. If one is sick and require care, health-care services will be purchase at any price. Several of the most important prices are determined by the nature of the investment in health by few big players in healthcare system like the government, insurance companies, and pharmaceutical companies.

Just as social determinants of health impact the overall health of an individual, social determinants also impact the demand for healthcare. Factors such as gender, family members, personal income, and perception of economic level affect the demand for health services. Higher-income families tend to have higher actual use of health services because they are able to afford the cost, but since they can also afford preventive care, they are able to reduce their real need for health services. This is the so-called double effect of income.

Price has a negative effect on the demand for health care. Although total demand for health care was found in several studies to be not so responsive to price changes, selection of the source of health care services was observed to be influenced by the price factor. Research has found that while the decision to use or not to use public facilities was affected by the price of private health care, and user fees can generate substantial revenues but demand becomes more sensitive to price changes as income falls. This implies that user fees would proportionately reduce the poor's access to health care more than the rich's. Non-monetary factors, such as time price, are expected to assume an increasingly important role in influencing the demand for health care as the out-of-pocket price falls. As net or out-of pocket price falls, either because of increasing insurance coverage or because of the availability of subsidized care, demand becomes relatively more sensitive to changes in time price. Demand for free health services is expected to be more responsive to changes in time price than non-free services because time shares a greater proportion of the total price when availing of free facilities compared to non-free facilities[36].

Aside from reducing the net price of health care, insurance may be viewed as a method of financing the demand for health care. It not only reduces the cost of care, it also increases the family's ability to secure health services. Therefore, health insurance is expected to raise the utilization and expenditure of health care. However, in places like the United States, the health insurance structure has been a significant factor in the ballooning of healthcare costs without the expected increase in health outcomes. The incidence and prevalence of illness varies with age, so does the need for health care. The presence of children and elderly persons in the family raises the frequency of illness, which in turn in creases the use of health services[36].

Sex discrimination is actually the major underlying reason for expecting differences in health service usage by men and women. In many societies, the perception that women have low economic value in the household leads to their low use of health care services, however woman are more likely to regularly go to the doctor or go to the doctor when she has a problem. This phenomena is often used to explain why single women in many parts of the world have a higher life expectancy than married women. And married men have a higher life expectancy than single men. In the same vein, within families the mother's education is crucial because she usually supervises the household. An individual's health knowledge and beliefs affect their efficiency in maintaining personal health through dietary, hygienic, and preventive measures. It also affects the choice of health facilities[36].

A clean environment and quality of healthcare services, medical equipment for diagnosis and treatment in health care facilities, adequate laboratory and analysis unit, information provided about

diagnosis and treatment by doctors, and the reliability of healthcare services provided by doctors emerged as the factors most affecting health demand[37]. It is recommended that managers responsible for managing healthcare facilities know the factors affecting the demand for healthcare, especially in cases where the possibility of choice exists[38]. Distance has been the most studied hindrance to the use of health facility. The more distant a facility is from potential users, the less likely it is to be visited[36].

Demand-side barriers are as important as supply factors in deterring patients from obtaining treatment. Developing countries including Ethiopia have been focusing on promoting health care utilization as an important policy to improve health outcomes and to meet international obligations to make health services broadly accessible. However, many policy and research initiatives focused on improving physical access rather than focusing on the pattern of health care service utilization related to demand side. Understanding of determinants of demand for health care services would enable to introduce and implement appropriate incentive schemes to encourage better utilization of health care services in the community of Tsegedie district, Northern Ethiopia[37].

Health as investment

Being healthy rather than being sick is everyone's preference. Investing in the health system not only saves lives, it is also a crucial investment in the wider economy, because ill-health impairs productivity, hinders job prospects and adversely affects human capital development. There has been a strong political and historical commitment to treating health as a social goal either through legislation or mandating and prioritizing expenditure on health. For instance, the governments of Brazil, Costa Rica and Thailand have established social security and health insurance systems for the entire population. The key question is while it is universally accepted that health is a noble and worthwhile investment, how can we demonstrate value for money, especially in areas that compete for government funding?

Investment in health increases the total amount of time available for the production of goods and services. The extent to which individuals choose to alter the consumption of health inputs depends on factors such as prices, income, and preferences. Individuals will invest in their health if they have access to the available health inputs. Stakeholders should make facilities available and accessible to

employees for health investment: Governments should introduce pro poor health programmes to make healthcare accessible to also the low income employees, firms should establish clinics at their workplaces to provide primary healthcare services to their employees since primary care provides greater access to needed services, greater focus on prevention, and early management of health problems[39].

One clear impact of health-care investment can be seen in mortality prevention. Investment in mortality prevention measure targeting different ages. In 2004, the mortality rate in the United States for people ages 15–24 was about 80 out of 100,000, or 0.08 percent. In contrast, the mortality rate for those over the age of 85 was 13,823 out of 100,000, or 13.8 percent. In other words, the typical young person has about a 1 in 10,000 chance of dying in a given year, whereas the typical old person has more than a 1 in 10 chance of dying. It is not surprising that the mortality rate increases with age, proving that young people have a lower probability of dying than older people. Infants are sometimes exceptional: a 6-month-old child is more likely to die than an 18-month-old child because very young children are particularly susceptible to certain diseases. But these average mortality rates disguise a lot of variation, much of which is under our control. There are many behaviors that have predictable effects on our likelihood of dying – diet, exercise, and risky behaviors, which includes everything from unprotected sex to skydiving affect mortality rates as well.

Health care which reduces mortality, however, also raises the output of workers in a nation by increasing the vitality of these workers; many diseases with high prevalence rates in underdeveloped nations diseases such as malaria, yaws, trachoma, schistosomiasis, and bilharziasis, many of which we'll discuss later in this course. Estimate that less than a 20 percent rise in productivity per worker over a seventy-five-year period (a percentage equivalent to less than a quarter of 1 per cent rise in productivity per annum). A less than 20 per cent rise in productivity over a seventy-five- year period would compensate for the combined effects of (a) the larger number of births due to increased numbers in the child-bearing ages, (b) the increased proportion of dependents in the popula- tion, and (c) the increased investment in physical capital goods required to maintain a consistent ratio of marginal capital to workers[40].

Smokers have a higher probability of dying than nonsmokers. Those who smoke and are obese have a higher probability of dying than those who are not. Cigarette smoking is linked to lung cancer and thus to mortality. If you compare two similar individuals of the same age, one who is a smoker and the other a nonsmoker, then the mortality rate is significantly higher for the smoker. This does not mean that the smoker will necessarily die before the nonsmoker. It means that all else being the same, smoking increases the probability of death. Refraining from smoking is a type of health investment.

Being healthy also means that you can work and earn wages. One of the costs of poor health is lost days at work. This is a cost not only to the individual but also to society as a whole: the economy's population is producing less output. When in poor health, one risk losing wages for the days when you cannot come to work. Many employers provide insurance for these lost wages through the provision of sick days: if sick, one is not expected to work but will still be compensated up to a contracted number of days per year. Private employers sometimes also offer disability insurance as part of their compensation packages, and can also purchase insurance directly from an insurance company.

Health Care Supply

Healthcare supply sectors thrives on labor, capital, and intermediate inputs. The labor in a healthcare systems includes general practitioners, surgeons, attendants, technicians, nurses, administrative staff, janitors, and several others. The hospital buildings are part of the hospital's capital stock. In addition, hospitals contain an immense quantity of other capital goods, such as hospital beds and diagnostic tools—everything from stethoscopes to x-ray machines. Intermediate inputs in a hospital include dressings for wounds, and pharmaceutical products, such as anesthetics used for operations.

Doctors: To become a doctor, one need to go through multiple years in medical school, thereafter, comes an internship and then graduation. In most countries, a license is required to practice medicine. This makes sense: it will enable an understanding that a particular individual is a qualified professional or a quack. If consumers cannot easily evaluate the quality of the good or the service they are purchasing, it is useful to have external validations of quality. Licensing provides more than a guarantee of quality supply. In the case of doctors, the underlying reason for licensing is not so nefarious. Lack of it creates a barrier to entry that limits competition and increases market power that allows the development of supply theory. Other Health-Care Workers: There are many kinds of workers in the health care industry, including nurses, dental hygienists, administrative staff, technicians, and staff in care facilities such as hospices and nursing homes, and many others who need years of specialized training.

A key issue linked with healthcare in Sub-Saharan Africa is poverty. The incidence of poverty is widespread among household survey, which in turn affect health supply, as we have discussed previously.

Identified the following factors affecting healthcare supply system, thus:

- Inadequate health facilities/structure
- Shortage of essential drugs and supplies
- Inadequate supervision within the healthcare system
- Poor human resources, management, remuneration and motivation
- Lack of sustainable healthcare financing and low per capita health spending

- Unequal economic and political relations
- The neo-liberal health policies and corrupt practices
- High out-of-pocket expenditure in health by citizens
- Absence of community-based system for disease prevention, surveillance and treatment

It is necessary to brainstorm to plan and strategize ways to address the aforementioned factors that militate against effective healthcare supply system. While the work has to continue, the follow three strategies are a beginning.

- Improved access to primary healthcare
- Strategic and purposeful leadership in health delivery services
- Increase funds to manage the health sector

Brainstorm ways to implement these strategies in Nigeria at the local, state, and federal level.

Conclusion

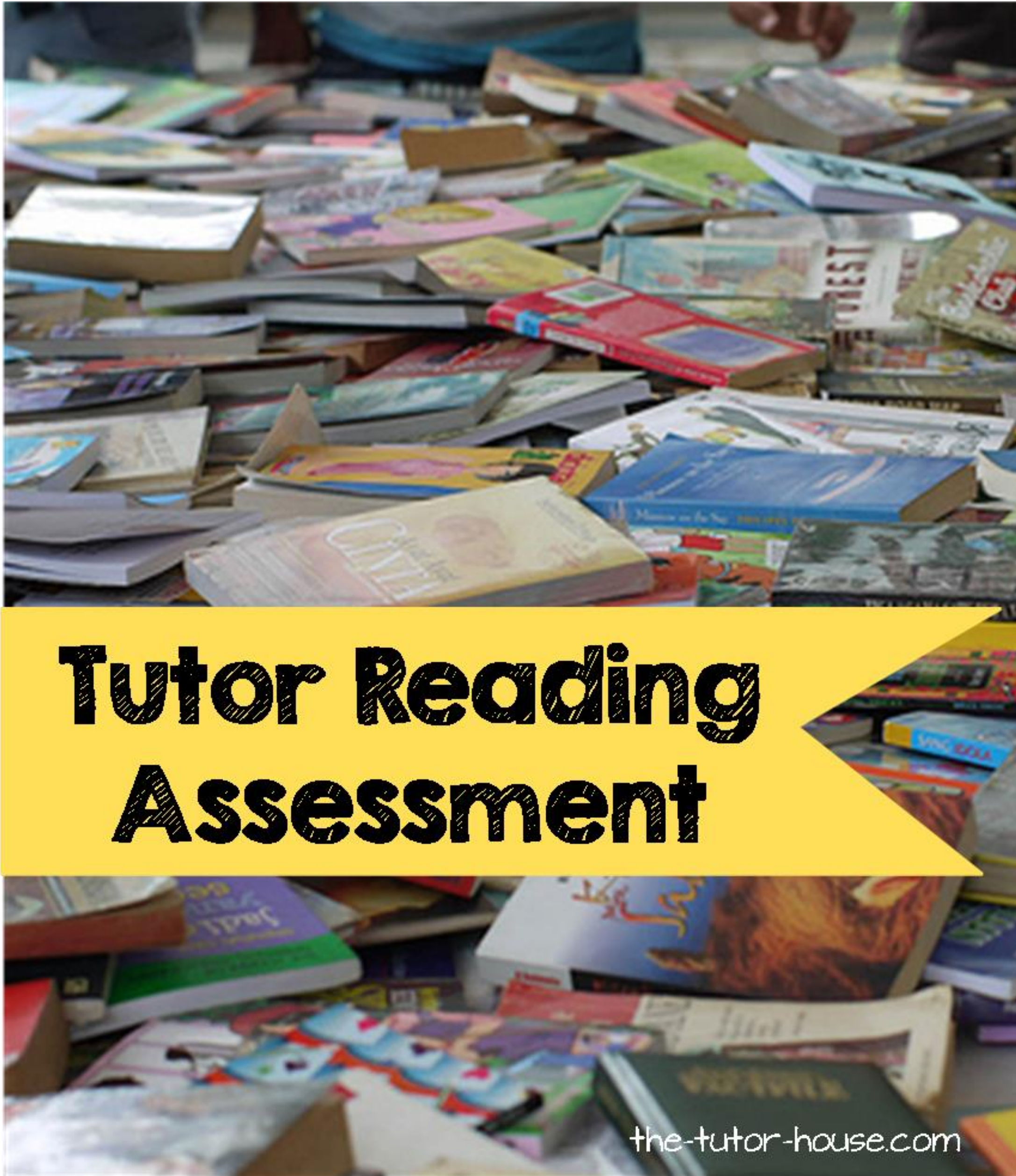
The unit concludes that public sector is the biggest player in the health-care market by determining the demand and supply direction of health-care services, price rates of certain procedures, health-care provider's regulation and negotiations—with other stakeholders. Also, insurance firms enhanced healthcare supply and demand processes, the practice of requiring prepayment is part of a policy to improve healthcare quality.

Summary

::: notes

Informational problems for households, market power by suppliers, and government intervention, in the market for health care today has an effect on health investment. The unit also posit that demand for health services, like other goods, depends on personal income and the price of the services. Unlike demand for many other goods, demand for healthcare services is influenced by the price and costs of health insurance. Also, unlike the case for other goods, consumers who demand health services are relatively uninformed about the service they are buying. The health supply mechanism takes inputs, such as doctors, nurses, and machines, and produces, as part of the factors that determining the price, quality healthcare services demand, health as investment and health care supply.

Tutor Marked Assignment



- Explain the factors that determine the price and quality of health care.
- What factors determine healthcare demand?
- Discuss health as investment and health care supply

References and Further Readings

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1. Arora M, Gigras Y. Importance of Supply Chain Management in Healthcare of Third World Countries. International Journal of Supply and Operations Management. 2018;5(1):101-106. www.ijsom.com.

2. Babalola O. Consumers and Their Demand for Healthcare. Journal of Health & Medical Economics. 2017;03(01). doi:10.21767/2471-9927.100032

3. Bhatia R, Farhang L, Lee M, et al. Minimum Elements and Practice Standards for Health Impact Minimum Elements and Practice Standards for Health Impact Assessment Assessment Recommended Citation Recommended Citation.; 2010. https://scholarworks.gsu.edu/ghpc{_}materials/11.

4. Boz C, Sur H, Söyük S. (PDF) The Affecting Factors of Healthcare Services Demand in terms of Health Services Use: A Field Application A R T I C L E I N F O. Edirne; 2015. https://www.researchgate.net/publication/319505919{_}The{_}Affecting{_}Factors{_}of{_}Healthcare{_}Services{_}Demand{_}in{_}terms{_}of{_}Health{_}Services{_}Use{_}A{_}Field{_}Application{_}A{_}R{_}T{_}I{_}C{_}L{_}E{_}I{_}N{_}F{_}O.

5. Ching P. FACTORS AFFECTING THE DEMAND FOR HEALTH SERVICES IN THE PHILIPPINES Philippine Institute for Development Studies.; 1992.

6. Cooper R, John A. Economics: Theory Through Applications. 1.0 ed.; 2012. https://2012books.lardbucket.org/books/theory-and-applications-of-economics/s20-01-supply-and-demand-in-health-ca.html.

7. Ellis RP, Mcguire TG. Supply-Side and Demand-Side Cost Sharing in Health Care. Vol 7.; 1993:135-151.

8. Folland S, Goodman AC, Stano M. The Economics of Health and Health Care: Pearson New International Edition. 2016. https://books.google.com.ng/books?hl=en{\&}lr={\&}id=qQ43DAAAQBAJ{\&}oi=fnd{\&}pg=PP1{\&}dq=economics+of+health+and+healthcare{\&}ots=vmANI0QCZ8{\&}sig=24sftx0P5aCV3{_}qXsAJ54f-M{_}8c{\&}redir{_}esc=y{\#}v=onepage{\&}q=economics of health and healthcare{&}f=false. Accessed March 15, 2021.

9. Frimpong AO. Health as an Investment Commodity: A Theoretical Analysis. Finance, Entrepreneurship, Accounting and Transport. 2014;2(3):58-62. doi:10.12691/jbe-2-3-1

10. Harris-Roxas B, Viliani F, Bond A, et al. Health impact assessment: the state of the art. Impact Assessment and Project Appraisal. 2012;30(1):43-52. doi:10.1080/14615517.2012.666035

11. Kapferer S. The importance of investing in health | World Economic Forum. December 2015. https://www.weforum.org/agenda/2015/12/the-importance-of-investing-in-health/. Accessed March 22, 2021.

12. Levy R. WHAT ARE THE MAIN FACTORS AFFECTING HEALTHCARE COSTS? December 2015. http://www.hbdinc.com/blog/what-are-the-main-factors-affecting-healthcare-costs/. Accessed March 20, 2021.

13. Lillrank P, Groop PJ, Malmström TJ. Demand and Supply–Based Operating Modes—A Framework for Analyzing Health Care Service Production. The Milbank Quarterly. 2010;88(4):595. doi:10.1111/J.1468-0009.2010.00613.X

14. Medic West Africa. Together for a healthier world 2019 Healthcare Market Insights: NIGERIA Report by.; 2019. https://www.medicwestafrica.com/content/dam/Informa/medic-west-africa/english/2019/HealthcareInsights.pdf.

15. Ministry of Foreign Affairs of Japan. "Health and Development" Initiative (HDI).; 2005.

16. Mosadeghrad AM. Factors influencing healthcare service quality. International Journal of Health Policy and Management. 2014;3(2):77-89. doi:10.15171/ijhpm.2014.65

17. Mushkin SJ. Health as an Investment. The University of Chicago Press. 1962;70:129-157. https://www.jstor.org/stable/pdf/1829109.pdf?casa{_}token=MrmNoBVTff0AAAAA:oHHPwenchU7x7eyZ9vX8qOC5cih0eFr{_}EaqGfyklpkoHueVCWnY2ALefjOqPnLFPR3eLZe7LgkkUnzSLD48MqXxfmxFVyvpRlZVBud6zyI1Uvcu3nafsJA.

18. Naidu A. Factors affecting patient satisfaction and healthcare quality. International Journal of Health Care Quality Assurance. 2009;22(4):366-381. doi:10.1108/09526860910964834

19. Osaro E, Charles AT. Harmony in health sector: A requirement for effective healthcare delivery in Nigeria. Asian Pacific Journal of Tropical Medicine. 2014;7(S1):S1-S5. doi:10.1016/S1995-7645(14)60196-6

20. Principles of health economics including: the notions of scarcity, supply and demand, distinctions between need and demand, opportunity cost, discounting, time horizons, margins, efficiency and equity | Health Knowledge. https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4d-health-economics/principles-he. Accessed March 20, 2021.

21. Robert G, Harkavy O. THE ROLE OF HEALTH IN DEVELOPMENT. University of Michigan, 1980. https://deepblue.lib.umich.edu/bitstream/handle/2027.42/23226/0000159.pdf?sequence=1.

22. Rossetti M, Marek D, Prabhu S, Bhonsle A, Sharp S, Liu Y. Inventory Management Issues in Health Care Supply Chains. July 2008. https://www.researchgate.net/publication/228586761{_}Inventory{_}Management{_}Issues{_}in{_}Health{_}Care{_}Supply{_}Chains. Accessed March 22, 2021.

23. Supply and Demand in Health-Care Markets. https://2012books.lardbucket.org/books/theory-and-applications-of-economics/s20-01-supply-and-demand-in-health-ca.html. Accessed March 20, 2021.

24. United Nations Technical Support Team. TST issues brief: HEALTH AND SUSTAINABLE DEVELOPMENT.; 2013. https://sustainabledevelopment.un.org/content/documents/18300406tstissueshealth.pdf.

25. Wagstaff A. The demand for health: Theory and aplications. Journal of Epidemiology and Community Health. 1986;40(1):1-11. doi:10.1136/jech.40.1.1

26. Wellay T, Gebreslassie M, Mesele M, et al. Demand for health care service and associated factors among patients in the community of Tsegedie District, Northern Ethiopia. BMC health services research. 2018;18(1):697. doi:10.1186/s12913-018-3490-2

27. World Health Organization. WHO | Health and development. https://www.who.int/healthsystems/topics/development/en/. Accessed March 20, 2021.

28. Biles, J. (2007). "Medicare: Care versus Cost, cjonline.com. http://www.cjonline.com/stories/102307/sta_211162036.shtml.

29. Martinez, B. (2008). "Cash before Chemo: Hospitals Get Tough. Wall Street Journal.

30. National Center for Health Statistics, National Vital Statistics System, "Mortality Tables," http://www.cdc.gov/nchs/nvss/mortality_tables.htm

31. Oyibocha, E.O., Irinoye, O., Sagua, E.O., Ogungide – Essien, O.T., Edeki, J.E. and Okome, O.L. (2014). Sustainable Healthcare System in Nigeria: Vision, Strategies and Challenges. IOSR Journal of Economics and Finance (IOSR-JEF).Volume 5, Issue 2, PP 28-39

32. Phil Buttell, Robert Hendler, and Jennifer Daley (2007). Quality in Healthcare: Concepts and Practice. https://www.researchgate.net/publication/255620653

Unit 2: Healthcare and Government intervention

Introduction

::: notes

Sustainable Development ensure healthcare intervention that improves citizens' health as a national priority, through which national healthcare system is influenced by social, economic, political and

several other factors. In this regard, the unit examine NGO/ governmental partnerships, health Interdependence, cost of health care delivery in Nigeria, cost analysis, cost-benefit analysis, cost effectiveness and efficiency of the healthcare sector.

Objectives

By the end of this unit, you should be able to:

- Understand the meaning of sustainable Development
- Describe NGO/governmental partnerships for development
- Discuss Health Interdependence

Main Content

- Sustainable Development
- NGO/Governmental
- Health Interdependence

Sustainable Development

Ensuring the health and well-being of all is essential to achieving sustainable development. Sustainable development help in attaining economic growth which in turn pave way for resilient health system. Sustainable healthcare system allows general public to reach their full potential, children to learned better, workers to be industrious and parents to discharge their responsibilities better.

Sustainable Development is also an indicator of a country's progress. A nation with a healthy population is more likely to experience sustained growth. Sustained economic growth alongside social and environmental factors are essential elements of sustainable development of a given region. Sustainable development is defined as the development of the present generation that did not compromised that of the future generation. Achieving sustainable development drew contribution from different governance sectors (public, private and civil society organization) in partnerships, to address development issues with severe impacts on families and communities that can exert increased pressure on health systems at both national and international borders.

The Sustainable Development Goals (SDGs), also known as the Global Goals, were adopted by all United Nations Member States in 2015 as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030. The 17 SDGs are integrated—that is, they recognize that action in one area will affect outcomes in others, and that development must balance social, economic and environmental sustainability.

Through the pledge to Leave No One Behind, countries have committed to fast-track progress for those furthest behind first. That is why the SDGs are designed to bring the world to several life-changing 'zeros', including zero poverty, hunger, AIDS and discrimination against women and girls.

The Sustainable Development Goals (SDGs) were born at the United Nations Conference on Sustainable Development in Rio de Janeiro in 2012. The objective was to produce a set of universal goals that meet the urgent environmental, political and economic challenges facing our world.

The SDGs replace the Millennium Development Goals (MDGs), which started a global effort in 2000 to tackle the indignity of poverty. The MDGs established measurable, universally-agreed objectives

for tackling extreme poverty and hunger, preventing deadly diseases, and expanding primary education to all children, among other development priorities.

For 15 years, the MDGs drove progress in several important areas: reducing income poverty, providing much needed access to water and sanitation, driving down child mortality and drastically improving maternal health. They also kick-started a global movement for free primary education, inspiring countries to invest in their future generations. Most significantly, the MDGs made huge strides in combating HIV/AIDS and other treatable diseases such as malaria and tuberculosis.

The SDGs coincided with another historic agreement reached in 2015 at the COP21 Paris Climate Conference. Together with the Sendai Framework for Disaster Risk Reduction, signed in Japan in March 2015, these agreements provide a set of common standards and achievable targets to reduce carbon emissions, manage the risks of climate change and natural disasters, and to build back better after a crisis.

The SDGs are unique in that they cover issues that affect us all. They reaffirm our international commitment to end poverty, permanently, everywhere. They are ambitious in making sure no one is left behind. More importantly, they involve us all to build a more sustainable, safer, more prosperous planet for all humanity.

Goal 1: Eradicating poverty in all its forms remains one of the greatest challenges facing humanity. While the number of people living in extreme poverty dropped by more than half between 1990 and 2015, too many are still struggling for the most basic human needs. As of 2015, about 736 million people still lived on less than US$1.90 a day; many lack food, clean drinking water and sanitation. Rapid growth in countries such as China and India has lifted millions out of poverty, but progress has been uneven. Women are more likely to be poor than men because they have less paid work, education, and own less property. Progress has also been limited in other regions, such as South Asia and sub-Saharan Africa, which account for 80 percent of those living in extreme poverty. New threats brought on by climate change, conflict and food insecurity, mean even more work is needed to bring people out of poverty. The SDGs are a bold commitment to finish what we started, and end poverty in all forms and dimensions by 2030. This involves targeting the most vulnerable, increasing basic resources and services, and supporting communities affected by conflict and climate-related disasters.

Goal 2: The number of undernourished people has dropped by almost half in the past two decades because of rapid economic growth and increased agricultural productivity. Many developing countries that used to suffer from famine and hunger can now meet their nutritional needs. Central and East Asia, Latin America and the Caribbean have all made huge progress in eradicating extreme hunger. Unfortunately, extreme hunger and malnutrition remain a huge barrier to development in many countries. There are 821 million people estimated to be chronically undernourished as of 2017, often as a direct consequence of environmental degradation, drought and biodiversity loss. Over 90 million children under five are dangerously underweight. Undernourishment and severe food insecurity appear to be increasing in almost all regions of Africa, as well as in South America. The SDGs aim to end all forms of hunger and malnutrition by 2030, making sure all people–especially children–have sufficient and nutritious food all year. This involves promoting sustainable agricultural, supporting small-scale farmers and equal access to land, technology and markets. It also requires international cooperation to ensure investment in infrastructure and technology to improve agricultural productivity.

Goal 3: Good health and well-being. We have made great progress against several leading causes of death and disease. Life expectancy has increased dramatically; infant and maternal mortality rates have declined, we've turned the tide on HIV and malaria deaths have halved. Good health is essential to sustainable development and the 2030 Agenda reflects the complexity and interconnectedness of the two. It takes into account widening economic and social inequalities, rapid urbanization, threats to the climate and the environment, the continuing burden of HIV and other infectious diseases, and emerging challenges such as noncommunicable diseases. Universal health coverage will be integral to achieving SDG 3, ending poverty and reducing inequalities. Emerging global health priorities not explicitly included in the SDGs, including antimicrobial resistance, also demand action. But the world is off-track to achieve the health-related SDGs. Progress has been uneven, both between and within countries. There's a 31-year gap between the countries with the shortest and longest life expectancy. And while some countries have made impressive gains, national averages hide that many are being left behind. Multisectoral, rights-based and gender-sensitive approaches are essential to address inequalities and to build good health for all.

Goal 4: Quality education. Since 2000, there has been enormous progress in achieving the target of universal primary education. The total enrollment rate in developing regions reached 91 percent in 2015, and the worldwide number of children out of school has dropped by almost half. There has also been a dramatic increase in literacy rates, and many more girls are in school than ever before. These are all remarkable successes. Progress has also been tough in some developing regions due to high levels of poverty, armed conflicts and other emergencies. In Western Asia and North Africa, ongoing armed conflict has seen an increase in the number of children out of school. This is a worrying trend. While Sub-Saharan Africa made the greatest progress in primary school enrollment among all developing regions – from 52 percent in 1990, up to 78 percent in 2012 – large disparities still remain. Children from the poorest households are up to four times more likely to be out of school than those of the richest households. Disparities between rural and urban areas also remain high. Achieving inclusive and quality education for all reaffirms the belief that education is one of the most powerful and proven vehicles for sustainable development. This goal ensures that all girls and boys complete free primary and secondary schooling by 2030. It also aims to provide equal access to affordable vocational training, to eliminate gender and wealth disparities, and achieve universal access to a quality higher education.

Goal 5: Gender equality. Ending all discrimination against women and girls is not only a basic human right, it's crucial for sustainable future; it's proven that empowering women and girls helps economic growth and development. UNDP has made gender equality central to its work and we've seen remarkable progress in the past 20 years. There are more girls in school now compared to 15 years ago, and most regions have reached gender parity in primary education. But although there are more women than ever in the labor market, there are still large inequalities in some regions, with women systematically denied the same work rights as men. Sexual violence and exploitation, the unequal division of unpaid care and domestic work, and discrimination in public office all remain huge barriers. Climate change and disasters continue to have a disproportionate effect on women and children, as do conflict and migration. It is vital to give women equal rights land and property, sexual and reproductive health, and to technology and the internet. Today there are more women in public office than ever before, but encouraging more women leaders will help achieve greater gender equality.

Goal 6: Clean water and sanitation. Water scarcity affects more than 40 percent of people, an alarming figure that is projected to rise as temperatures do. Although 2.1 billion people have improved water sanitation since 1990, dwindling drinking water supplies are affecting every continent. More and

more countries are experiencing water stress, and increasing drought and desertification is already worsening these trends. By 2050, it is projected that at least one in four people will suffer recurring water shortages. Safe and affordable drinking water for all by 2030 requires we invest in adequate infrastructure, provide sanitation facilities, and encourage hygiene. Protecting and restoring water-related ecosystems is essential. Ensuring universal safe and affordable drinking water involves reaching over 800 million people who lack basic services and improving accessibility and safety of services for over two billion. In 2015, 4.5 billion people lacked safely managed sanitation services (with adequately disposed or treated excreta) and 2.3 billion lacked even basic sanitation.

Goal 7: Affordable and clean energy. Between 2000 and 2018, the number of people with electricity increased from 78 to 90 percent, and the numbers without electricity dipped to 789 million. Yet as the population continues to grow, so will the demand for cheap energy, and an economy reliant on fossil fuels is creating drastic changes to our climate. Investing in solar, wind and thermal power, improving energy productivity, and ensuring energy for all is vital if we are to achieve SDG 7 by 2030. Expanding infrastructure and upgrading technology to provide clean and more efficient energy in all countries will encourage growth and help the environment.

Goal 8: Decent work and economic growth. Over the past 25 years the number of workers living in extreme poverty has declined dramatically, despite the lasting impact of the 2008 economic crisis and global recession. In developing countries, the middle class now makes up more than 34 percent of total employment – a number that has almost tripled between 1991 and 2015. However, as the global economy continues to recover we are seeing slower growth, widening inequalities, and not enough jobs to keep up with a growing labor force. According to the International Labour Organization, more than 204 million people were unemployed in 2015. The SDGs promote sustained economic growth, higher levels of productivity and technological innovation. Encouraging entrepreneurship and job creation are key to this, as are effective measures to eradicate forced labor, slavery and human trafficking. With these targets in mind, the goal is to achieve full and productive employment, and decent work, for all women and men by 2030.

Goal 9: Industry, innovation and infrastructure. Investment in infrastructure and innovation are crucial drivers of economic growth and development. With over half the world population now living in cities, mass transport and renewable energy are becoming ever more important, as are the growth of new industries and information and communication technologies. Technological progress is also key to finding lasting solutions to both economic and environmental challenges, such as providing new jobs and promoting energy efficiency. Promoting sustainable industries, and investing in scientific research and innovation, are all important ways to facilitate sustainable development. More than 4 billion people still do not have access to the Internet, and 90 percent are from the developing world. Bridging this digital divide is crucial to ensure equal access to information and knowledge, as well as foster innovation and entrepreneurship.

Goal 10: Reduced inequalities. Income inequality is on the rise—the richest 10 percent have up to 40 percent of global income whereas the poorest 10 percent earn only between 2 to 7 percent. If we take into account population growth inequality in developing countries, inequality has increased by 11 percent. Income inequality has increased in nearly everywhere in recent decades, but at different speeds. It’s lowest in Europe and highest in the Middle East. These widening disparities require sound policies to empower lower income earners, and promote economic inclusion of all regardless of sex, race or ethnicity. Income inequality requires global solutions. This involves improving the regulation and monitoring of financial markets and institutions, encouraging development assistance

and foreign direct investment to regions where the need is greatest. Facilitating the safe migration and mobility of people is also key to bridging the widening divide.

Goal 11: Sustainable cities and communities. More than half of us live in cities. By 2050, two-thirds of all humanity—6.5 billion people—will be urban. Sustainable development cannot be achieved without significantly transforming the way we build and manage our urban spaces. The rapid growth of cities—a result of rising populations and increasing migration—has led to a boom in mega-cities, especially in the developing world, and slums are becoming a more significant feature of urban life. Making cities sustainable means creating career and business opportunities, safe and affordable housing, and building resilient societies and economies. It involves investment in public transport, creating green public spaces, and improving urban planning and management in participatory and inclusive ways.

Goal 12: Responsible consumption and production. Achieving economic growth and sustainable development requires that we urgently reduce our ecological footprint by changing the way we produce and consume goods and resources. Agriculture is the biggest user of water worldwide, and irrigation now claims close to 70 percent of all freshwater for human use. The efficient management of our shared natural resources, and the way we dispose of toxic waste and pollutants, are important targets to achieve this goal. Encouraging industries, businesses and consumers to recycle and reduce waste is equally important, as is supporting developing countries to move towards more sustainable patterns of consumption by 2030. A large share of the world population is still consuming far too little to meet even their basic needs. Halving the per capita of global food waste at the retailer and consumer levels is also important for creating more efficient production and supply chains. This can help with food security, and shift us towards a more resource efficient economy.

Goal 13: Climate action. There is no country that is not experiencing the drastic effects of climate change. Greenhouse gas emissions are more than 50 percent higher than in 1990. Global warming is causing long-lasting changes to our climate system, which threatens irreversible consequences if we do not act. The annual average economic losses from climate-related disasters are in the hundreds of billions of dollars. This is not to mention the human impact of geo-physical disasters, which are 91 percent climate-related, and which between 1998 and 2017 killed 1.3 million people, and left 4.4 billion injured. The goal aims to mobilize US$100 billion annually by 2020 to address the needs of developing countries to both adapt to climate change and invest in low-carbon development. Supporting vulnerable regions will directly contribute not only to Goal 13 but also to the other SDGs. These actions must also go hand in hand with efforts to integrate disaster risk measures, sustainable natural resource management, and human security into national development strategies. It is still possible, with strong political will, increased investment, and using existing technology, to limit the increase in global mean temperature to two degrees Celsius above pre-industrial levels, aiming at 1.5°C, but this requires urgent and ambitious collective action.

Goal 14: Life Below Water. The world's oceans – their temperature, chemistry, currents and life – drive global systems that make the Earth habitable for humankind. How we manage this vital resource is essential for humanity as a whole, and to counterbalance the effects of climate change. Over three billion people depend on marine and coastal biodiversity for their livelihoods. However, today we are seeing 30 percent of the world's fish stocks over exploited, reaching below the level at which they can produce sustainable yields. Oceans also absorb about 30 percent of the carbon dioxide produced by humans, and we are seeing a 26 percent rise in ocean acidification since the beginning of the industrial revolution. Marine pollution, an overwhelming majority of which comes from land-based sources, is reaching alarming levels, with an average of 13,000 pieces of plastic litter to be

found on every square kilometer of ocean. The SDGs aim to sustainability manage and protect marine and coastal ecosystems from pollution, as well as address the impacts of ocean acidification. Enhancing conservation and the sustainable use of ocean-based resources through international law will also help mitigate some of the challenges facing our oceans.

Goal 15: Life on land. Human life depends on the earth as much as the ocean for our sustenance and livelihoods. Plant life provides 80 percent of the human diet, and we rely on agriculture as an important economic resources. Forests cover 30 percent of the Earth's surface, provide vital habitats for millions of species, and important sources for clean air and water, as well as being crucial for combating climate change. Every year, 13 million hectares of forests are lost, while the persistent degradation of dry lands has led to the desertification of 3.6 billion hectares, disproportionately affecting poor communities. While 15 percent of land is protected, biodiversity is still at risk. Nearly 7,000 species of animals and plants have been illegally traded. Wildlife trafficking not only erodes biodiversity, but creates insecurity, fuels conflict, and feeds corruption. Urgent action must be taken to reduce the loss of natural habitats and biodiversity which are part of our common heritage and support global food and water security, climate change mitigation and adaptation, and peace and security.

Goal 16: Peace, justice and strong institutions.We cannot hope for sustainable development without peace, stability, human rights and effective governance, based on the rule of law. Yet our world is increasingly divided. Some regions enjoy peace, security and prosperity, while others fall into seemingly endless cycles of conflict and violence. This is not inevitable and must be addressed. Armed violence and insecurity have a destructive impact on a country's development, affecting economic growth, and often resulting in grievances that last for generations. Sexual violence, crime, exploitation and torture are also prevalent where there is conflict, or no rule of law, and countries must take measures to protect those who are most at risk. The SDGs aim to significantly reduce all forms of violence, and work with governments and communities to end conflict and insecurity. Promoting the rule of law and human rights are key to this process, as is reducing the flow of illicit arms and strengthening the participation of developing countries in the institutions of global governance.

Goal 17: Partnerships for the goals. The SDGs can only be realized with strong global partnerships and cooperation. Official Development Assistance remained steady but below target, at US$147 billion in 2017. While humanitarian crises brought on by conflict or natural disasters continue to demand more financial resources and aid. Many countries also require Official Development Assistance to encourage growth and trade. The world is more interconnected than ever. Improving access to technology and knowledge is an important way to share ideas and foster innovation. Coordinating policies to help developing countries manage their debt, as well as promoting investment for the least developed, is vital for sustainable growth and development. The goals aim to enhance North-South and South-South cooperation by supporting national plans to achieve all the targets. Promoting international trade, and helping developing countries increase their exports is all part of achieving a universal rules-based and equitable trading system that is fair and open and benefits all.

NGO/ governmental partnerships

- Addressing SDGs
- Obstacles and Opportunities

Health systems is responsible for people`s health throughout their lifespan. Health is crucial to the development of individuals, families and societies everywhere. A real progressive health system is the one with potentials to the achievement of Sustainable Development Goals. Additionally, addressing national health priorities depends vitally on stronger health systems. Improving health is clearly the main goal of every health system, in two folds; the best attainable average level of goodness, and fairness. Goodness means a health system that respond well to people's expectation, and fairness means a responds that is equally well to everyone, free of all kind of discrimination.

Health services are delivered by variety of organizations, usually in partnerships. Health systems is multi-organizational, widespread and integrated, classified according to ownership and motives. For example, Health maintenance organizations, sickness funds, preferred provider organizations, and managed care systems are private health financing entities. These organizations are sometimes faced by emerging environmental pressures, new rules and technologies, shift in demography and ageing, accountable to multiple constituents, and constraints on resources.

Health systems organization allocate and use resources efficiently and effectively. Health systems organization strive for continuous services that improves health services, through effective and efficient resource allocation and utilization in partnerships with relevant stakeholders. According to the World Health Organization (WHO), each national health system should strive to achieve three overall objectives, thus; good health, response to the population expectations, and fairness of financial contribution. Achieving the three aforementioned objectives depends critically on how well the governance sector (Public, Private, and Civil Society Organizations) conduct four vital functions, thus; service provision, resource generation, financing and stewardship in partnerships.

Health systems are expected to serve the population needs in an effective, efficient and equitable manner. Therefore, the importance of strengthening of public, private and community health systems has been emphasized time and again. In most of the developing countries, certain weaknesses and gaps in the government health systems have been hampering the achievement of improved health outcomes. Thus or many years, international and local non-governmental organizations (NGOs) have endeavored to fill the gaps in health service delivery, research and advocacy. NGOs have relatively performed better and achieved the results because of the flexible planning and the ability to design population based projects on health education, health promotion, social marketing, community development and advocacy. In an effort to streamline service and generate efficiency, governments have looked increasingly to non-government organizations (usually not-for-profit charities) to deliver service to the public. This way of subcontracting is often referred to as partnership and has created interesting challenges for both government and non-government sectors. These range from threats to the autonomy of NGOs to the downloading of deficits to the private sector.

Public and private sectors have been working with civil society organizations as partners. Civil Society Organizations (CSOs) are group of not-for-profit institutes that includes Non-governmental Organizations (NGOs), Trade Unions, Professional bodies, Community Based Organizations, Philanthropists, Academic among others. CSOs representatives engaged public and Private sectors with common interest in development, to conduct gender based and other charity services in developing countries, in form of Public Private Partnerships. CSOs are crucial partners through under the coordination and leadership of governmental agencies, performed services that increased cross disciplinary coherence in partnerships. Equally, the CSOs partner with international institutions, in particular the World Bank, UN bodies, and Global Fund, and Unilateral agencies like USAID, to offer health Systems services.

CSOs particularly NGOs and government are different. They have different goals, different mandates, and different constraints. But this difference can be a benefit to both, NGOs can be nimble and flexible and can try things that governments cannot afford to do, whether financially or politically. And while NGOs can take risks and fail, NGOs need governments to scale, especially in fields like health care and education. Governments set national policies and funding, which provide scale and sustainability. And governments can leverage the support of NGOs to innovate and enhance accountability.

Partnerships are key component approach to achieving health system. Comparing the way these sectors functions provide a basis of understanding the performance variations of development sectors' CSOs. Therefore, working collaboratively with international organizations and CSOs in the performance of life-saving immunizations, nutritional supplements, and other health related activities, more effectively and efficiently. CSOs in partnerships among the sectors, provide their targeted communities with prevention and treatment of prominent diseases and illnesses that include HIV/AIDS, tuberculosis, malaria, diarrhea, pneumonia, malnutrition and under-nutrition among other primary causes of morbidity and mortality. Indeed, the CSOs works to enhanced knowledge and understanding of how the actions of relevant institutions impact population health, and also recognizes the significant and increasing interdependence roles of local, national and international institutions as development partners.

While these partnerships can be extremely beneficial it can easily run into obstacles. There are ways that an NGO can ease the path for partnering with the government: (1) Center the voice of government, (2) Implement within existing government delivery and data systems, (3) Build relationships with government partners at all levels, (4) Progressively transfer real ownership to government partners

The literature on scale through public sector "adoption" tends to disproportionately focus on NGOs, positioning governments as the passive recipients of innovation. However, success stories illustrate that achieving impact through the public sector at scale requires building genuine, bi-directional partnership. Founding a genuine partnership requires putting government at the center from the earliest stages of designing a program or pilot. If seeing is believing, then seeing a program work within the existing system is a prerequisite to scale with government. However, sometimes effectively integration of the program's impact data into the government's data collection systems can prove difficult, both logistically and politically. There are always risks associated with trying something new, but securing buy-in from multiple levels within a system or hierarchy can minimize those risks for individual actors.

The process of transferring ownership from NGOs to governments requires a transition. Given the risks associated with new or innovative ideas, it is understandable that government officials want to

be convinced of the program's feasibility and effectiveness before they are willing to take the reins. But ownership is absolutely critical to long-term success and sustainability. Effective government ownership ensures that a program will continue once the NGO is no longer leading implementation. However, while many of these steps might work well in some developmental contexts they do not always work well in others. It is important to understand the policy, transparency, and corruption environment that an NGO is working in and make the appropriate decisions.

Health Interdependence

- Interconnectedness of individuals aka Social Support
- Interconnected of Health and Security
- Interconnected of Countries

The concept of interdependence in health was buried on the purpose on which it was built. Interdependence was defined as more than an entity working together to achieve a common objective. The word is apply to the advance practices of various nursing specialties, clinical practices, and the conduct of research in partnerships. The concept of interdependence displays a working relationships among healthcare professionals, and show how each unit work collectively to achieve a common goal.

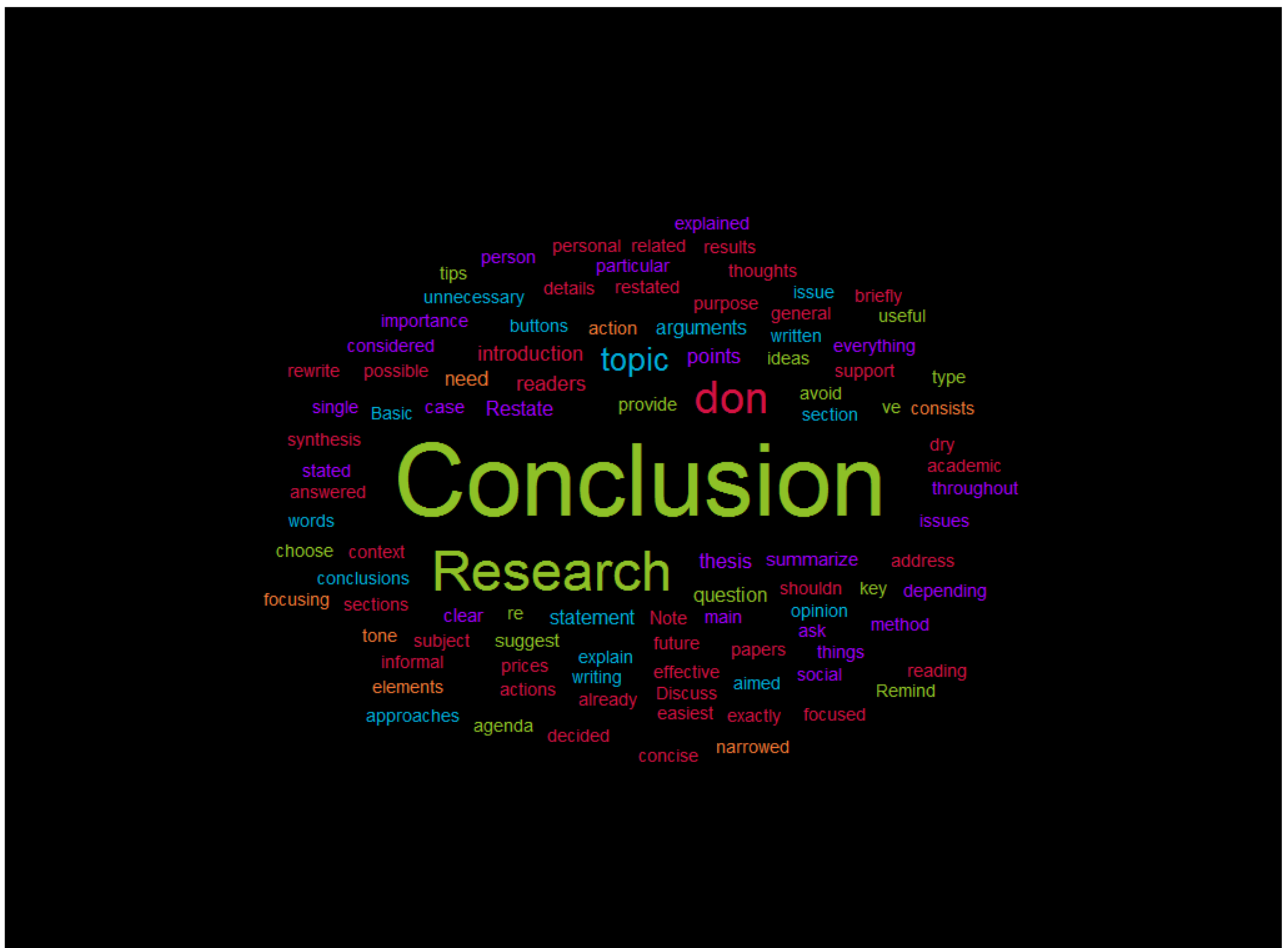
The concept of interdependence is of great importance in healthcare. No single unit of healthcare delivery, one person or department, cannot solely provide complete and competent healthcare services. As such, healthcare system is composed of several departments and entities, but not limited to registered nurse, patient care technician, doctor, therapy, laboratory, pharmacy and even the patient. The concept of interdependence display the working relationships in healthcare and convey how each entity works harmoniously to achieve a common goal. Interdependence has been considered an important quality that advance practice through a constant contact among team members, such as the medical team, that require a mutual alliance and respect while working towards a combined purpose. Interdependent is important when it comes to the relationship with physicians and other healthcare team members, by highlighting the requirement of a partnership, rather than a dictatorship.

Interdependence involves dependence between things. Interdependence was shown as the quality or condition of being interdependent, or mutually reliant on each other. It also means a reciprocal relation between interdependent entities (objects or individuals or groups)" for example the relationship involving all aspects of healthcare including the patient, advance practice nurse, registered nurse, patient care technician, doctor, therapy, laboratory, pharmacy and the patient. This has highlight the importance of mutual dependence with each party involved in order to achieve interdependence. The collective individuals are required to work in unison to accomplish a common goal; in this case, the goal is efficient patient care. As discussed above, interdependence has been paramount in the healthcare environment because a single person cannot exclusively accomplish

holistic and effective patient care. Rather, a skilled group of individuals mentioned above need to possess mutual alliance and trust in order to achieve success.

We are all profoundly dependent on others for our physical and psychological well being. Society has built up a wide range of structures and forms of assistance which disguise our mutual dependence. People are often forced by a wide range of societal pressures to disguise or mitigate their vulnerability to behave in an acceptable way in the public realm. Dependency is an inevitable facet of human life and thus care is needed. At all times in our life we need the care of others to meet our practical and emotional needs. Indeed the care we provide for others is an important part of our well being too. Interdependence begins with dependence. It begins with the dependency of an infant, and often ends with the dependency of a very ill or frail person close to dying. The infant may develop into a person who can reciprocate, an individual upon whom another can be dependent and whose continuing needs make her interdependent with others. The frail elderly person … may herself have been involved in a series of interdependent relations. But at some point there is a dependency that is not yet or no longer an interdependency. By excluding this dependency from social and political concerns, we have been able to fashion the pretense that we are independent – that the cooperation between persons that some insist is interdependence is simply the mutual (often voluntary) cooperation between essentially independent persons.

Conclusion



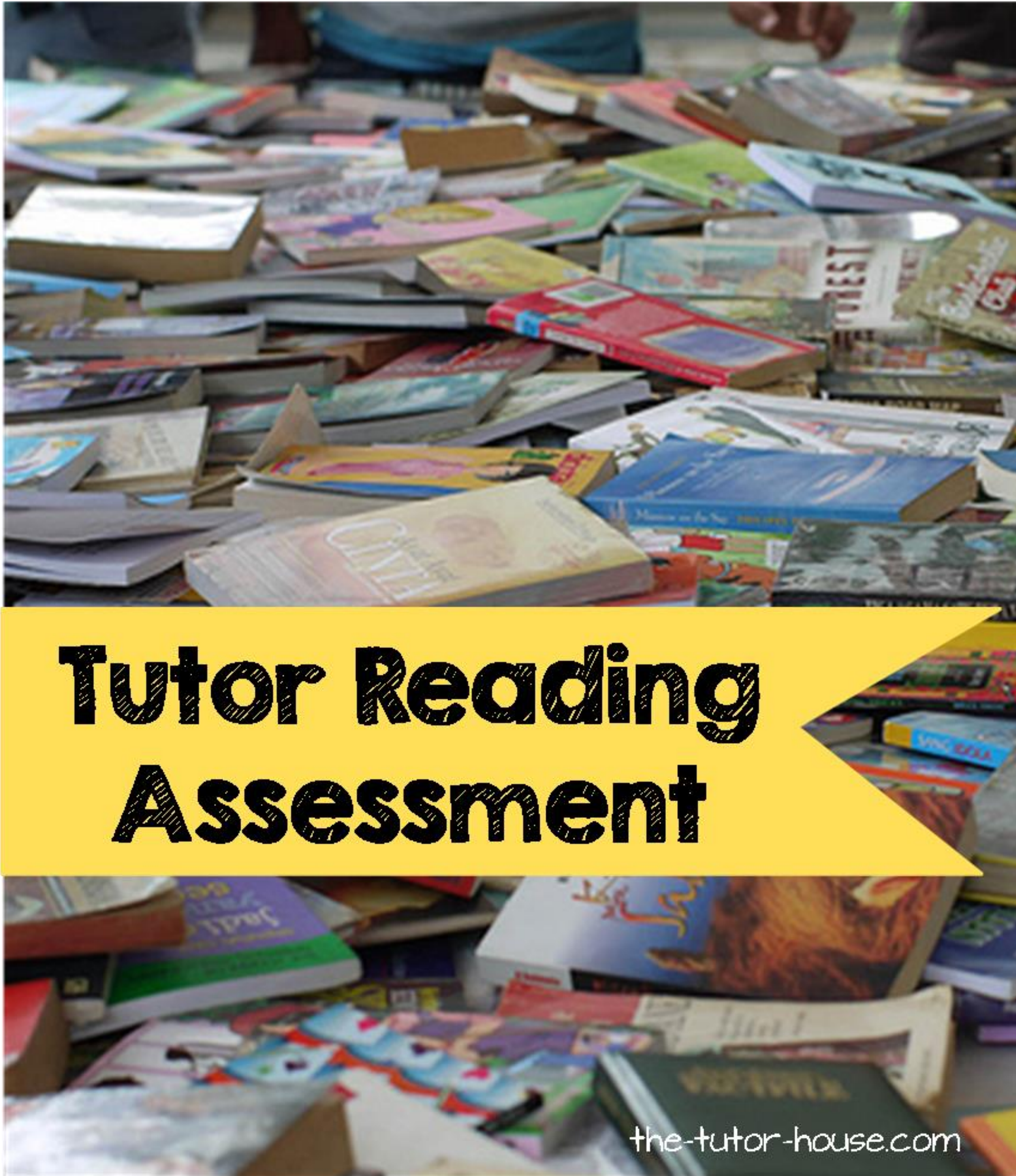
::: notes

The unit concludes that sustainable development is essential to the attainment of a quality healthcare system through both social and private coverage. CSOs work closely with both local, national, regional and international organizations such as the World Health Organization; Global Fund and many other development partners. Basic economics terms are also used to determine and analyze healthcare cost. Substantial changes in the health systems are necessary, through the greater roles of the diverse sectors involved in healthcare delivery for increase market efficiency, through the use of economic terms by healthcare providers as well as consumers.

Summary

In this unit, Sustainable Development is found to be significant in ensuring a functional health system intervention that improves the citizens' health as a national priority. Indeed, national healthcare system is influenced by social, economic, political and several other factors. In this regard, the unit explain the contributions of CSOs and partnerships, health Interdependence as constituent of the sustainable healthcare system.

Tutor Marked Assignment



References and Further Readings

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1. Abuelaish I, Goodstadt MS, Mouhaffel R. Interdependence between health and peace: a call for a new paradigm. Health Promotion International. 2020;35(6):1590-1600. doi:10.1093/heapro/daaa023

2. E. Asakitikpi A. Healthcare Coverage and Affordability in Nigeria: An Alternative Model to Equitable Healthcare Delivery. In: Universal Healthcare [Working Title]. IntechOpen; 2019. doi:10.5772/intechopen.85978

3. Bergmo TS. How to measure costs and benefits of ehealth interventions: An overview of methods and frameworks. 2015;17. doi:10.2196/jmir.4521

4. Background of the Sustainable Development Goals | UNDP. https://www.undp.org/content/undp/en/home/sustainable-development-goals/background.html. Accessed March 20, 2021.

5. Ejaz I, Shaikh BT, Rizvi N. NGOs and government partnership for health systems strengthening: A qualitative study presenting viewpoints of government, NGOs and donors in Pakistan. BMC Health Services Research. 2011;11(1):122. doi:10.1186/1472-6963-11-122

6. Gbeleou SC, Schechter J. How NGOs Can Work With Governments to Build Partnerships That Will Scale. September 2020. https://ssir.org/articles/entry/how{_}ngos{_}can{_}work{_}with{_}governments{_}to{_}build{_}partnerships{_}that{_}will{_}scale. Accessed March 22, 2021.

7. Grover LL. How Cost-Effectiveness Analysis Helps in Health Care Decision-Making - Modern Optometry. September 2019. https://modernod.com/articles/2019-sept/how-cost-effectiveness-analysis-helps-in-health-care-decision-making.

8. Herring J. Health as vulnerability; interdependence and relationality. New Bioethics. 2016;22(1):18-32. doi:10.1080/20502877.2016.1151255

9. Idemudia U. Environmental Business–NGO Partnerships in Nigeria: Issues and Prospects. Business Strategy and the Environment. 2017;26(2):265-276. doi:10.1002/bse.1915

10. Jesica Gómez-Jauregui. The Feasibility of Government Partnerships with NGOs in the Reproductive Health Field in Mexico. Reproductive Health Matters. 2004;12(24):42-55. https://www.jstor.org/stable/pdf/3776581.pdf.

11. In Nigeria, Health Care Often Comes at a Steep Cost | Pulitzer Center. https://pulitzercenter.org/stories/nigeria-health-care-often-comes-steep-cost. Accessed March 20, 2021.

12. Njoku ET. Good NGOs, Bad NGOs: Nigerian Government Partnership with NGOs in Counter-terrorism Operations | Democracy in Africa. November 2019. http://democracyinafrica.org/good-ngos-bad-ngos-nigerian-government-partnership-ngos-counter-terrorism-operations/. Accessed March 20, 2021.

13. Owen T. NGO-government partnerships. Journal of International Migration and Integration / Revue de l'integration et de la migration internationale. 2000;1(1):131-137. doi:10.1007/s12134-000-1012-6

14. Teegen H, Doh JP, Vachani S. The importance of nongovernmental organizations (NGOs) in global governance and value creation: An international business research agenda. In: Journal of International Business Studies. Vol 35.; 2004:463-483. doi:10.1057/palgrave.jibs.8400112

15. The Global Goals. https://www.globalgoals.org/. Accessed March 20, 2021.

Unit 3: Healthcare delivery in Nigeria

Introduction

This study unit focuses on the healthcare system in Nigeria, examining the different levels- their inception, roles, and the ways that they work with each other. Given the diversity of Nigeria and many other countries in the developmental sector, the course examine the importance of culture and how it can be, and often needs to be, integrated into the healthcare system. Finally this unit examines healthcare delivery systems and how technology can be leveraged to improve them.

Objectives

By the end of this unit, you should be able to:

- Understand the role and purpose of the current system of healthcare delivery
- Explain the relevance of integrating culture into healthcare
- Discuss the relationship between healthcare delivery systems and technology

Main Content

- Healthcare system
- Culture and Healthcare Delivery
- Healthcare Delivery Systems and Technology

Health care system

- Primary
- Secondary
- Tertiary
- Traditional

Nigeria is made up of at least 250 linguistic/ethnic groups of which 3 are major groups comprising over 60% of the total population. Although all of these groups share common major macro-culture and macro-traditions, each evolved its own micro-culture and micro-traditions in response to prevailing environmental circumstances. Traditional medicine and healing constituted part of the micro cultural evolution.

In pre-explorers and pre-western trader's Nigeria, traditional medicine was the system of health care delivery. Traditional healing and medical practices included herbalists, divine healers, soothsayers, midwives, spiritualists, bone-setters, mental health therapists and surgeons. In spite of more than 150 years of introduction of Western style medicine to Nigeria, traditional healing and medical practices remain a viable part of the complex health care system in Nigeria today. In 1988, a casual survey in Benin City revealed that for every sign-post that indicated a Western-style clinic or office, there were 3 that indicated a traditional doctor. Although this traditional system of health evolved separately in different micro-cultures, there is a great deal of philosophical and conceptual similarities. The origin of diseases in Africa was simplistic. It is either an enemy had cast a spell on you or you are being punished by divine powers for your sins. Although the Arabs have had the distinction of early-organized medical services, there is no recorded evidence of the introduction of such services to Sub-Saharan Nigeria during trade interactions of the fifteenth century. The same thing is true of the early Portuguese and English traders in their interactions with the Delta/Riverine areas of Nigeria during the later part of the fifteenth century.

The first record of modern medical services in Nigeria was during the various European expeditions in the early-to mid-nineteenth century. The earlier explorations of Mungo Park and Richard Lander were seriously hampered by disease. In the expedition of 1854, Dr. Baikie introduced the use of quinine, which greatly decreased mortality and morbidity among the expeditioners. It is still a subject of considerable debate whether the use of quinine by Dr. Baikie was his original discovery or whether he borrowed the idea from traditional herbalists with whom he had interacted in the course of his expeditions. Whatever is the true situation, the use of quinine both as prophylaxis against and as therapy for malaria fever, expanded exploration and trade[74].

In the western adopted medical system, there are 3 different levels of health care systems: primary, secondary, and tertiary[75]. In the Lord Dawson Report, an influential British study written in 1920, the author (1975) proposed that each of the three levels of care should correspond with certain unique patient needs.

1. Primary care involves common health problems (e.g., sore throats, diabetes, arthritis, depression, or hypertension) and preventive measures (e.g., vaccinations or mammograms) that account for 80% to 90% of visits to a physician or other caregiver.

- Devolved to cities and municipalities
- Usually the first contact between the community members and other levels of the health facility.
- Center physicians, public health nurses, rural health midwives, traditional healers.

2. Secondary care involves problems that require more specialized clinical expertise such as hospital care for a patient with acute renal failure.

- Given by physicians with basic health training.
- Usually given in health facilities either privately owned or government-operated.
- Infirmaries, municipal, district hospital, out-patient departments.
- Rendered by specialists in health facilities.

3. Tertiary care, which lies at the apex of the organizational pyramid, involves the management of rare disorders such as pituitary tumors and congenital malformations.These referral systems are interlinked or interconnected to one another.

- Referral system for the secondary care facilities.
- Provided complicated cases and intensive care.
- Medical centers, regional and provincial hospitals, and specialized hospitals

There are two contrasting approaches can be used to organize a health care system around these levels of care: (1) the carefully structured Dawson model of regionalized health care and (2) a more free-flowing model. Approach (1) uses the Dawson model as a scaffold for a highly structured system. This model is based on the concept of regionalization: the organization and coordination of all health resources and services within a defined area. In a regionalized system, different types of personnel and facilities are assigned to distinct tiers in the primary, secondary, and tertiary levels, and the flow of patients across levels occurs in an orderly, regulated fashion. This model emphasizes the primary care base and a population-oriented framework for health planning. Approach (2), allows for more fluid roles for caregivers, and more free-flowing movement of patients, across all levels of care. This model tends to place a higher value on services at the tertiary care apex than at the primary care base. Although most health care systems embody elements of both models, some gravitate closer to one polarity or the other. The traditional British National Health Service (NHS) and some large integrated delivery systems in the United States resemble the regionalized approach, while US health care as a whole traditionally followed the more dispersed format[76].

A few numbers, while there are 30,000 primary care centers in the country, it is estimated that only about 20% are working (6000). Most of the primary care facilities in Nigeria lack the capacity to provide essential health-care services, in addition to having issues such as poor staffing, inadequate equipment, poor distribution of health workers, poor quality of health-care services, poor condition of infrastructure, and lack of essential drug supply. In part, problems with the implementation of PHC in Nigeria are related to the hand over in 1980s to the local government administration, which is the weakest level of government. The inability of primary care centers to provide basic medical services to the Nigerian population have made both secondary and tertiary health-care facilities experience an influx of patients. Which has had its toll on the secondary and tertiary levels of care.

There are 6,071 secondary health facilities and 160 tertiary health facililites

Culture and Healthcare Delivery

Social determinants, as we have discussed before, draws on a lot of different disciplines. Culture is a construct that we've taken from the Anthropology and Sociology literature and way of thinking about things. Although it is something that we deal with every single day, defining it is a bit of a challenge. Culture has been defined in a variety of ways including focusing on its structure and patterns, its functions, its processes, its power, or its group membership. An extremely useful way to find culture, is that it is a style or set of skills or habits that people have at their disposal to solve different kinds of problems in their lives. It is how we learn to interact within our environment. It provides those socially meaningful resources that are used to develop action strategies for everyday life. Discussed a different way, culture is the rules that organize society and the way that we learn those rules and transmit them from one generation to the next. The lens through which individuals perceive and learn about the world and develop behaviors for dealing with the world and interacting with other people. A set of shared beliefs, symbols, and customs; those implicit and explicit guidelines that we learn from others. The are passed on from generation to generation about how to view the world, how to experience it, how to behave relative to other people, and our environment. Ethnicity is a sub-cultural group in a multicultural society that share a common national or tribal heritage and their social connections are based in geography, language, shared norms, prejudices, activities, and history – things that bind people together.

Cultural respect means understanding the values and beliefs of a population in order to respond to and meet the needs of diverse patients. Cultural respect should influence how healthcare organizations build care frameworks, conduct and analyze research, engage populations, and build trusting patient-provider relationships.

Here is a non-healthcare example of cultural respect: A hairstylist serves a multicultural population in Cambridge, Massachusetts. Men and women of all ages and ethnicities frequent her salon. In fact, she is often the recipient of local awards and praise because of her skills and efforts to be culturally inclusive. One evening after work a client visited the salon for a regular hair trim. Upon entering the salon they was surprised to find the windows covered and a sign that said “no men”. Upon questioning the receptionist about what was going on, the client was told that a young Muslim woman was receiving services and that she cannot be seen by men when she isn't wearing her Hijab. The hairstylist took the time to adjust her environment and change her schedule to make sure her client felt comfortable and received the best service.

What if every healthcare experience could be modeled this way? What if we could be made to feel comfortable and cared for when we feel the most vulnerable? What if healthcare workers and patient

communicators took the time to educate themselves about the culture, ideas and beliefs of patients and used that information to engage and educate patients and provide better care? As a healthcare provider organization, when you respect culture, you are acknowledging that patients are capable of making the best healthcare choices for themselves and their families. You understand the invisible barriers that may deter a patient from managing a chronic condition effectively or prevent them from seeking care all together. Culturally respectful organizations tailor their engagement strategies, care, and educational materials to fit their patients' beliefs, attitudes, and needs. As a result, patients: 1) understand their care, 2) trust the answers given to their questions, and 3) feel empowered to manage their own care or enlist the help of family or community resources[77]. In Nigeria, with a lot diversity of ethno-religious groups, it is important for the healthcare sectors to be culturally aware of the socio-cultural norms of the communities that they are placed and not to make assumptions.

There is growing body of evidence to suggest that negative health consequences can occur when culture is ignored, for both the patient and the overall community. What are potential impacts of ignoring culture on health? Cultural beliefs are often cited as the reasons for failure to obtain adequate and appropriate health care or they are cited as barriers to obtaining care. People do not want to go into the traditional health care system because it is either contradictory to their beliefs or they feel that the health care system does not understand their cultural beliefs and is not willing to work with them. Health behavior occurs within a larger environment. It is associated with the interpretation of definitions of health, how people perceive their health risk, disease occurrence, and duration and impact of negative health behaviors, including the social environment. But even before that, there is a pattern of beliefs and values that is fully embedded in the sociocultural context. All of this works together to influence health behavior which in turn then influences health outcomes.

One way to work with culture is to create culturally competent messaging into your program, sensitization events, healthcare messages. Through integrating culturally relevant factors, individuals can potentially enhance the effectiveness of the tailored messages. If you are speaking to a group about things that matter to them, in ways that are relevant to them, then it is more likely that they will pay attention and be influenced by what it is that you have to say

Healthcare Delivery Systems and Technology

When designing and implementing new health technology in the developing world. Important factors:

Impact: How much difference will the technology make in improving health?

Appropriateness: Will the intervention be affordable, robust and adjustable to health care settings in developing countries, and will it be socially, culturally and politically acceptable?

Burden: Will this technology address the most pressing health needs?

Feasibility: Can it realistically be developed and deployed in a time frame of 5–10 years?

Knowledge gap: Does the technology advance health by creating new knowledge?

Indirect benefits: Does it address issues such as environmental improvement and income generation that have indirect, positive effects on health?

A well-functioning health system working in harmony is built on having trained and motivated health workers, a well-maintained infrastructure, and a reliable supply of medicines and technologies, backed by adequate funding, strong health plans and evidence-based policies. At the

same time, because of the interconnectedness of our globalized world, health systems need to have the capacity to control and address global public health threats such as epidemic diseases and other severe events.

Most healthcare interactions involve consumers, professionals and facilitating organizations. In this scheme, consumers seek healthcare, professionals provide the care, and the facilitating organizations perform a myriad of supporting administrative, regulatory and financing functions to support or control these healthcare encounters. All sustainable and effective healthcare systems work to balance these three goals: 1) appropriate access to necessary healthcare services; 2) assurance of quality workforce, services and institutions; and 3) acceptable cost to society.

In hopes of improving quality and enhancing revenue, many healthcare delivery systems are modernizing their existing systems. Modernization involves the improvement or replacement of an existing, typically outdated, systems that are unable to meet organizational, regulatory, or other requirements over the long term. The term "modernization" differs from adoption, which involves the first-time implementation of a system within a healthcare setting, often replacing manual and/or paper-based processes with technological solutions. Modernization, however, replaces or upgrades an existing system, often with the intent of centralizing systems and enhancing technological efficiency. In different countries, the need to modernize of adopt systems will vary.

Both modernization and adoption are a significant undertaking, involving the investment of time, labor, and financial resources into overhauling or replacing the current system. Some healthcare organizations opt to purchase a commercial-off-the-shelf product, while others have developed and maintained their own homegrown system. This occurs both in private healthcare systems and systems under government operation, such as the resource-constrained systems such as those in developing countries.

The vast inequities in disease burden between developed and developing countries are causing donors, advocates, and researchers to resources to accelerate the production of new health technologies that may help to bridge this gap- specifically to modernize and improve the existing infrastructure. In developing countries, researchers and innovators face tremendous challenges, including the lack of technical training, research tools, financial resources, and up-to-date scientific information. These barriers impede activists from developing and implementing innovative and low cost technologies.

One such health technology that has the potential to save and improve lives is the disposable needle. Increasing numbers of people in developing countries are getting the vaccinations that they need to protect their health, but clean needle practices have not caught up. At least 50% of injections in developing countries are unsafe, and in some places that number is as high as 70%.

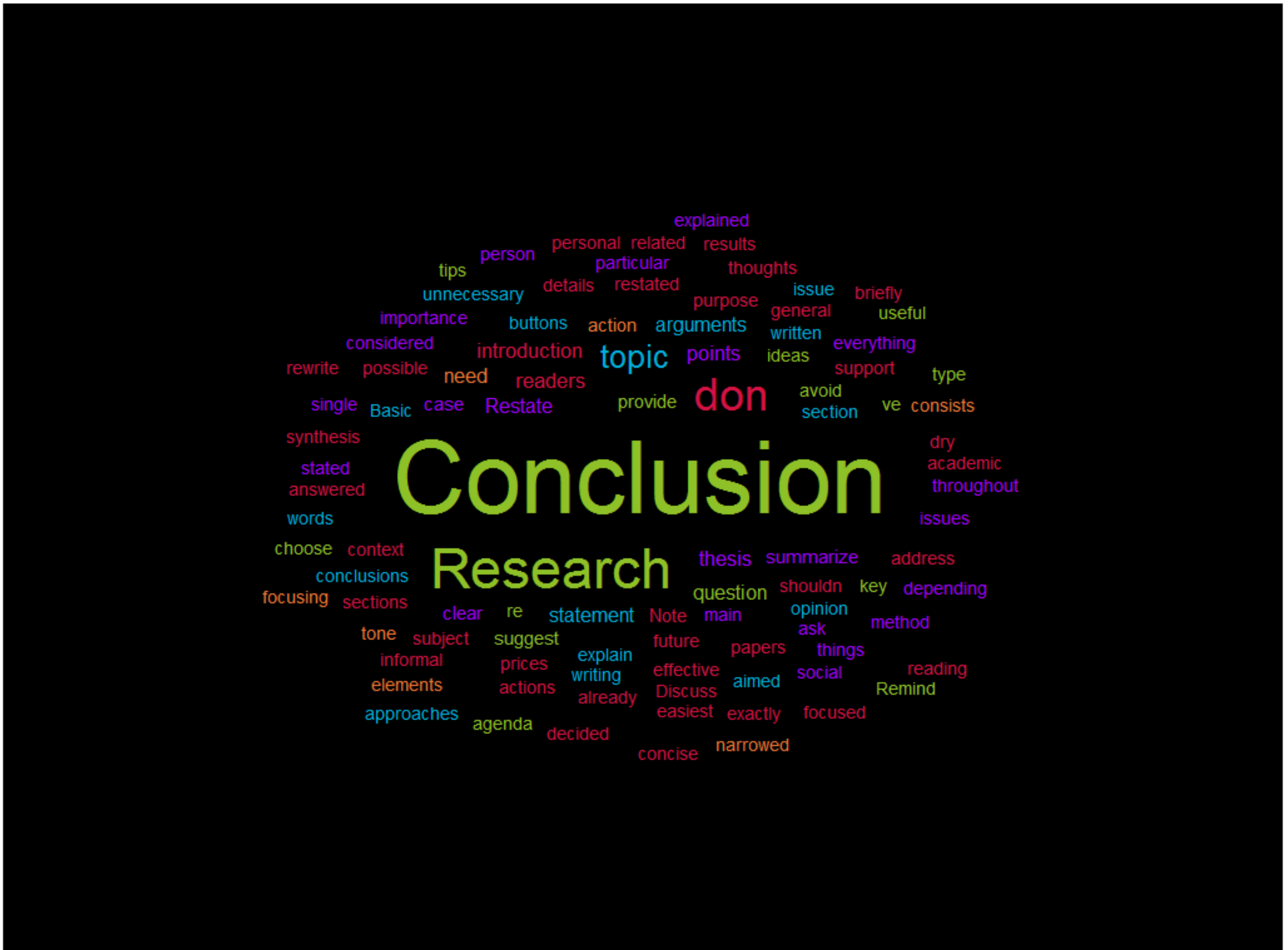
Oftentimes in resource-poor settings, health care personnel do not have adequate technology to diagnose patients. Facilities in developing countries frequently lack access to the highly advanced laboratories that produce reliable diagnoses in wealthy countries. Furthermore, health care facilities can be far away, serving widely dispersed populations. A lack of quality equipment can undermine the entire health care system. If health workers cannot correctly diagnose a disease, they are unable to treat it effectively. Without diagnostic testing, health care professionals are forced to rely on evaluating symptoms to diagnose and treat illness—an imperfect method. This lack of clarity puts individuals, communities, and the world in danger. Incorrect diagnoses can harm people and even cost lives and ineffectively treated disease can become a starting point for epidemics and contribute to the development of drug- resistant parasites. Fortunately, there are promising new tests—

inexpensive, portable, easy-to-use diagnostics that are practical at even small, local health centers. Some of these tests are adaptations of established technologies. Others are innovative scientific advances. The problem of diagnostics is accentuated by a lack of health personnel in developing countries, particularly in rural settings. Not only is there a lack of appropriate diagnostic tools, there is a shortage of health workers who are able to use this technology. In order to address this problem, telemedicine, has gained much attention. Telemedicine can be broadly defined "as the use of telecommunications technologies to provide medical information and services." Although this definition includes medical uses of the telephone, email, and distance education, telemedicine is increasingly being used as shorthand for remote electronic clinical consultation. Telemedicine seeks to deliver the best medical advice and treatment options to patients irrespective of their location. Telemedicine's major constraints include the access to and cost of the higher bandwidth that is required for transmitting physiological data and complex medical images. These constraints are more severe in developing countries where even telephone-line-based access is limited and broadband access is either not available or is far too expensive. The promise of telemedicine is also limited by a number of features which are common to most poor developing countries. These include large gaps in basic infrastructure availability, and the ability and willingness of health workers and others to make use of the opportunities. The constraints suggest that, rather than helping to improve health care delivery, telemedicine could generate a new "digital divide" that creates further disparities in health. Additionally, the rapid changes in technology can result in an inability to continue to use the technologies.

Diffusing a new innovation requires an understanding of the local environment. Social, economic, and cultural environments vary greatly across and even within countries, and deploying new technologies requires understanding these environments. Innovators must consider the need for expertise in sociology, anthropology, public policy, and economics, as well as for engineers, and establish coherent criteria for selecting countries to target based on social, economic, and cultural realities. Innovative technology can be disruptive and trigger a backlash from incumbents.

A recent study of health biotechnology in developing countries found that local public-private partnerships, sustained government support for research, and the availability of venture capital were important factors in the ability of an innovative technology to meet national health needs. In order for a health technology to be appropriate, feasible, and driven by public health goals, it should be designed in coordination with the public sector (or depending on the country, the private sector). Some manufacturers in developing countries pursue a business model in which they specialize in high-volume, low-margin production, which leads to low-cost products. Products produced in this way may be more affordable, an important factor in access to medicines and healthcare.

Conclusion



This unit focused on the Nigerian health care system and it's three tiers of healthcare services sectors are involved in the implementation of health services delivery at the national, state and local government area levels- Primary, Secondary, and Tertiary services, as well as how traditional medicine plays a role. The way that culture can and often does intersect with health and the healthcare system. In addition, this unit examined healthcare delivery systems and the role that technology can play moving forward.

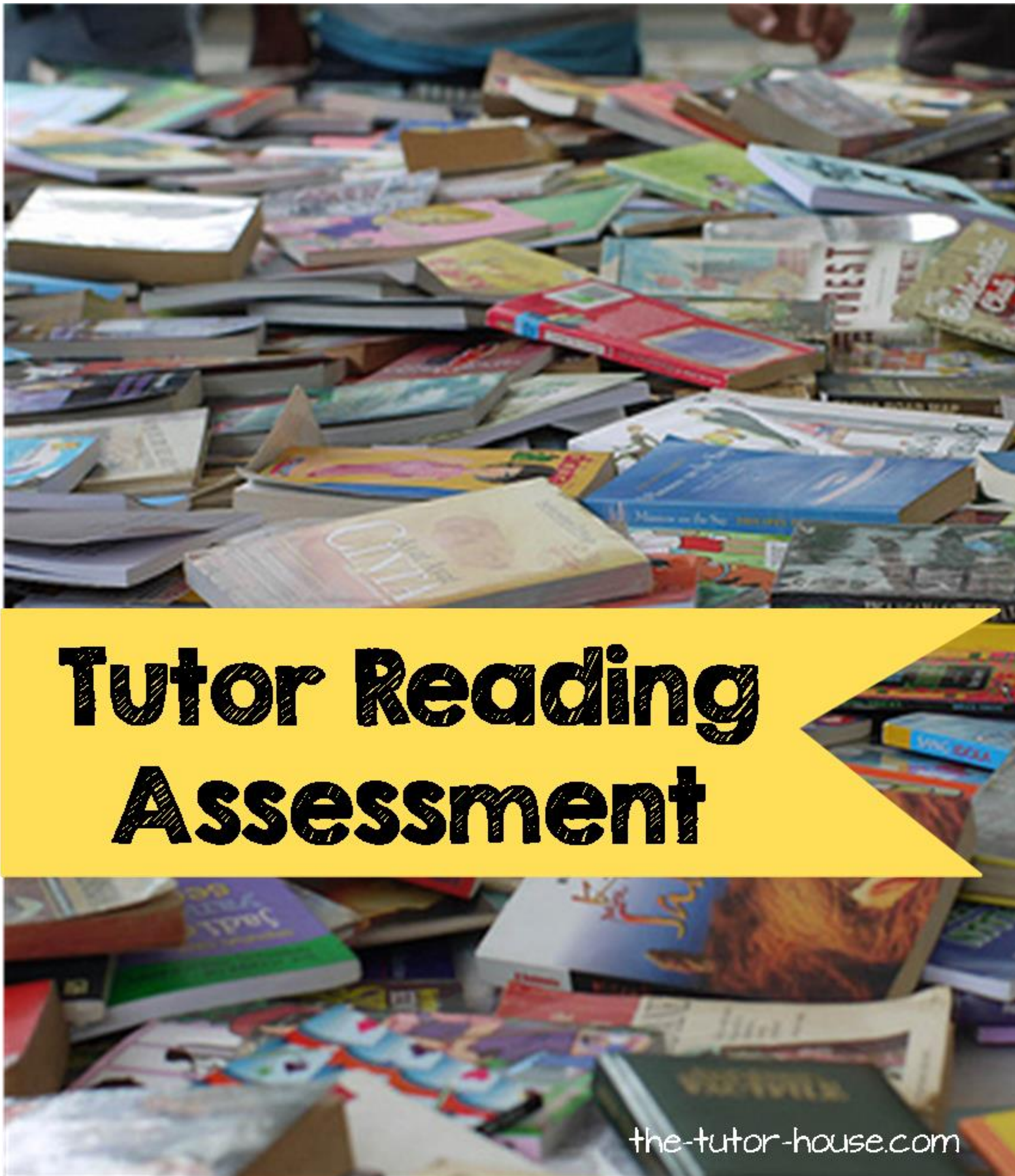
Summary

- Primary, Secondary, Tertiary, and Traditional levels of healthcare delivery each has its own role and history
- Cultural respect means understanding the values and beliefs of a population in order to respond to and meet the needs of diverse patients.
- Healthcare delivery and the role of technology

In this unit, we explored the different level of the healthcare system. health as public good, was explained as a good that excluded nobody from its use, and its use by others does not diminish its availability to other users. We discussed the meanings of cultural respect and how it should influence how healthcare organizations build care frameworks, conduct and analyze research, engage populations, and build trusting patient-provider relationships. Finally, we addressed health systems and the role that technology can play. Remember when designing and implementing new health technology in the developing world, important factors to keep in mind: impact, appropriateness, burden, feasibility, knowledge gap, indirect benefits of the process, system, or technology.

Tutor Marked Assignment

- What are the cost of Health care delivery in Nigeria?
- Explain the meaning of cost analysis, cost-benefit analysis, effectiveness and efficiency



References and Further Readings

60,74–94

1. Adebayo Omotosho, Omotanwa Adegbola, Justice Emuoyibofarhe. (PDF) ICT in Health care delivery system: A Framework for developing nations. Conference: International Conference on ICT for Africa (ICT4A). April 2011. https://www.researchgate.net/publication/274633485{_}ICT{_}in{_}Health{_}care{_}delivery{_}system{_}A{_}Framework{_}for{_}developing{_}nations.

2. Amlung J, Huth H, Cullen T, Sequist T. Modernizing health information technology: lessons from healthcare delivery systems. JAMIA Open. 2020;3(3):369-377. doi:10.1093/jamiaopen/ooaa027

3. Aregbeshola BS, Khan SM. Primary health care in Nigeria: 24 years after Olikoye Ransome-Kuti's leadership. 2017;5:48. doi:10.3389/FPUBH.2017.00048

4. E. Asakitikpi A. Healthcare Coverage and Affordability in Nigeria: An Alternative Model to Equitable Healthcare Delivery. In: Universal Healthcare [Working Title]. IntechOpen; 2019. doi:10.5772/intechopen.85978

5. Basicmedical Key. How Health Care Is Organized—I: Primary, Secondary, and Tertiary Care | Basicmedical Key. June 2016. https://basicmedicalkey.com/how-health-care-is-organized-i-primary-secondary-and-tertiary-care/. Accessed March 24, 2021.

6. Bukachi F, Pakenham-Walsh N. Information technology for health in developing countries. Chest. 2007;132(5):1624-1630. doi:10.1378/chest.07-1760

7. Edoh TO, Teege G. Using information technology for an improved pharmaceutical care delivery in developing countries. Study case: Benin. In: Journal of Medical Systems. Vol 35. Springer; 2011:1123-1134. doi:10.1007/s10916-011-9717-y

8. Health Dialog. Cultural Respect in Patient Engagement | Health Dialog. March 2016. https://www.healthdialog.com/blog/why-cultural-respect-important-patient-engagement-and-healthcare-delivery. Accessed March 24, 2021.

9. Health Technology in Resource-Poor Settings - Social Entrepreneurship Certificate Program. http://www.uniteforsight.org/global-health-university/technology. Accessed March 24, 2021.

10. Koce F, Randhawa G, Ochieng B. Understanding healthcare self-referral in Nigeria from the service users' perspective: A qualitative study of Niger state. 2019;19:209. doi:10.1186/s12913-019-4046-9

11. Nigeria Health Facility Registry. https://hfr.health.gov.ng/facilities/hospitals-search?{_}token=ol3nGLLcpHHGhgNtfdeIhD7WuvTDX5bXVpOiOqD1{&}state{_}id=1{&}lga{_}id=1{&}ward{_}id=0{&}facility{_}level{_}id=3{&}ownership{_}id=0{&}operational{_}status{_}id=0{&}registration{_}status{_}id=0{&}license{_}status{_}id=0{&}geo{_}codes=0{&}service{_}type=0{&}service{_}category{_}id=0{&}facility{_}name={&}entries{_}per{_}page=10. Accessed March 24, 2021.

12. The Nigerian Health System. https://www.who.int/pmnch/countries/nigeria-plan-chapter-3.pdf.

13. Nwokocha EE. Traditional healthcare delivery systems in the 21st century Nigeria: moving beyond misconceptions. World health & population. 2008;10(1):23-33. doi:10.12927/whp.2008.19730

14. Omotosho A, Ayegba P, Emuoyibofarhe J, Meinel C. Current State of ICT in Healthcare Delivery in Developing Countries. International Journal of Online and Biomedical Engineering (iJOE). 2019;15(08):91. doi:10.3991/ijoe.v15i08.10294

15. Raji SO. Multiple Sources of Healthcare Delivery System and the Formal Recognized State Healthcare: The Bane of Nigeria Healthcare Development. Primary Health Care Open Access. 2018;08(04). doi:10.4172/2167-1079.1000315

16. Sanchez TR, Plawecki JA, Plawecki HM. The Delivery of Culturally Sensitive Health Care to Native Americans. Journal of Holistic Nursing. 1996;14(4):295-307. doi:10.1177/089801019601400403

17. Scott-Emuakpor A. The evolution of health care systems in Nigeria: Which way forward in the twenty-first century. Nigerian Medical Journal. 2010;51(2):53. https://www.nigeriamedj.com/article.asp?issn=0300-1652;year=2010;volume=51;issue=2;spage=53;epage=65;aulast=Scott-Em https://www.nigeriamedj.com/article.asp?issn=0300-1652;year=2010;volume=51;issue=2;spage=53;epage=65;aulast=Scott-Em;type=0.

18. Takim Asu O, David Gever I, Pefun Joshua N. African Cultural Practices and Health Implications for Nigeria Rural Development.

19. Timothy G, Irinoye O, Yunusa U, Dalhatu A, Ahmed S, Suberu A. Balancing Demand, Quality and Efficiency in Nigerian Health Care Delivery System. Vol 6. Online; 2014. www.iiste.org.

20. Tiziano Marovino. Technology: Changing the Delivery Of Healthcare. April 2017. https://www.practicalpainmanagement.com/treatments/rehabilitation/technology-changing-delivery-healthcare. Accessed March 24, 2021.

21. Vera M. Levels of Health Care Referral System - Nurseslabs. December 2013. https://nurseslabs.com/levels-of-health-care-referral-system/. Accessed March 24, 2021.

22. White P. The concept of diseases and health care in African traditional religion in Ghana. 2015. doi:10.4102/hts.v71i3.2762

Unit 4: Ethics in Development

Introduction

This study unit focuses on the importance of ethics in health development. There are many opportunities for improvement in this field of work. As such there are many people who need the services who are extremely vulnerable. It is imperative that we always act with the highest possible ethic standards, for the sake of the communities that we work with, the organizations we represent, the society we want to create, and the lives that we want to have.

Objectives

At the end of this unit, you should be able to:

- Discuss the core principles of ethics
- Explain how to ethically engage communities in research

Main Content

- Principles
- Participatory Development

Ethical Principles

Principles:

- Beneficence (do good)
- Nonmaleficience (do no harm)
- Autonomy (control by the individual)
- Justice (fairness)

Ethical motivation:

- Completing a ethical action.
- Ethical orientation

Before we go into the different aspects of ethics, it is important to understand what ethics is.

- Ethics is the philosophical study of moral behavior, of moral decision making, or of how to lead a good life.
- Ethics involves the analysis of moral language and the study of the process of moral deliberation and justification.
- Ethics requires a person to reflect on what is right or wrong (actions) and good or bad (motives, persons, intentions, goals, etc.)

There is a difference between ethics and morality. Morality is the activity of making choices and of deciding, judging, justifying, and defending actions or behaviors (personal level), where ethics is the activities that studies how choices were made or should be made; considers and reflects on how we judge, justify, and defend our moral choices. Different field and disciplines have their own code of ethics that help to guide the field and the practitioners of the profession.

The four core principles of ethics are beneficence, nonmaleficience, autonomy, and justice. From these four principles most other ethical principles arise (similar to how the 3 base colors red, green, blue creates all the other colors in technology).

Beneficence means that we have an obligation to bring about good in all of our actions. This means that we must take steps to prevent harm. While this sounds great in theory, it often comes in conflict with the principle of autonomy. Autonomy is latin for self rule. We have an obligation to respect the autonomy of other persons, meaning that we have to respect the decisions made by other people concerning their own lives. This principle is often known by another name- the principle of human dignity. It endows us with two duties- (1) not to interfere with the decisions of competent adults, and (2) to empower others who we are responsible for.

The principle of non-maleficence means that we have an obligation not to harm others , i.e "First do no harm". So where harm cannot be avoided, we are obligated to minimized it; we cannot increase the harm to others, and it is wrong to waste resources that could be used for good.

The principle of justice, we have an obligation to provide others with whatever they are owed or deserve. So we are obligated to treat all people equally, fairly, and impartially, and conversely we cannot impose unfair burdens on others.

Ethical motivation has two aspects. One is concerned about completing a particular ethical action. The other is an ethical orientation to everything one does. If one is not driven by an ethical identity generally, one may take actions that harm other persons. Similarly, if one does not have an ethical

goal in mind when taking an action, one may act in ways that harm the self or others. Ethical motivation is nurtured when one learns to respect others, act responsibly, and develop a positive identity. As with Ethical Sensitivity and Ethical Judgment, there are many aspects of Ethical Motivation that can be taught.

Participatory Development

Ethics in Practice

- Truthfulness and confidentiality
- Autonomy
- Informed Consent
- Beneficence and Non maleficence
- Justice

Ethics makes sense in theory. But it is important to take that theory and turn it into a practice that you can implement in your everyday life. The first point is the duality of truthfulness and confidentiality. Truthfulness is about telling the truth to someone who has the right to know it[95]. For example, while working in the community as a community health worker, you are informed about the result of an HIV test taken by someone in the community, then that persons asks to know their results you should tell the person the truth even if the truth might be upsetting to them. This concept of truthfulness mandates/urges professionals not to lie. On the other hand, the concept of confidentiality urges you to keep a secret – meaning knowledge or information that a person has the right or obligation to conceal. Using our same example, if the family of a person's HIV test you know the results of, demands that you give them the result, you must not tell them. You must keep the result of that test confidential unless and until your client gives you permission to tell their family or anyone else.

The professional obligation to keep a secret or keep things confidential arised from the ethical principles of autonomy and do not harm. If you fail to keep the confidence, harm will be likely to occur if the information is revealed. In this situation and similar ones there are three types of secrets:

1. Natural secret: information which, if revealed, is harmful by its nature.
2. Promised secret: information that we have promised to conceal which, if broken, leads to public mistrust.

3. Professional secret: knowledge which, if revealed, will harm the client, the profession and the society that obtain services from the profession. A professional secret is the most serious of all secrets, because its violation can cause the greatest harm.

Autonomy, as we already stated, refers to every individual's right of self-determination, independence and freedom to make their own choices. Within the context of healthcare, autonomy is most concerned with the ethical obligation of practitioners to respect their clients' right to make decisions about their own health. Autonomy must be respected even if the healthcare provider does not agree with a client's decision. So going back to our example, Dr Adegbola may feel that Zainab's family should know about her condition or her situation that they may be better able to care for her. But you must respect Zainab's right to maintain confidentiality about her condition. With that said, there are conditions where personal choice or autonomy may be restricted because of concern for the well being of the community. For example, if a communicable disease, such as tuberculosis or Ebola or even COVID-19, is diagnosed, clients can be required to take prescribed medication and may have to be isolated to prevent the spread of the infectious agent to others.

Getting informed consent is an extremely important aspect of the research process. Informed consent means that each person who has any sort of procedure or engages in any type of research in a healthcare context or research capacity should give their approval for that procedure to be done to them, or in a research context given the opportunity to understand what they are doing. In order to be fully informed, it is the duty of the healthcare worker to tell the person exactly what the procedure will involve as well as the things that might happen if the procedure is not carried out. When participating in research, individuals should know what is going to happen, why it is happening, what the benefits are to engaging in the work, as well as the risks associated with participating.

Beneficence tells you about 'doing good' for your client, for instance by providing immunization. Non-maleficence on the other hand, tells you to 'do no harm' either intentionally or unintentionally to your clients. With that said, there are sometimes situations where it is impossible to 'do good' and 'avoid doing harm' all at the same time. Think of an example that illustrates this point.

For instance, you may plan to provide birth control to all the women in your locality who are in need of it, but resource availability, cultural beliefs of the community, clients' reaction to the service and other factors can limit you from doing good to the greatest number. Moreover, you cannot always avoid doing harm to a client; for instance, in times when a communicable disease arises in your vicinity, you may have to suggest isolating individuals with the infection against their will to contain the spread of the disease and for the good of the majority, like what we saw this past year in regards to COVID-19… and unfortunately we saw the impact of not doing that in many countries and the loss of life that resulted in that decision.

Justice is while often used in everyday life, is a fairly complex ethical principle. It entails fairness, equality and impartiality; it is the obligation to be fair to all people. There are two categories of justice: distributive justice and social justice.

- Distributive justice: individuals have the right to be treated equally regardless of ethnic group, gender, culture, age, marital status, medical diagnosis, social standing, economic level, political or religious beliefs, or any other individual characteristics. Everyone should be treated in the same way.
- Social justice: application of equitable rights to access and participation in all aspects of goods and services provided in a society, regardless of their individual characteristics. Everyone should have access to the same things that might improve their health.

To carry out these forms of justice, you will need to enable the inclusion and empowerment of all people living within your area to exercise their rights. These definitions of justice begs the question of why justice is important in the first place. Practically or if you like, selfishly, if you are not fair to individuals and community groups in your vicinity while practicing your profession, you will not be able to gain public trust and this will negatively affect your ability to carry out your responsibilities. In your job, as a future graduate of this university, and really life in general, you should be fair and maintain high ethical standards at all times, including confidentiality and truthfulness towards all your clients equally.

Conclusion

In this unit we discussed the importance of ethics while working in health and development. While I would strongly encourage you to read the suggested readings, I would like to encourage you even more strongly to internalize the reason why we have the ethical principles that we do. Look in your everyday life at way that the principles have not been applied, look at how they have been applied and understand the impact that the decision that others have made to be (or not to be) ethical has helped or harmed you and/or your family. Ethics unlike many other things is not something to memorize. Rather it is something to internalize and make an essential aspect of your professionalism.

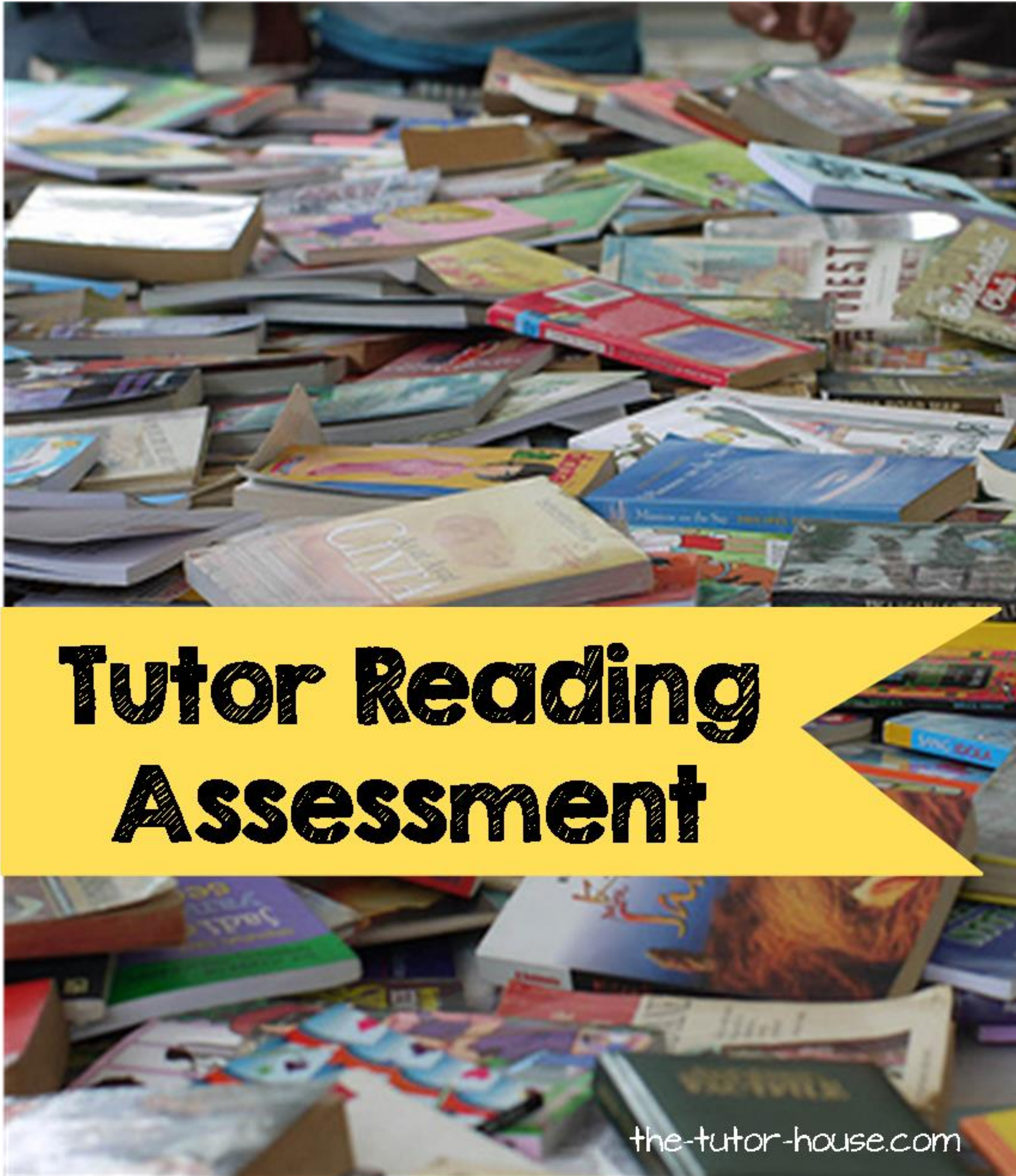
Summary

- Core principals of ethics

- Ethical Motivations
- Ethics in Practice

This unit looked at the core principles of ethics: Beneficence (do good), Nonmaleficience (do no harm), Autonomy (control by the individual), Justice (fairness); Ethical motivation: Completing a ethical action and Ethical orientation; as well as ethics in practice. Through this unit we understood the goal of ethics, some of the contradictions created by the principles and the ways to implement some of these principles in various capacities that you may encounter in the future.

Tutor Marked Assignment



References and Further Readings

95–101

1. Andrew Sumner. What are the Ethics of Development Studies. IDS Bulletin. 2007;38(2). https://core.ac.uk/download/pdf/286043967.pdf.
2. Four fundamental principles of ethics. http://web.mnstate.edu/gracyk/courses/phil 115/Four{_}Basic{_}principles.htm. Accessed March 26, 2021.
3. Global Health Ethics Key issues Global Network of WHO Collaborating Centres for Bioethics.; 2015. www.who.int.

4. Health Management, Ethics and Research Module: 7. Principles of Healthcare Ethics: View as single page. https://www.open.edu/openlearncreate/mod/oucontent/view.php?id=225{\&}printable=1. Accessed March 26, 2021.

5. Importance of Ethics. https://www.managementstudyguide.com/importance-of-ethics.htm. Accessed March 28, 2021.

6. Keahey J. Ethics for Development Research. Sociology of Development. 2020;6(4):395-416. doi:10.1525/sod.2020.6.4.395

7. Lies J, Narvaez D, Endicott L, Bock T, Mitchell C. Ethical Motivation Ethical Motivation Ethical Motivation Ethical Motivation Ethical Motivation Activity Booklet 3 Nurturing Character in the Middle School Classroom Sensitivity Judgment Motivation Motivation Motivation Motivation Motivation Action.

Module 3: Challenges of Healthcare delivery in Nigeria

Unit 1: The challenges of Healthcare delivery in Nigeria Unit 2: Socioeconomic status and health Unit 3: Cultural Competence Unit 4: Healthcare Financing

Unit 1: The challenges of Healthcare delivery in Nigeria

Introduction

This study unit focuses on the unique challenges of healthcare delivery in Nigeria. With a special focus on the infrastructure of effective healthcare delivery and the structure of that system in Nigeria. The unit also covers efforts to reform the health sector over time. Due to many of the challenges of healthcare delivery, there is a large number of Nigerians who engage in health tourism to obtain the health services that they need. Finally this unit examines the history of disease surveillance.

Objectives

By the end of this unit, students should be able to:

- Discuss the drivers of health tourism
- Describe the history of disease surveillance
- Understand the history of health sector reform and it's challenges
- Explain the building blocks of a good healthcare infrastructure

Main Content

- Infrastructure
- Health Sector Reform
- Health Tourism
- Disease Surveillance

Infrastructure

The five components of health infrastructure:

- Skilled workforce,
- Integrated electronic information systems,
- Public health organizations,
- Resources, and
- Research

Nigeria, known as “the Giant of Africa”, is the most populous country in Africa and the seventh most populous country in the world with over 200 million people and more than 250 ethnic groups, is consistently ranked among the poorest nations in the world, and is frequently marked as one of the most corrupt[51]. Per capita income is estimated at 692 USD, with an estimated two-thirds of the population living in poverty. While the recurrent expenditure on health has risen over the years, healthcare delivery remains sub optimal.

This suboptimality is traceable to several factors: lack of professional harmony and team work among professionals in the health sector, gross under funding and shortage of skilled medical personnel. This shortage of skilled medical professionals is especially disheartening considering the number of Nigerian doctors there are in the world. However due to brain-drain, the frustrations of living in Nigeria (lack of consistent power, corruption, etc), many people with the option leave. In addition, there is lack of political will to get real health reforms pushed forward, bureaucratic bottlenecks in public health care delivery in Nigeria. Additionally, between the marginalization and poor sense of belonging felt by many health professionals in the health sector and the deplorable condition of the

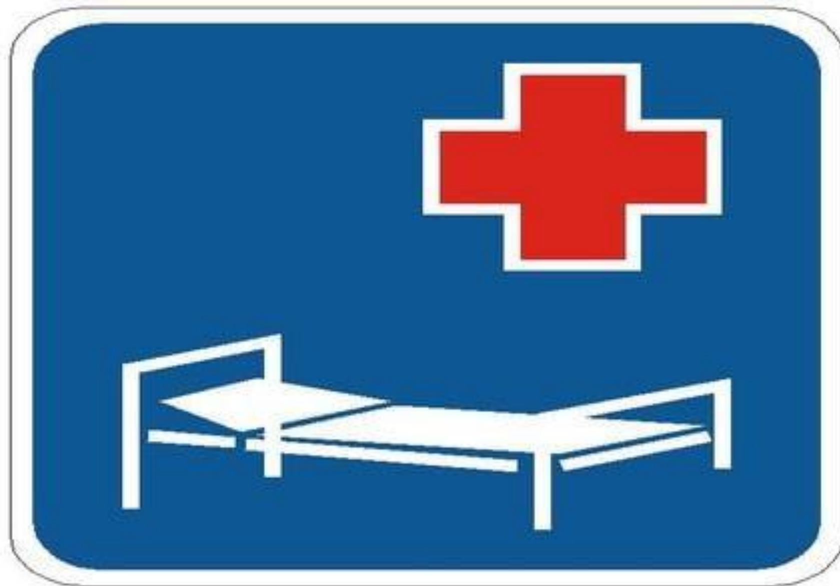
health sector, despite government spending on the sector. Many people are disenchanted by the sector.

Additional issues have been identified within the healthcare sector, especially in training, funding, employment, and deployment of the health workforce[49]. There have been a number of health workforce crises have been reported in recent times due to lack of payment of salaries for months' at a time, poor welfare, lack of appropriate health facilities and emerging factions among health workers. According to the WHO suggests that Nigeria has one of the largest stocks of human resources for health (HRH) in Africa but, like the other 57 HRH crisis countries, has densities of nurses, midwives and doctors that are still too low to effectively deliver essential health services (1.95 per 1,000). The patient-to-doctor ratio in Nigeria is 2500:1, more than four times higher than the WHO'S recommendation of 600:1. Given this gap and current demography, the country needs up to 10 times its current number of, according to comments made by the president of the Nigerian Medical Association. In recent years, migration to foreign countries has declined, and the primary challenge for Nigeria is inadequate production and inequitable distribution of health workers, the WHO reports. The health workforce is concentrated in urban tertiary health care services delivery in the southern part of the country, particularly in Lagos.

Health infrastructure is an important indicator for promoting health care policy and welfare mechanism within the country[102]. It emphasizes making provisions of health care facilities throughout the country. Infrastructure has been described as the basic support for the delivery of public health activities. The five components of health infrastructure are, skilled workforce, integrated electronic information systems, public health organizations, resources and research. The individuals, employed in medical and health care centers must possess the essential educational qualifications, competencies and abilities; be well-aware in terms of their job duties; need to be well-equipped with the usage of technologies.

A weak health care infrastructure has logistic supports which are weak, obsolete and defective which come from under funding or the mismanagement of fund allocated to the sector[103]. This is characterized by: inadequate maintenance of buildings, medical equipment and vehicles, shortage of drugs, faulty compounding of drugs, poor management of drugs, the expiry of drugs and vaccines and other essential requirements for patients care. The situation in Nigeria is often compounded by irregular water supply, erratic/epileptic supply of electricity, and poor telecommunication services. On yet another layer, there is often an absence or inadequacy of equipment in many Hospitals. For example, while a hospital may have a x-ray or MRI machine, the person who knows how to run the machine may not be around. In addition to all of these factors, the poor network of roads and neglect of roads transportation do not make accessibility easy. Thus, many patients referred from the primary or secondary level of care, often find it difficult to get to where they can obtain a respite for their ailment and most times worsen the case that ordinarily requires minor treatment. The poor health financing often results in weak and obsolete infrastructure in the hospitals, congestion of patients to access health care because of limited human resources, poor supply of water, wards congestion, irregular supply of electricity, weak telemedicine facility and recruitment, training and retraining of staff of hospitals etc.[103].

Health Sector reform



Fuente: Banco de imágenes y sonidos del ITE

Health policies are typically formulated in a "one way traffic" type of situation[103]. This means that often the interests in Abuja take precedence and are passed down to the states. However effect policy policy must receive inputs from all stakeholders and the beneficiaries of the policy. Often, formulated polices may lack proper coordination because are they are not related to any economic target. Since 1960, health policies had been outlined in various forms either in the National Development Plans or as specific decisions. Political instability and unsettled economic order has resulted in a serious setback to healthcare policy formulation, implementation, monitoring and evaluation. Due to the frequent changes of governance from the civilian to military, within the military and back to the civilian, there has been no policy continuity. Potentially good policies initiated by one regime were either frustrated or poorly implemented in contradiction to the intention which the originator of the policies had in mind within another[103].

It is interesting that in the absence of a clear policy framework, some of the most significant health sector reforms in Nigeria occurred (i.e. Alma Ata Declaration (1978); National Health Policy (1988))[104]. A few of the major benchmarks of health policy since the Alma Ata Declaration: - Introduction of primary health care programmes in place of the existing basic health services scheme (1986), - Launching of the National Health Policy and Strategy to Achieve Health for all Nigerians 1988, and - Full devolution of the responsibility for the management and provision of PHC for four years. - National Rolling Plan (1986).

During the second half of the 1980s, considerable success was recorded with health systems and the health status of Nigerians. Unfortunately, this success was not sustained. From the late 1980s to early 1990s, the country began to experience a downward trend in health development, which is attributed to the introduction of Structural Adjustment Programme.

Nigeria has not maximized fully the opportunities provided by the various reforms implemented. It has been put forward by some researchers that in order for the reforms to actually be effective, they must be explicit about reducing inequality in access to health services and ensuring that public health systems mitigate the impact of economic and social inequalities. In layman's terms, this means that equity must be built into the system from the beginning and not an afterthought in order to ensure that people living in poverty benefit as much as those who are better off.

Prioritizing for-profit private healthcare delivery is extremely unlikely to deliver better health outcomes for poor people. Time has shown that leaving the provision of health care to the market will only thrive in countries with strong institutions with capacity to monitor and regulate provisions as well as address the dangers of an often predatory corporate health sector, which is not at this time feasible in many African countries. This is in part due to weak institutional capacities, in addition, publicly financed and delivered health care services offer higher performing, more equitable health systems for all citizens.

Research conducted in Asia found that no low or middle-income country in the region had achieved universal or near universal access to health care without relying predominantly on tax funded public sector delivery. In Nepal significant improvements in access to health care were achieved after user fees were removed for primary health care services in public services in 2008. Public services are critical in the fight against inequality, they mitigate the impact of skewed income distribution and re-distributive wealth by putting virtual income into the pockets of the poor. In the face of growing inequality in Nigeria, urgent and dedicated action is needed to strengthen public health systems, so that money can stay in the hands of those who need it most.

In addition to health policy reforms, more efforts are needed to ensure transparency and accountability in the disbursement of funds for the health sector in the country[104]. In addition, improving transparency and accountability will help to address the corruption present in the health sector. As we have learned earlier in this course, it is not only the things stereotypical thought of as "health related" that in fact impact health. Therefore, more work is needed to create the political will to establish complementary infrastructure to health services delivery, such as access roads, electricity, among others. To make the connection between healthcare and health more accessible to vulnerable people and those who actually need care, which is key to sustainable development.

According to Dr Jong-Wook Lee, former Director General of the WHO, there is an urgent need to work together towards ensuring access to a motivated, skilled and supported health worker by every person everywhere[105]. Good governance is needed to achieve a sound national health system, especially with regard to human resources for health. The Nigerian government, especially to health governance needs a driving, visionary, systemic and structural change so that crises in health workforce and service delivery can be stemmed and reversed.

Health Tourism

- Brain Drain Syndrome
- Under funding
- Dilapidated Structures and Obsolete Medical Equipment
- Industrial Strikes
- The Culture of Nigerians Preferring Anything Foreign

According to Price Waterhouse Coopers (2016) report, Nigerians spend US$ 1 billion annually on medical tourism with 60% of it on four key specialties: oncology, orthopedics, nephrology and cardiology[49]. This amount is nearly 20% of annual government spending on the public health sector, including salaries of the public sector doctors, nurses and other healthcare workers as well as other health programmes like malaria, tuberculosis, polio and HIV/AIDS prevention.

This situation of health tourism is caused my multiple factors including but not limited to brain-drain[106], under funding, dilapidated structures and obsolete medical equipment, industrial strikes, culture of preferring anything foreign,

Nigeria is a major health staff-exporting country in Africa and this has affected the development of the healthcare system negatively due to shortage of health care providers. Many health care providers in Nigeria have left the in pursuit of greener/more comfortable pastures abroad. Ironically, some of the best doctors in the world who have made remarkable contributions in the field of medicine come from Nigeria. In 2010, the number of Nigerian trained doctors practicing in the United States and the United Kingdom stood at 2,392 and 1,529 respectively while the ratio of doctors to patients in Nigeria is 39 per 100,000 people. While we have already discussed the lack of adequate funding for the health sector, it bares repeating. The Nigerian government currently allocates 4.3% of budget to the health sector which is a far cry from the 15% that the government said that it intended to spend, an still significantly less than the 26% recommended by the United Nations. This under funding helps to fuel the motivation for health tourism.

Despite the high number of available medical institutions in Nigeria, Nigeria still records below average health statistics because of inability to provide quality health care due to inadequate basic infrastructure and obsolete medical equipment. Many of the hospitals, especially government owned hospitals in and around the country, are in bad shape; due to many of the reasons we have already discussed. In many developed countries, Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans and other modern diagnostic procedures are common and affordable but in Nigeria, such procedures are still an exclusive preserve of the rich. Some government owned hospitals for example, still refer patients to private laboratory and diagnostic centers for their laboratory examinations and investigations.

The Nigerian health system has experienced numerous strikes involving doctors, nurses and allied healthcare workers as a result of various demands and unhealthy rivalries among health professionals. Which has negatively impacted on the healthcare system, leading to several avoidable deaths, complications and outgoing medical tourism, as the wealthy seek health services abroad.

According to some of the literature, Nigerians have insatiable appetite for anything foreign. While the wealthy prefer the United States or European markets for treatment, others prefer Middle-Eastern and South African markets for treatment, and another portion prefers India. It is estimated that over 5,000 people fly out of Nigeria monthly for medical treatment. Most ironic is that a large number of these medical tourism trips were conducted by politicians who were treated by Nigerian doctors abroad. Even minor ailments that could be easily treated in Nigeria are taken abroad often by the same politicians that have the power to improve the system (i.e. the Nigerian President travelling to a London hospital for ear infection, politicians going overseas to treat malaria)[106].

Disease Surveillance

- Introduction of surveillance
- National Task Force of Epidemic control
- Challenges in Implementation

Disease surveillance and notification was introduced in Nigeria in 1988 following a major outbreak of yellow fever in 1986/87 which claimed many lives in the country and also affected ten out of the then 19 states of the country[107]. Prior to then, there was no coordinated system of disease reporting and surveillance, some states were sending weekly reports, others were sending annual reports and still others never sent any. This lack of regular communication became a major cause for concern, resulted in denied access to health information vital for a timely response to disease outbreaks.The National Task Force on Epidemic control was created to find a lasting solution to disease notification.

The Task Force identified poor disease surveillance and notification as a major national problem and as an important constraint to effective disease control in Nigeria[107]. To start, 42 diseases were officially designated as notifiable for regular monthly reporting, later the number of diseases needing to be reported was cut to 22 (in 1998). The current system was approved by the Nigerian National Council on Health in 1989. In September of 1998, the WHO Regional Committee for Africa met in Harare, Zimbabwe adopting the Integrated Disease Surveillance and Response (IDSR) as a regional strategy for strengthening the weak national disease surveillance system in the African region. The scheme's aim was to integrate multiple surveillance system to enhance early detection of outbreaks of diseases in Africa so that human and other resources can be used more efficiently and effectively.

The IDSR strategy since its adoption has been most widely implemented in the WHO–AFRO region[108]. Mixed challenges are reported across the different countries. Primary challenges include non-sustainable financial resources, inadequate training and turnover of peripheral staff, erratic feedback, lack of supervision from higher authorities and weak laboratory capacities. The best outcomes in core surveillance functions and maximum quality are seen when support functions (i.e laboratory capacity, supervision, training, resources [financial, human, material/equipment] and co-ordination) each perform optimally.

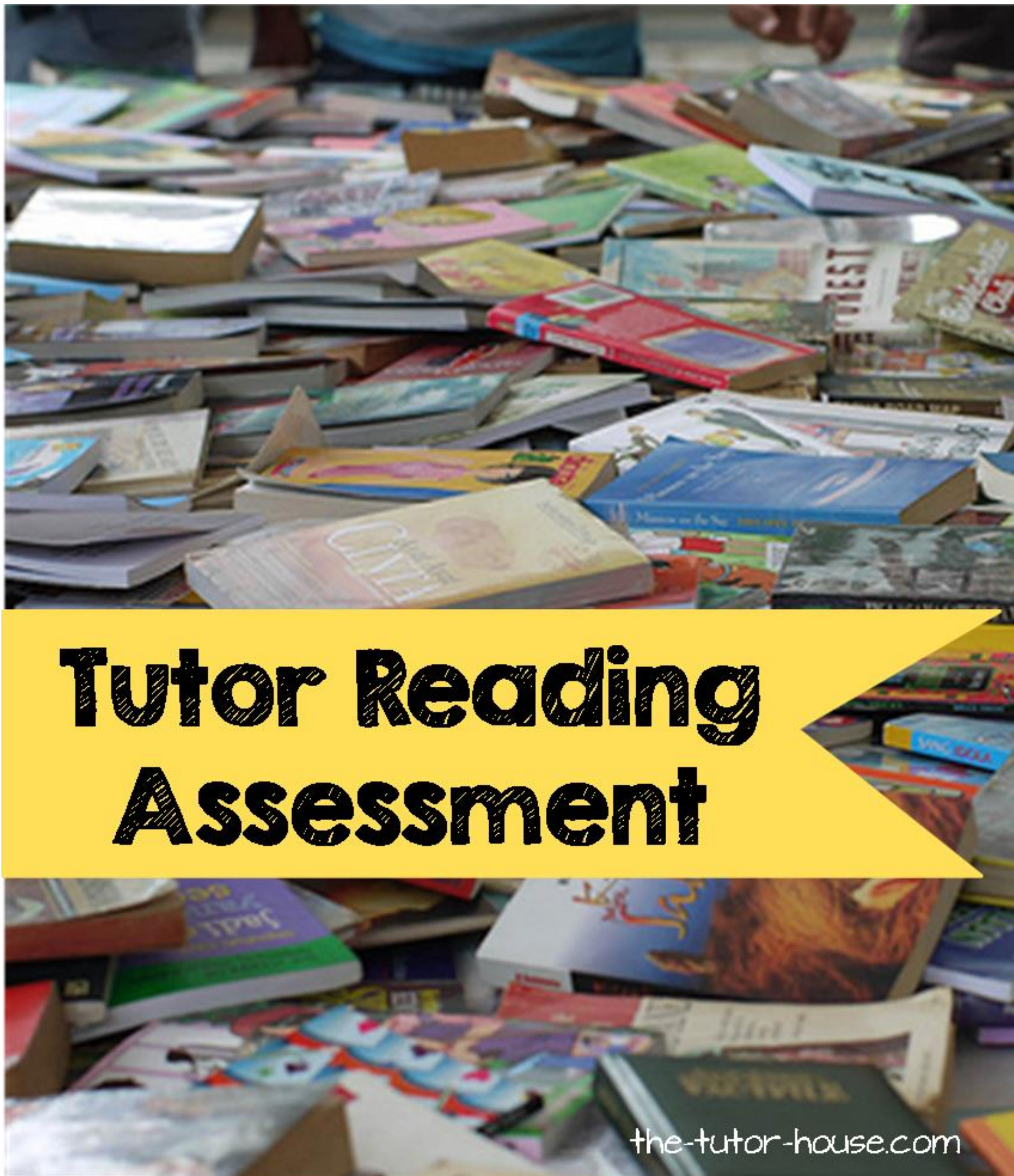
Conclusion

This unit concludes with understanding the challenges facing the Nigerian Healthcare sector. While the problems are not easily explained or solved, it is vital to understand the decisions and policies that got us to where we are today. In addition, it is important to understand the facilitators and barriers to change that currently are at play.

Summary

In this unit, we gained an understanding of the infrastructure of the Nigerian health sector and the aspect of infrastructure that make a good infrastructure that can support the needs of the people it is built to serve. We explored the history of health sector reform in Nigeria, and many of the drivers of health tourism. In addition we explored the history of disease surveillance.

Tutor Marked Assignment



References and Further Readings

102–108

1. Abubakar M, Basiru S, Oluyemi J, et al. Medical tourism in Nigeria: Challenges and remedies to health care system development. International Journal of Development and Management Review. 2018;13(1). https://www.ajol.info/index.php/ijdmr/article/view/172290.

2. Adeloye D, David RA, Olaogun AA, et al. Health workforce and governance: The crisis in Nigeria. Human Resources for Health. 2017;15(1):32. doi:10.1186/s12960-017-0205-4

3. Isere E, Fatiregun A, Ajayi I. An overview of disease surveillance and notification system in Nigeria and the roles of clinicians in disease outbreak prevention and control. Nigerian Medical Journal. 2015;56(3):161. doi:10.4103/0300-1652.160347

4. Kapur R. Significance of Health Infrastructure. July 2020. https://www.researchgate.net/publication/342832865{_}Significance{_}of{_}Health{_}Infrastructure.

5. Omoleke I, Taleat B. Contemporary issues and challenges of health sector in Nigeria. Research Journal of Health Sciences. 2018;5(4):210. doi:10.4314/rejhs.v5i4.5

6. Phalkey RK, Yamamoto S, Awate P, Marx M. Challenges with the implementation of an Integrated Disease Surveillance and Response (IDSR) system: Systematic review of the lessons learned. 2015;30:131-143. doi:10.1093/heapol/czt097

7. Uchenna Anaemene B. HEALTH SECTOR REFORMS AND SUSTAINABLE DEVELOPMENT IN NIGERIA: A HISTORICAL PERSPECTIVE. Journal of Sustainable Development in Africa. 2016;18(4).

Unit 2: Socioeconomic status and health

- Demographic Overview of Population
- Morbidity and Mortality
- Population Vulnerability

Introduction

This study unit focuses on the demographics of the Nigerian populace, focusing on the factors that lead to health complications, areas of vulnerability, and the morbidity and mortality rates of the country. Understanding the demographics allows you to gain a deeper understanding and appreciation of what the current reality is for many people so that you will begin to ask yourself "what can we do next", and begin to create solutions.

Objectives

At the end of this unit, you should be able to:

- Explain the demographics of the country
- Understand the vulnerabilities of the population
- Discuss Morbidity and Mortality rates

Main Content

- Demographics
- Population Vulnerability
- Morbidity and Mortality

Demographic Overview of Population

While we have mentioned a number of times some of the demographics of Nigeria, but now we're going to delve more deeply into it. While we are focusing on Nigeria in some of the following units, I want you to walk away with the understand that many other countries have levels to their complexity that are not always immediately obvious.

There are over 200 million people in Nigeria, the 7th largest population in the world, with an estimated growth rate of 2.53%[109]. This means that every year the population grows by 5.0610^{6}. Part of why we are growing so quickly is partly because of our high fertility rate, there are an estimated 4.72 children per woman. The prevalence of contraceptive use is low at 16.6%- this means that only 16.6% of women who are able to have children are on some form of birth control. In addition, we have a young population, with the median age of 18.6 years old and a life expectancy of 60.4 years, it is estimated that ~40% of the population is between the ages of 0 and 14. Nigeria actually accounts for about a quarter of the population of West Africa, has a net migration of -.02%. This means that people are moving away more than they are moving in… this is part of the brain drain phenomena that we discussed earlier in the unit. Most movement of Nigerians is happening within the country- the number of people moving to cities is growing, right now it is estimated that 52% of the population live in a city, and the rate of change or said another way, the rate that the cities/urban dwellers grow is 4.23%. The number of Nigerians moving to the rest of West Africa, to the Western countries, and all over the world, is like an outlet for those looking for economic opportunities, seeking asylum, and pursuing higher education. The immigration (of primarily other West Africans) is for the most part not enough to offset the loss (brain drain) of the highly skilled and educated population. Unfortunately, Nigeria is also a major source, transit, and destination for human trafficking, both forced labor and sexual.

All of these factors lead to population projections for 2050, to be about 392 million- which would make Nigeria the 4th largest country in terms of population in the world. These factors as well as the high birth rate do not seem to have an end in sight in the foreseeable future. There have not been many successful family planning programs to reduce or space the number of children born. The reasons for these (like everything), is multifactoral- a lack of political will, lack of adequate government financing, the availability and affordability of birth control, a cultural preference for large families, and others. While there is not a large scale effort across the country to reduce the number of children and reduce the population size- many states (like Gombe and Akwa Ibom) are

providing different forms of birth control to the women in rural communities for free. The purpose behind these actions may be reduction in population size, or an attempt to reduce the maternal mortality rates, or reduce the number of almajeri or street children within their communities. With such a large and growing population, the literacy rate (the number of people over the age of 15 who can read and write) is especially concerning, 62% of the population is literate (71.3% of men, 52.7% of women). There are regional differences in these numbers- which speaks to the importance of cultural norms on the community.

In addition to the age structure of the country, we also have a wide diversity of cultures, ethic groups and languages. There are more than 250 different ethno-linguistic groups, different faiths. The three largest ethnic groups Hausa (30%), Yoruba (15.5%), Igbo (15.2), make up 60.7 of the population. In addition to the ethnic differences, there is a stark religious divide- 53% of the country is Muslim, 35.3% is Christian, 10.6% is Roman Catholic, and the rest are "other".

In combination or rather in the same vein as the ethnoreligious divisions, there are stark regional divides both in terms of health outcomes, sociodemographic factors, norms, and insecurity. For example, while much of the population is considered extreme poor, the percentage of extreme poor is highest in the North. We also see the same situation in literacy levels (especially among women)- where the North has the lowest rate of literacy. There are many reasons for these inequities, some are due to natural distribution of resources, climate and physical condition of the areas, history, and institutional policies[110]. These factors combine to create a non-uniform economic landscape, which then impacts the opportunities available to the populace and thus differences in levels of per capita incomes, employment levels, physical quality of life, human and capital development, access to education, property acquisition, etc. In addition, due to the ethno-religious differences one of the overarching themes in polities revolves around preventing/resisting fears of one region or ethnic group becoming dominant over the others.

Population Vulnerability

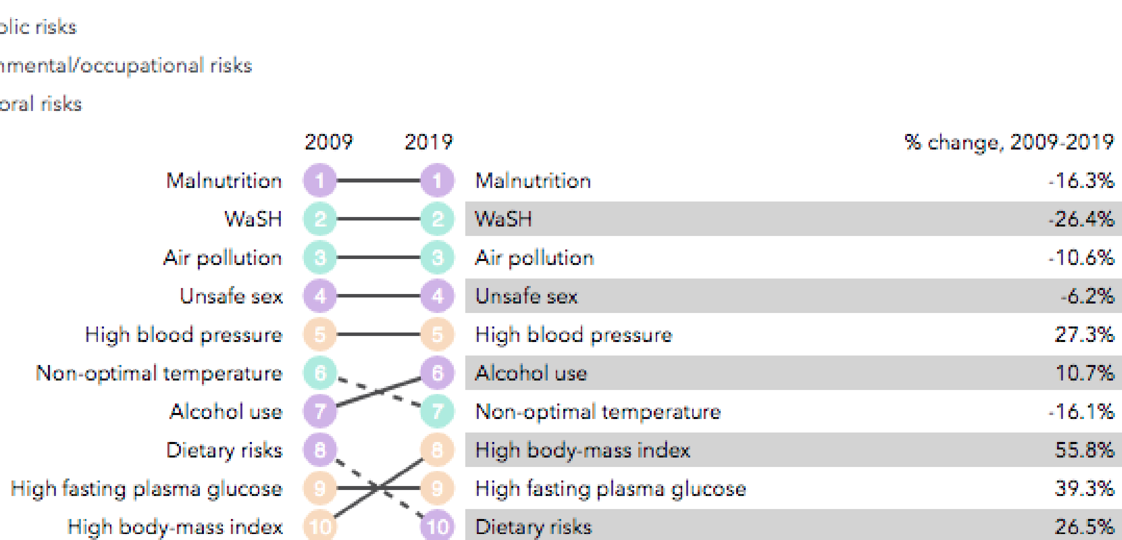
- Poverty
- Illiteracy
- Gender inequality

Nigeria's health indicators are one of the worst in Africa despite its fast-growing population[111]. As we have mentioned frequently over the course of this course, socioeconomic factors contribute

significantly to the relatively low quality of life and general depression of health across the country. The most notable factor influencing health is education. Education is more than a marker of socioeconomic situation, for example the probability of death among children born to illiterate mothers is two times the rate of death of infants born to literate mothers. Illiteracy has been found to be directly related to poverty, malnutrition, ill-health and high infant and child mortality. Overall, 59.6% of the overall population is literate, 69.2% of men and 49.7% of women. This level of literacy lends us a world ranking of 171 (out of 194)- demonstrating that globally we are performing extremely poorly[112].

More than half of Nigeria's population lives below the poverty line, which negatively impacts the overall health of the nation. As we have seen time and time again, the wealthier an area is, the more developed the health facilities are and the more access to healthcare and healthcare professionals that population has. However (again), health services are not only limited in number but can be extremely costly. Gender inequality, which we will discuss more later, is often encountered in the country where it is traditionally believed that a fair share of the family's resources should be given to the male child. This includes but not limited education, nutrition and family inheritance. Thus, the many women and girls are put a a disadvantage, since the mothers are traditionally the major caregiver of a child, the more uneducated and malnourished she is, the higher the likelihood of poor health in her child.

Morbidity and Mortality



As we have discussed multiple times over this course, the general health of Nigerians is not ideal. The top 10 causes of death[113] are Influenza and Pneumonia (14.89%), Diarrhoeal diseases (9.21%), HIV/AIDS (8.32%), Tuberculosis (5.95%), Coronary Heart Disease (5.60%), Malaria (5.24%), low birth weight (4.61%), Maternal conditions (3.60%), stroke (3.57%). While knowing the factors that are killing Nigerians are sad, understand where Nigeria stands on these same issues is more shocking for example we rank number 1 in the world for the number of people who are dying from influenza and pneumonia, number 6 for diarrhoel diseases, 5 for tuberculosis, 15th for HIV/AIDS, 2 in maternal conditions and liver disease, and 7th for prostate cancer. In many ways we are outperforming the rest of the world in an arena that no one else wants to win. These factors help to explain way so many organizations are putting money into Nigeria (as we have discussed in other units)[112].

Conclusion

::: notes

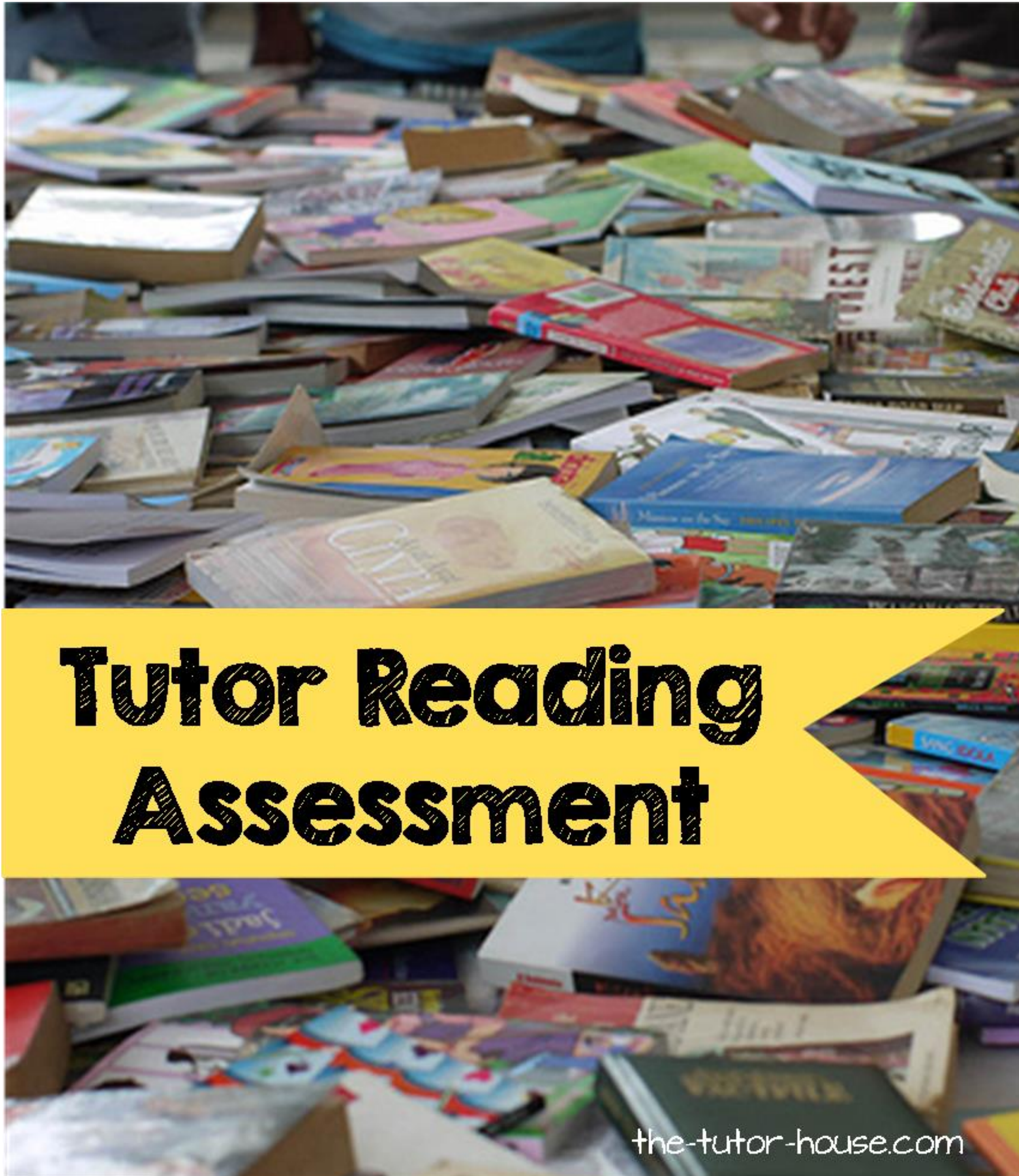
The unit examined the demographics of Nigeria, discussing the growth rate, life expectancy, and touching on brain drain. We discussed the ethno-religious divisions within the country and the relationship some of those division have on politics and health outcomes.

Summary

Tutor Marked Assignment

On an interesting note, that I personally found a bit amusing in terms of risk factor and I would like you to *do research related to explain why-*

1. Alcohol Liters – we rank 4th in the world (13.4 Liters)
2. Smoking % – 17.4% of men and 1.1% of women smoke, giving Nigeria a rank of 118 and 115 respectively
3. Obesity % – 4.6% of men and 13.1% of women are obese, giving us a rank of 154 and 145 respectively
4. Happiness Score – 5.16, giving us a rank of 87



References and Further Readings

110–117

1. Www.worldlifeexpectancy.com. HEALTH PROFILE NIGERIA. https://www.worldlifeexpectancy.com/country-health-profile/nigeria. Accessed March 28, 2021.
2. Murray CJ, Aravkin AY, Zheng P, et al. Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. The Lancet. 2020;396(10258):1223-1249. doi:10.1016/S0140-6736(20)30752-2
3. Joe-Ikechebelu N, Osuorahi CDI, Nwankwo BE, Ngene W, Nwaneli EI. Evaluation of social determinants of health (SDH) in communities across the south-eastern region of Nigeria. The Anatolian Journal of Family Medicine. 2020;3(1):10-16. doi:10.5505/anatoljfm.2019.40085
4. Okoroiwu HU, Uchendu KI, Essien RA. Causes of morbidity and mortality among patients admitted in a tertiary hospital in southern Nigeria: A 6 year evaluation. Lazzeri C, ed. PLOS ONE. 2020;15(8):e0237313. doi:10.1371/journal.pone.0237313
5. Oyeleye OI, Adeniji MA. Regional Imbalances and Inequalities in Nigeria: Causes, Consequences and Remedies. 2014;4. https://core.ac.uk/download/pdf/234674109.pdf.
6. Statista. Nigeria: main causes of death 2019 | Statista. March 2021. https://www.statista.com/statistics/1122916/main-causes-of-death-and-disability-in-nigeria/. Accessed March 28, 2021.
7. World Health Organization. WHO | Nigeria. WHO. 2007.
8. Worldometer. Nigeria Demographics 2020 (Population, Age, Sex, Trends) - Worldometer. https://www.worldometers.info/demographics/nigeria-demographics/. Accessed March 28, 2021.

Unit 3: Cultural Competency in Development

Introduction

This study unit focuses on the role that religion, ethnicity, and gender play in obtaining health services. This unit asks students to take what has been taught in the course thus far, merge it with their life experience, and find additional information to fill in and contextualize both the work and their personal experiences. It is vital, that you realize that your experiences in life to this point are not something distinct from health and development, but rather, that these life experience are what allow you to see options, opportunities, and potential innovative solutions that others may not see.

Objectives

At the end of this unit, you should be able to:

- Discuss how ethnicity and region play a role in creating inequities
- Understand the role that religion plays in health
- Explain gender bias in healthcare

Main Content

- Religion
- Ethnicity
- Gender based bias

Religion

Why are religion and spirituality important in healthcare? Religion and spirituality are important factors in the majority of patients seeking care. Unfortunately, health providers may not take religious beliefs into account when they are dealing with difficult medical decisions for patients and their families. In the history of man, religious leaders and health providers were often the same. Only within recent times has medicine taken on a scientific approach that has resulted in a separation between medicine and religion. The challenge for health professionals is in understanding that patients often turn to their religious and spiritual beliefs when making medical decisions. Religion and spirituality can impact decisions regarding diet, medicines based on animal products, modesty, and the preferred gender of their health providers. Some religions have strict prayer times that may interfere with medical treatment. Healthcare providers should be respectful of a patient's religious and spiritual needs. Many patient's anxieties are reduced when they turn to their faith during healthcare challenges. Because many patients turn to their beliefs when difficult healthcare decisions are made, it is vital for healthcare professionals to recognize and accommodate the patient's religious and spiritual needs. Health professionals should provide an opportunity for patients to discuss their religious and spiritual beliefs and tailor their evaluation and treatment to meet their specific needs[118]

Ethnicity

In a country like Nigeria that has over 250 different ethic groups with different cultures, norms, and languages it is important to understand the impact that ethnicity plays on health. In addition, it is important to recognize the potential bias that both healthcare and patients may have so that special efforts can be made to reduce the impact those biases may have on the quality of care that a patient receives. Research suggests that patient–doctor consultations that are discordant in terms of race, ethnicity, or language are characterized by less participatory decision–making, lower levels of patient satisfaction, and higher rates of miscommunication, even after adjusting for markers of socioeconomic status. As a result, it has been postulated that an ethnic/racial match between doctor and patient may result in superior outcomes. In fact, in Nigeria research has found that interpersonal communication between the doctors and respondents becomes more engaging when the doctor and patient are from the same ethnic group.

In general, the nature of health care providers' relationships with the communities that they serve remains largely unexplored. However, some research has shown that doctors' ethnicity, family, background, training, and economic factors are related to their care of ethnic minority and under-served communities. Ethnic minority doctors are more likely to care for patients of their own race or ethnic group. They may practice in undeserved areas or care for poor patients and those who report poor health status and use more acute medical services such as emergency rooms and hospital care. Part of why this may be the case is because coming from those same types of communities, the physicians are intrinsically aware of the gaps in the medical infrastructure and are determined to help address them. In general, ethnicity-based therapeutic relationships and disparities have a lasting influence on the extent of medical care a patient receives.

The perception of similarity to one's physician is a multidimensional construct with some components more strongly related to outcomes than others. Patients who believed they were more similar to their doctor with respect to personal beliefs, values, and ways of communicating reported more trust in the physician, more satisfaction with care, and stronger intention to adhere to recommendations. They are better able to connect with their physician. In addition, a physicians' use of patient-centered care or behavior was related to patients' beliefs that they and the physician achieved a common understanding of their (the patient's) health conditions. However what is really important, is that while having the same culture or ethnicity as a patient made it easy to initially connect, a physician who is skilled in informing, showing respect, and supporting patients' involvement can transcend issues of race and sex to establish a connection with the patient, and this in turn contributes to greater patient satisfaction, trust, and commitment to treatment[119]. Given the tension between people of different ethicities, genders, regions, and religions, it is vital that physicians show respect to their patients regardless of ethnic background so that they have continue to live by their oath to do no harm.

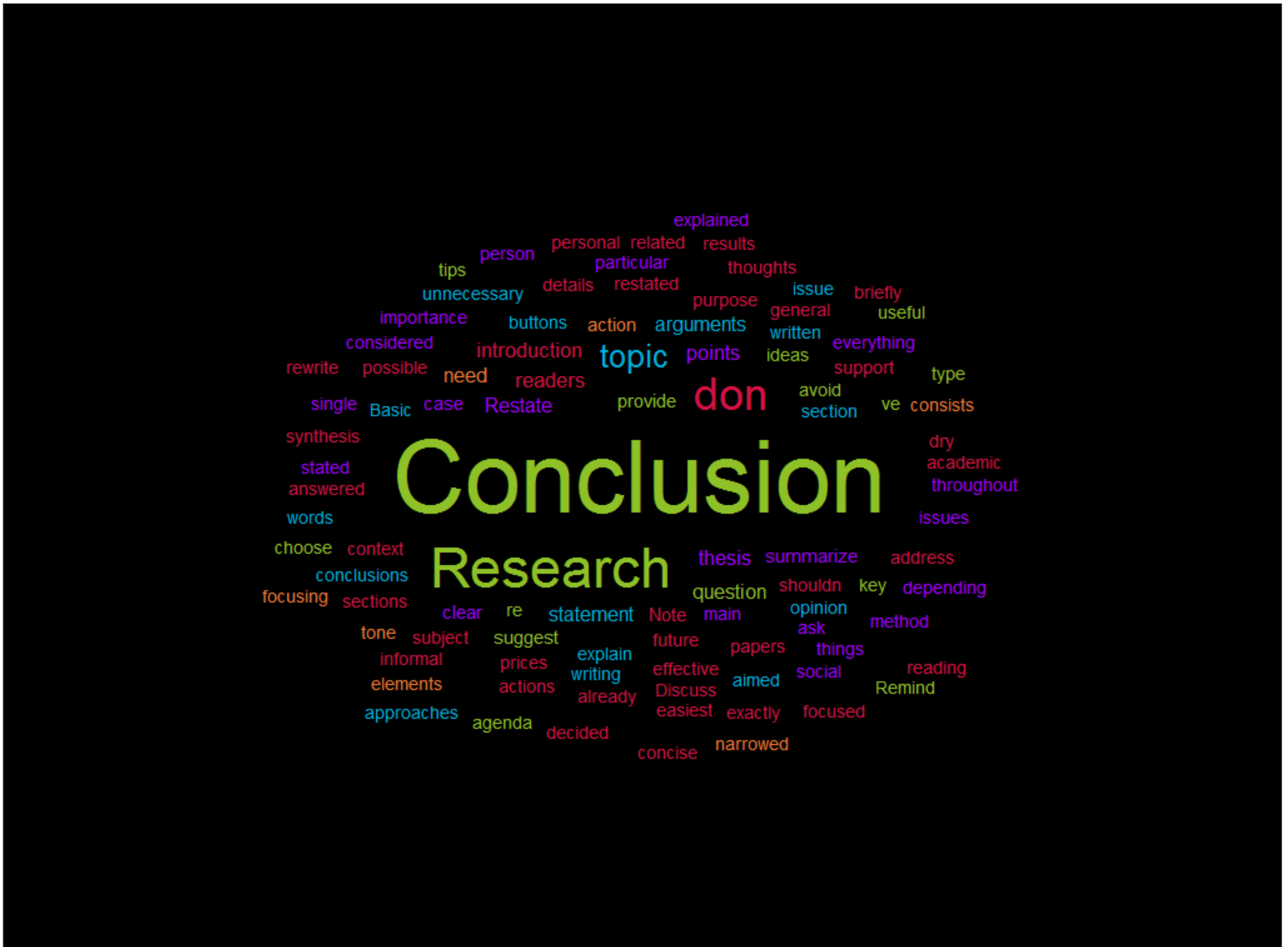
Gender based bias

Gender inequality is often encountered in the country where it is traditionally believed that a fair share of the family's resources should be given to the male child[111]. This includes but not limited education, nutrition and family inheritance. Thus the girl child and then women are often systematically disadvantaged. Since the mothers are traditionally the major caregiver of a child, the more uneducated and malnourished she is, the higher the likelihood of poor health in her child.

Gender-based perceptions, attitudes and expectations influence provider-patient communication. Cultural concordance and the interactions among patient gender, culture and patient satisfaction.

Gender differences in medical encounters have important implications for medical communication processes and outcomes and should be taken into consideration along with age, ethnicity, nationality, SES, and situational attributes that also influence health care provider-patient interaction[120].

Conclusion



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This unit examined how religion, ethnicity, and gender bias play a role in health outcomes.

Summary

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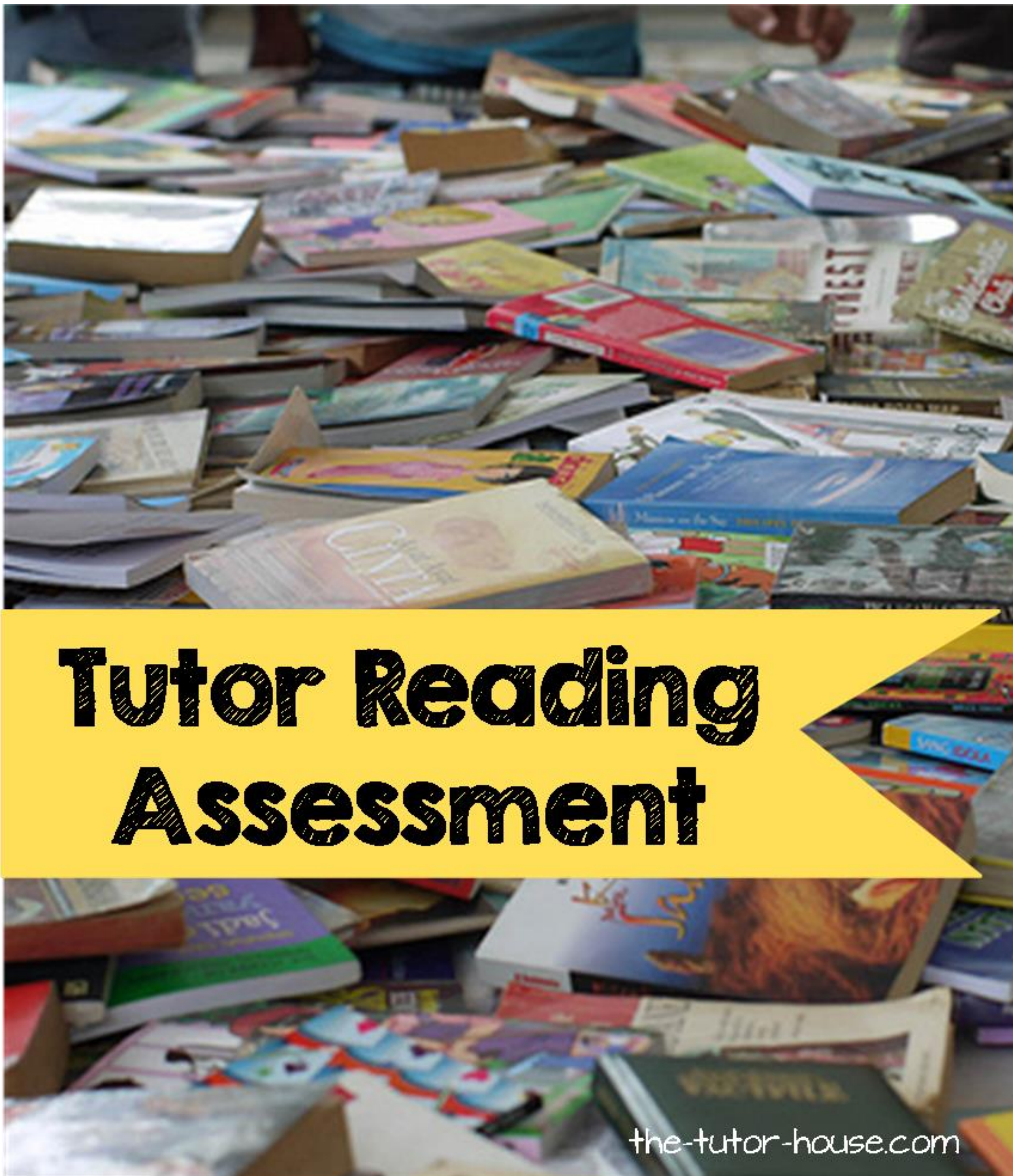

References and Further Readings

118–120

1. Ahmed R, Bates B. Gender Differences in Patients' Perceptions of Physicians' Cultural Competence in Health Care Interactions. December 2007:58-80. https://www.researchgate.net/publication/259694087{_}Gender{_}Differences{_}in{_}Patients{\%}27{_}Perceptions{_}of{_}Physicians{\%}27{_}Cultural{_}Competence{_}in{_}Health{_}Care{_}Interactions. Accessed March 28, 2021.

2. Nwabueze C, Nwankwo NN. Ethnicity and Doctor-Patient Communication: An Exploratory Study of University of Abuja Teaching Hospital, Nigeria | Journal of Participatory Medicine. October 2016. https://participatorymedicine.org/journal/evidence/research/2016/10/07/ethnicity-and-doctor-patient-communication-an-exploratory-study-of-university-of-abuja-teaching-hospital-nigeria/. Accessed March 28, 2021.

3. Swihart DL, Yarrarapu SNS, Martin RL. Cultural Religious Competence in Clinical Practice. February 2021. http://www.ncbi.nlm.nih.gov/pubmed/29630268.

Unit 4: Healthcare Financing

Introduction

This study unit focuses on the ways that healthcare is financed globally, trends in financing, and unique challenges to financing in Nigeria. This unit helps to illuminate the health financing landscape and shows both opportunities for improvement, facilitators, and barriers to changing the current system.

Objectives

At the end of this unit, you should be able to:

- Discuss the challenges of health financing
- Understand the global trends of health financing
- Explain International Health Financing

Main Content

- International Health Financing
- Trends and Challenges Globally
- Trends and Challenges Unique to Nigeria

International Health Financing

- Levers of Financing
- Health Financing Functions
  - Revenue collection
  - Pooling of resources
  - Purchase of Interventions

We've touched on this subject a few times in previous units, overall government spending on health is rising (yay), but in countries (like Nigeria) health spending remains too low. In terms of the numbers, between 2000 and 2016 in upper middle income countries, expenditure per person went from $130 to $270; while in lower middle income countries during the same time expenditure went from $30 to $58. Not only does the expenditure remain low, but many of low to middle income countries cannot afford many of the basic interventions needed for a minimal package for the health of their people[121].

In a situation where a country cannot afford to provide the infrastructure for a basic system for their population. There is the option of international health financing. Health financing systems are critical for reaching the goal of universal health coverage, and protecting that human right. The interrelated areas that health financing addresses[122]: - Raising funds for health; - Reducing financial barriers to access through prepayment and subsequent pooling of funds in preference to direct out-of-pocket payments; and - Allocating or using funds in a way that promotes efficiency and equity.

Health financing involves the basic functions of revenue collection, pooling of resources, and purchase of interventions[123].

- Revenue collection is how health systems raise money from households, businesses, and external sources. Another way to think of this is like taxes.
- Pooling is the accumulation and management of revenues. Members of the pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures. This is often how companies buy their HMO coverage. Prepayment allows pool members to pay for average expected costs in advance, relieves them of uncertainty, and ensures compensation should a loss occur. Pooling coupled with prepayment enables the establishment of insurance and the redistribution of health spending between high- and low-risk individuals and high- and low-income individuals.
- Purchasing refers to the mechanisms used to purchase services from public and private providers.

At the country level the financing functions translate into: - Raise sufficient and sustainable revenue efficiently and equitably in order to provide both a basic package of essential services and financial protection in the event of unpredictable life events. - Manage collected revenue to equitably and efficiently pool health risks; and, - Ensure the purchase of health services in a technically efficient and allocatively way.

The financing functions are embodied in three stylized health financing models:

- national health service (NHS): compulsory universal coverage, national general revenue financing, and national ownership of health sector inputs. This is exemplified by the UK healthcare system.
- social insurance: compulsory universal coverage under a social security (publicly mandated) system financed by employee and employer contributions to nonprofit insurance funds with public and private ownership of sector inputs
- private insurance: employer-based or individual purchase of private health insurance and private ownership of health sector inputs. This type of system is exemplified by the US healthcare system.

These models provide a general framework for classifying health systems and ways of financing them, however, they are not particularly useful from a micro policy standpoint. This is mainly due to the fact that all health systems embody various features of three different models. The key health policy issue is the amount of revenue raised and the extent to which it is raised in an efficient, equitable, and sustainable way Similarly, nothing is intrinsically good or bad about public versus private ownership and provision. The important issue is whether the systems in place ensure access, equity, and efficiency for the people.

Trends and Challenges Globally

- Gap in health spending
- The global aid quagmire

The current forecasts show that among a group of high-income countries that are currently spending on average $5221 per capita on health will increase their spending by more than $3994 between 2014 and 2040. Low-income countries on the other hand, will increase their current per capita health expenditure currently ~ $120, by only $75 over that same time[124]. The widening of the already wide gap between on health investment between high, middle, and low income countries will continue to significantly impact the life expectancy, life-quality, and expectations of what good health is for the citizens of these countries. While not directly related to this topic, this widening expenditure will also continue to make the flow of brain drain from low and middle income countries to high income countries continue to be a torrent. This means that low and middle income countries have to begin to truly make a sustainable investment in their health infrastructure, as well as maintain the promotion of development assistance for health policies.

By sustainable investment, we mean that it is not enough to allocate the funds no matter how much is allocated, but also the effectiveness of the funds. There are stories across the developing world that

point to programs both locally and from the developed nations where the amount of money allocated for a program and the amount of money that actually makes it on ground are not even remotely similar. For example there was an incident where less than 4% of the money allocated from a developed nation to address an issue in a developing nation actually made it to the recipients of the program. Due to corruption and government instability, ensuring that effectiveness of an intervention or program would be needed to understand it's long term usefulness. One way to address both the diversion of funds due to corruption and the diversioning of funds due to the bureaucratic procedure, is to increase the transparency that all nations have both in respect to health and overall.

Some problems with the architecture of health aid and aid in general come from a lack of global governance and overlapping mandates[125]. Look at some of the governmental agencies, find at least 2 that have similar or overlapping mandates. What types of problems can these overlapping mandates cause? Some of the other problems come from the methodology and instruments utilized for aid delivery. At the country level, the unique dysfunctions of the country and its politics combined with the complexities of the health sector further complicate the situation. Globally, there is no one in charge. That is to say that one organization body does not regulate all the activities that are occurring. There are more than 100 major organizations involved in distributing health aid around the world, yet there is not a single organization that has the mandate to take the lead from all the other ones. There is no clear delineation of mandates or roles for donor organizations; no mechanisms to ensure that countries live up to their aid commitments and help both donors and countries coordinate the hundreds of channels for official and private aid flow; and no organization that helps to improve aid predictability and longevity, harmonize donor procedures, and align these procedures with country systems. In recent years, there has been a shift in the way that aid is financed and delivered. Private foundations and global funds, provide about 15% of all development assistance for health, yet much of the assistance provided is distributed not on the basis of greatest need but rather on the basis of an individual application process. Part of the problem with these methods of financing is that some countries get redundant funds, working on projects that are not sustainable because everything is piecemealed, rather than getting all the funds together to build an infrastructure that is sustainable and would make a larger long lasting impact on multiple communities.

Trends and Challenges Unique to Nigeria

- Why are we in this position?
- How can we get out?

Achieving a successful health care financing system continues to be a challenge in Nigeria. While there are many reasons why this is, and I'm sure that before I start to extol a few you (by virtue of

being in this course to this point), know what they are. Some of the challenges include, but are not limited to: limited institutional capacity, corruption, unstable economic, and political context[126]. Not only is there severe catastrophic healthcare financing, but there is also an ineffective use of the funding that is put in place. Additional challenges include:

i. Inadequate political commitment to health which leads to the poor funding of health in general, especially Primary Health Care.
ii. Gaps in the area of stewardship and governance, evidenced by lack of clarity of the role of government, at all levels in financing health care.
iii. Inadequate or non implementation of health policy that clearly spells out how funds are allocated and spent.
iv. Governance issues with the NHIS and poor buy-in by the states which limits coverage.
v. Dominance of Out of Pocket payment system which introduces the possibility of under/oversupply of services depending on the financial abilities of the patient.
vi. Non exploitation of other sources of health financing
vii. Several stakeholders, including development partners finance health independently and not in accordance with governments policy focus, which has lead to frequent duplication of efforts and the inefficient use of scarce resources.

While a single course and a single unit cannot provide all the solutions to fixing the health financing issues that are facing Nigeria, we can begin to examine what we know about the system and its points of failure, where we want to be in terms of addressing health and its place as a human right, then explore the difference. To begin, we should explore sources of financing that are efficient, equitable, fair and sustainable:

1. There is some evidence that the private sector could key delivering health services thus impacting health outcomes, including financing.
2. The federal government should increase health spending to the 15% it committed to at the Abuja declaration, though we have discussed this is many of the previous units, per capita health spending is slightly lower than US$35 per person per year. Per capita health spending needs to increase to $60 per person per year, in order to provide a minimum range of services.
3. Promote the development of industries and relevant manpower to enhance local capabilities in the production of drugs, medical equipment, and spare parts to improve supplies and maintenance capabilities as well as, reduce costs and improve efficiency.
4. Ban the financing of government officials going overseas for medical treatment.
5. Pay-for- performance bonuses and other incentive programs to motivate health workers to provide high-quality care efficiently.

The Federal Ministry of Health needs to provide strategic, progressive leadership. Leadership that is willing to discard failed and tired structures, systems and indeed individuals who are promoting their own self interest rather than the country's. Proper and prudent management of funds as well as, effective monitoring and evaluation (M&E) of performance, tracking the use of resources, health policies and reforms. In addition, the implementation of health financing policies and actions must be monitored and evaluated at regular intervals.

Conclusion

::: notes

This unit examined the functions of health financing, how revenue is raised, pooled, and used. It also explored some of the challenges globally, specifically examining the gaps in health spending and global spending “quagmire”. Finally this unit examined how Nigeria got into the position it is today and examined possible ways to move forward.

Summary

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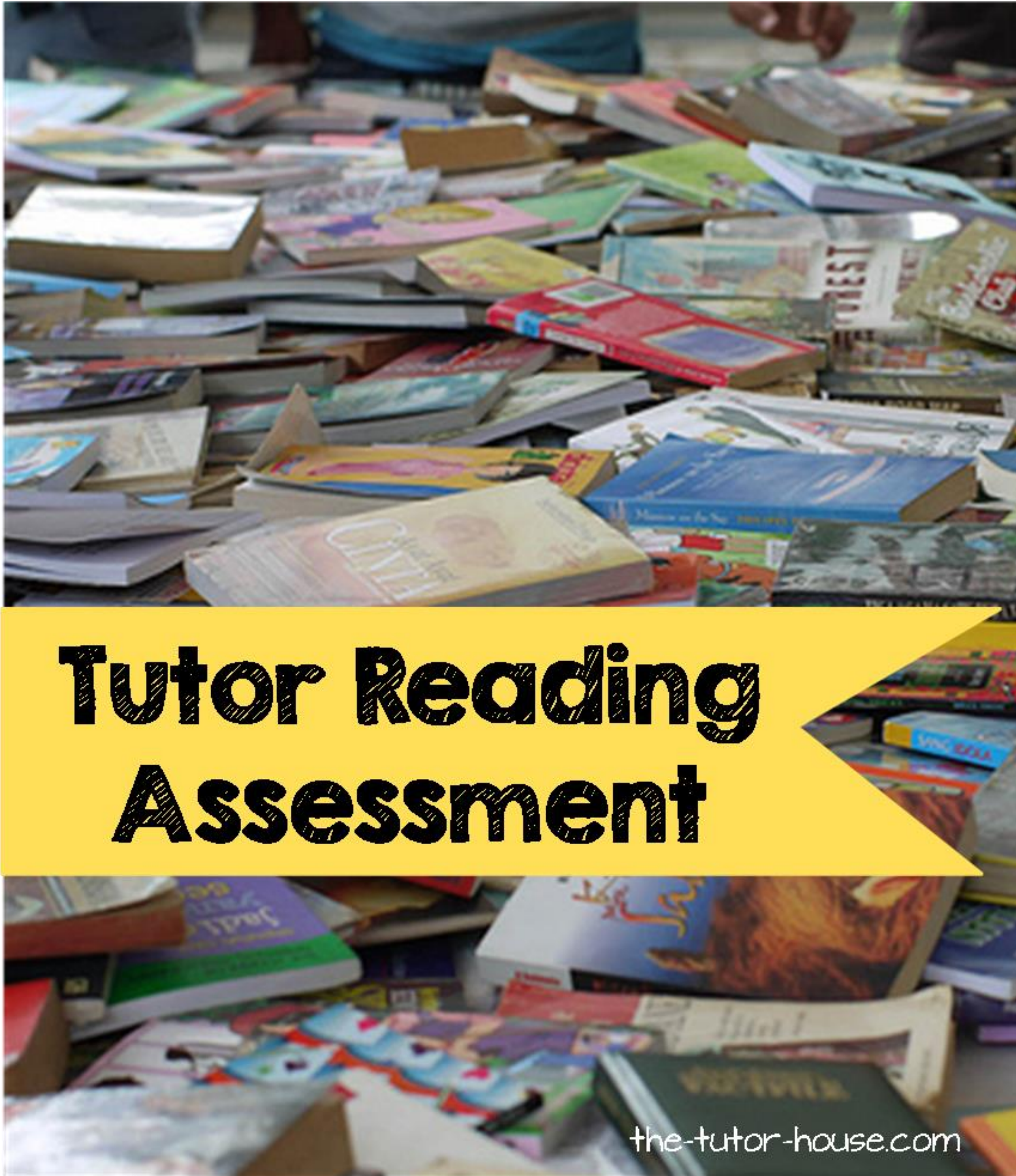


References and Further Readings

121–126

1. Gomez-Gonzalez JE, Reyes NR. Patterns of global health financing and potential future spending on health. 2017;389:1955-1956. doi:10.1016/S0140-6736(17)31001-2

2. Schäferhoff M, Martinez S, Ogbuoji O, Sabin ML, Yamey G. Trends in global health financing. 2019;365. doi:10.1136/bmj.l2185

3. Schieber G, Baeza C, Kress D, Maier M. Financing Health Systems in the 21st Century. The International Bank for Reconstruction; Development / The World Bank; 2006. http://www.ncbi.nlm.nih.gov/pubmed/21250347.

4. Schieber GJ, Gottret P, Bank W. Getting Real on Health Financing Working with WHO in Iran on Fiscal and Health Financing Reform Issues View project Lisa K Fleisher.; 2006. https://www.researchgate.net/publication/265199649.

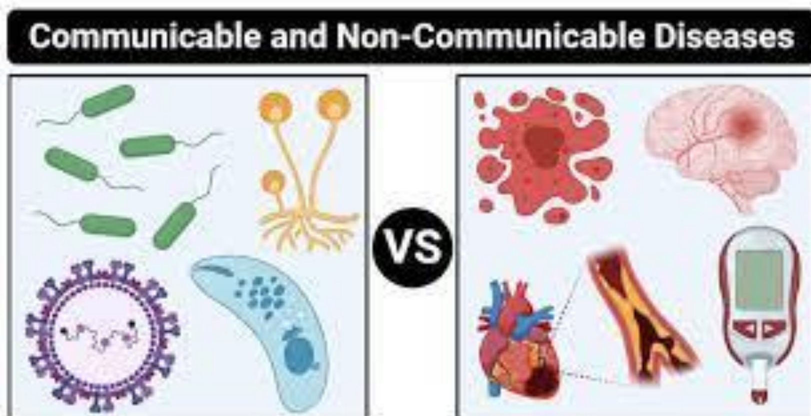
5. World Health Organization. WHO | Health systems financing. 2012.

6. Yunusa U, Timothy GD, Dalhatu AE, Ahmed SF. Trends and Challenges of Public Health Care Financing System in Nigeria: The Way Forward. Vol 4.; 2014:28-34. www.iosrjournals.orgwww.iosrjournals.org.

Module 4: Disease Burden in Development

Unit 1: Communicable and Non-communicable diseases Unit 2: Neglected tropical diseases and Health inequities Unit 3: Cost analysis Unit 4: Health and productivity, Health, savings and investments

Unit 1: Communicable and Non communicable diseases



Introduction

This study unit focuses on some of the common communicable and non-communicable diseases affecting Nigerians. This unit helps to explain some of the reasons why there are so many NGOs, international bodies, and local groups with a focus on health.

Objectives

At the end of this unit, you should be able to:

- Discuss the role that disease has on health and healthcare
- Understand the impact that different diseases have on the nigerian populace
- Explain the symptoms and treatment of the various disease

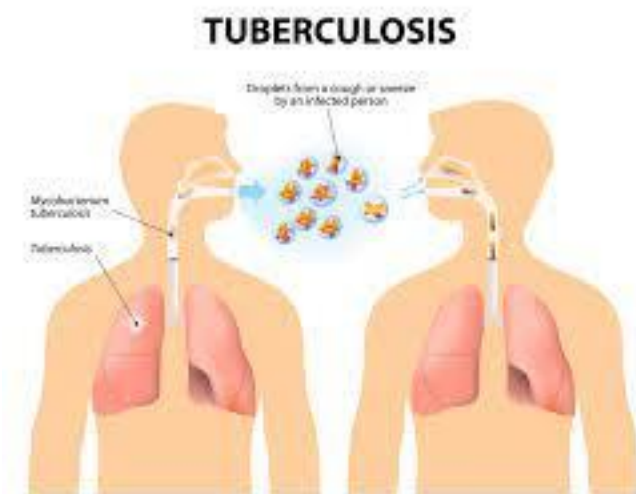
Main Content

- Tuberculosis
- HIV/AIDS
- Hepatitis
- Malaria
- Cardiovascular diseases
- Cancers

Tuberculosis

SYMPTOMS: Most people do not show any form of symptoms and when symptoms tend to occur, they usually involve a cough, weight loss night sweat and fever.

TREATMENTS: Patients with active symptoms requires long form of treatments involving antibiotics.



Tuberculosis (TB)[127] is a contagious infection that usually attacks your lungs though it can also spread to other parts, like the brain and spine. It is caused by Mycobacterium tuberculosis, a bacteria spread through the air (like the cold or flu). You can get TB only if you come into contact with someone who has it.

3 Type of tuberculosis infections: Active Tuberculosis, Latent Tuberculosis, and Military Tuberculosis.

A major issue with TB in Nigeria is the low rate of finding cases for both adults and children. For example, in 2017 only 104,904 TB cases were detected out of an estimated 407,000, indicating treatment coverage of just 25.8%. This leaves 302,096 people with TB who were either undetected or detected but not notified especially in “non DOTS sites”. This is of particular concern because according to the WHO, Nigeria is among the top ten countries that account for 64% of the global number of TB cases. India, Indonesia and Nigeria alone account for almost half of the total TB cases in the world.

HIV/AIDS

GLOBAL HIV STATISTICS

- 26 million people were on antiretroviral therapy in June 2020.
- 38.0 million people globally are living with HIV in 2019.
- 1.7 million people became infected with HIV in 2019.
- 690,000 people died from an AIDS-related illness in 2019.
- 75.7 million people have become infected with HIV since the beginning of the epidemic (end 2019).
- 32.7 million people have died from AIDS-related illnesses since the start of the epidemic (end 2019).

Human immunodeficiency virus (HIV) is an infection that attacks the body's immune system, specifically the white blood cells called CD4 cells. And is commonly transmitted through contact with infected blood. HIV destroys these CD4 cells, weakening a person's immunity against infections such as tuberculosis and some cancers. In some areas, HIV infection has spread rapidly to the general population; in others, the spread has remained among higher-risk sub-populations, including sex workers and their customers, men who have sex with men, and injection drug users (IDUs). Worldwide, the adult prevalence rate is 1.07% of the population, and 47% of infections occur among women.

It is estimated that about 3.3 million people live with HIV in Nigeria, with over 200 thousand new cases and deaths every year[128]. High risk groups involving female sex workers, men who have sex with men and injecting drug users contribute substantially to new infections, however stigma and fear keeps many more people from going to find out their status. Nigeria has one of the largest populations of persons living with HIV in sub-Saharan Africa.

HIV has a long painful history across the world and in the development sector. While we will not go in too much depth about that history in this course, I strongly encourage you to read about the history of HIV on your own time.

Hepatitis

Causes: - Alcohol and other toxins: Excessive alcohol consumption can cause liver damage and inflammation. This is sometimes referred to as alcoholic hepatitis. - Autoimmune system response: In some cases, the immune system mistakes the liver as a harmful object and begins to attack it. It causes ongoing inflammation that can range from mild to severe, often hindering liver function.

Signs and symptoms of acute hepatitis appear quickly. They include: Fatigue, Flu-like symptoms, Dark urine, Pale stool, Abdominal pain, Loss of appetite.

Hepatitis refers to an inflammatory condition of the liver. It's commonly caused by a viral infection, but there are other possible causes of hepatitis. These include autoimmune hepatitis and hepatitis that occurs as a secondary result of medications, drugs, toxins, and alcohol. Viral infections of the liver that are classified as hepatitis include hepatitis A, B, C, D, and E. A different virus is responsible for each type of virally transmitted hepatitis. Hepatitis A is always an acute, short-term disease, while hepatitis B, C, and D are most likely to become ongoing and chronic. Hepatitis E is usually acute but can be particularly dangerous in pregnant women.

A few causes of hepatitis include: - Excessive alcohol consumption which can cause liver damage and inflammation, sometimes referred to as alcoholic hepatitis. - In some cases, the immune system mistakes the liver as a harmful object and begins to attack it, ongoing inflammation can range from mild to severe, often hindering liver function.

Signs and symptoms of acute hepatitis appear quickly. They include: Fatigue, Flu-like symptoms, Dark urine, Pale stool, Abdominal pain, and Loss of appetite.

Treatment options vary depending on which type of hepatitis you have. You can prevent some forms of hepatitis through immunizations and lifestyle precautions.

Hepatitis B has a prevalence of 8.1% and Hepatitis C at 1.1%, based on a recent Nigeria HIV/AIDS Indicator and Impact Survey(NAIIS) report[129]- meaning that there are an ~ 19 million Nigerians living with Hepatitis B and or C.

Malaria

Symptoms

- Chills, fever and sweating which occurs few weeks after been bitten.

Treatment

- Anti-malaria Dimitrios Trichopoulos

Malaria has had a greater impact on world history than any other infectious disease. More than 300 to 500 million individuals worldwide are infected with Plasmodium spp, the parasite that causes malaria. Malaria is endemic in over 90 countries in which 2400 million people live; representing 40% of the world's population. Approximately 90% of malaria deaths occur in Africa.

According to the latest World malaria report, in 2019 there were 229 million cases, and 409 thousand people died. The WHO African Region continues to carry a disproportionately high share of the global malaria burden. In 2019, 6 countries accounted for approximately half of all malaria deaths worldwide, Nigeria alone has 25% of all malaria cases[130].

Cardiovascular diseases

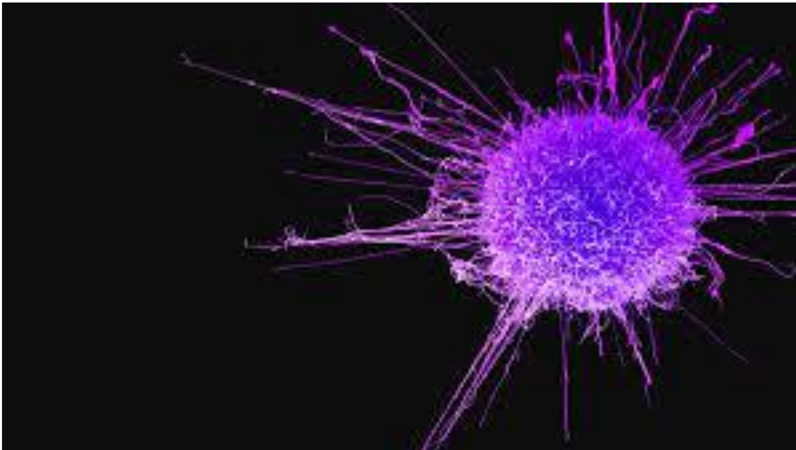
Cardiovascular diseases are the leading cause of morbidity and mortality among women worldwide. The pathophysiological basis of cardiovascular health among men and women is not identical and leads to differing responses to stimulus and differing presentation of symptoms. In the past decade more risk factors for cardiovascular diseases specific to women have been identified. These risk factors include menopause, hypertensive disease of pregnancy, and depression, confer additional risk in women besides the traditional risk factors. Prevention of cardiovascular diseases include lifestyle factors, blood pressure control, lowering cholesterol, anti thrombotic therapy, and fixed-dose combination therapy.

Cardiovascular disease are increasing in prevalence in Nigeria which is a worrying development. Cardiovascular diseases which have increased over the past 20 years in Nigeria include hypertension, heart failure, and stroke and now account for an estimated 11% of deaths[131].

Cancers

Caused by changes to the DNA. - Genetic mutations are inherited

Environment can force changes: - Exposure to cancer-causing chemicals, called carcinogens - Exposure to radiation - Unprotected exposure to the sun - Certain viruses, such as human papilloma virus (HPV) - Smoking - Lifestyle choices, such as type of diet and level of physical activity



Cancer is one of the most dreaded diseases of the 20th century and spreading further with continuance and increasing incidence in the 21st century. The situation is so alarming that every fourth person is having a lifetime risk of cancer. Cancer is an umbrella term for a large group of diseases caused when abnormal cells divide rapidly, and spread to other tissue and organs.

TYPE OF CANCERS

Cancers are named for the area in which they begin and the type of cell they are made of, even if they spread to other parts of the body. For example, a cancer that begins in the lungs and spreads to the liver is still called lung cancer. There are also several clinical terms used for certain general types of cancer:

- Carcinoma is a cancer that starts in the skin or the tissues that line other organs.
- Sarcoma is a cancer of connective tissues such as bones, muscles, cartilage, and blood vessels.
- Leukemia is a cancer of bone marrow, which creates blood cells.
- Lymphoma and myeloma are cancers of the immune system.

RISK FACTORS AND TREATMENT

The direct cause of cancer is changes (or mutations) to the DNA in your cells. Genetic mutations can be inherited. They can also occur after birth as a result of environmental forces. Some of these forces include:

- Exposure to cancer-causing chemicals, called carcinogens
- Exposure to radiation
- Unprotected exposure to the sun
- Certain viruses, such as human papilloma virus (HPV)

- Smoking
- Lifestyle choices, such as type of diet and level of physical activity

Cancer risk tends to increase with age. Some existing health conditions that cause inflammation may also increase your risk of cancer. An example is ulcerative colitis, a chronic inflammatory bowel disease.

Cancer in Nigeria like in other parts of the world is problematic[132].

Chronic respiratory diseases

- Symptoms
- Prevention
- Treatment

Chronic respiratory diseases encompass a group of diverse conditions affecting the airways, which all impair lung function over time. They include cystic fibrosis (CF), idiopathic pulmonary fibrosis (IPF), chronic obstructive pulmonary disease (COPD) and asthma, which together affect hundreds of millions of people.

SYMPTOMS - asthma and respiratory allergies, - chronic obstructive pulmonary disease (COPD), - occupational lung diseases, - sleep apnea syndrome and pulmonary hypertension. - Allergic rhinitis or "hay fever

PREVENTION - Adequate ventilation and early detection are vital to addressing occupational lung diseases. - Indoor and Outdoor Air Quality - Improvements in cook-stove technology can help reduce exposure to indoor air pollution in homes. - Smoke free legislation protects air quality in workplaces, public places, health care facilities, educational facilities and public transportation. Other air quality controls can reduce and eliminate exposure from industrial emissions, traffic, etc. - Diet and Nutrition

TREATMENT[133] Treatments differ depending on the condition, though some of the chronic respiratory diseases are incurable due to permanent damage done to the lungs.

Conclusion

This unit touched on some of the common communicable and non communicable diseases impacting Nigerians. It explored the symptoms, treatments, and prevalence of these diseases.

Summary

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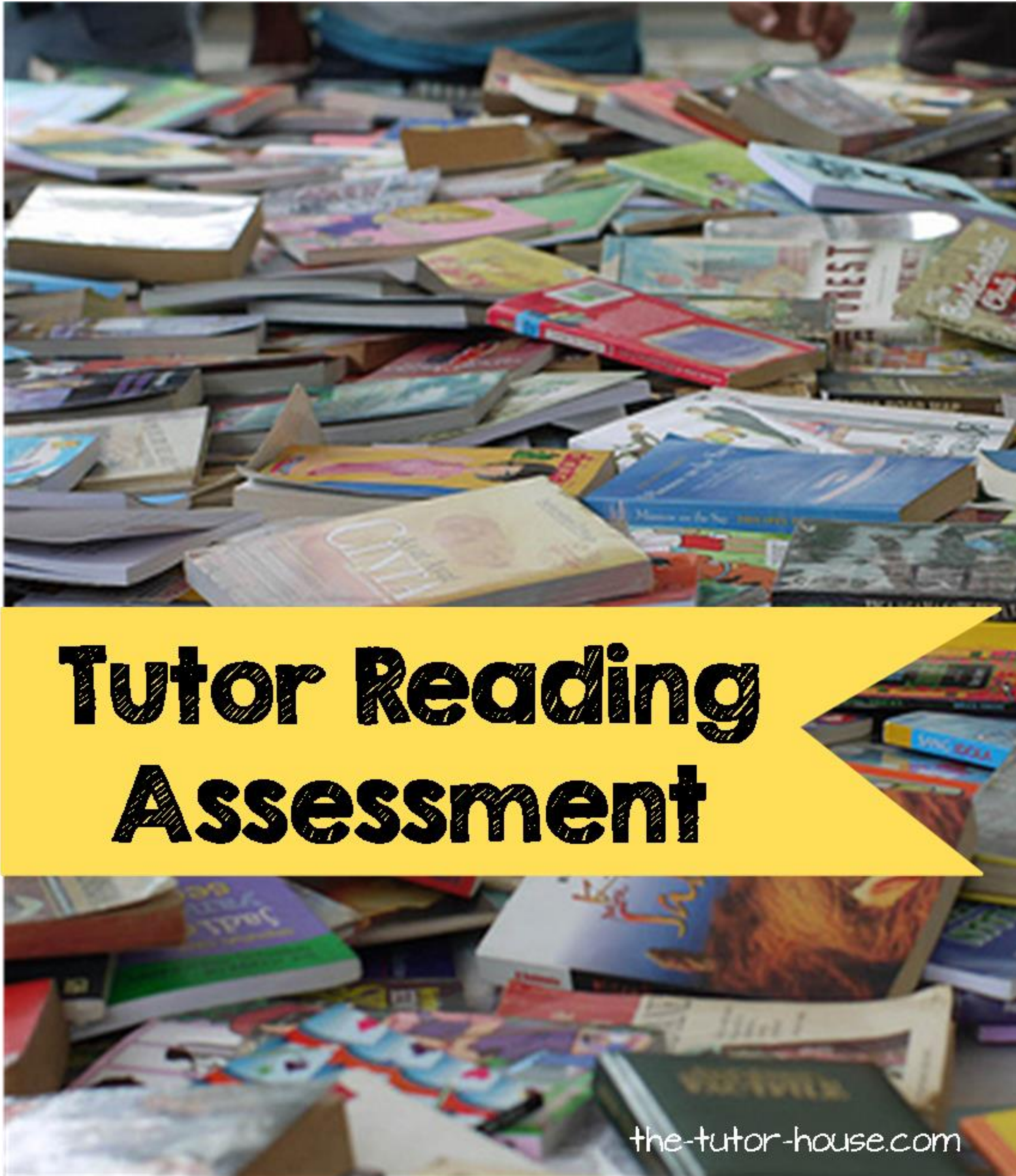


References and Further Readings

109,127–140

1. Awofala AA, Ogundele OE. HIV epidemiology in Nigeria. 2018;25:697-703. doi:10.1016/j.sjbs.2016.03.006

2. Christman BW. Tuberculosis Overview.

3. Desalu OO, Oluwafemi JA, Ojo O. Respiratory diseases morbidity and mortality among adults attending a tertiary hospital in Nigeria. Jornal brasileiro de pneumologia : publicaça{combining double acute accent} o oficial da Sociedade Brasileira de Pneumologia e Tisilogia. 2009;35(8):745-752. doi:10.1590/s1806-37132009000800005

4. Garcia LS. Malaria. 2010;30:93-129. doi:10.1016/j.cll.2009.10.001

5. Hepbtalk. The Journey to Hepatitis Elimination in Nigeria - Hepatitis B Foundation. January 2020. https://www.hepb.org/blog/journey-hepatitis-elimination-nigeria/. Accessed March 27, 2021.

6. Ike S, Onyema C. Cardiovascular diseases in Nigeria: What has happened in the past 20 years? Nigerian Journal of Cardiology. 2020;17(1):21. doi:10.4103/njc.njc_33_19

7. mundi I. Nigeria Demographics Profile. 2020. https://www.indexmundi.com/nigeria/demographics{_}profile.html. Accessed March 27, 2021.

8. Jedy-Agba E, Curado MP, Ogunbiyi O, et al. Cancer incidence in Nigeria: A report from population-based cancer registries. Cancer Epidemiology. 2012;36(5):271-278. doi:10.1016/j.canep.2012.04.007

9. Leong DP, Joseph PG, McKee M, et al. Reducing the global burden of cardiovascular disease, part 2: Prevention and treatment of cardiovascular disease. 2017;121:695-710. doi:10.1161/CIRCRESAHA.117.311849

10. Roy PS, Saikia BJ. Cancer and cure: A critical analysis. 2016;53:441-442. doi:10.4103/0019-509X.200658

11. Saeed A, Kampangkaew J, Nambi V. Prevention of Cardiovascular Disease in Women. 2017;13:185-192. doi:10.14797/mdcj-13-4-185

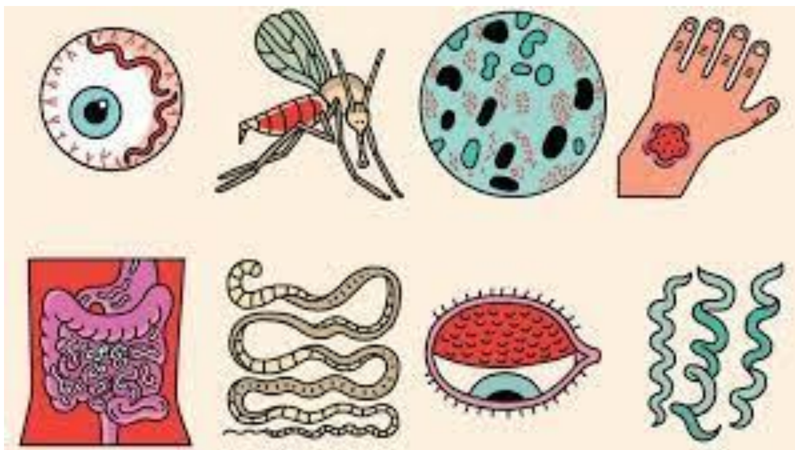
12. TBfacts.org. TB in Nigeria - Funding, children, diagnosing TB, HIV/TB. https://tbfacts.org/tb-nigeria/. Accessed March 26, 2021.

13. Uloko AE, Musa BM, Ramalan MA, et al. Prevalence and Risk Factors for Diabetes Mellitus in Nigeria: A Systematic Review and Meta-Analysis. Diabetes Therapy. 2018;9(3):1307-1316. doi:10.1007/s13300-018-0441-1

14. UNAIDS. UNAIDS fact sheet, 2019.

15. World Health Organization. Malaria. November 2020. https://www.who.int/news-room/fact-sheets/detail/malaria. Accessed March 27, 2021.

Unit 2: Neglected tropical diseases and Health inequalities



Introduction

This study unit focuses on neglected tropical diseases and health inequalities. Specifically the impact of issues like maternal mortality, Gender based violence, female genital mutilation, and VVF have on the women of Nigeria.

Objectives

At the end of this unit, you should be able to:

- Discuss the underlying causes of health inequities
- Understand some of the signs and symptoms of neglected tropical diseases

Main Content

- Neglected Tropical Diseases
- Health inequities

Neglected Tropical diseases

- Schistosomiasis
- Leprosy
- Trachoma
- Filariasis
- Hydatid
- Leishmaniasis

Schistosomiasis is a disease caused by infection with freshwater parasitic worms in certain tropical and subtropical countries, is a neglected tropical parasitic disease associated with severe pathology, mortality and economic loss worldwide. Schistosoma species detection by environmental DNA assays in African fresh waters. The parasite can be found in sub-Saharan Africa, the Middle East, Southeast Asia and the Caribbean. The fresh water becomes contaminated from infected animal or human urine or feces. The parasites penetrate human skin to enter the bloodstream and migrate to the liver, intestines and other organs.

SYMPTOMS- Fever, blood in stools or urine, and abdominal discomfort.

TREATMENT- Anti parasitic drug praziquantel (Biltricide) often effectively treats schistosomiasis, especially in acute phase disease.

Schistosomiasis remains one of the most prevalent neglected tropical diseases especially in Nigeria which has the greatest number of infected people worldwide[141]. The Southwestern part of Nigeria appears to be most affected with schistosomiasis with the prevalence of infection ranging from 44.8% to 71.5% in endemic areas of Osun and Ogun States[142].

Leprosy or Hansen's disease is a chronic infection caused by Mycobacterium leprae (M. leprae) or Mycobacterium lepromatosis (M. lepromatosis). It mainly affects the skin, eyes, nose and peripheral nerves Leprosy can be cured with 6-12 months of multi-drug therapy. Early treatment avoids disability.

Symptoms include light-colored or red skin patches with reduced sensation, numbness and weakness in hands and feet.

TREAMENT- Hansen's disease is treated with a combination of antibiotics. Typically, 2 or 3 antibiotics are used at the same time, this is called multidrug therapy. This strategy helps prevent the development of antibiotic resistance by the bacteria, which may otherwise occur due to length of the treatment.

According to official reports received from 138 countries across all WHO regions, the global prevalence of leprosy at the end of 2015 was 176,176 cases.In Nigeria, leprosy remains a disease of public health importance with over 3500 people diagnosed with leprosy every year and about 25% of patients having some degree of disability[143]. Stigma and discrimination against persons and communities affected by leprosy in Nigeria is very high, due to myths and superstitions associated with fear of the disease[144].

Trachoma is a bacterial infection that affects the eyes, is the leading preventable cause of blindness worldwide. It's very contagious and requires a medical diagnosis. Trachoma almost always affects both eyes.

SYMPTOMS- Begin with mild itching and irritation of the eyes and eyelids. They may progress to blurred vision and eye pain.

TREATMENT- Antibiotics treat early-stage trachoma. Surgery is required in later stages. Access to clean water and improved sanitation are key to prevention.

More population-based surveys across several states of northern Nigeria later reaffirmed that trachoma of public health concern indeed exist in Nigeria. The prevalence of the disease is in the range 0.6%-17.6% for Trichiasis and 5%-49% for active trachoma across the trachoma belt of Nigeria[145], it is trachoma is the second highest cause of partial blindness or low vision[146], and Trachoma remains a major cause of blindness in Yobe state[147]

Filariasis is an infectious tropical disease caused by any one of several thread-like parasitic round worms. The two species of worms most often associated with this disease are Wuchereria bancrofti and Brugia malayi. Lymphatic Filariasis (LF) is commonly known as elephantiasis. It is a disfiguring and disabling disease, which is generally acquired in childhood. It also increases the risk of frequent bacterial infections that harden and thicken the skin (elephantiasis). The larval form of the parasite transmits the disease to humans by the bite of a mosquito.

SYMPTOMS- Rarely, long-term damage to the lymph system causes swelling in the legs, arms and genitalia, hydrocele and can cause a raft of societal stigma.

TREATMENT - Antibiotics and anti-parasitic taken yearly can kill the parasites.

Of the 36 states in Nigeria, prevalence data were available only for 19 states. Furthermore, in the six geopolitical zones, North-West had the highest disease burden (44 per 10 000) of Years Lived with Disability (YLD), while North-Central (4 per 10 000) had the lowest disease burden[148,149].

Hydatid is a tapeworm infection that affects the liver, lungs, brain and other organs. Echinococcosis is spread by contact with animal faces contaminated with tapeworm eggs. Sources include contaminated food, water and animal fur. Cysts containing tapeworm larvae may grow in the body for years before symptoms appear. Fewer than 500 cases per year (Nigeria)

SYMPTOMS- Nausea, weakness, coughing and stomach or chest pain.

TREATMENT- Anti-parasitic, Surgery, Removal of fluid from the cysts and medication.

Leishmaniasis is a disease caused by an intracellular protozoan parasite (genus Leishmania) transmitted by the bite of a female phlebotomine sand-fly. There are 3 main forms of leishmaniases – visceral (also known as kala-azar, which is and the most serious form of the disease), cutaneous (the most common and the form most often seen in Nigeria[150]), and mucocutaneous. The clinical spectrum of leishmaniasis ranges from a self-resolving cutaneous ulcer to a mutilating mucocutaneous disease and even to a lethal systemic illness. Liposomal amphotericin B is FDA-approved for treatment of visceral leishmaniasis and generally is the treatment of choice for U.S. patients.

Health inequities

- Maternal Mortality
- Female Genital Mutilation
- Vesicovaginal fistula (VVF)
- Gender-based violence (GBV)

Maternal death or maternal mortality is defined by the World Health Organization (WHO) as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. According to the World Health Organization (WHO), Nigeria had the second highest number of annual maternal deaths in the world in 2010 and contributed 14% of all maternal deaths globally Nigeria has a maternal mortality ratio of about 814 per 100,000 live births as at 2015. Between 2005 and 2015, it is estimated that there were over 600,000 maternal deaths and no less than 900,000 maternal near-miss cases[151]. The lifetime risk of a Nigerian woman dying during pregnancy, childbirth, postpartum or post-abortion is 1 in 22, in contrast to the lifetime risk in developed countries estimated at 1 in 4900. Current evidence suggests that the high rate of maternal and neonatal mortality in Nigeria is linked to the three forms of maternal delay, (1) making decision to seek maternal health care; (2) delay in locating and arriving at

a medical facility; (3) and delay in receiving skilled pregnancy care when the woman gets to the health facility[152].

According to a study published in the Lancet which covered the period from 1990 to 2013, the most common causes are:

- postpartum bleeding (15%)
- complications from unsafe abortion (15%),
- hypertensive disorders of pregnancy (10%),
- postpartum infections (8%),
- obstructed labor (6%).
- blood clots (3%)
- pre-existing conditions (28%)

Maternal mortality caused by severe bleeding and infections are mostly after childbirth. Indirect causes are malaria, anemia, HIV/AIDS, and cardiovascular disease, all of which may complicate pregnancy or be aggravated by it.

Like what we have seen repeatedly, the poor typically do not have antenatal visits, whereas the rich typically have at least four visits. These findings are consistent across all the geopolitical zones and rural and urban areas, with inequalities more prevalent in the northern zones (which also have the highest incidence of poverty in the country) and the rural areas. Significant contributors to inequalities in antenatal utilization are zone of residence, wealth, women's education (especially secondary) and employment, urban-rural residence, ethnicity, spousal education, and problems with obtaining permission to seek health care and distance to the clinic[153].

Female genital mutilation (FGM) involves the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons and having no health benefits for girls and women. FGM is mostly carried out on young girls between infancy and age 15 can cause severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths. More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated, which is a violation of the human rights of girls and women. In Nigeria, 20 per cent of women aged 15 to 49 have undergone FGM. Once are married, only 1.2 per cent of those aged 15 to 19 have their contraception needs met, leading to high levels of early and teenage pregnancy[154]. Due to its large population, Nigeria has the highest absolute number of female genital mutilation (FGM) worldwide, accounting for about one-quarter of the estimated 115–130 million circumcised women in the world. Just like other health conditions, the prevalence FGM differs by region, with the North having the lowest prevalence.

The WHO is opposed to all forms of FGM, and is opposed to health care providers performing FGM (medicalization of FGM). Treatment of health complications of FGM in 27 high prevalence countries costs 1.4 billion USD per year. The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. In many settings, health care providers perform FGM due to the belief that the procedure is safer when medicalized.

TYPES OF FGM

Female genital mutilation is classified into 4 major types.

Type 1: this is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/ clitoral hood (the fold of skin surrounding the clitoral glans).

Type 2: this is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).

Type 3: Also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and re-positioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans (Type I FGM).

Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Immediate complications can include:

- Severe pain
- Excessive bleeding (hemorrhage)
- Genital tissue swelling
- Fever
- Infections e.g., tetanus
- Urinary problems
- Wound healing problems
- Injury to surrounding genital tissue
- Shock
- Death.

Long-term complications can include: - Urinary problems (painful urination, urinary tract infections); - Vaginal problems (discharge, itching, bacterial vaginosis and other infections); - Menstrual problems (painful menstruation, difficulty in passing menstrual blood, etc.); - Scar tissue and keloid; - Sexual problems (pain during intercourse, decreased satisfaction, etc.); - Increased risk of childbirth complications (difficult delivery, excessive bleeding, cesarean section, need to resuscitate the baby, etc.) and newborn deaths; - Need for later surgeries: for example, the sealing or narrowing of the vaginal opening (Type 3) may lead to the practice of cutting open the sealed vagina later to allow for sexual intercourse and childbirth (de-infibulation). Sometimes genital tissue is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term risks; - Psychological problems (depression, anxiety, post-traumatic stress disorder, low self-esteem, etc.).

Vesicovaginal fistula (VVF) represents a significant morbidity in female urology, is still a major cause for concern in many developing countries. Continual wetness, odor, and discomfort cause serious social problems. The diagnosis of the condition has traditionally been based on clinical methods and dye testing. A successful repair of such fistulas requires an accurate diagnostic evaluation and timely repair using procedures that exploit basic surgical principles and the application of interposition flaps. The method of closure depends on the surgeon’s training and experience. The main complication of VVF surgery is recurrent fistula formation.

VVFs can be classified in various ways:

- Simple fistulas are usually small in size (≤0.5cm) and are present as single non-radiated fistulas.
- Complex fistulas include previously failed fistula repairs or large-sized (≥2.5 cm) fistulas, more often a result of chronic diseases or radiotherapy. Most authors consider intermediate-sized fistulas (between 0.5 and 2.5 cm) as complex ones.

Vaginal fistula doesn't usually hurt, but it can cause some problems that need medical care. If you have a vesicovaginal fistula (an opening between your vagina and bladder), urine will constantly leak from your bladder into your vagina. This can make you unable to control your urination (incontinent). Also, your genital area may get infected or sore, and you can have pain during intercourse.

Gender-based violence (GBV) is violence that is directed at an individual based on his or her biological sex OR gender identity. It includes physical, sexual, verbal, emotional, and psychological abuse, threats, coercion, and economic or educational deprivation, whether occurring in public or private life. Adolescent girls face elevated risks of gender-based violence in humanitarian settings because of the intersectionality of age and gender, and the additional and exacerbated risk factors relevant to emergencies. Because there is no clear division of labor between the gender-based violence and child protection sectors, adolescent girls are often neglected by both groups, and violence against this sub-population goes unaddressed. Gender-based domestic violence, often targeted against women and girl children, is a global problem that has, in recent times, assumed an alarming proportion and dimension. The consequences of domestic violence are legion—it takes a devastating toll on women, families and nations, and furthermore, recent researches have shown increasing links between domestic violence and the high vulnerability of women to HIV/AIDS.

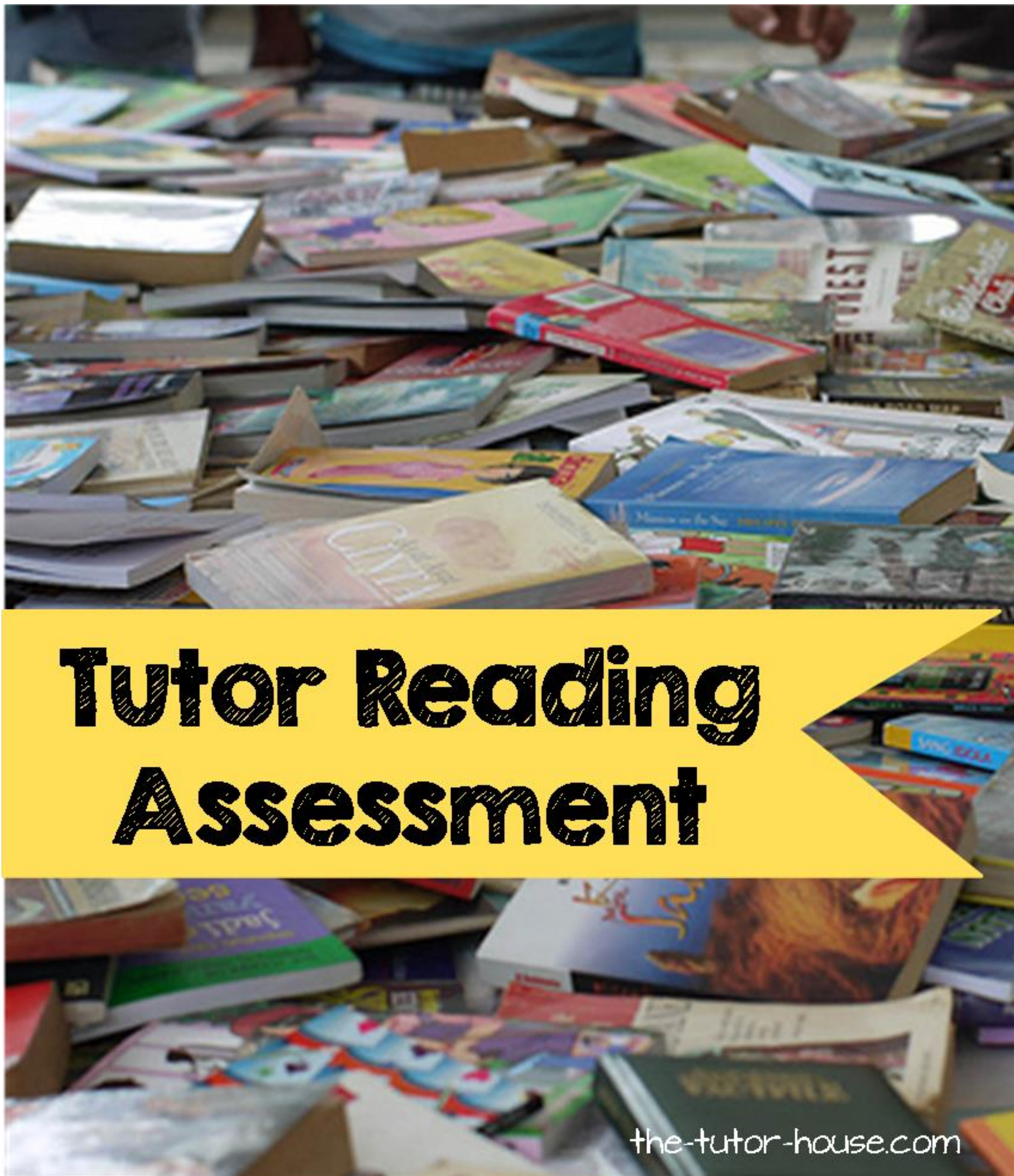
Globally, it is estimated that one in three women experience either physical or sexual intimate partner violence or non-partner sexual violence in their lifetime. These figures are mirrored in Nigeria, with 30 per cent of girls and women aged between 15 and 49 reported to have experienced sexual abuse. Insurgency and protracted conflict have only served to exacerbate the occurrence of GBV in the North East. Harmful practices such as child marriage are prevalent, with 43% of girls married before the age of 18[154].

Conclusion

This unit explored the symptoms and treatments of neglected tropical diseases as well as some of the health inequities that particularly impact women and girls in Nigeria.

Summary

Tutor Marked Assignment



References and Further Readings

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1. Alemu Belachew W, Naafs B. Position statement: LEPROSY: Diagnosis, treatment and follow-up. Journal of the European Academy of Dermatology and Venereology. 2019;33(7):1205-1213. doi:10.1111/jdv.15569

2. Alzaylaee H, Collins RA, Rinaldi G, et al. Schistosoma species detection by environmental DNA assays in African freshwaters. Greenberg RM, ed. PLOS Neglected Tropical Diseases. 2020;14(3):e0008129. doi:10.1371/journal.pntd.0008129

3. Amene P, Jacob A, Swarup A. Hydatid lung disease in a Nigerian female. 1984;7:173-175. https://scholar.google.com/scholar{_}lookup?journal=Niger+Med+Pract{\&}title=Hydatid+lung

+disease+in+a+Nigerian+female{\&}author=P+Amene{\&}author=A+Jacob{\&}author=A+Swarup{\&}volume=7{\&}publication{_}year=1984{\&}pages=173-175{\&}.

4. Chika IS. Gender-Based Domestic Violence in Nigeria. Indian Journal of Gender Studies. 2012;19(1):137-148. doi:10.1177/097152151101900107

5. Dada BJ. Taeniasis, cysticercosis and echinococcosis/hydatidosis in Nigeria: I—prevalence of human taeniasis, cysticercosis and hydatidosis based on a retrospective analysis of hospital records. Journal of Helminthology. 1980;54(4):281-286. doi:10.1017/S0022149X00006775

6. Dawaki S, Al-Mekhlafi HM, Ithoi I, et al. Prevalence and risk factors of schistosomiasis among Hausa communities in Kano state, Nigeria. Revista do Instituto de Medicina Tropical de Sao Paulo. 2016;58(1). doi:10.1590/S1678-9946201658054

7. Fasina O, Ogun OG. Hydatid cyst of the orbit in a young Nigerian female: a case report. Ghana medical journal. 2017;51(4):204-206. doi:10.4314/gmj.v51i4.11

8. Hussaini A, Isaac C, Rahimat H, Inegbenosun C, Obasuyi C, Solomon E. The Burden of Bancroftian Filariasis in Nigeria: A Review. 2020;30:301-310. doi:10.4314/ejhs.v30i2.18

9. Igbe M, Duhlinska D, Agwale S. Epidemiological Survey of Cutaneous Leishmaniasis in Jos East L.G.A. Of Plateau State Nigeria. 2008;4. https://ispub.com/IJPD/4/1/11715.

10. Mpyet C, Ogoshi C, Goyol M. Prevalence of trachoma in Yobe state, North-Eastern Nigeria. Ophthalmic Epidemiology. 2008;15(5):303-307. doi:10.1080/09286580802237633

11. Nair M, Nelson-Piercy C, Knight M. Indirect maternal deaths: UK and global perspectives. Obstetric Medicine. 2017;10(1):10-15. doi:10.1177/1753495X16689444

12. Nigeria Centre for Disease Control. Leprosy. January 2017. https://ncdc.gov.ng/diseases/factsheet/33. Accessed March 27, 2021.

13. Nwosu CO, Ataguba JE. Socioeconomic inequalities in maternal health service utilisation: A case of antenatal care in Nigeria using a decomposition approach. BMC Public Health. 2019;19(1):1493. doi:10.1186/s12889-019-7840-8

14. Odjimogho E, Odjimogho S. Trachomaas one of the leading cause of low vision In Kano State. Journal of the Nigerian Optometric Association. 2011;10(1). doi:10.4314/jnoa.v10i1.64435

15. Ohiolei JA, Yan HB, Li L, et al. Review of Cystic Echinococcosis in Nigeria: A Story of Neglect. 2020;65:1. doi:10.2478/s11686-019-00124-x

16. Okeke T, Anyaehie U, Ezenyeaku C. An overview of female genital mutilation in Nigeria. Annals of Medical and Health Sciences Research. 2012;2(1):70. doi:10.4103/2141-9248.96942

17. Okorie PN, Davies E, Ogunmola OO, et al. Lymphatic filariasis baseline survey in two sentinel sites of Ogun state, Nigeria. Pan African Medical Journal. 2015;20(397). doi:10.11604/pamj.2015.20.397.5686

18. Okwori E, Nock IH, Galadima M, Ibrahim S. PREVALENCE OF CUTANEOUS LEISHMANIASIS IN PARTS OF KADUNA STATE, NIGERIA. Vol 11.; 2001:2-4.

19. Ope BW. Reducing maternal mortality in Nigeria: addressing maternal health services' perception and experience. Journal of Global Health Reports. May 2020. doi:10.29392/001c.12733

20. Oyeyemi OT, de Jesus Jeremias W, Grenfell RFQ. Schistosomiasis in Nigeria: Gleaning from the past to improve current efforts towards control. 2020;11:100183. doi:10.1016/j.onehlt.2020.100183

21. Ozoilo KN, Iya D, Kidmas AT, Uwumarogie O, Hassan S. Anterior abdominal wall hydatid cyst; an unusual presentation. Nigerian journal of medicine : journal of the National Association of Resident Doctors of Nigeria. 2007;16(2):181-182. doi:10.4314/njm.v16i2.37261

22. Rabiu M, Muhammed N, Isiyaku S. Challenges of trachoma control: An assessment of the situation in Northern Nigeria. Middle East African Journal of Ophthalmology. 2011;18(2):115-121. doi:10.4103/0974-9233.80699

23. Sixl W, Rosegger H, Schneeweis H, Withalm H, Schuhmann G. Serological investigations in Nigeria for anthropozoonoses in human sera: brucellosis, echinococcosis, toxoplasmosis, chlamydial diseases, listeriosis, rickettsiosis (Coxiella burneti and Rickettsia conori). 1987. https://pubmed.ncbi.nlm.nih.gov/3443751/. Accessed March 27, 2021.

24. Stark L, Seff I, Reis C. Gender-based violence against adolescent girls in humanitarian settings: a review of the evidence. 2020;5. doi:10.1016/S2352-4642(20)30245-5

25. Udo S, Chukwu J, Obasanya J. Leprosy situation in Nigeria. Leprosy review. 2013;84(3):229-237. doi:10.47276/lr.84.3.229

26. UN Women, UNFPA, UNICEF, UN Sytem in Nigeria. GENDER-BASED VIOLENCE IN NIGERIA DURING THE COVID-19 CRISIS: THE SHADOW PANDEMIC.; 2020. https://www.unwomen.org/en/news/.

27. World Health Organization. Health statistics and information systems: Maternal mortality ratio (per 100 000 live births.

28. World Health Organization. WHO | Maternal health in Nigeria: generating information for action. WHO. 2019. http://www.who.int/reproductivehealth/maternal-health-nigeria/en/.

Unit 3: Cost analysis

Introduction

This study unit focuses on the cost of healthcare in Nigeria- both financial and human. It covers costs, examines a cost-benefit analysis, and looks at how efficient the system is and potential opportunities for improvement.

Objectives

- Discuss Cost of Health care delivery in Nigeria
- Explain cost analysis, cost-benefit analysis, effectiveness and efficiency

Main Content

- Cost of Healthcare Delivery in Nigeria
- Cost-Benefit Analysis
- Cost Effectiveness
- Cost Efficiency

Cost of Healthcare Delivery in Nigeria

- Social
- Private
- Role of the Private sector

Federal Government of Nigeria aims to improve health care financing. Improved healthcare financing will achieve a reduction in the healthcare cost accrued by individuals. Health financing mechanisms used in Nigeria are mainly user fees and social health insurance schemes. The schemes benefit mainly people in the formal sector (civil servants and those in organized private sector), with a vast majority of the people in the informal sector (farmers, traders, other self-employed and the unemployed) left out. Also, development partners like the WHO, UNICEF and USAID played active role in health financing in Nigeria. There are two types of healthcare spending that dominates the healthcare financing in Nigeria, Social health Insurance and Private Health Insurance.

Social Health Insurance: Social health insurance scheme is a mandatory insurance services through which everyone in a given group has to enroll and pay the specified premium. Once enrolled and paid, some special benefits becomes an entitlement of the bearer. Premiums and benefit are determined by law or regulation and are therefore not easily adjustable and hard to change. It is based on implicit agreement between those insured and the system. Citizens agree to pay a certain amount with the expectation that the funds will be used fairly and effectively to fund healthcare of those in the system. Social health insurance scheme make exclusive fund designated for it use. The advantage of a social health insurance scheme over other form taxes is the funds collected earmarked for the health system and cannot be usurped by other sectors in the budgeting process. It also allows

you to put a price tag on the demands for health services by the voters – they see direct correlation between their demands and the amount of the social insurance premium they have to pay.

Social insurance schemes do not necessarily cover everyone. They are usually confined to workers in the formal sector where insurance premium can be collected through payroll reductions. People that fall outside of this sector (the unemployed, retired workers in the informal sector, small businesses and farmers) must be covered either by general taxes or some other form of private insurance or out-of-pocket contributions. Social insurance has its drawback. Among the drawback of social health insurance is that it increases the cost of labor as employers have to contribute a significant share of the insurance as a percentage of their payroll. Employers can either shift this burden backward to workers by lowering their wages or shift it forward in the form of higher prices if there are strong labor market to prevent shifting of the burden to the employees

Private Health Insurance: In a private insurance scheme, buyers voluntarily purchase insurance coverage from private, independent, competitive for profit or not-for-profit insurance companies. The insurance companies charge premiums that reflect the buyer's risks rather than their ability to pay. Buyers can be individuals or groups of individuals. Group of individuals are usually based in their place of employment. One of the differences between a social insurance system and private insurance is that due to the competition between private insurance companies the benefits packages and premiums will be much more differentiated depending on the demand for such packages

The contribution of the private sector to the Nigerian healthcare industry is increasing. With rising levels of disposable income among some segments of society and the limited supply of public hospitals that are overstretched and under-funded, there is greater demand for private coverage[49]. According to a report by Fitch Solutions, healthcare expenditure in Nigeria is predicted to reach NGN 5,762.061 billion by 2021 growing at a rate of 8.35% per year. This is up from an estimated NGN 5,318.061 billion in 2020. By 2021, healthcare spending is estimated to make up 2.94% of the country's GDP. While the government is expected to spend NGN 1,477.77 billion by 2021, the private sector will spend NGN 4,284.469 billion in the same period. This is up from NGN 1,190.71 billion and NGN 3,709.120 billion respectively in 2019 [@ MedicWest2019]. However, despite this increase in healthcare spending, this percentage (2.94%) is still short of the goals that the federal government set of 15%.

Cost-Benefit Analysis

- Marginal Cost Analysis
- Direct costs
- Indirect costs

Economist define marginal cost of an output to be the additional cost incurred in producing the last (or next) unit of that output. The value of the extra benefit that individuals and societies derive from the last unit of any output consumed is just equal to the opportunity cost of the resources (i.e. value in the next best use) used by producers to create that unit of out-put. Allocation efficiency is taken into consideration, personnel, space, supplies and equipment with more benefit. The concept of marginal cost is intuitively simple. The concept adopt an identical rules to that used by individuals in their daily money and time allocation. People often make judgment on the extra benefit of doing something such as buying of new stuff, or doing something is worthy of the extra cost or not.

Marginal cost is also considered at the societal level. It is equally true when pursuing healthcare activities in the societies, because each activity is produced only, when the extra benefit of production equal the extra cost. It is therefore satisfactory, when each good or service produced, the marginal cost equal the marginal benefit, while a stable allocation of resources is reached through a system

price. Cost analysis denotes the measurement of cost in monetary terms. The measured cost in money terms are compared to the consequences in the physical unit of effectiveness. For instance, treatment of certain cases like malaria is evaluated base on the prevention cost per case, compared the cost of the cured case and/or the cost of the malaria death averted. Cost analysis bring forth measures of what is actually valued, through value weighing that address questions of allocative efficiency.

The costs of healthcare can be divided into two broad categories: direct health care costs and indirect health care costs. Direct health care costs refer to the physical health resources required to produce a specific service. Indirect care costs are those outside the health care sector, for example, time costs, such as production loss, lost leisure time, travel costs, and costs associated with child care.

Direct health care costs are calculated in three steps. First, the health resources are identified by estimating the different categories to be included in the analysis. These can be staff, consumables, equipment, installation, re-admissions, emergencies, and overhead. Second, these different resource categories are measured using appropriate physical units, for example, type of staff, the amount of time spent on different activities, type of equipment, and number of re-admissions and emergencies. Third, the resources are valued using appropriate unit costs. These can be based on hospital staff salaries, marked prices, or price weights based on national tariffs or charges.

The most commonly used method for measuring and valuing health care costs is to use the resource costing method. This method involves collecting health resource use data from patient charts, hospital records, or from case report forms in trials or observational studies and then multiplying service use by price weights. There is no standard method for selecting appropriate resource use and price weights. One way is to break every cost item down into its underlying components, such as laboratory tests, provider time, and drug doses (i.e., micro-costing). Another more common method is to identify and count health care encounters, different types of service use, or bundles of service use, such as bed days, hospital stays, outpatient consultations, and general practitioner (GP) visits (i.e, gross-costing). The decision as to which bundle of resource units to include in the analysis will depend on the ease of data collection and the availability of price weights. The resource units used must also be able to identify a true cost difference if it exists. Many evaluations use a combination of the two costing methods.

Non-health Care Costs- A societal perspective considers all costs, regardless of who incurs them. Non-health care costs are, for example, costs to social services, patients, family, and friends as informal care costs. Costs to employers as loss of production due to absence from work are also non-health care costs. These costs can be measured in clinical trials or observational studies. Private costs can include travel costs, out-of-pocket fees, and time costs. Time costs refer to the time patients spend seeking and receiving care and the time family members spend caring for a relative. Time off work is measured as a productivity loss. Production costs are typically valued using gross wage rates. The friction cost method can also be used. Here, the basic idea is that the amount of production loss depends on the time it takes to restore the production level to where it would have been without the worker's absence. The time costs most relevant for e Health interventions are the patients' healthy time lost due to morbidity, assuming e Health services improve health outcomes, and the time patients take off work to receive health care. There is no consensus on whether productivity costs should be included in cost-effectiveness analyses. Nor is there any consensus on how time costs should be valued if they are included[61].

Cost Effectiveness

Cost-Benefit analysis is an approach to assessing efficiency and consequences. The consequences are measured and valued in monetary unit, commonly by asking relevant individuals how much the can afford to pay to obtain the consequences. The approach is applied using 'Contingent Valuation', through which the analyst predict how many years could be expected and what would their health status be, and how much can they afford to pay to enjoy those health benefit.

Cost-benefit analysis is the only technique that can on its own, fully address the allocative efficiency question and it does so on the basis of the criterion of a potential improvement. However, a recent analysis of the potential cost benefit analysis highlights many approaches to reaching the goals. The analyses suggest multiple approaches needed to eliminate consequences in health. Since the relevant sectors operate somewhat independently, there may be less direct competition for priorities than occurs within domains, and it makes sense to push on as many fronts as possible. What is needed is a broad-gauged approach to the multiple determinants of cost disparities in health if we are to eliminate, or even greatly reduce, these disparities.

Data on costs and consequences can broadly be collected in two ways: alongside trials and observational studies, and from the existing literature. New economic data can be collected alongside randomized controlled trials (RCTs), non randomized interventions, and observational studies. General issues in economic evaluations are common to all of these methods. The RCT is often used as the gold standard for assessing the effectiveness of health interventions, but it is not always practical in e Health research settings. Furthermore, strictly controlled trials are not well-suited for economic evaluations. Data collected alongside RCTs will provide reliable information on the particular intervention studied, but not regarding the intervention costs and how well it works for normal caseloads in usual practice. The trial context is usually very different from real-world settings, and conditions that will improve internal validity in randomized controlled trials will undermine the economic evaluation. One way to improve the usefulness of the economic evaluation is to modify the study protocol so it better reflects usual care. A naturalistic or pragmatic study design will increase the generalizability to other patients not included in the trial. A naturalistic study design is considered the gold standard for economic evaluation in health care[61].

Benefits refer to the effects that alternative interventions have on people's health. These non-resource benefits are often measured as health changes and can range from bio-medical markers, to event-free time, or to more final health outcomes. Outcome measures included can, for example, be blood pressure and glucose levels, cases of illness avoided, symptom-free days, successful treatments, lives saved, and life years gained. These measurements describe symptom relief and disease progression. However, the outcomes in economic evaluations should include the value patients place on the symptoms and the particular health state. The parallel is with service use on the cost side of the equation, where resource use, such as bed days and outpatient consultations, are not only counted, but also valued by measuring their costs. One outcome measure that puts value on the health outcome is the QALY. The QALY includes quantity and quality of life and incorporates the valuation patients place on each health state. The QALY is the preferred outcome measure for many economists and reimbursement agencies . The use of QALYs in telehealth studies has recently been reviewed and can be found in Bergmo.

Health outcomes are typically measured in clinical trials using case report forms, patient records, or patient-reported questionnaires at different time points during the trial. To estimate QALYs, the patients complete a generic health-related, quality-of-life (QoL) questionnaire with pre-existing preference weights (values). One of the most commonly used descriptive systems is the EuroQol-5D

(EQ-5D). The EQ-5D is a recognized tool for describing different health states and is recommended in economic evaluation guidelines. Another system is the Short-Form Health Survey-6D (SF-6D), which can be extracted from the 36-item Short-Form Health Survey (SF-36) and the 12-item Short-Form Health Survey (SF-12). These quality weights are then combined with the longevity of the improvement. This involves multiplying the quality weights for the health states developed from the questionnaires with the duration of each health state experienced by the patients. For example, 1 year in full health is one QALY; 4 years in a 0.5 quality state is two QALYs. Details on the measurement and valuation of health outcomes are fully described elsewhere[61].

Cost Efficiency

- cost analysis,
- cost-utility analysis (CUA),
- cost-benefit analysis (CBA), and
- cost-effectiveness analysis (CEA).

Economic evaluation involves the costs and consequences—that is, the inputs and outputs—of activities, and suggests choices based on a set of criteria. Cost effectiveness analysis are the cost measured in money terms. The cost are measured in comparison to the consequences in the physical units of a program. Cost effectiveness measures the consequences in natural or physical unit, to be used to compare alternatives that produce same type of consequences. It makes use of a common currency for measuring the consequences Efficiency is the most common criterion used in the conduct of analysis. The primary criterion that economics uses to organize and conduct these analysis is efficiency, which is used most commonly, is get most out of scarce resources.

There are four main types of studies involving economic evaluation: cost analysis, cost-utility analysis (CUA), cost-benefit analysis (CBA), and cost-effectiveness analysis (CEA). Each is a way of comparing the benefits of a health care intervention or program with its costs, but each differs in the way that the consequences (i.e., outcomes) of the intervention are measured and valued. Briefly, cost analysis deals only with costs in monetary units and does not include an analysis of consequences. CUA and CBA both can involve single or multiple effects, but they differ in how these effects are valued. CUA uses health state preference scores (also known as utility scores), such as healthy years, typically measured in quality-adjusted life years (QALYs; stay tuned for more on these) to value the consequences of an intervention. By contrast, CBA uses a monetary value to weigh outcomes.

In general terms, the utility in CUA refers to patient preferences for a particular set of health outcomes or state of health: for example, how many years of life one would be willing to give up for a year of perfect eye health. CEA differs from these other types of analysis in that it looks at only one consequence of an intervention—a single effect or outcome that is common to both alternatives in question—and assesses how that effect is achieved to differing degrees by the alternatives.

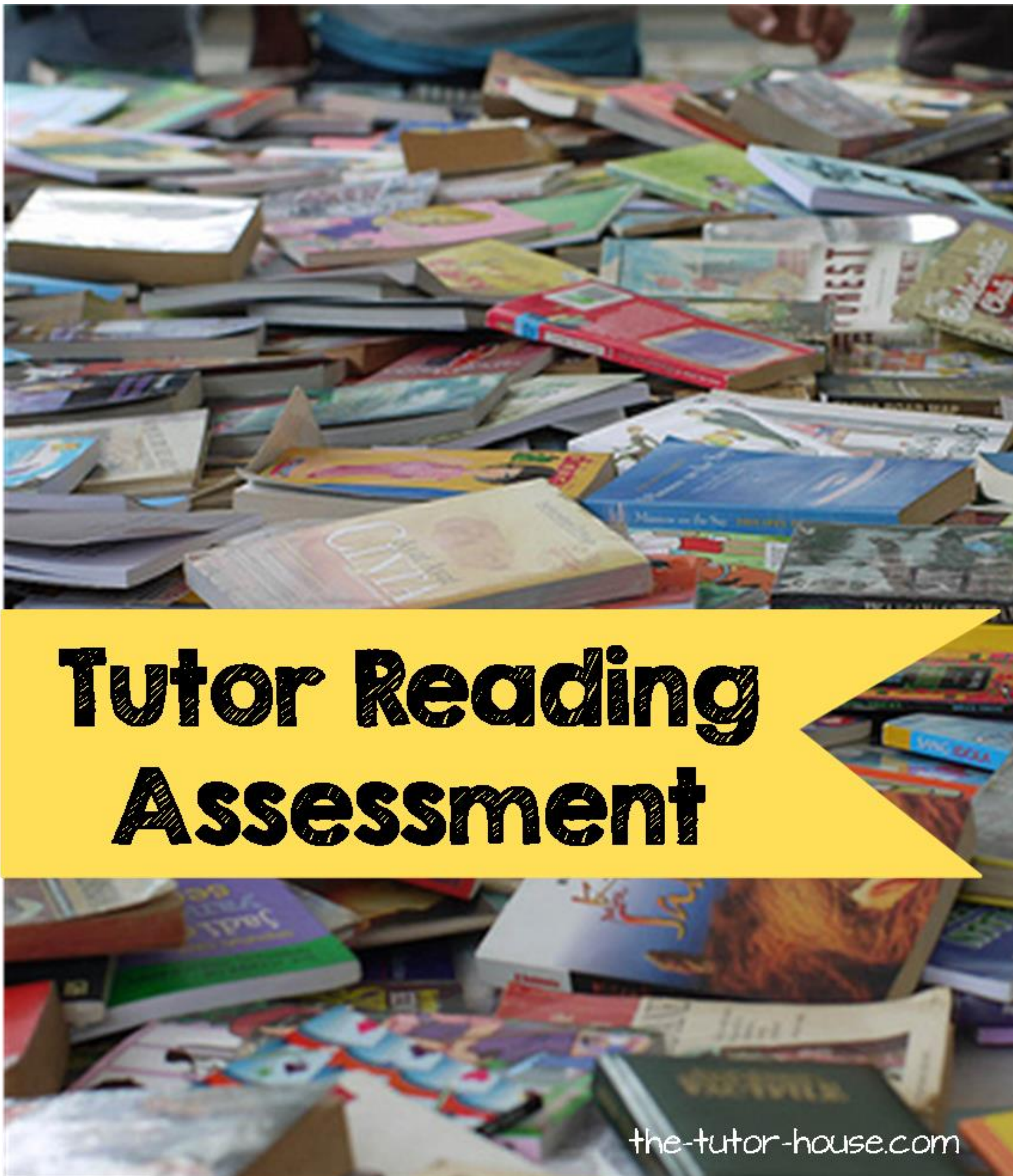
CEA involves what is considered a "natural" effect of an intervention, such as the number of years of life gained, proper diagnoses made, or disability days saved. Examples of other effectiveness measures commonly seen in the literature include millimeters of mercury (mm Hg) of blood pressure reduction, percentage of serum cholesterol change, and number of episode-free days. In CEA, no attempt is made to value the outcome; it is assumed that the outcome of interest is desirable. In summary, all these types of evaluations share similarities in identifying costs and subsequent money-related outcomes; they differ in the nature of outcomes and consequences being examined. CEA looks specifically at an intervention and tells how much health benefit we can get for the money[65].

Conclusion

This unit explored the types of financing social insurance versus private health insurance and the general costs associated with both.

Summary

Tutor Marked Assignment



References and Further Readings

169–171

1. Babigumira JB. Types of Economic Evaluation in Healthcare.

2. CDC. Cost-Benefit Analysis | POLARIS | ADP-Policy | CDC. March 2021. https://www.cdc.gov/policy/polaris/economics/cost-benefit/index.html?CDC{_}AA{_}refVal=https{\%}3A{\%}2F{\%}2Fwww.cdc.gov{\%}2Fpolicy{\%}2Fpolaris{\%}2Feconomics{\%}2Fcost-benefit-analysis.html. Accessed March 26, 2021.

3. Ghimire P. Cost Benefit Analysis in Health Care. August 2018. https://www.slideshare.net/PrabeshGhimire/cost-benefit-analysis-in-health-care. Accessed March 26, 2021.

Unit 4: The Role of Healthcare in Human and Capital Development

Introduction

This study unit focuses on the relationship between health and productivity; health savings, and opportunities for improvement of the system. This unit ties up everything covered over the four modules.

Objectives

At the end of this unit, you should be able to:

- Discuss opportunities for improvement
- Understand the relationship between health and productivity
- Explain health and savings

Main Content

Health and productivity

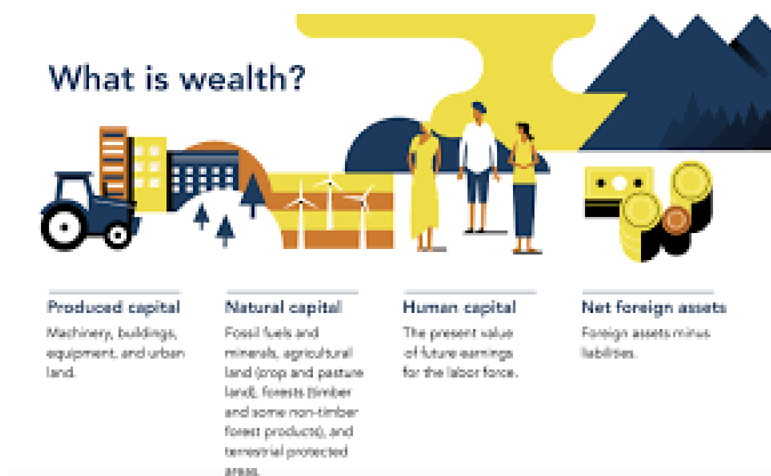
Health and Work:

- Improve employee health,
- Increase employee morale, and
- Attenuate the costs

The primary reasons U.S. employers provide health promotion and disease-prevention programs is not because they are alturistic. The real reason is because investing in prevention at the office can improve employee health, increase employee morale, and attenuate the rising costs of medical care. A

relationship between health risks and medical care costs has been firmly established and has demonstrated a positive return on investment in health promotion programs[172]. This is great for the states, but what does that mean for development? So given the potential partners in the private sector and the need for more health spending, there is an opportunity to invest more in health promotion activities. However, considering that many of the health issues that faces, for example Nigeria are not only behavioral, but also systemic- the programs and investments would need to be coordinated.

Health, savings and investments



As we have seen over the course of this course, there is a relationship between health and income. Where the more income someone has, the more access they have to quality healthcare. Likewise there is a relationship between health and wealth[173]. Unhealthy behavior can be expensive in both the short and long term. If we give an example from the states- if you eliminate a $10 a day smoking or junk food habit, you can save $3,650 a year. In Nigeria if someone goes out for a drink everyday and has 3 drinks at 2,000 Naira, that's 6,000 NGN a day, 2,190,000 NGN a year… and that's just the immediate savings. There are also savings over the long term for the rest of someone's life- in terms of liver damage, car accidents, and opportunity costs, just to name a few.

Financial problems can affect a person's health status and someone's health status can create financial problems. Stress from lack of funds or not being able to afford to go to see a doctor can exacerbate medical problems or can cause a physical manifestation of stress (e.g., migraines, insomnia, and anxiety) and/or delayed or inadequate treatment. Financial distress makes it difficult to afford and engage in recommended health maintenance practices, (i.e. routine check-ups, eating healthy, engaging in regular exercise, maintaining good sleep hygiene).

People in poor health often die at a relatively young age and their potential contribution the the world is lost. Below are specific relationships between health status, behaviors, and personal finances:

- A typical non-smoker's net worth has been found to be about 50% higher than that of light smokers and about twice the level of heavy smokers.
- Studies have found that physical appearance affects a person's earning ability.
- Higher health costs, in general, affect those with health "issues" (e.g., hypertension and diabetes) the most, due to the ongoing cost of prescription drugs, deductibles, co-payments, and other expenses.
- Healthy lifestyle choices, such as proper diet and exercise, increase the odds of living a long and healthy life. People who live longer have more time to grow their savings through the awesome power of compound interest. If someone continues to grow their money between, say, ages 75

and 90, instead of dying in their mid 70s, their survivors and heirs will be in a much better financial position.
- Financial security and health are strongly related to personal happiness and to one another.

The ancient philosopher, Virgil said, "The greatest wealth is health." In other words, health is as much of an "investment" as stock or bonds. However, it is important to realize that in development especially in countries with low access to healthcare, it is important to work with what is available to help provide the highest possible quality of life.

Opportunities for improvement

- Increase the number of medical staff
- Enforce action against medical negligence
- Addressing the Battle for Supremacy among Health Workers
- Adequate funding

While it may seem overwhelming to examine all the challenges that are facing Nigeria and many other developing countries- this can be re-framed as opportunities for improvement.

In order to address the need for more staff in the primary, secondary, and tertiary health systems[103,106]:

- increased recruitment of hospitals staff.
- increased training and when necessary retraining the human resources on the ground for health technological to update knowledge. While there is a lot of training that occurs, that information is not always passed down to others within the facility. Thus we need to train the trainers, build institutional memory, and institutional capacity.
- pay medical professionals better. This is essential to help stem the brain drain or rather the brain hemorrhage that is occurring and begin to reverse that flow.
- increase the transparency of how health care dollars are allocated.
- the owners and managers of the hospitals must not wait until doctors, pharmacists, nurses, image scientists, laboratory technologists and hospital administrations go on industrial strikes before their grievances are addressed. Address the grievances sooner rather later.
- address the current and potential tensions between health professional and the inferiority and superiority complex that often springs up.

- Government should expand hospitals, medical centers and health clinics in order to have the capacity to absorb the newly trained and inducted doctors, pharmacists etc. It is waste of fund, time and human resources when health professionals trained by Nigeria are utilized by other countries, especially due to our systems lacking the capacity to absorb them.

While we want to make sure that systems are in place to protect and support medical professional, laws also need to be enforced to protect the right to health of patients. Cases of medical negligence and other professional misconduct are rarely taken to the courts and victims rarely get justice.

The medical system is not only made of physicians, nor is it physicians plus others. An effective healthcare system has a variety of different healthcare professional working both inside and outside of the hospital to improve the health of all people. These groups each have a role to play and inter-professional bickering and struggle for supremacy does not help patient, the system, or the individuals fighting. Innovative ways to address these issues cannot come from the government, but rather come from the institutions and the professional bodies.

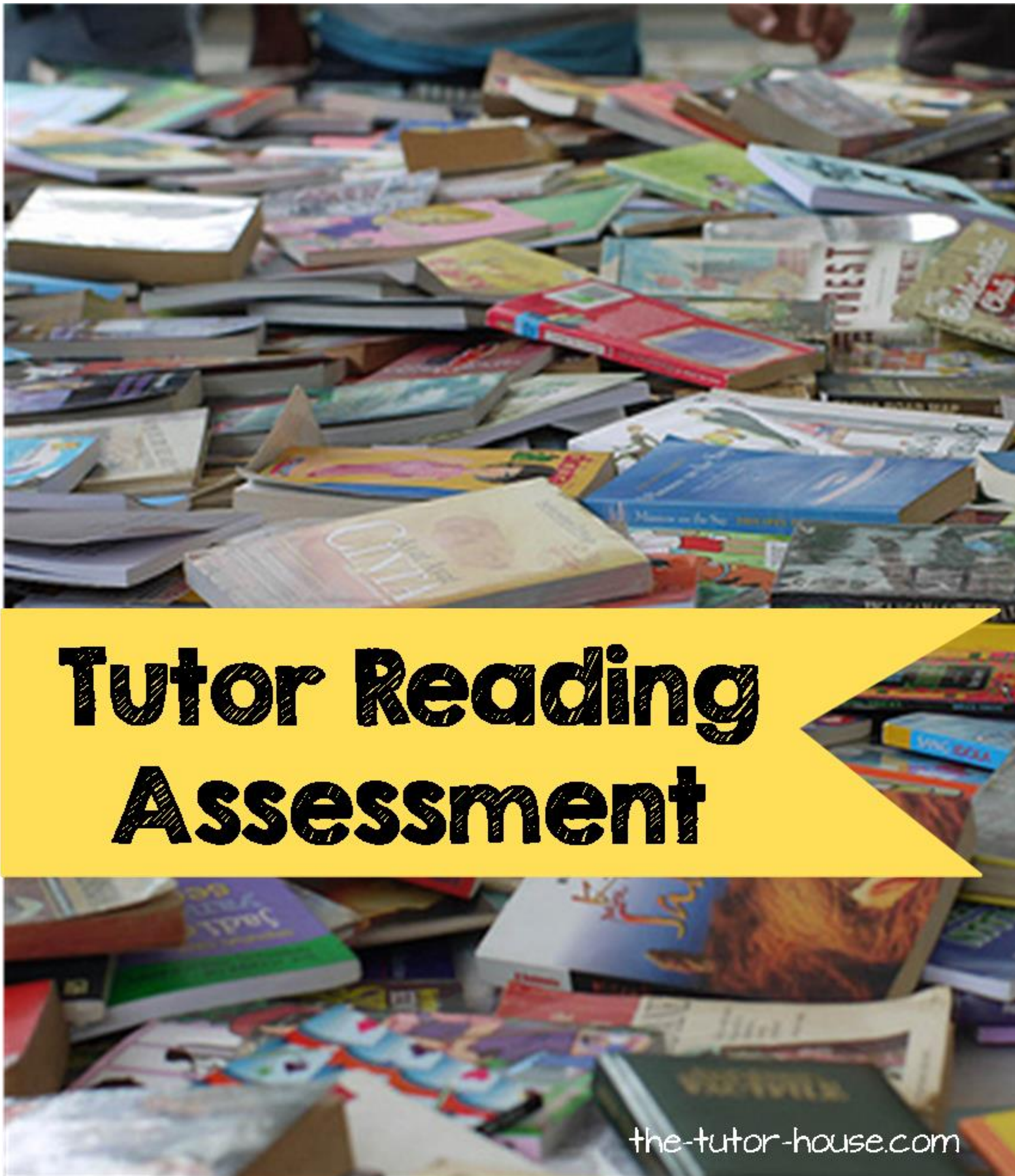
Adequate Funding of the System This topic has been covered exhaustively within this course.

Conclusion

Summary

Tutor Marked Assignment

While the relationship between health and productivity has been well estimated in developed countries, it follows that it would also be the case in developing countries, though the way that the relationship would operate may be different. Write a research paper exploring the relationship between health and productivity in Nigeria using everything you have learned thus far.



References and Further Readings

103,106,172–175

1. Abubakar M, Basiru S, Oluyemi J, et al. Medical tourism in Nigeria: Challenges and remedies to health care system development. International Journal of Development and Management Review. 2018;13(1). https://www.ajol.info/index.php/ijdmr/article/view/172290.

2. Boles M, Pelletier B, Lynch W. The relationship between health risks and work productivity. Journal of Occupational and Environmental Medicine. 2004;46(7):737-745. doi:10.1097/01.jom.0000131830.45744.97

3. Hafner M, Van Stolk C, Saunders C, Krapels J, Baruch B. Health, well being and productivity in the workplace: A Britain's Healthiest Company summary report.; 2015. www.randeurope.org.

4. Omoleke I, Taleat B. Contemporary issues and challenges of health sector in Nigeria. Research Journal of Health Sciences. 2018;5(4):210. doi:10.4314/rejhs.v5i4.5

5. Rolle Remi Ahuru, Osaze Daniel, Henry Akpojubaro Efegbere. What Role Does Health Play in Enhancing Labour Productivity in Nigeria? Academic Journal of Economic Studies. 2020;6(2):102-111. https://www.researchgate.net/publication/342349589{_}What{_}Role{_}Does{_}Health{_}Play{_}in{_}Enhancing{_}Labour{_}Productivity{_}in{_}Nigeria.

6. Rutgers. The Financial Impact of Improved Health Behaviors (Rutgers NJAES). https://njaes.rutgers.edu/health-finance/health-behaviors.php. Accessed March 26, 2021.

Works Cited

1. Bolaji Aregbeshola. Health care in Nigeria: Challenges and recommendations | socialprotection.org. 2019. https://socialprotection.org/discover/blog/health-care-nigeria-challenges-and-recommendations. Accessed March 4, 2021.

2. Frakt AB. How the economy affects health. 2018;319:1187-1188. doi:10.1001/jama.2018.1739

3. WHO. Human rights and health. https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health. Accessed March 4, 2021.

4. Lange S, Vollmer S. The effect of economic development on population health: A review of the empirical evidence. 2017;121:47-60. doi:10.1093/bmb/ldw052

5. OHCHR. OHCHR and the right to health. https://www.ohchr.org/EN/Issues/ESCR/Pages/Health.aspx. Accessed March 4, 2021.

6. OHCHR. Special Rapporteur on the right to physical and mental health. https://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx. Accessed March 4, 2021.

7. Onyedinefu G. Ratio of Nigerian doctors to population is 1: 2753 - FG - Businessday NG. March 2020. https://businessday.ng/uncategorized/article/ratio-of-nigerian-doctors-to-population-is-1-2753-fg/. Accessed March 4, 2021.

8. Paul Hunt. Human Rights and Health (Introduction). In: 2004:1.

9. Saudi Arabian royal family used to visit Nigeria for treatment – Health minister – Punch Newspapers. https://punchng.com/saudi-arabian-royal-family-used-to-come-to-nigeria-for-treatment-health-minister/. Accessed March 4, 2021.

10. Thoa NTM, Thanh NX, Chuc NTK, Lindholm L. The impact of economic growth on health care utilization: A longitudinal study in rural Vietnam. *International Journal for Equity in Health*. 2013;12(1):19. doi:10.1186/1475-9276-12-19

11. *The Right to Health*.

12. Welcome MO. The Nigerian health care system: Need for integrating adequate medical intelligence and surveillance systems. In: *Journal of Pharmacy and Bioallied Sciences*. Vol 3. Wolters Kluwer – Medknow Publications; 2011:470-478. doi:10.4103/0975-7406.90100

13. Right to Health – WMA – The World Medical Association. https://www.wma.net/what-we-do/human-rights/right-to-health/. Accessed March 4, 2021.

14. *From a crisis response to institutional capacity building: Experiences from Zimbabwe on cholera outbreak*.

15. *Integrating social determinants of health in all public policies: The case of health development in Botswana*.

16. *Rio Political Declaration on Social Determinants of Health*.; 2011.

17. World Health Organization. *Closing the gap in a generation: health equity through action on the social determinants of health - Final report of the commission on social determinants of health*.; 2008. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1.

18. (US) NRC, (US) I of M, Woolf SH, Aron L. Physical and Social Environmental Factors. 2013. https://www.ncbi.nlm.nih.gov/books/NBK154491/.

19. Berridge V, Loughlin K, Herring R. *HISTORICAL DIMENSIONS OF GLOBAL HEALTH GOVERNANCE*.; 2009.

20. Brinkerhoff DW, Fort C, Stratton S, Governance G, Progress A, Rwanda I. *Good Governance and Health: Assessing Progress in Rwanda TWUBAKANE Decentralization and Health Program Rwanda*.; 2009.

21. Cheld Policy Team. Mental Health Law in Nigeria. https://cheld.org/wp-content/uploads/2021/01/Mental-Health-Policy-Brief-CHELD-1.pdf. Accessed March 8, 2021.

22. Gavi. About our Alliance. https://www.gavi.org/our-alliance/about. Accessed March 11, 2021.

23. HEALTH CARE POLICIES IN NIGERIA SINCE INDEPENDENCE: ISSUES, CHALLENGES AND PROSPECTS – Katsina-Ala Multi-disciplinary Journal. https://kamjournal.org/2016/06/26/health-care-policies-in-nigeria-since-independence-issues-challenges-and-prospects/. Accessed March 11, 2021.

24. Kirigia JM, Kirigia DG. The essence of governance in health development. *International Archives of Medicine*. 2011;4(1). doi:10.1186/1755-7682-4-11

25. Nigeria. http://www.healthpolicyplus.com/nigeria.cfm. Accessed March 8, 2021.

26. Ruger JP. Shared health governance. *American Journal of Bioethics*. 2011;11(7):32-45. doi:10.1080/15265161.2011.568577

27. UNAIDS. Health and development | UNAIDS. https://www.unaids.org/en/keywords/health-and-development. Accessed March 8, 2021.

28. Braveman P, Gottlieb L. The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*. 2014;129(SUPPL. 2):19-31. doi:10.1177/00333549141291s206

29. Laura McGovern. *The Relative Contribution of Multiple Determinants to Health*.; 2014. doi:10.1377/hpb20140821.404487

30. Sartorius N. The meanings of health and its promotion. 2006;47:662-664. www.cmj.hr.

31. World Health Organization. *Helsinki Statement Framework for Country Action*.; 2014. www.who.int.

32. Levy R. WHAT ARE THE MAIN FACTORS AFFECTING HEALTHCARE COSTS? December 2015. http://www.hbdinc.com/blog/what-are-the-main-factors-affecting-healthcare-costs/. Accessed March 20, 2021.

33. Cooper R, John A. *Economics: Theory Through Applications*. 1.0 ed.; 2012. https://2012books.lardbucket.org/books/theory-and-applications-of-economics/s20-01-supply-and-demand-in-health-ca.html.

34. Naidu A. Factors affecting patient satisfaction and healthcare quality. *International Journal of Health Care Quality Assurance*. 2009;22(4):366-381. doi:10.1108/09526860910964834

35. Mosadeghrad AM. Factors influencing healthcare service quality. *International Journal of Health Policy and Management*. 2014;3(2):77-89. doi:10.15171/ijhpm.2014.65

36. Ching P. *FACTORS AFFECTING THE DEMAND FOR HEALTH SERVICES IN THE PHILIPPINES Philippine Institute for Development Studies*.; 1992.

37. Wellay T, Gebreslassie M, Mesele M, et al. Demand for health care service and associated factors among patients in the community of Tsegedie District, Northern Ethiopia. *BMC health services research*. 2018;18(1):697. doi:10.1186/s12913-018-3490-2

38. Boz C, Sur H, Söyük S. *(PDF) The Affecting Factors of Healthcare Services Demand in terms of Health Services Use: A Field Application A R T I C L E I N F O*. Edirne; 2015. https://www.researchgate.net/publication/319505919{_}The{_}Affecting{_}Factors{_}of{_}Healthcare{_}Services{_}Demand{_}in{_}terms{_}of{_}Health{_}Services{_}Use{_}A{_}Field{_}Application{_}A{_}R{_}T{_}I{_}C{_}L{_}E{_}I{_}N{_}F{_}O.

39. Frimpong AO. Health as an Investment Commodity: A Theoretical Analysis. *Finance, Entrepreneurship, Accounting and Transport*. 2014;2(3):58-62. doi:10.12691/jbe-2-3-1

40. Mushkin SJ. Health as an Investment. *The University of Chicago Press*. 1962;70:129-157. https://www.jstor.org/stable/pdf/1829109.pdf?casa{_}token=MrmNoBVTff0AAAAA:oHHPwenchU7x7eyZ9vX8qOC5cih0eFr{_}EaqGfyklpkoHueVCWnY2ALefjOqPnLFPR3eLZe7LgkkUnzSLD48MqXxfmxFVyvpRlZVBud6zyI1Uvcu3nafsJA.

41. Arora M, Gigras Y. Importance of Supply Chain Management in Healthcare of Third World Countries. *International Journal of Supply and Operations Management*. 2018;5(1):101-106. www.ijsom.com.

42. Babalola O. Consumers and Their Demand for Healthcare. *Journal of Health & Medical Economics*. 2017;03(01). doi:10.21767/2471-9927.100032

43. Bhatia R, Farhang L, Lee M, et al. *Minimum Elements and Practice Standards for Health Impact Minimum Elements and Practice Standards for Health Impact Assessment Assessment Recommended Citation Recommended Citation*.; 2010. https://scholarworks.gsu.edu/ghpc{_}materials/11.

44. Ellis RP, Mcguire TG. *Supply-Side and Demand-Side Cost Sharing in Health Care*. Vol 7.; 1993:135-151.

45. Folland S, Goodman AC, Stano M. The Economics of Health and Health Care: Pearson New International Edition. 2016. https://books.google.com.ng/books?hl=en{\&}lr={\&}id=qQ43DAAAQBAJ{\&}oi=fnd{\&}pg=PP1{\&}dq=economics+of+health+and+healthcare{\&}ots=vmANI0QCZ8{\&}sig=24sftx0P5aCV3{_}qXsAJ54f-M{_}8c{\&}redir{_}esc=y{\#}v=onepage{\&}q=economics of health and healthcare{\&}f=false. Accessed March 15, 2021.

46. Harris-Roxas B, Viliani F, Bond A, et al. Health impact assessment: the state of the art. *Impact Assessment and Project Appraisal*. 2012;30(1):43-52. doi:10.1080/14615517.2012.666035

47. Kapferer S. The importance of investing in health | World Economic Forum. December 2015. https://www.weforum.org/agenda/2015/12/the-importance-of-investing-in-health/. Accessed March 22, 2021.

48. Lillrank P, Groop PJ, Malmström TJ. Demand and Supply–Based Operating Modes—A Framework for Analyzing Health Care Service Production. *The Milbank Quarterly*. 2010;88(4):595. doi:10.1111/J.1468-0009.2010.00613.X

49. Medic West Africa. *Together for a healthier world 2019 Healthcare Market Insights: NIGERIA Report by*.; 2019. https://www.medicwestafrica.com/content/dam/Informa/medic-west-africa/english/2019/HealthcareInsights.pdf.

50. Ministry of Foreign Affairs of Japan. *"Health and Development" Initiative (HDI)*.; 2005.

51. Osaro E, Charles AT. Harmony in health sector: A requirement for effective healthcare delivery in Nigeria. *Asian Pacific Journal of Tropical Medicine*. 2014;7(S1):S1-S5. doi:10.1016/S1995-7645(14)60196-6

52. Principles of health economics including: the notions of scarcity, supply and demand, distinctions between need and demand, opportunity cost, discounting, time horizons, margins, efficiency and equity | Health Knowledge. https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4d-health-economics/principles-he. Accessed March 20, 2021.

53. Robert G, Harkavy O. *THE ROLE OF HEALTH IN DEVELOPMENT*. University of Michigan, 1980. https://deepblue.lib.umich.edu/bitstream/handle/2027.42/23226/0000159.pdf?sequence=1.

54. Rossetti M, Marek D, Prabhu S, Bhonsle A, Sharp S, Liu Y. Inventory Management Issues in Health Care Supply Chains. July 2008. https://www.researchgate.net/publication/228586761{_}Inventory{_}Management{_}Issues{_}in{_}Health{_}Care{_}Supply{_}Chains. Accessed March 22, 2021.

55. Supply and Demand in Health-Care Markets. https://2012books.lardbucket.org/books/theory-and-applications-of-economics/s20-01-supply-and-demand-in-health-ca.html. Accessed March 20, 2021.

56. United Nations Technical Support Team. *TST issues brief: HEALTH AND SUSTAINABLE DEVELOPMENT*.; 2013. https://sustainabledevelopment.un.org/content/documents/18300406tstissueshealth.pdf.

57. Wagstaff A. The demand for health: Theory and aplications. *Journal of Epidemiology and Community Health*. 1986;40(1):1-11. doi:10.1136/jech.40.1.1

58. World Health Organization. WHO | Health and development. https://www.who.int/healthsystems/topics/development/en/. Accessed March 20, 2021.

59. Abuelaish I, Goodstadt MS, Mouhaffel R. Interdependence between health and peace: a call for a new paradigm. *Health Promotion International*. 2020;35(6):1590-1600. doi:10.1093/heapro/daaa023

60. E. Asakitikpi A. Healthcare Coverage and Affordability in Nigeria: An Alternative Model to Equitable Healthcare Delivery. In: *Universal Healthcare [Working Title]*. IntechOpen; 2019. doi:10.5772/intechopen.85978

61. Bergmo TS. How to measure costs and benefits of ehealth interventions: An overview of methods and frameworks. 2015;17. doi:10.2196/jmir.4521

62. Background of the Sustainable Development Goals | UNDP. https://www.undp.org/content/undp/en/home/sustainable-development-goals/background.html. Accessed March 20, 2021.

63. Ejaz I, Shaikh BT, Rizvi N. NGOs and government partnership for health systems strengthening: A qualitative study presenting viewpoints of government, NGOs and donors in Pakistan. *BMC Health Services Research*. 2011;11(1):122. doi:10.1186/1472-6963-11-122

64. Gbeleou SC, Schechter J. How NGOs Can Work With Governments to Build Partnerships That Will Scale. September 2020. https://ssir.org/articles/entry/how{_}ngos{_}can{_}work{_}with{_}governments{_}to{_}build{_}partnerships{_}that{_}will{_}scale. Accessed March 22, 2021.

65. Grover LL. How Cost-Effectiveness Analysis Helps in Health Care Decision-Making - Modern Optometry. September 2019. https://modernod.com/articles/2019-sept/how-cost-effectiveness-analysis-helps-in-health-care-decision-making.

66. Herring J. Health as vulnerability; interdependence and relationality. *New Bioethics*. 2016;22(1):18-32. doi:10.1080/20502877.2016.1151255

67. Idemudia U. Environmental Business–NGO Partnerships in Nigeria: Issues and Prospects. *Business Strategy and the Environment*. 2017;26(2):265-276. doi:10.1002/bse.1915

68. Jesica Gómez-Jauregui. The Feasibility of Government Partnerships with NGOs in the Reproductive Health Field in Mexico. *Reproductive Health Matters*. 2004;12(24):42-55. https://www.jstor.org/stable/pdf/3776581.pdf.

69. In Nigeria, Health Care Often Comes at a Steep Cost | Pulitzer Center. https://pulitzercenter.org/stories/nigeria-health-care-often-comes-steep-cost. Accessed March 20, 2021.

70. Njoku ET. Good NGOs, Bad NGOs: Nigerian Government Partnership with NGOs in Counter-terrorism Operations | Democracy in Africa. November 2019. http://democracyinafrica.org/good-ngos-bad-ngos-nigerian-government-partnership-ngos-counter-terrorism-operations/. Accessed March 20, 2021.

71. Owen T. NGO-government partnerships. *Journal of International Migration and Integration / Revue de l'integration et de la migration internationale*. 2000;1(1):131-137. doi:10.1007/s12134-000-1012-6

72. Teegen H, Doh JP, Vachani S. The importance of nongovernmental organizations (NGOs) in global governance and value creation: An international business research agenda. In: *Journal of International Business Studies*. Vol 35.; 2004:463-483. doi:10.1057/palgrave.jibs.8400112

73. The Global Goals. https://www.globalgoals.org/. Accessed March 20, 2021.

74. Scott-Emuakpor A. The evolution of health care systems in Nigeria: Which way forward in the twenty-first century. *Nigerian Medical Journal*. 2010;51(2):53. https://www.nigeriamedj.com/article.asp?issn=0300-1652;year=2010;volume=51;issue=2;spage=53;epage=65;aulast=Scott-Em https://www.nigeriamedj.com/article.asp?issn=0300-1652;year=2010;volume=51;issue=2;spage=53;epage=65;aulast=Scott-Em;type=0.

75. Vera M. Levels of Health Care Referral System - Nurseslabs. December 2013. https://nurseslabs.com/levels-of-health-care-referral-system/. Accessed March 24, 2021.

76. Basicmedical Key. How Health Care Is Organized—I: Primary, Secondary, and Tertiary Care | Basicmedical Key. June 2016. https://basicmedicalkey.com/how-health-care-is-organized-i-primary-secondary-and-tertiary-care/. Accessed March 24, 2021.

77. Health Dialog. Cultural Respect in Patient Engagement | Health Dialog. March 2016. https://www.healthdialog.com/blog/why-cultural-respect-important-patient-engagement-and-healthcare-delivery. Accessed March 24, 2021.

78. Adebayo Omotosho, Omotanwa Adegbola, Justice Emuoyibofarhe. (PDF) ICT in Health care delivery system: A Framework for developing nations. *Conference: International Conference on ICT for Africa (ICT4A)*. April 2011. https://www.researchgate.net/publication/274633485{_}ICT{_}in{_}Health{_}care{_}delivery{_}system{_}A{_}Framework{_}for{_}developing{_}nations.

79. Amlung J, Huth H, Cullen T, Sequist T. Modernizing health information technology: lessons from healthcare delivery systems. *JAMIA Open*. 2020;3(3):369-377. doi:10.1093/jamiaopen/ooaa027

80. Aregbeshola BS, Khan SM. Primary health care in Nigeria: 24 years after Olikoye Ransome-Kuti's leadership. 2017;5:48. doi:10.3389/FPUBH.2017.00048

81. Bukachi F, Pakenham-Walsh N. Information technology for health in developing countries. *Chest*. 2007;132(5):1624-1630. doi:10.1378/chest.07-1760

82. Edoh TO, Teege G. Using information technology for an improved pharmaceutical care delivery in developing countries. Study case: Benin. In: *Journal of Medical Systems*. Vol 35. Springer; 2011:1123-1134. doi:10.1007/s10916-011-9717-y

83. Health Technology in Resource-Poor Settings - Social Entrepreneurship Certificate Program. http://www.uniteforsight.org/global-health-university/technology. Accessed March 24, 2021.

84. Koce F, Randhawa G, Ochieng B. Understanding healthcare self-referral in Nigeria from the service users' perspective: A qualitative study of Niger state. 2019;19:209. doi:10.1186/s12913-019-4046-9

85. Nigeria Health Facility Registry. https://hfr.health.gov.ng/facilities/hospitals-search?{_}token=ol3nGLLcpHHGhgNtfdeIhD7WuvTDX5bXVpOiOqD1{\&}state{_}id=1{\&}lga{_}id=1{\&}ward{_}id=0{\&}facility{_}level{_}id=3{\&}ownership{_}id=0{\&}operational{_}status{_}id=0{\&}registration{_}status{_}id=0{\&}license{_}status{_}id=0{\&}geo{_}codes=0{\&}service{_}type=0{\&}service{_}category{_}id=0{\&}facility{_}name={\&}entries{_}per{_}page=10. Accessed March 24, 2021.

86. The Nigerian Health System. https://www.who.int/pmnch/countries/nigeria-plan-chapter-3.pdf.

87. Nwokocha EE. Traditional healthcare delivery systems in the 21st century Nigeria: moving beyond misconceptions. *World health & population*. 2008;10(1):23-33. doi:10.12927/whp.2008.19730

88. Omotosho A, Ayegba P, Emuoyibofarhe J, Meinel C. Current State of ICT in Healthcare Delivery in Developing Countries. *International Journal of Online and Biomedical Engineering (iJOE)*. 2019;15(08):91. doi:10.3991/ijoe.v15i08.10294

89. Raji SO. Multiple Sources of Healthcare Delivery System and the Formal Recognized State Healthcare: The Bane of Nigeria Healthcare Development. *Primary Health Care Open Access*. 2018;08(04). doi:10.4172/2167-1079.1000315

90. Sanchez TR, Plawecki JA, Plawecki HM. The Delivery of Culturally Sensitive Health Care to Native Americans. *Journal of Holistic Nursing*. 1996;14(4):295-307. doi:10.1177/089801019601400403

91. Takim Asu O, David Gever I, Pefun Joshua N. African Cultural Practices and Health Implications for Nigeria Rural Development.

92. Timothy G, Irinoye O, Yunusa U, Dalhatu A, Ahmed S, Suberu A. *Balancing Demand, Quality and Efficiency in Nigerian Health Care Delivery System*. Vol 6. Online; 2014. www.iiste.org.

93. Tiziano Marovino. Technology: Changing the Delivery Of Healthcare. April 2017. https://www.practicalpainmanagement.com/treatments/rehabilitation/technology-changing-delivery-healthcare. Accessed March 24, 2021.

94. White P. The concept of diseases and health care in African traditional religion in Ghana. 2015. doi:10.4102/hts.v71i3.2762

95. Health Management, Ethics and Research Module: 7. Principles of Healthcare Ethics: View as single page. https://www.open.edu/openlearncreate/mod/oucontent/view.php?id=225{\&}printable=1. Accessed March 26, 2021.

96. Andrew Sumner. What are the Ethics of Development Studies. *IDS Bulletin*. 2007;38(2). https://core.ac.uk/download/pdf/286043967.pdf.

97. Four fundamental principles of ethics. http://web.mnstate.edu/gracyk/courses/phil 115/Four{_}Basic{_}principles.htm. Accessed March 26, 2021.

98. *Global Health Ethics Key issues Global Network of WHO Collaborating Centres for Bioethics*.; 2015. www.who.int.

99. Importance of Ethics. https://www.managementstudyguide.com/importance-of-ethics.htm. Accessed March 28, 2021.

100. Keahey J. Ethics for Development Research. *Sociology of Development*. 2020;6(4):395-416. doi:10.1525/sod.2020.6.4.395

101. Lies J, Narvaez D, Endicott L, Bock T, Mitchell C. *Ethical Motivation Ethical Motivation Ethical Motivation Ethical Motivation Ethical Motivation Activity Booklet 3 Nurturing Character in the Middle School Classroom Sensitivity Judgment Motivation Motivation Motivation Motivation Motivation Action*.

102. Kapur R. Significance of Health Infrastructure. July 2020. https://www.researchgate.net/publication/342832865{_}Significance{_}of{_}Health{_}Infrastructure.

103. Omoleke I, Taleat B. Contemporary issues and challenges of health sector in Nigeria. *Research Journal of Health Sciences*. 2018;5(4):210. doi:10.4314/rejhs.v5i4.5

104. Uchenna Anaemene B. HEALTH SECTOR REFORMS AND SUSTAINABLE DEVELOPMENT IN NIGERIA: A HISTORICAL PERSPECTIVE. *Journal of Sustainable Development in Africa*. 2016;18(4).

105. Adeloye D, David RA, Olaogun AA, et al. Health workforce and governance: The crisis in Nigeria. *Human Resources for Health*. 2017;15(1):32. doi:10.1186/s12960-017-0205-4

106. Abubakar M, Basiru S, Oluyemi J, et al. Medical tourism in Nigeria: Challenges and remedies to health care system development. *International Journal of Development and Management Review*. 2018;13(1). https://www.ajol.info/index.php/ijdmr/article/view/172290.

107. Isere E, Fatiregun A, Ajayi I. An overview of disease surveillance and notification system in Nigeria and the roles of clinicians in disease outbreak prevention and control. *Nigerian Medical Journal*. 2015;56(3):161. doi:10.4103/0300-1652.160347

108. Phalkey RK, Yamamoto S, Awate P, Marx M. Challenges with the implementation of an Integrated Disease Surveillance and Response (IDSR) system: Systematic review of the lessons learned. 2015;30:131-143. doi:10.1093/heapol/czt097

109. mundi I. Nigeria Demographics Profile. 2020. https://www.indexmundi.com/nigeria/demographics{_}profile.html. Accessed March 27, 2021.

110. Oyeleye OI, Adeniji MA. Regional Imbalances and Inequalities in Nigeria: Causes, Consequences and Remedies. 2014;4. https://core.ac.uk/download/pdf/234674109.pdf.

111. Joe-Ikechebelu N, Osuorahi CDI, Nwankwo BE, Ngene W, Nwaneli EI. Evaluation of social determinants of health (SDH) in communities across the south-eastern region of Nigeria. *The Anatolian Journal of Family Medicine*. 2020;3(1):10-16. doi:10.5505/anatoljfm.2019.40085

112. Www.worldlifeexpectancy.com. HEALTH PROFILE NIGERIA. https://www.worldlifeexpectancy.com/country-health-profile/nigeria. Accessed March 28, 2021.

113. Statista. Nigeria: main causes of death 2019 | Statista. March 2021. https://www.statista.com/statistics/1122916/main-causes-of-death-and-disability-in-nigeria/. Accessed March 28, 2021.

114. Murray CJ, Aravkin AY, Zheng P, et al. Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*. 2020;396(10258):1223-1249. doi:10.1016/S0140-6736(20)30752-2

115. Okoroiwu HU, Uchendu KI, Essien RA. Causes of morbidity and mortality among patients admitted in a tertiary hospital in southern Nigeria: A 6 year evaluation. Lazzeri C, ed. *PLOS ONE*. 2020;15(8):e0237313. doi:10.1371/journal.pone.0237313

116. World Health Organization. WHO | Nigeria. *WHO*. 2007.

117. Worldometer. Nigeria Demographics 2020 (Population, Age, Sex, Trends) - Worldometer. https://www.worldometers.info/demographics/nigeria-demographics/. Accessed March 28, 2021.

118. Swihart DL, Yarrarapu SNS, Martin RL. Cultural Religious Competence in Clinical Practice. February 2021. http://www.ncbi.nlm.nih.gov/pubmed/29630268.

119. Nwabueze C, Nwankwo NN. Ethnicity and Doctor-Patient Communication: An Exploratory Study of University of Abuja Teaching Hospital, Nigeria | Journal of Participatory Medicine. October 2016. https://participatorymedicine.org/journal/evidence/research/2016/10/07/ethnicity-and-doctor-patient-communication-an-exploratory-study-of-university-of-abuja-teaching-hospital-nigeria/. Accessed March 28, 2021.

120. Ahmed R, Bates B. Gender Differences in Patients' Perceptions of Physicians' Cultural Competence in Health Care Interactions. December 2007:58-80. https://www.researchgate.net/publication/259694087{_}Gender{_}Differences{_}in{_}Patients{\%}27{_}Perceptions{_}of{_}Physicians{\%}27{_}Cultural{_}Competence{_}in{_}Health{_}Care{_}Interactions. Accessed March 28, 2021.

121. Schäferhoff M, Martinez S, Ogbuoji O, Sabin ML, Yamey G. Trends in global health financing. 2019;365. doi:10.1136/bmj.l2185

122. World Health Organization. WHO | Health systems financing. 2012.

123. Schieber G, Baeza C, Kress D, Maier M. *Financing Health Systems in the 21st Century*. The International Bank for Reconstruction; Development / The World Bank; 2006. http://www.ncbi.nlm.nih.gov/pubmed/21250347.

124. Gomez-Gonzalez JE, Reyes NR. Patterns of global health financing and potential future spending on health. 2017;389:1955-1956. doi:10.1016/S0140-6736(17)31001-2

125. Schieber GJ, Gottret P, Bank W. *Getting Real on Health Financing Working with WHO in Iran on Fiscal and Health Financing Reform Issues View project Lisa K Fleisher*.; 2006. https://www.researchgate.net/publication/265199649.

126. Yunusa U, Timothy GD, Dalhatu AE, Ahmed SF. *Trends and Challenges of Public Health Care Financing System in Nigeria: The Way Forward*. Vol 4.; 2014:28-34. www.iosrjournals.orgwww.iosrjournals.org.

127. TBfacts.org. TB in Nigeria - Funding, children, diagnosing TB, HIV/TB. https://tbfacts.org/tb-nigeria/. Accessed March 26, 2021.

128. Awofala AA, Ogundele OE. HIV epidemiology in Nigeria. 2018;25:697-703. doi:10.1016/j.sjbs.2016.03.006

129. Hepbtalk. The Journey to Hepatitis Elimination in Nigeria - Hepatitis B Foundation. January 2020. https://www.hepb.org/blog/journey-hepatitis-elimination-nigeria/. Accessed March 27, 2021.

130. World Health Organization. Malaria. November 2020. https://www.who.int/news-room/fact-sheets/detail/malaria. Accessed March 27, 2021.

131. Ike S, Onyema C. Cardiovascular diseases in Nigeria: What has happened in the past 20 years? *Nigerian Journal of Cardiology*. 2020;17(1):21. doi:10.4103/njc.njc_33_19

132. Jedy-Agba E, Curado MP, Ogunbiyi O, et al. Cancer incidence in Nigeria: A report from population-based cancer registries. *Cancer Epidemiology*. 2012;36(5):271-278. doi:10.1016/j.canep.2012.04.007

133. Desalu OO, Oluwafemi JA, Ojo O. Respiratory diseases morbidity and mortality among adults attending a tertiary hospital in Nigeria. *Jornal brasileiro de pneumologia : publicaça{combining double acute accent} o oficial da Sociedade Brasileira de Pneumologia e Tisilogia*. 2009;35(8):745-752. doi:10.1590/s1806-37132009000800005

134. Christman BW. Tuberculosis Overview.

135. Garcia LS. Malaria. 2010;30:93-129. doi:10.1016/j.cll.2009.10.001

136. Leong DP, Joseph PG, McKee M, et al. Reducing the global burden of cardiovascular disease, part 2: Prevention and treatment of cardiovascular disease. 2017;121:695-710. doi:10.1161/CIRCRESAHA.117.311849

137. Roy PS, Saikia BJ. Cancer and cure: A critical analysis. 2016;53:441-442. doi:10.4103/0019-509X.200658

138. Saeed A, Kampangkaew J, Nambi V. Prevention of Cardiovascular Disease in Women. 2017;13:185-192. doi:10.14797/mdcj-13-4-185

139. Uloko AE, Musa BM, Ramalan MA, et al. Prevalence and Risk Factors for Diabetes Mellitus in Nigeria: A Systematic Review and Meta-Analysis. *Diabetes Therapy*. 2018;9(3):1307-1316. doi:10.1007/s13300-018-0441-1

140. UNAIDS. *UNAIDS fact sheet ,2019*.

141. Dawaki S, Al-Mekhlafi HM, Ithoi I, et al. Prevalence and risk factors of schistosomiasis among Hausa communities in Kano state, Nigeria. *Revista do Instituto de Medicina Tropical de Sao Paulo*. 2016;58(1). doi:10.1590/S1678-9946201658054

142. Oyeyemi OT, de Jesus Jeremias W, Grenfell RFQ. Schistosomiasis in Nigeria: Gleaning from the past to improve current efforts towards control. 2020;11:100183. doi:10.1016/j.onehlt.2020.100183

143. Udo S, Chukwu J, Obasanya J. Leprosy situation in Nigeria. *Leprosy review*. 2013;84(3):229-237. doi:10.47276/lr.84.3.229

144. Nigeria Centre for Disease Control. Leprosy. January 2017. https://ncdc.gov.ng/diseases/factsheet/33. Accessed March 27, 2021.

145. Rabiu M, Muhammed N, Isiyaku S. Challenges of trachoma control: An assessment of the situation in Northern Nigeria. *Middle East African Journal of Ophthalmology*. 2011;18(2):115-121. doi:10.4103/0974-9233.80699

146. Odjimogho E, Odjimogho S. Trachomaas one of the leading cause of low vision In Kano State. *Journal of the Nigerian Optometric Association*. 2011;10(1). doi:10.4314/jnoa.v10i1.64435

147. Mpyet C, Ogoshi C, Goyol M. Prevalence of trachoma in Yobe state, North-Eastern Nigeria. *Ophthalmic Epidemiology*. 2008;15(5):303-307. doi:10.1080/09286580802237633

148. Hussaini A, Isaac C, Rahimat H, Inegbenosun C, Obasuyi C, Solomon E. The Burden of Bancroftian Filariasis in Nigeria: A Review. 2020;30:301-310. doi:10.4314/ejhs.v30i2.18

149. Okorie PN, Davies E, Ogunmola OO, et al. Lymphatic filariasis baseline survey in two sentinel sites of Ogun state, Nigeria. *Pan African Medical Journal*. 2015;20(397). doi:10.11604/pamj.2015.20.397.5686

150. Igbe M, Duhlinska D, Agwale S. Epidemiological Survey of Cutaneous Leishmaniasis in Jos East L.G.A. Of Plateau State Nigeria. 2008;4. https://ispub.com/IJPD/4/1/11715.

151. World Health Organization. WHO | Maternal health in Nigeria: generating information for action. *WHO*. 2019. http://www.who.int/reproductivehealth/maternal-health-nigeria/en/.

152. Ope BW. Reducing maternal mortality in Nigeria: addressing maternal health services' perception and experience. *Journal of Global Health Reports*. May 2020. doi:10.29392/001c.12733

153. Nwosu CO, Ataguba JE. Socioeconomic inequalities in maternal health service utilisation: A case of antenatal care in Nigeria using a decomposition approach. *BMC Public Health*. 2019;19(1):1493. doi:10.1186/s12889-019-7840-8

154. UN Women, UNFPA, UNICEF, UN Sytem in Nigeria. *GENDER-BASED VIOLENCE IN NIGERIA DURING THE COVID-19 CRISIS: THE SHADOW PANDEMIC.*; 2020. https://www.unwomen.org/en/news/.

155. Alemu Belachew W, Naafs B. Position statement: LEPROSY: Diagnosis, treatment and follow-up. *Journal of the European Academy of Dermatology and Venereology*. 2019;33(7):1205-1213. doi:10.1111/jdv.15569

156. Alzaylaee H, Collins RA, Rinaldi G, et al. Schistosoma species detection by environmental DNA assays in African freshwaters. Greenberg RM, ed. *PLOS Neglected Tropical Diseases*. 2020;14(3):e0008129. doi:10.1371/journal.pntd.0008129

157. Amene P, Jacob A, Swarup A. Hydatid lung disease in a Nigerian female. 1984;7:173-175. https://scholar.google.com/scholar{_}lookup?journal=Niger+Med+Pract{\&}title=Hydatid+lung+

disease+in+a+Nigerian+female{\&}author=P+Amene{\&}author=A+Jacob{\&}author=A+Swarup{\&}volume=7{\&}publication{_}year=1984{\&}pages=173-175{\&}.

158. Chika IS. Gender-Based Domestic Violence in Nigeria. *Indian Journal of Gender Studies*. 2012;19(1):137-148. doi:10.1177/097152151101900107

159. Dada BJ. Taeniasis, cysticercosis and echinococcosis/hydatidosis in Nigeria: I—prevalence of human taeniasis, cysticercosis and hydatidosis based on a retrospective analysis of hospital records. *Journal of Helminthology*. 1980;54(4):281-286. doi:10.1017/S0022149X00006775

160. Fasina O, Ogun OG. Hydatid cyst of the orbit in a young Nigerian female: a case report. *Ghana medical journal*. 2017;51(4):204-206. doi:10.4314/gmj.v51i4.11

161. Nair M, Nelson-Piercy C, Knight M. Indirect maternal deaths: UK and global perspectives. *Obstetric Medicine*. 2017;10(1):10-15. doi:10.1177/1753495X16689444

162. Ohiolei JA, Yan HB, Li L, et al. Review of Cystic Echinococcosis in Nigeria: A Story of Neglect. 2020;65:1. doi:10.2478/s11686-019-00124-x

163. Okeke T, Anyaehie U, Ezenyeaku C. An overview of female genital mutilation in Nigeria. *Annals of Medical and Health Sciences Research*. 2012;2(1):70. doi:10.4103/2141-9248.96942

164. Okwori E, Nock IH, Galadima M, Ibrahim S. *PREVALENCE OF CUTANEOUS LEISHMANIASIS IN PARTS OF KADUNA STATE, NIGERIA*. Vol 11.; 2001:2-4.

165. Ozoilo KN, Iya D, Kidmas AT, Uwumarogie O, Hassan S. Anterior abdominal wall hydatid cyst; an unusual presentation. *Nigerian journal of medicine : journal of the National Association of Resident Doctors of Nigeria*. 2007;16(2):181-182. doi:10.4314/njm.v16i2.37261

166. Sixl W, Rosegger H, Schneeweis H, Withalm H, Schuhmann G. Serological investigations in Nigeria for anthropozoonoses in human sera: brucellosis, echinococcosis, toxoplasmosis, chlamydial diseases, listeriosis, rickettsiosis (Coxiella burneti and Rickettsia conori). 1987. https://pubmed.ncbi.nlm.nih.gov/3443751/. Accessed March 27, 2021.

167. Stark L, Seff I, Reis C. Gender-based violence against adolescent girls in humanitarian settings: a review of the evidence. 2020;5. doi:10.1016/S2352-4642(20)30245-5

168. World Health Organization. Health statistics and information systems: Maternal mortality ratio (per 100 000 live births.

169. Babigumira JB. *Types of Economic Evaluation in Healthcare*.

170. CDC. Cost-Benefit Analysis | POLARIS | ADP-Policy | CDC. March 2021. https://www.cdc.gov/policy/polaris/economics/cost-benefit/index.html?CDC{_}AA{_}refVal=https{\%}3A{\%}2F{\%}2Fwww.cdc.gov{\%}2Fpolicy{\%}2Fpolaris{\%}2Feconomics{\%}2Fcost-benefit-analysis.html. Accessed March 26, 2021.

171. Ghimire P. Cost Benefit Analysis in Health Care. August 2018. https://www.slideshare.net/PrabeshGhimire/cost-benefit-analysis-in-health-care. Accessed March 26, 2021.

172. Boles M, Pelletier B, Lynch W. The relationship between health risks and work productivity. *Journal of Occupational and Environmental Medicine*. 2004;46(7):737-745. doi:10.1097/01.jom.0000131830.45744.97

173. Rutgers. The Financial Impact of Improved Health Behaviors (Rutgers NJAES). https://njaes.rutgers.edu/health-finance/health-behaviors.php. Accessed March 26, 2021.

174. Hafner M, Van Stolk C, Saunders C, Krapels J, Baruch B. *Health, wellbeing and productivity in the workplace: A Britain's Healthiest Company summary report*.; 2015. www.randeurope.org.

175. Rolle Remi Ahuru, Osaze Daniel, Henry Akpojubaro Efegbere. What Role Does Health Play in Enhancing Labour Productivity in Nigeria? *Academic Journal of Economic Studies*. 2020;6(2):102-111. https://www.researchgate.net/publication/342349589{_}What{_}Role{_}Does{_}Health{_}Play{_}in{_}Enhancing{_}Labour{_}Productivity{_}in{_}Nigeria.