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Covid-19 Pandemic: Nigeria's Health Sector and the Imperatives of Reform

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Abstract

This paper examines the impact of Coronavirus Disease 2019 (Covid-19) on Nigeria's health sector. The novel Covid-19 which allegedly originated from Wuhan in Hubei Province of the People's Republic of China in December, 2019, has been declared a pandemic – a global public health emergency – by the World Health Organization (WHO). The disease has been reported in over 192 countries across Asia, Europe, America, Africa, and Latin America, and the John Hopkins University Centre for Systems Science and Engineering (CSSE) currently estimates 119,875,420 infected persons, 67,895,864 recovered, and 2,653,652 deaths globally, with Nigeria having over 13,245 active cases, 145,399 recovered, and 2,013 deaths. Without disregard for the overwhelming effect of the pandemic on healthcare systems globally, Nigeria's casualty is not unconnected to the sordid state of her healthcare sector. This paper argues that successive governments have neglected the country's health sector and this has impacted its preparedness to respond to the Covid-19 pandemic. The study adopts content analysis and contends that the poor state of the healthcare system in Nigeria is associated with the phenomenon of medical tourism. The paper calls for the imperatives of reform in the health sector, emphasizing the integration of traditional medicine into mainstream healthcare delivery (vaccine nationalism) while prioritizing recruitment and re-training of health sector personnel and increase funding of the health sector in budgetary allocations.

Keywords: *Covid-19, pandemic, health sector, medical tourism, reform, Nigeria*

Introduction

Coronavirus Disease 2019 (Covid-19) which allegedly originates from Wuhan-China in December 2019 from a seafood market in Huanan has threatened health sector preparedness globally. Coronavirus belongs to a family of viruses that cause different illnesses ranging from the common cold, severe respiratory syndrome, and fever (WHO, 2020). Etymologically, the name or term coronavirus comes from a Latin word "*corona*" meaning "crown" or "halo". When examine under a microscope the virus looks surrounded by a solar corona and with over twenty variants originally affecting animals – cats, bats, chickens, and pangolins, etc.

In the 1930s when coronavirus first appeared it was found in chickens which affected their respiratory system. Later in the 1940s, it was discovered in mice. The human variant

of coronavirus was first recorded in 1960, which was believed to have been transmitted from domestic animals. The three most dangerous coronaviruses are SARS (severe acute respiratory syndrome) that was common in 2002-2003, MERS (Middle East Respiratory Syndrome) that appeared in 2014, and coronavirus that is destructive to humans is the novel Covid-19 which was identified by Chinese authorities on January 7 and since then otherwise named SARS-CoV-2 (Naik, 2020; WHO, 2020). The most common symptoms of the Covid-19 are fever, shortness of breath or breathing difficulties, loss of taste and frequent sneezing, and sore throat, with an incubation period of 1 to 14 days. This is because most infected persons show symptoms within 5 to 6 days. The preventive measures against Covid-19 are; social distancing, coughing into the elbow or tissue, washing of hands using sanitizer or soap under running water, and wearing N95 face masks.

As of 19 July, 2020, the disease was reported in over 188 countries across Asia, Europe, America, Africa, and Latin America. The Centre for Systems Science and Engineering (CSSE), a John Hopkins University's dedicated resource center for CoronaVirus, estimated 14,313,657 infected persons, 8,045,982 recovered or discharged cases, and 602,776 deaths globally, with Nigeria having over 36,107 active cases, 14,938 recovered or discharged case, and 778 deaths as at 19 July 19, 2020 (John Hopkins University, 2020). On 27th February, 2020, Nigeria recorded its first case of Covid-19 from an Italian in Lagos as an index case. This spurred the Federal Government of Nigeria to contain the virus (NCDC, 2020), but curtailing its spread faces daunting challenges from the structural, functional, and political will of leaders at the various level of authority.

It is in this context that the paper examines the challenges affecting the Nigerian health sector in containing the spread of Covid-19 and argues why there is a need for reform to forestall future global public health emergencies. The paper is divided into five sections following this introduction. The second section highlights the method of analysis while the third examines Covid-19 as a global public health emergency vis-à-vis Nigeria's health sector. The fourth section discusses the phenomenon of medical tourism, the distribution of healthcare services, and the issues of healthcare funding as related developments undermining effective healthcare delivery services in Nigeria while the fifth wraps up the paper and calls for the imperatives of reform, with recommendations on the direction of reform.

Methodology

The paper adopts a content analytical approach to examine data derived from secondary sources. Secondary data derives primarily from the Federal Ministry of Health official documents/publications, Centre for Disease Control, reports and publications from states and federal agencies, media commentaries, and newspaper articles. Others include scholarly articles, conference reports, and textbooks.

Covid-19: A Global Public Health Emergency

The novel coronavirus appeared from the blues and disrupts almost everything under the Sun globally. The first case was recorded in Huanan-Wuhan in Hubei Province of China in December, 2019. It is assumed that the Covid-19 originates from the seafood market. The wet market provides food and medicine for the population and by extension the Asian people. Covid-19 caught the world totally unprepared and with no proof and available medical response. Ad-hoc cocktails and learning-by-doing constitute the strategic package. In most Western countries, the cocktail of response has included a coterie of defensive measures including; border closure; prepare isolation centers, and mobilize medical personnel/facilities; implement "stay at home" orders or lockdowns (Onuh, 2021) except for food, medicine, and essential services; campaign for basic hygiene and social distancing; arrange welfare packages for the vulnerable; and also economic stimulus package to mitigate the effects on the macroeconomy (Soludo, 2020).

Prior to the Covid-19 global health crisis, several global public health emergencies had occurred in recent times. The Swine flu in 2009, Polio in 2014, Ebola in 2014, Zika in 2016, and Ebola in 2019. On January 30, 2020, the World Health Organization considered Covid-19 as a serious global public health emergency. Furthermore, on March 11, the WHO declared the novel disease as a pandemic due to its geographical spread and deadly impact (WHO, 2020; Mohammed, 2020).

In her efforts to proactively mitigate the spread of Covid-19 in the country the Federal Government of Nigeria (FGN) and its various agencies have taken some measures considered to be proactive. On January 28, the FGN strengthened surveillance at three international Airports at Enugu, Rivers, and Lagos. Similarly, on the same date, the Nigeria Centre for Disease Control (NCDC) announced that it has already set up the Covid-19 working group. On January 31, the FGN set a Covid-19 group to mitigate the possible negative impact of the disease in Nigeria. Moreover, President Muhammadu Buhari on

March 9 announced the formation of a Presidential Task Force (PTF) on Covid-19, and on March 18 the PTF announced that nationals from 13 countries will not be granted permission into Nigeria until Covid-19 is over. These countries are; China, Italy, Iran, South Korea, Spain, Japan, France, Germany, United Kingdom, United States, Norway, Netherlands, and Switzerland (FGN, 2020).

On March 20, the FGN closed all schools throughout the federation and, the next day announced the closure of Lagos and Abuja International Airports. In a similar development, the Central Bank of Nigeria on March 26 announced receipt of Covid-19 donation by 7 Nigerian billionaires. Moreover, on the same day, the FGN announced receipt of 107 medical supplies from Chinese businessman and philanthropist, Jack Ma. The NCDC on March 27 launched WhatsApp APL, a free-to-use service for current and verified data on Covid-19. Two days later, President Buhari made his maiden presidential broadcast on Covid-19, and on March 30, he signed the Covid-19 Regulation Bill into law. On the same day, President Buhari in a national broadcast announced lockdown in Abuja and Lagos under Emergency Executive Powers (Vanguard April 1, 2020; Adesina, 2020).

Overview of Nigeria's Health Sector

Health is wealth and without a healthy population, a nation's economy and security would be in jeopardy. The health sector in Nigeria belongs to the concurrent list which means that all three tiers of government have a stake in it. There exist a variety of healthcare types and services in Nigeria. There are traditional, bio-medical or Western/orthodox, synthetic healers, and bone settlers (Erinosho, 2006; Owumi, 1995). This variety provides insight into its history, infrastructure in terms of delivery, maintenance, and management. And, more importantly, the existence of the various types is a constant source of tension, conflict, and mistrust among the practitioners, which underscores the absence of synergy in terms of research and development amongst them (Owumi, 2005).

The 19th century Industrial Revolution had a profound influence on society generally. In particular, it occasioned a shift from rural/community subsistence economic patterns which were rooted in particularism, i.e., face-to-face relationships, to urban/metropolitan specialized economy based on universalism or what is known as bureaucracy, where the relationship is basically official and impersonal. Here, there is an emphasis on the division of labor, specialization, bureaucracy, and expansive skill acquisition through long training and higher studies, marking the emergence and proliferation of experts trained in specific areas of modern medicine (Park, 2000;

Onokerhoraye, 1982). With Britain as a major hub of the revolution, its effects rapidly spread across its erstwhile colonies and this shift impacted on and later informed the progressive development of public health, hospital, and infrastructure in Nigeria.

Though formal decolonization ended in 1960, Nigeria's developmental strategies have not departed significantly from those bequeathed by the colonialists. This colonial reproduction replicates a pattern in the medical care delivery which favors the urban population at the expense of rural settlers (Pearce, 2001). Moreover, health services are hospital-based with technology propelled by two main factors, namely bureaucracy, and specialization. Bureaucracy spells out rules and mechanisms of its operation while specialization entails the acquisition of expertise and mastery of specific areas in health care dispensation. Although the first medical centers in Nigeria were established in the rural areas by Christian Missionaries (Onokerhoraye, 1982), this, however, was with surreptitious support from the colonialists to expand Christianity across the colonies.

The medical centers established by the missionaries were largely concentrated in the rural areas because of the goal of evangelism, which was to get the rural 'pagans' to embrace the new religion. These medical centers, however, were merely mobile clinics and at most community dispensary out-posts to treat primary health problems – snake bites and minor injuries. It was in later years when British rule had consolidated that the administrators promoted the creation of medical centers in the real sense of hospitals to take care of epidemics, such as sleeping sickness, smallpox, malaria, and other primary health concerns (Onibonoje, 1985; Aluko-Arowolo, 2006). Two distinct spin-off effects could be deducted immediately from this particular arrangement. First total neglect of rural areas in matters of healthcare and, second, an institutionalized system of inequality between urban and rural areas, where urban centers are home to the colonialists and their Black associates while rural areas serve the general citizenry. Rather unfortunate, over fifty years after acclaimed independence, these residential patterns are still glaring in our towns and cities, and between urban and rural areas (Mabogunje, 2007; Home, 1983). Besides these, there was no attention to traditional healthcare and this created a huge vacuum that further entrenched inequality between the haves and have-nots and between the urban and rural settlements.

This colonially-structured dichotomy brought to the fore the current challenges in the healthcare system and other associated services, in that infrastructure and personnel that are very essential to efficient hospital system like food, roads, pipe-borne water and

electricity for storage of drugs and surgical operation, etc., were not provided for (Aluko-Arowolo, 2005). This later influenced the health policy of subsequent governments in Nigeria (Mabogunje, 2007). From the above, a 'roadmap' was designed for the health system and sundry services in Nigeria which placed health services specifically on three pedestals: primary, secondary, and tertiary health institutions for rural, mixed population, and urban elite, respectively.

There are three health structures in Nigeria, which are arranged in a hierarchical order. These are primary, secondary, and tertiary health institutions. Primary Health Care (PHC) by policy arrangements is within the purview of Local Government, based on the residual operation of Local Government Authority. Primary health structures are unarguably the first points of call for the sick and injured persons. They undertake mild healthcare cases like treatment for malaria, fever, cold, nutrition disorder, among others. They are specifically for milder health problems and health education. They also handle infant, maternal and pregnancy-related matters.

Other health issues in their care are family planning and immunization (Badru, 2003). Additionally, primary health centers emphasize health care and are involved in record-keeping, case reporting, and patient’s referral to higher tiers. Primary health centers are known within the system by the content of the health centers, maternity homes/clinics, and dispensaries. Primary healthcare centers refer complicated cases to secondary health institutions i.e. general hospitals. According to the Medical and Dental Council of Nigeria (MDCN) in Badru (2003), primary health centers are also to undertake such functions as health education, diagnosis, and treatment of common ailments, through the use of appropriate technology, infrastructure, and essential drugs.

Secondary health centers are involved with not only prevention but also all treatments and management of minimal complex cases. However, the more complicated cases are referred to the tertiary or specialist hospital. Examples of secondary types are comprehensive health centers and general hospitals. The comprehensive health centers are often owned by private individuals(s) or a group of individuals e.g., Gold Cross Ikoyi, Lagos; Victory Hospital, Ijebu-Igbo, etc., while general hospitals are owned and funded by the government. Examples are general hospitals in Ijebu-Ode, Ikeja, IIesa, Oluyoro in Ibadan, Owerri, Bida, Abeokuta, etc. In addition, currently, there are 22 Federal Medical Centers (FMCs) spread across the federation and, as a general rule, most are situated in the capital of the States. General hospitals have provisions for accident and emergency

units and diagnosis units [including X-ray, scan machines, and other pathological services] among other services (Badru, 2003). The status of being the second layer of health institutions imposes certain acceptable standards, level of infrastructure, and capacity for certain special cases.

A tertiary health institution, also called a specialist/teaching hospital, handles complex health problems/cases either as referrals from general hospitals or on direct admission to its own facility. It has features such as accident and emergency unit, diagnostic unit, wards units, treatment unit, and outpatient consultation unit. All these units are to be equipped with the necessary facilities and staffed by skilled personnel. Teaching hospitals also conduct research and share knowledge with the government as a way of influencing health policies. This explains why this type of health institution is often university-based. Examples are Lagos University Teaching Hospital (LUTH), University College Hospital (UCH), Ibadan, The National Orthopedic Hospital, IgbobiYaba, Lagos, and the Psychiatric Hospitals in Aro, Abeokuta. Others are National Hospital in Abuja, University of Nigeria Teaching Hospital, Enugu, University of Port Harcourt Teaching Hospital, Choba, etc.

Furthermore, teaching hospitals are supposed to be fully developed and accredited for teaching of various medical disciplines. They are to conform to international and acceptable standards. It should be stressed also that apart from the provision of infrastructure for health matters, there is also the need for availability of teaching materials and specialists in such fields as surgery, general medicine, pediatrics, obstetrics, dentistry, otolaryngology, and psychiatry among other disciplines (Erinosho, 2005; Badru, 2003). To this end, each department should have a certain number of consultants with its own outpatients, consultation sessions, ward units, surgical sessions, and skilled personnel and auxiliary staff to man these units.

Table1: **The Strata of Health Care Facilities and Level of Responsibilities in Nigeria**

Responsibility of	Levels	Number of Health facilities	Types of Health Care Facilities
Federal Government	Tertiary Care	47	Teaching Hospitals and Federal Medical Centers
State Governments	Secondary Care	3,768	District Hospital, Comprehensive Health Center and Specialist, and General Hospitals
Local Government Areas	Primary Care	29,854	Dispensary & Health Posts (30%), Health Centers (44%), Clinics (26%)
TOTAL	**-**	**33,669**	**-**

Source: PharmAccess, 2016.

Discussion of Findings

Medical Tourism in Nigeria

Nigerian elites, especially but not limited to the political class, are known globally for their unbridled preference for medical attention abroad for the slightest medical issue – a tacit demonstration of lack of faith in the institutions they continuously swear to improve. This is popularly referred to as "*medical tourism*" in Nigeria. It is a situation whereby leaders or political elites abandon their country's healthcare facilities in a despicable state and travel overseas for treatment of common illnesses. The countries that Nigerians frequent for medical tourism include the United Kingdom, United Arab Emirates, United States, India, Saudi Arabia, Malaysia, Singapore, France, Canada, China, Ghana, Benin Republic, and Egypt among others. Every month over 5,000 Nigerians leaves the country seeking medical attention abroad for illnesses that can be treated in Nigeria (Guardian, 2021 March 31).

According to the World Health Organization, Nigeria is ranked 187 out of 191 countries in the global health index. This shows the level of neglect and decay in the Nigerian health system. It is estimated that Nigerians lose over $1 billion annually to medical tourism which has caused a serious burden to the health sector. The major key specialties where

Nigerians seek treatment abroad are; oncology, orthopedic, nephrology, and cardiology (PriceWaterHouse, 2016; Punch 2016 October 14; WHO, 2019).

This phenomenon, medical tourism, has forced President Muhammadu Buhari-led Federal Government to ban all government officials from seeking medical attention abroad, at least, theoretically. The neglect of domestic healthcare systems and preference for their foreign counterparts have had several negative impacts on the nation's health infrastructure i.e. lack of and decaying facilities, poor working environment and pitiable working conditions for health workers, and an exodus of health professionals for greener pasture, etc. For instance, despite the challenges in the health care system, there are over 3000 and 5000 trained Nigerian doctors in the United Kingdom and the United States, respectively. And, whereas Nigeria is in dire need of more doctors to meet what WHO has recommended for the doctor-patient ratio of 1:600 persons, the number of registered doctors stands at a paltry 42,000. This means for Nigeria to meet the WHO standard; 333,000 doctors are required to attend to her over 200 million population.

Nevertheless, medical tourism did not spur out of the blues and neither is it sui generis; rather it is the outcome of a series of interrelated activities, of which government neglect and corruption rank high. The decay in the health sector which underscores the willingness of the political elite to comfortably seek medical attention anywhere else except those under their care bespeaks of a larger problem which corruption and lack of political will fuel. A recent study, which explores financing mechanisms in Nigeria's health sector, reveals that health workers not only admit to the incapacity of the healthcare sector to handle any major health challenge such as the current Coronavirus pandemic; it noted that corrupt practices by political elites, administrators and professionals have reduced the health sector to a national hazard (Onwujekwe, Ezumah and Mbachu*et al*.2019).

Onwujekwe, Ezumah, and Mbachu *et al*. (2019) identified 49 corrupt practices which continue to maintain Nigeria's health sector as comatose. These included "absenteeism, procurement-related corruption, under-the-counter payments, health financing-related, and employment-related corruption" (*ibid*. 1). Acknowledging the perversity of corruption in the sector, they dismiss the intractability of reversing the tide and repositioning the sector for effective healthcare delivery. The challenges are surmountable and only require a concerted effort from critical stakeholders and

deliberate action directed at addressing the hydra-headed corruption that seats at the core of decay in health sector management (*ibid*.).

Emergence and Inertia of Organized Health Care Services

It would seem from available accounts that the earliest form of Western-style health care in Nigeria was provided by doctors brought by explorers and traders to cater for their own well-being. The services were not available to the indigenes. It was the Church Missionaries that first established health care services for the people. In this regard, tribute must be paid to the Roman Catholic Mission, the Church Missionary Society (Anglican), and the American Baptist Mission. It is on record that the first health care facility in the county was a dispensary opened in 1880 by the Church Missionary Society in Obosi, followed by others in Onitsha and Ibadan in 1886. However, the first hospital in Nigeria was the Sacred Heart Hospital in Abeokuta, built by the Roman Catholic Mission in 1885.

There are several anecdotal reports of practices within these missionary health care facilities across Africa to suggest that they were primarily used as tools for winning converts and expanding their followership (Manji & O'Coill, 2002). Consequently, these facilities were competitive rather than complementary. In spite of these facts, they were of relatively high quality that, by Independence in 1960, Mission-owned hospitals were more than Government-owned hospitals. This high quality is also evidenced by the fact that the Seventh Day Adventist Hospital in Ilesha as well as the Wesley Guild Hospital in Ile-Ife became the nucleus of the teaching Hospital complex of a major university in Nigeria. Even today in Nigeria, the Baptist Hospitals in Ogbomosho and Eku function as referral centers in the health care delivery matrix. Because of the evangelical functions of these health care facilities, it was left for the government to organize and develop policies for general health care. It is well known that towards the end of the 19th century, European powers were at war with each other for ownership of the vast rich land of Africa. They established frontiers needed to be secure and so there was a powerful British military presence in Nigeria. For the military, this was located in Lokoja, the British force, therefore, established medical services there. Under the Governor, Lord Lugard, Lokoja was the military headquarters in 1900. Aside from military health services, civilian services were also established and it is known that the first government hospital for civilians, the St. Margaret's Hospital, was built in Calabar in 1889.

Between 1952 and 1954, the control of medical services was transferred to the Regional governments, as was the control of other services. Consequently, each of the three regions (Eastern, Western and Northern) set up their own Ministries of Health, in addition to the Federal Ministry of Health. Although the federal government was responsible for most of the health budget of the States, the state governments were free to allocate the health care budget as they deemed fit. Nevertheless, most efforts directed at organizing health services as evidenced in the various national development plans have focused more on the formal/urban sector – a legacy of colonial administrative pattern – without a comprehensive healthcare system that would synthesize local knowledge and capacity for effective and efficient service delivery.

Nationwide Health Care Services

The health care services in Nigeria have been characterized by short-term planning, as is the case with the planning of most aspects of her national life. The major national development plans are as follows:

1. The First Colonial Development plan from 1945- 1955 (Decade of Development)
2. The Second Colonial Development plan from 1956- 1962
3. The First National Development Plan from 1962- 1968
4. The Second National Development Plan from 1970- 1975
5. The Third National Development Plan from 1975- 1980
6. The Fourth National Development Plan from 1981- 1985
7. Nigeria's five-year Strategic Plan from 2004 - 2008

   (Usman, 2013).

All of these plans formulated goals for national health care services. The overall national policy for Nationwide Health Care Services was clearly stated in a 1954 Eastern Nigeria government report on "Policy for Medical and Health Services." This report stated that the aim was to provide national health services for all. The report emphasized that since urban services were well developed (by the standards then), the government intended to expand rural services. These rural services would be in the form of rural hospitals of 20-24 beds, supervised by a medical officer, who would also supervise dispensaries, maternal and child welfare clinics, and preventive work (such as sanitation workers). The policy made local governments contribute to the cost of developing and maintaining such rural services, with grants-in-aid from the regional government. This report was

extensive and detailed in its description of the services envisaged. This was the policy before and during Independence. After independence in 1960, the same basic health care policy was pursued.

By the time the Third National Development Plan was produced in 1975, more than 20 years after the report mentioned above, not much had been done to achieve the goals of the Nationwide Health Care Services policy. This plan, which was described by General Yakubu Gowon, the then Head of State, as "A Monument to Progress", stated, "Development trends in the health sector have not been marked by any spectacular achievement during the past decade". This development plan appeared to have focused attention on trying to improve the numerical strength of existing facilities rather than evolving a clear health care policy to boost quality and accessible healthcare delivery.

The Fourth National Development plan (1981- 1985) addressed the issue of preventive health services for the first time. The policy statement contained in this plan called for the implementation of the Basic Health Services Scheme (BHSS), which provides for the establishment of three levels of health care facilities; namely 1) Comprehensive Health Centers (CHC) to serve communities of more than 20,000 people; 2) Primary Health Centers (PHC) to serve communities of 5000 to 20,000 persons; 3) Health Clinics (HC) to serve 2000 to 5000 persons. Thus, a CHC would have at least 1 PHC in its catchment area (ideally 4) and a PHC would have at least 1 HC in its catchment area (ideally 2). These institutions were to be built and operated by state and local governments with financial aid from the federal government. By this policy, the provision of health services would be the joint responsibility of the federal, state, and local governments. In its outlook, this policy is not different from the one published in 1954 by the Eastern Nigerian Government previously mentioned.

Today there are 26 medical schools in Nigeria, compared to 1 in 1960, 2 in 1965, 6 in 1975, 11 in 1984, and 18 in 2005, all providing medical education with curriculum borrowed from each other. Even our premier university and our revered seat of medical excellence, the University of Ibadan, College of Medicine, has not changed its curriculum since its inception. It has trained doctors in the same old way inherited from the colonizers as if the society is static. Even British Medical Education has changed several times over, yet ours has remained static and unchanging. Fortunately, a change in medical curriculum is on its way in Ibadan and this, we are confident, will revolutionize the way we understand health and train our doctors.

Funding

Funding the health sector has remained a major challenge with successive governments in Nigeria. Like education, health has been largely underfunded and this has had a significant impact on its infrastructure as well as its ability to conduct extensive research and development. While successive regimes have emphasized the importance of bolstering growth in the health sector, the same has not been reflected in practice and this is evident in the way resources are allocated to the sector in the national budget.

Table2:Budgetary Allocations to the Ministry of Health (2010 – 2020)

Year	Budget	Allocation to Min. of Health	Percentage (%)
2010	₦4,427,184,596,534	₦111,908,323,964	3%
2011	₦4,484,736,648,992	₦202,458,852,933	5%
2012	₦4,648,849,156,932	₦224,512,036,669	5%
2013	₦4,987,220,425,601	₦279,819,553,930	6%
2014	₦4,695,190,000,000	₦214,946,652,273	5%
2015	₦4,493,363,957,158	₦237,075,742,847	5%
2016	₦6,060,677,358,227	₦221,412,548,087	4%
2017	₦7,441,175,486,758	₦252,854,396,662	3%
2018	₦9,120,334,988,225	₦269,965,117,887	3%
2019	₦8,916,964,099,373	₦315,717,344,056	4%
2020	₦10,594,362,364,830	₦336,597,463,881	3%

Source: Authors Compilation 2021 with data from Federal Ministry of Health

The above table shows budgetary allocations to the health sector in the last decade. Through the years 2011 to 2015 complied with the minimum 5% recommended by the WHO, 2016 to date (with the exception of 2019) has witnessed a significant downward slope in health allocation even as the budget continues upward. Closer home, the African Union (AU) had recommended 15% of Gross Domestic Product (GDP) given the imperative to reposition the continent's healthcare system to cater for its teeming population. In defiance, Nigeria lags far behind the 15% benchmark set in the 2001 Abuja Declaration of the AU as allocation to the health sector.

However, besides poor funding and wanton neglect by the political elite, a major challenge is the disjuncture between knowledge and development. This is concretely

reflected in the static nature of the educational curriculum noted above, which draws from colonial logic and continues to service interests outside the former colonies by way of extraversion. The disconnection between traditional medicine and the medical institutions of research and learning is a manifestation of failure to use indigenous knowledge to solve local problems. Traditional medical practices often referred to in developing societies as alternative medicine, are understood to be a cumulative expression of a cultural understanding of nature appropriated for the healthcare purposes of the given society. For instance, the WHO defines traditional medicine as “the sum of all knowledge and practices (whether explicable or not) used in the diagnosis of, prevention and elimination of the physical, mental, and social imbalance and relying exclusively on the practical experience and observations handed down from generation to generation whether verbally or orally or in writing” (quoted in Falodun and Imieje 2013).

Although the WHO’s acknowledgment and increasing interest in traditional medicine spurred the establishment of the Nigeria Natural Medicines Development Agency in Lagos and the National Institute for Pharmaceutical Research, in 1988 and 1992 respectively, they have not been effective in integrating traditional medicine into the nation’s health care system. The advent of Covid-19 and its overwhelming effect on medical systems globally calls for the imperative to explore all possibilities with a view to providing a robust system of health care delivery. It is against this background the need to explore a synergy between traditional and western medicine becomes imperative.

Conclusion: The Imperatives of Reforms in Nigeria’s Health Sector

In times preceding western explorers, missionaries, and traders’ incursion to the area currently designated Nigeria, the inhabitants had long survived through traditional medicine as their system of health care delivery. Traditional healing and medical practices included herbalists, divine healers, soothsayers, midwives, spiritualists, bone-setters, Islamic medicine, 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 signpost that indicated a Western-style clinic or office, there were 3 that indicated a traditional doctor. Although this traditional system of healthcare evolved separately in different micro-cultures, there is a great deal of philosophical and conceptual similarities. Intrinsic in this regard is the

fact that traditional medicine is not only readily available; it is the only available, accessible, and affordable to a lot of people in developing societies, especially those living in rural areas. In Nigeria, traditional medicine is widely used in rural and urban centers. However, more importantly, what this suggests is that there is a high sense of patronage and reliance on traditional healthcare albeit the proliferation of Western medicine in the country. And, more so, the obstinacy of traditional herbal practice reveals that it is an enduring part of the culture of the people, especially subsisting in spite of sustained revulsion and campaign of denigration by orthodox medicine which is espoused as though possessing the finest grain of medical knowledge. The effect is that whereas orthodox medicine usually occupies the center stage in health discourse, it is a traditional medicine that reaches out to the bulk of society. This, according to Kasilo and Trapsida (2010), is a result of "its cultural acceptability, affordability, and accessibility" to most people in Africa, Asia, and Latin America, even as interest in traditional medicine continues to gather momentum in Europe and America (Ekeopara and Ugoha, 2017).

It is important to note that tales of how missionary-established health centers transmuted, albeit narcissistic practices, into general hospitals and specialist outfits litter the annals of medical practices in Nigeria. That is to say, although medical centers and clinics saturate rural areas; their presence has not been appropriated to integrate local knowledge into dispense health care services. Rather, the transformations have been largely teleguided to favor the development of orthodox medicine at the impairment of indigenous herbal practices. Yet, a preponderance of health challenges in the country is attended to outside the purview of the formal health sector, by a perverse but suppressed traditional medicine that has only recently been accorded the status of an 'informal sector. According to a World Health Organization (WHO) recent estimate, about 80% of Asia, Latin American, and African populations use traditional medicine to cater to their primary health care needs (Ekeopara and Ugoha, 2017). The figure for the western world is estimated at 50 percent, while an estimated 4 billion of the world population use herbal medicine for aspects of primary health concern (Falodun and Imieje, 2013).

The point is that, not only is the world's population largely dependent on traditional medicine, all societies throughout human history have been known to rely on herbal medicine for their healthcare. Every culture has explored, systematized, and used herbal plants for medicinal purposes, so that the bedrock of medical progression is premised on improvement in human understanding and utilization of herbs (Falodun & Imieje, 2013;

Ekeopara & Ugoha, 2017). However, while this course of human progression continues to gain momentum in some societies, in others, especially those interrupted by the combined forces of slavery and colonialism, the reverse is the case. The continuing legacies of colonialism have occasioned institutionalized dependence of the former colonies on their erstwhile colonizers for virtually everything (Sakue-Collins, 2020), including abandoning traditional medicine for Western medicine in the erroneous belief that Western medicine – itself a 'traditional medicine' from whence it comes – latter is superior.

Thus, it is no brainer that Nigeria, as a former colony, has been privy to a battered healthcare sector partly due to neglect of its traditional medicine. Traditional medicine, the engine room of primary health care, has been marginalized even though it caters to the majority of the population who happen to live in rural areas while urban centers get more attention albeit with limited infrastructure. The effect is the inability of the health system to face the challenges of an epidemic that stretches its capacity. Moreover, a society that is predominantly rural and with most of its population living closer to the fringes of nature than the fanfares of modernization, cannot afford to ignore the bountifulness of nature without facilitating its own perils. Conversely, a society with the majority of its population relying on traditional medicine will benefit greatly if the potentials of nature are harnessed and those who understand this practice integrated into the mainstream to boost the national healthcare delivery system.

The imperative to reform the health sector in Nigeria and, indeed, Africa will require a comprehensive overhaul of the existing structures which undergird its knowledge generation and application among others, but bridging the chasm between traditional and orthodox notions of medicine sits at the crux of such reform. Reform of the health sector, beginning from health education curriculum, needs to move beyond mere change of name or transmutation (i.e. from colonial to postcolonial structure) to reflect the needs of the society as well as grounding in indigenous knowledge systems. Political leaders at all levels must lead by example, by demonstrating willingness to revitalise the ailing health system.

A veritable catalyst in this regard will be by placing a ban on foreign medical trip or tourism by government officials. There is an urgent need for a Fifth National Development Plan, whose focus in the health sector will be, among other things, to build a synergy between traditional and orthodox medical practices, with emphasis on

developing indigenous knowledge systems through research and innovations. Here, while integrating traditional and modern medicine, emphasis is on recruitment and re-training of health sector personnel. Yet, there will be no meaningful reform of the health sector without corresponding political will, and therefore requesting political elite to ensure substantial increase in budgetary allocation for health and religious implementation of the national plan. For Nigeria to achieve optimal healthcare system reform, there is an imperative for vaccine nationalism, based on local capacity to cater for a sizable population of the country against the deadly virus. This will invariably curtail the phenomenon of brain drain of qualified medical professionals and promote national development.

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