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Moving the Goal Post: Sustainability and the Global Goals – Which Way Nigeria?

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Abstract It has been about a year since the sustainable development goals came into effect, and countries have had to adopt the sustainability agenda. Leaving the millennium development goals and their emphasis behind to chart a new course focusing on integrating and strengthening health systems would require innovative and strategic thinking at the country and global level, in addition to harnessing the potential for multiple inter-sectoral collaborations for success. Despite the adoption of the sustainability agenda post-2015, the achievements of the millennium development goals must still be leveraged and lessons learnt from both its successes and failures for the sustainable development goals to maximize their potential and result in positive global health outcomes. In the context of sub-Saharan Africa, several strengths, weaknesses and opportunities have been highlighted as either stepping stones or possible obstacles to the attainment of the sustainable development goals on the continent in general and Nigeria in particular. The outlook is optimistic but will call upon the galvanizing of partnerships and collaborations in order to build, strengthen and integrate background health systems for people, the planet and for prosperity. This paper is therefore a general reflection which aims at emphasizing Nigeria and Africa's challenges with achieving the millennium development goals and delineating the prospects which exist for achieving the sustainable development goals.

Keywords: *sustainable development, global goals, health systems, Nigeria, Africa*

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1. Introduction

In January 2016, the 17 Sustainable Development Goals (SDGs) of the Sustainable Development Agenda that had been adopted by various world leaders at the United Nations Summit of the preceding year officially came into force [1]. The aim of the Global Goals is to over the next fifteen years, put an end to poverty using strategies which enhance economic growth and address social needs such as education, health, social protection and job opportunities; while simultaneously tackling climate change and environmental protection [1].

The SDGs while building on the successes of the Millennium Development Goals (MDGs), aim to go even further by putting an end to all forms of poverty on the globe with the underpinning principle of "leaving no one behind" [1,2]. Whereas the MDGs for health (MDGs 4, 5 and 6) prioritized reduction in maternal and child mortality, diseases like HIV and AIDS, Malaria and 'Other Diseases', the SDGs by its third goal "to ensure healthy lives and wellbeing at all ages" aims to step away from the somewhat narrow confines and somewhat vertically-disposed orientation of the MDGs for health, and broadens its health focus to capture other disease areas which various stakeholders deem to have been neglected in the MDGs [1-4]. Disease conditions such as tuberculosis, neglected tropical diseases and even mental health conditions were considered de-emphasized by the MDGs [2,4]. Despite this, the MDGs which were designed to eradicate some common diseases, reduce inequalities in health, improve environmental health and build global partnerships for progress [3] were achieved and even exceeded by several countries, leading to measurable improvements in global health indices. However, many countries especially in sub-Saharan Africa struggled to even approach the set targets [5,6]. Some writers have gone on to argue that the primary reason for the failure of many African countries to achieve the MDGs was basically due to way the MDGs were designed and set [6,7]. It is believed that few local non-governmental organizations (NGOs) in Nigeria and Africa were involved in the development and setting of the MDGs, as the processes were led by government agencies with the support of consultants [8]. This occurrence is deemed unsurprising due to the challenges with capacity and support for capacity-building prevalent amongst Nigerian NGOs [8]. Even where some of these local NGOs are supported by funding agencies, the emphasis is usually on outputs, outcomes and results as opposed to NGO strengthening and staff empowerment [8].

While admittedly, the MDGs provided a foundation for global and national policy development and a driver for funding to improve the lives of the world's poor, it failed to address the root causes of poverty, gender inequality

and the nature of development [5]. In addition, the verticalization of health care services designed to tackle numerous disease entities captured in the MDGs have been pointed at as a reason for the lack of sustainable and long term benefits in health outcomes, despite immediate and tangible short term benefits [5]. The kick-off of the SDGs therefore presents an opportunity to look at prevalent health issues and health systems more holistically in a bid to strengthen these systems for more enduring and lasting outcomes and results. Highlighting this opportunity and the prospects for health systems strengthening in order to achieve the sustainable development goals is therefore the aim of this general reflection.

2. The Sustainability Agenda, Silos and Africa

Nigeria has been a beneficiary of international development aid in various sectors, notable among which is healthcare. Usually, this aid comes in the form of grants directed at specific disease entities with clearly delineated targets and objectives. Some of the diseases that have attracted international global funding include HIV and AIDS, malaria, tuberculosis, river blindness, poliomyelitis and guinea worm amongst others [5].

Donors in the African health ecosystem include the United States Agency for International Development (USAID), United States President's Emergency Plan for AIDS Relief (PEPFAR), United Kingdom's Department for International Development (DFID), Bill and Melinda Gates Foundation, The World Bank, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Clinton Health Access Initiative, Global Alliance for Vaccines Initiative (GAVI) Alliance and The Carter Foundation. This funding would usually be presented in a structured vehicle for delivery specifically designed for implementation for the particular disease entity. The programmes typically have distinct administrative structures, personnel, accounting and budgeting structures, and reporting channels with no cross-benefitting of programmes as they are structurally separate and removed from the general health system [8,9].

Where the government could have provided a more holistic monitoring and supervisory function in these programmes, the ministerial divisions overseeing each disease control or prevention programme are often structurally separate with virtually no internal structures for harmonising the objectives of the programmes and aligning them with national health objectives.

There is a consensus that vertical programmes can be beneficial in certain circumstances –where weak national health systems exist; where rapid results are required; economies of scale needed; where hard-to-reach populations need to be targeted and where complex services need to be delivered by a highly skilled workforce [11]. However, there is evidence to show that vertical programmes have negatively affected the effective management of health systems in areas like HIV, tuberculosis, substance abuse and mental disorders [11]. It is therefore advisable according to World Health Organization (WHO) reports, to balance vertical programmes with horizontal elements in order to achieve sustainability [11].

In a rapidly changing world plagued by sudden epidemic upsets with huge potential for global harm like the Ebola epidemics of recent years, it is only prudent, pro-active and cost-efficient to ride on the back of vertical programming with clear targets and gains to build on foundational health systems. It is these strengthened systems that would be able to withstand and resist the shocks and threats posed by unforeseen disease entities. It makes little sense to increase the longevity of people with communicable diseases such as HIV/AIDS, Tuberculosis and Malaria, only to have their lives cut short by preventable epidemics such as Cholera, Dengue and even Ebola; not to mention co-morbidities from non-communicable diseases (NCDs) which are growing in prevalence in Nigeria such as cancer, hypertension, and diabetes [12] and which rely on strong health system delivery frameworks to reduce morbidity and mortality from these conditions. Asides from epidemics and NCDs, recipients of interventions for these communicable diseases stand the risk of mortality from complications of their diseases inappropriately or insufficiently managed in a backdrop of weak health systems [9]. There is therefore a need to "actively de-emphasize" vertical health programming, and focus on strengthening existing health systems [5].

One of the achievements of the MDGs in Nigeria was the marginal reduction in the number of underweight children from 27.40% in 2012 to 25.50% in 2015 [13]. However, in a backdrop of weak health systems, conflict, terrorism and insurgency, Nigeria has seen stunting in children aged below five years in northern Nigeria rise to 50% in the last year alone [14]. Successes in areas such as reductions in under five mortality rates and maternal mortality rates are being threatened by the challenges in access to quality health care in areas of conflict and insurgency. Where the numbers of skilled birth attendants overseeing child deliveries and access to antenatal care and child immunization services increased substantially over the period of the MDGs [13], those gains have been heavily denigrated by present conflicts which have led to millions of Nigerians in the north-eastern part of the country being displaced from their homes or having their communities over-run by the terror group Boko Haram; thereby rendering them inaccessible to health care services. In addition, health financing constraints in the country prevented Nigeria from achieving MDG targets such as universal access to reproductive health services and treatment for HIV/AIDS [13]. Acute severe malnutrition now affects 14% of the population [14], and diseases like polio which had been declared eliminated from Nigeria by the WHO in a widely publicized and disseminated news release in 2015 which not only declared Nigeria "polio-free" but involved her removal from WHO's list of polio-endemic countries [15] have resurfaced nearly a year later due to pockets of wild polio virus detected in areas of conflict and have led to the paralysis of infected children [16]; with internal displacement of persons putting many unaffected communities and millions of Nigerians at great risk.

Prior to the declaration of Nigeria as a "polio-free" country, as at 2012, Nigeria accounted for over 50% of cases of polio worldwide [15]. The successful fight against polio in Nigeria was attributed to collaborative efforts by The

Global Polio Eradication Initiative (GPEI) – a public-private partnership involving national governments such as the Government of Nigeria and development partners like WHO, Rotary International, the United States Centers for Disease Control and Prevention (CDC) and United Nations Children's Emergency Fund (UNICEF), and supported by the Bill & Melinda Gates Foundation [15]. These disease elimination efforts while focused and well-meaning could have been bolstered by a comprehensive and holistic health system integrated effort. With a strengthened health system, surveillance activities would have been more robust and led to a more sustained disease elimination.

Current local and global economic challenges also provide a major incentive to build on health systems and rethink health systems delivery on the continent. Firstly, dwindling funding from international donor agencies in Europe and the United States have occurred because of slow recovery from the global financial crises [17]. By the end of 2015, The Global Fund experienced a funding gap of nearly $2.8 billion, between funds committed and funds disbursed for various intervention programmes [18]. The United States' President's Emergency Plan for AIDS Relief (PEPFAR) has also experienced funding gaps. Between 2014 and 2015, there is a gap of about $53 million in funding to Nigeria [19]. Secondly, in May 2016, the Global Fund after a series of investigations, reported that a long-term relationship with a ministerial department in Nigeria was to be discontinued following evidence of misappropriation of Global Fund grants [20]. The conclusion by the Office of the Inspector General of the GFATM was that the ministerial department and its supervisory extra-ministerial agency had weak and ineffective systems of internal controls to safeguard grant funds [20]. Given that funding from the GFATM to Nigeria have contributed immensely to improving the access of people living with HIV/AIDS to antiretroviral drugs, detection and treatment of cases of tuberculosis and distribution of insecticide-treated bed nets to help combat the spread of malaria; it is crucial that recipient countries start looking inwards at how to organically strengthen their health systems with in-built programme fund monitoring and oversight mechanisms to ensure the appropriate deployment of funds. Experiences such as these lend credence to the preference for vertical silos in programme delivery. However, such embarrassing occurrences should only drive home the need to strengthen recipient health systems to avoid similar recurrences in future. These examples highlight challenges donor countries and organizations are currently facing in raising and justifying development aid to the global south.

3. Shattering the Silos and Clearing the Path to Sustainability

The third sustainable development goal "To ensure healthy lives and wellbeing for all at all ages" is a clarion call for the unification and integration of the health systems delivery approach [5]. The time has come for all stakeholders in national and global health and development to come together as a unified force and harness global partnerships in order to bring about improved health outcomes on a global scale [5]. "Leaving no one behind" means ensuring that entire populations regardless of age and gender, entire communities whether rural or urban, and the entirety of prevalent disease entities including those that have long been stigmatized such as mental health disorders and neglected tropical diseases are deemed worthy of intervention efforts.

One of the fundamental principles in the sustainable development goals is the provision of universal health coverage to ensure access to safe quality health care for every citizen regardless of age, gender, location or socio-economic status at costs that are affordable to them and will not tip them into financial ruin. In Nigeria, out-of-pocket expenditure constitutes about 96% of health expenses, rendering many families penniless after incurring health care expenses where these are available [21]. A major reason for this inequity of access is the fact that the Nigerian National Health Insurance Scheme (NHIS) is grossly underfunded, with only 4% of the total population having access to services under the NHIS, over ten years after the scheme came into existence in Nigeria [22]. This therefore means that given the present economic provisions under the existing social insurance scheme, 96% of the populace are being "left behind". The NHIS is beleaguered by perceptions of minimal clarity in its structure, purpose, governance, accountability and scope [23]. It was created as an autonomous agency, and in practical terms appears to work with and engage health care provider facilities and health management organizations in the various states of the federation, bypassing the structure of the Federal or State Ministries of Health [23]. This operational framework would appear to not only hinder the process of health system strengthening, but actively weaken the system.

The rural poor in Nigeria, majority of whom belong to the informal sector and whose means of livelihood comprise mainly farming, fishing and trading in addition to having little or no access to social insurance, also have limited access to adequate health care services [21]. One reason for this is that the health system is plagued by myriad resource allocation inefficiencies which lead to the over-population of health care delivery resources in the urban areas to the detriment of the rural areas [21]. Another reason is the dearth of community health financing initiatives in majority of the rural areas [24]. Primary health care centres (PHCs) which are built and located in the rural areas are therefore very often under-equipped and under-staffed. The few healthcare workers deployed to these PHCs are not attractively remunerated, and coupled with the difficulties inherent in Nigerian rural community living such as irregular power supply, poor transportation, and inadequate water and sanitation facilities, it is difficult to motivate well-trained healthcare personnel to relocate to these areas when cushy jobs and attractive positions exist in the cities. Conflict, economic and budgetary constraints have in addition contributed to a reduced ability of governments in Africa to attract, employ and retrain well-trained health workers [25], further worsening an already bad situation.

The adoption of the SDGs therefore provides the opportunity for governments to seek innovative and strategic ways of capitalizing on the benefits of vertical programmes while building and integrating existing systems. Under the MDGs, a large number of health

workers were employed and trained by international donor agencies in order to deliver the specialized services required to meet delineated targets in specific areas. Many of these trainings could be stepped down to local work-forces and translated to basic health service provision, using those trained by the international donor programmes as resource persons and thereby minimizing funding requirements for capacity building. Another opportunity afforded by the SDGs is that by promoting sustained, inclusive and sustainable economic growth, with full and productive employment with the empowerment of women and the use of clean, affordable and renewable energy [1], home-grown solutions to funding constraints can be realized. In addition, by working to make cities and human settlements safe and inclusive as spelt out in SDG 11, resilient infrastructure, inclusive and sustainable infrastructure and a culture of innovation can be engendered (SDG9). These will open up multiple investment opportunities and the potential for innovative healthcare financing mechanisms such as public-private partnerships in healthcare delivery and revenues from taxation of new and emerging industries for example. Admittedly, current healthcare delivery models are very facility-based, doctor-centred and disease-specific; leading to over 400 million people worldwide unable to access much-needed services [26]. A re-thinking of healthcare delivery to embrace more patient-centred and community-centric services has enormous potential to 'carry more people along' and provide access to good care. The cost-effective and equitable achievement of universal health coverage in Nigeria would therefore require a well-integrated primary health care system [27]. Emphasis on the five key principles of primary health care namely accessibility, health promotion, use of appropriate technology, inter-sectoral collaboration and community participation in the implementation of an efficient PHC system in the country will help address many of the challenges inherent in achieving not only SDG3, but many of the other 16 SDGs [27].

The healthcare workforce and its deployment to rural or urban locations needs to be strategically addressed as a revitalized PHC system cannot function without sufficient thought into the human resources and manpower that will be required to deliver care to previously under-served populations. Planning for the deployment of healthcare professionals such as primary care doctors, nurses, midwives, birth attendants and community health workers (CHWs) to rural versus urban areas must be strategic, and conceptualized even from the time health workers are undergoing pre-service training in the professional institutions of learning [27]. A recognizable challenge in Nigeria and indeed Africa, is the training of an exceedingly large proportion of the healthcare workforce for hospital-based practice at the expense of strengthening the community-based workforce leading to unavailability of health services at the point of the most need [27]. Many of the existing primary health care centres are thus under-utilized, with a lack of confidence on the part of community residents and citizens. Recently, the Nigerian Society of Family Physicians offered to collaborate with the government on the deployment of trained family physicians to oversee these rural centres and ensure availability of quality services in rural communities that are home to the larger population and have the greatest healthcare needs [28]. This offers the government a large pool of skilled personnel already trained and prepared for community work. Government should capitalize on this offer as an opportunity to begin the process of strengthening the Nigerian health system from the bottom up and therefore ensuring a stronger foundation for healthcare service delivery.

Furthermore, achieving the SDG targets for health would require a departure from global health practice in times past. To achieve the targets over the next fifteen years, there is a need for multi-sectoral collaborations within and between countries in the spirit of true global partnering. These collaborations and partnerships will ensure that the social and economic determinants of health are taken into consideration in the planning, development and implementation of programmes. This method stands the best chance of strengthening and enriching the background health system by harnessing strengths and opportunities from multiple sectors. This is therefore the time for governments and global health organizations such as the World Health Organization (WHO) to ensure that investments in energy, infrastructure, food and gender equality have maximum health impact [29]. The WHO has been criticized strongly for a seeming lack of engagement with other sectors to determine risk factors for many of the SDG health targets [30]. Now is therefore as good a time as any for the WHO, and other global health stakeholders to step away from that perception and build strong multi-sectoral global partnerships. By creating new platforms and providing opportunities and incentives for intersectoral engagement [17,19], global health stakeholders would be broadening the chances of achieving and even surpassing the SDG health targets. Civil society can also play a vital role, by transforming data into moral arguments, helping build coalitions beyond the traditional health sector, democratizing policy debates and offering innovative options, enhancing the legitimacy of global health initiatives and institutions, serving as watchdogs and advocates for accountability, and demanding action to address and confront commercial determinants of ill health [31]. However, for civil society to add value and work to achieve these, they must be fully engaged by health institutions, in addition to being informed and empowered as stakeholders in the health sector.

4. The Road to 2030

If there is any hope for the achievement of the SDGs, now more than ever there is a need to harness existing opportunities and systems through multiple inter-sectoral collaborations. This is especially important for a country like Nigeria which due to its large population and poor health indices stands to contribute greatly to the achievement of the global goals following local achievement of the SDGs. The development of appropriate policy has never been an area where Nigeria has fallen short. It is however, the implementation of those policies that has proven a ubiquitous challenge to the country in the areas of health, economic and social development.

Nigeria, the African continent and the world at large must therefore join forces in truly robust multi-sectoral collaborations to bring about a shift in the way policies

have been implemented in the past in order to realize lasting and sustainable change.

Such partnerships would have to bring to bear varying degrees of experience and expertise which stand to benefit weak and fragmented health systems and result in stronger health systems by the year 2030. It is time for the gentrified world of 'global health' to emerge from its shell and embrace partners from beyond its walls in order to achieve the global goals for people, the planet and prosperity.

List of Abbreviations

AIDS – Acquired Immune Deficiency Syndrome
CDC – United States' Centers for Disease Control and Prevention
CHF – Community Health Financing
CHWs – Community Health Workers
DFID – United Kingdom Department for International Development
GAVI – Global Alliance for Vaccines Initiative
GFATM – The Global Fund to fight AIDS, Tuberculosis and Malaria
GPEI – The Global Polio Eradication Initiative
HIV – Human Immunodeficiency Virus
MDGs – Millennium Development Goals
NCDs – Non-Communicable Diseases
NGO – Non-Governmental Organization
NHIS – National Health Insurance Scheme
PEPFAR – United States President's Emergency Plan for AIDS Relief
PHC – Primary Health Care
SDGs – Sustainable Development Goals
TB – Tuberculosis
UNICEF – United Nations Children's Emergency Fund
USAID – United States Agency for International Development
WHO – World Health Organization

Statement of Competing Interests

The author has no competing interests.

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References

[1] United Nations. (2016). United Nations sustainable development agenda [Online]. Available from: http://www.un.org/sustainabledevelopment/development-agenda/ [Accessed 22nd October 2016].

[2] Smith J, Taylor EM. (2016). What Is Next for NTDs in the Era of the Sustainable Development Goals? *PLoS Negl Trop Dis* [Online]. 10(7): e0004719. Available from: http://www.ncbi.nlm.nih.gov/pubmed/27387209 [Accessed 5th October 2016].

[3] United Nations. (2015). United Nations Millennium Development Goals [Online]. New York, United Nations. Available from: http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf [Accessed 23rd October 2016].

[4] Gureje O, Thornicroft G. (2015). Health equity and mental health in post-2015 sustainable development goals. The Lancet Psychiatry. 2: 12-4.

[5] Oleribe OO, Crossey MME, Taylor-Robinson SD. (2015). Sustainable Health Development Goals (SHDG): breaking down the walls. *Pan Afr Med J* [Online]. 22:306. Available from: http://www.ncbi.nlm.nih.gov/pubmed/26966502 [Accessed 23rd October 2016].

[6] Easterly W. (2009). How the Millennium Development Goals are Unfair to Africa. *World Dev*. 37(1):26-35.

[7] Clemens MA, Kenny CJ, Moss TJ. (2007). The Trouble with the MDGs: Confronting Expectations of Aid and Development Success. *World Development*. 35(5):735-51.

[8] Walker, J-A. (2016). "Achieving health SDG 3 in Africa through NGO capacity building - insights from the Gates Foundation Investment in Partnership in Advocacy for Child and Family Health (PACFaH) Project," *Afr. J. Reprod. Health*, 20(3): 55-61.

[9] National Institute of Health. (2009). Addressing the Threat of Drug-Resistant Tuberculosis: A Realistic Assessment of the Challenge: Workshop Summary. National Academies Press (US). Available from: http://www.ncbi.nlm.nih.gov/pubmed/20669505 [Accessed 23rd October 2016].

[10] Magnussen L, Ehiri J, Jolly P. (2004). Comprehensive versus selective primary health care: lessons for global health policy. *Health Aff* [Online]. 23(3): 167-76. Available from: http://www.ncbi.nlm.nih.gov/pubmed/15160814 [Accessed 23rd October 2016].

[11] Atun RA, Bennett S, Duran A. (2008). When do vertical (stand-alone) programmes have a place in health systems? WHO European Ministerial Conference on Health Systems Policy Brief – June 2008. Copenhagen, WHO Regional Office for Europe. 1-28.

[12] Maiyaki MB and Garbati MA. (2014). The burden of non-communicable diseases in Nigeria; in the context of globalization. *Ann. Afr. Med.* 13(1): 1-10.

[13] National Bureau of Statistics. (2015). Nigeria MDGs Performance Survey Report 2015 | UNDP in Nigeria. Abuja.

[14] Save the Children. (2016). Child malnutrition in northern Nigeria: An illustrative case study | Tools for Food Security and Nutrition Analysis. [Online]. Available from: http://www.heawebsite.org/countries/nigeria/reports/child-malnutrition-norther-nigeria-illustrative-case-study [Accessed 23rd November 2016].

[15] World Health Organization. (2015). WHO Removes Nigeria from Polio-Endemic List. *WHO Media Centre.* [Online]. Available from: http://www.who.int/mediacentre/news/releases/2015/nigeria-polio/en/ [Accessed 13th December 2016].

[16] World Health Organization. (2016). WHO | Government of Nigeria reports 2 wild polio cases, first since July 2014. *WHO Media Centre*, 2016. [Online]. Available from: http://www.who.int/mediacentre/news/releases/2016/nigeria-polio/en/ [Accessed 13th December 2016].

[17] Armah BK. (2015). Sustaining Health for Wealth: Perspectives for the Post-2015 Agenda: Comment on Improving the World's Health Through the Post-2015 Development Agenda: Perspectives From Rwanda. *Int J Heal Policy Manag* [Online]. 4(10):673-5.

[18] Global fund. (2016). Global Fund Grant Portfolio [Online]. Available from: http://www.theglobalfund.org/en/portfolio/[Accessed 23rd October 2016].

[19] PEPFAR. (2016). Country Operational Plans - Fiscal Years 2007-2016 [Online]. 2016. Available from: http://www.pepfar.gov/countries/cop/index.htm [Accessed 24th October 2016].

[20] Global Fund. (2016). Investigation in Nigeria - The Global Fund to Fight AIDS, Tuberculosis and Malaria [Online]. Available from: http://www.theglobalfund.org/en/oig/updates/2016-05-03_Investigation_in_Nigeria/ [Accessed 24th October 2016].

[21] Okpani AI, and Abimbola S. (2015). Operationalizing universal health coverage in Nigeria through social health insurance. *Niger. Med. J.*, vol. 56(5): 305-10.

[22] Onoka CA, Onwujekwe OE, Uzochukwu BS and Ezumah NN. (2013). Promoting universal financial protection: constraints and enabling factors in scaling-up coverage with social health insurance in Nigeria. *Health Res. Policy Syst.*, vol. 11: 20.

[23] Onoka, C. (2015). Accountability for Universal Coverage Efforts in Nigeria: an Agenda for the Future. *Nigeria Health Watch*. [Online]. Available from: http://nigeriahealthwatch.com/accountability-for-universal-coverage-efforts-in-nigeria-an-agenda-for-the-future/ [Accessed: 14th December 2016].

[24] Adinma, E and Adinma, B. (2010). Community Based Healthcare Financing: An Untapped Option to a more Effective Healthcare Funding in Nigeria. *Niger. Med. J.* 51(3):95.

[25] Anyangwe SCE, Mtonga C. (2007). Inequities in the global health workforce: the greatest impediment to health in sub-Saharan Africa. *Int J Environ Res Public Health* [Online]. 4(2):93-100. Available from: http://www.ncbi.nlm.nih.gov/pubmed/17617671 [Accessed 5th October 2016].

[26] World Health Organization. (2015). Tracking universal health coverage: First global monitoring report [Online]. Available from: http://www.who.int/healthinfo/universal_health_coverage/report/2015/en/ [Accessed 24th October 2016].

[27] Onokerhoraye. AG (2016). Achieving universal access to health care in Africa: the role of primary health care. *Afr. J. Reprod. Health*. 20(3): 29-31.

[28] Moses LA. (2016). Family Doctors Seek Partnership with Government to Improve Health Services | Medical World Nigeria. In *19th Annual General Meeting and Scientific Conference of Society of Family Physicians of Nigeria*, 2016.

[29] Nordstrom A. (2013). Changing the perspective: from disease control to healthy people. *The Lancet Global Health Blog* [Online]. Available from: http://globalhealth.thelancet.com/2013/06/25/changing-perspective-disease-control-healthy-people [Accessed 24th October 2016].

[30] Gopinathan U, Watts N, Hougendobler D, Lefebvre A, Cheung A, Hoffman SJ, et al. (2015). Conceptual and institutional gaps: understanding how the WHO can become a more effective cross-sectoral collaborator. *Global Health* [Online]. 11:46. Available from: http://www.ncbi.nlm.nih.gov/pubmed/26596963 [Accessed 24th October 2016].

[31] Smith J, Buse K, Gordon C. (2016). Civil society: the catalyst for ensuring health in the age of sustainable development. Global Health [Online]. *BioMed Central* 12(1):40. Available from: http://www.ncbi.nlm.nih.gov/pubmed/27424031 [Accessed 5th October 2016].