Nigeria

Nigeria (population 137.25 million) is a country in Western Africa that covers an area of 923,768 square kilometres. Its boundaries border the Gulf of Guinea, between Benin and Cameroon, Niger and Chad. The capital city of Nigeria is Abuja.

According to the United Nations human development index (HDI), Nigeria is ranked 151/177 countries worldwide (0.466) [1] and 21/45 African countries for which an index is available. This places Nigeria in the group of countries with low human development.

PALLIATIVE CARE SERVICE PROVISION

Current services

Palliative care services are provided by two organisations in Nigeria, the Palliative Care Initiative (Ibadan) and Hospice Nigeria (Lagos) (Table 1).

Table 1 Palliative care provision in Nigeria, 2004

Adult Services								
Nigeria	*Freestanding unit*	*Hospital unit*	*Hospital support team*		*Home care*	*Day care*	*Clinic/ Drop-in centre*	*Grand Total*
Palliative Care Initiative, Ibadan			1				1	2
Hospice Nigeria, Lagos					1			1
Total services			1		1		1	3

In resource poor areas, the blending of supportive care with hospice/ palliative care is frequently linked to the development of previously established services, particularly home based care. Where opioids are unavailable, however, the definition of palliative care can be problematic. We have taken the view that where a service is in the process of development from (largely) physical care to a broader form of holistic care that approximates to the WHO definition, it should be included in the review.

Palliative care services in Nigeria are undeveloped. There is continuing resistance to some palliative care concepts including opiate use, the multidisciplinary team approach to the management of medical problems and the inclusion of patient and family as the unit of care.

Palliative Care Initiative, Nigeria (PCIN)

Palliative care is being introduced to Nigeria through the Palliative Care Initiative, Nigeria based at the College of Medicine, University of Ibadan. PCIN is a multidisciplinary group of medical specialists who implement the major objectives of training, service and research in this area of medical care. The group was formed in January 2003 and in addition to sensitizing the public on the importance of palliative care, it has sponsored some of its members to attend palliative care courses and conferences in other countries. It operates a pain and palliative care clinic at the University College Hospital, Ibadan. This was commissioned in February 2005 to provide support for patients with chronic pain and cancer patients. [2] In its current form as a chapter of the International Association for the Study of Pain the group is working towards including palliative care into the curriculum of medical and nursing students, based upon guidelines developed by Hospice Africa Uganda. Funding has been obtained to develop home based palliative care services. A train the trainers programme is expected to produce locally trained palliative care practitioners. Olaitan Soyannwo summarises the current situation:

> So what we have in terms of palliative care right now is that we have a lot of individuals, oncologists, surgeons, physicians, you know, just managing patients as best as they can. But the holistic approach, we've just introduced that using a small clinic in the radiotherapy clinic and a group of us, two anaesthetists, one oncologist, one nurse, psycho-oncologist, who does counselling, we run a clinic there once a week and then patients on the ward are referred to us, patients with terminal illness, but one major problem is availability of opioids. We don't have oral morphine in the country: we have injectable opioids – even that one was not available for about four years, and we had to do a lot of advocacy because there was some years back some regulatory problems and opioids were banned with, because they were grouped with narcotics, so although it's on the National Drug Formulary…we don't have the oral form, even on the Formulary, so we're doing a lot of advocacy to get that in now for management of palliative care, for palliative care and management of ill patients.[3]

She envisages palliative care as a helpful approach in managing the HIV/AIDS epidemic in Nigeria.

> We had a group, an international group, like a collaborative from my university, Medical Women's Association from Lagos and a group from California, which were mainly alumni of university who are interested in cancer pain management. Although we focused on cancer of the breast and cervix which are the two commonest cancers, we want to use the template to do a lot of advocacy for patients with cancer and HIV/AIDS. And the good thing that I think we have in my institution is that we're already on the national programme in terms of ARV therapy and also prevention of mother to child transmission, so since we are, that is already established, I'm hoping that it will not be too difficult with the support from APCA, this new organisation, to be able to convince them back home that palliative care should be part of this AIDS programme in the country.[4]

PCIN organised a one day workshop on the art and science of palliative care and the management of terminally ill patients in Nigeria on 27 January 2005. Participants

included the Provost and Principal Officers of the College of Medicine, The Chief Medical Director, Chairman, Medical Advisory Committee and Director of Administration of the University College Hospital, Ibadan. Also present were representatives of the Commissioner of Health (Oyo State), Permanent Secretary, Ministry of Health (Osun State), retired and serving members of the judiciary, clergy, health professionals, students, the public and the press. There were also representatives of Hospice Nigeria based in Lagos and the Palliative Care Association based in Abeokuta. International guests included Anne Merriman, Founder of Hospice Africa Uganda and Jack Jagwe, a Senior Adviser on Drugs Policy in Uganda.[5] A primary focus for the workshop was to advocate for palliative care in Nigeria. The main outcomes of the workshop include:

> the need to promote a greater awareness of the benefits of palliative medicine in the population at large and among all cadres of professional and traditional healthcare providers. The workshop also recommended a review of the existing restrictions on the availability of oral morphine and other opioids in recognized hospitals and clinics for the relief of severe pain, especially in terminal care situations. It recognizes palliative care as a specialty in itself and the need to train trainers in the field.
>
> The workshop recognizes the leadership roles of the Federal Ministry of Health (FMOH) and the National Agency for Food and Drug Administration and Control (NAFDAC) in these endeavours and urges the Palliative Care Initiative of Nigeria (PCIN) to seek the cooperation of these institutions in these matters.
>
> The workshop strongly recommends the formation of a National Committee or a National Association on Palliative Care to coordinate the activities of satellite groups nationwide, to establish the standards and ethics of terminal care, and to foster relations with similar organizations worldwide.[6]

Hospice Nigeria

This non-governmental organisation in Lagos was registered in 1993 and provides home based care to the terminally ill. It is most often utilised by patients returning home to Nigeria from abroad. The founder, Olusola Fatunmbi ,explains the system:

> I had more patients referred to me from London at Lagos Hospitals than within Nigeria, but they knew I had drug problems, and on that basis they promised to see that the patients come with enough oral morphine and some other palliative drugs for their use. And my home care service with my husband and occasionally some of the members of the Trustees, was acquired, was free because we had no funding from anybody, and the counselling, the only thing is that the patients buy their own drugs.[7]

A cancer public awareness campaign has resulted in a few local patients benefiting from the organisation’s help although scarce supplies of oral morphine result in poor pain management.

Several other organisations and individuals may offer some elements of palliative care in clinics and support services for HIV/AIDS patients. Two doctors based at Federal

Medical Centre, Abeokuta (Ogun State) and Zaria have formed a Palliative Care Association and are understood to be promoting palliative care.

Reimbursement and funding for services

The Diana, Princess of Wales Memorial Fund sponsored a visit by Olaitan Soyannwo and two of her colleagues to Hospice Africa Uganda. The aim of this visit was to develop a strategy towards training of trainers within Nigeria in order to build palliative care capacity.

A one day palliative care workshop in Ibadan in January 2005 was co-sponsored by Help the Hospices, UK and the African Palliative Care Association (APCA).

Initial funding has been provided by Hospice Africa Uganda to develop home based care services by PCIN. This programme has not yet been established.

Opioid availability and consumption

The International Narcotics Control Board [8] has published the following figures for the consumption of narcotic drugs in Nigeria: codeine 296 kg; Pholcodine 19kg; pethidine 5 kg.

For the years 2000-2002, the average defined daily dose consumption of morphine for statistical purposes (S-DDD)[9] in Nigeria was 0. This compares with other African countries as follows: Swaziland 1; Egypt 2; Uganda 4; Zimbabwe 13; Namibia 73; South Africa 103. Twenty nine countries reported no morphine consumption during 2000-2002 (Table 2).

Olaitan Soyannwo confirms that opioid analgesics (parenteral and oral) are not available in government stores and health facilities.[10]

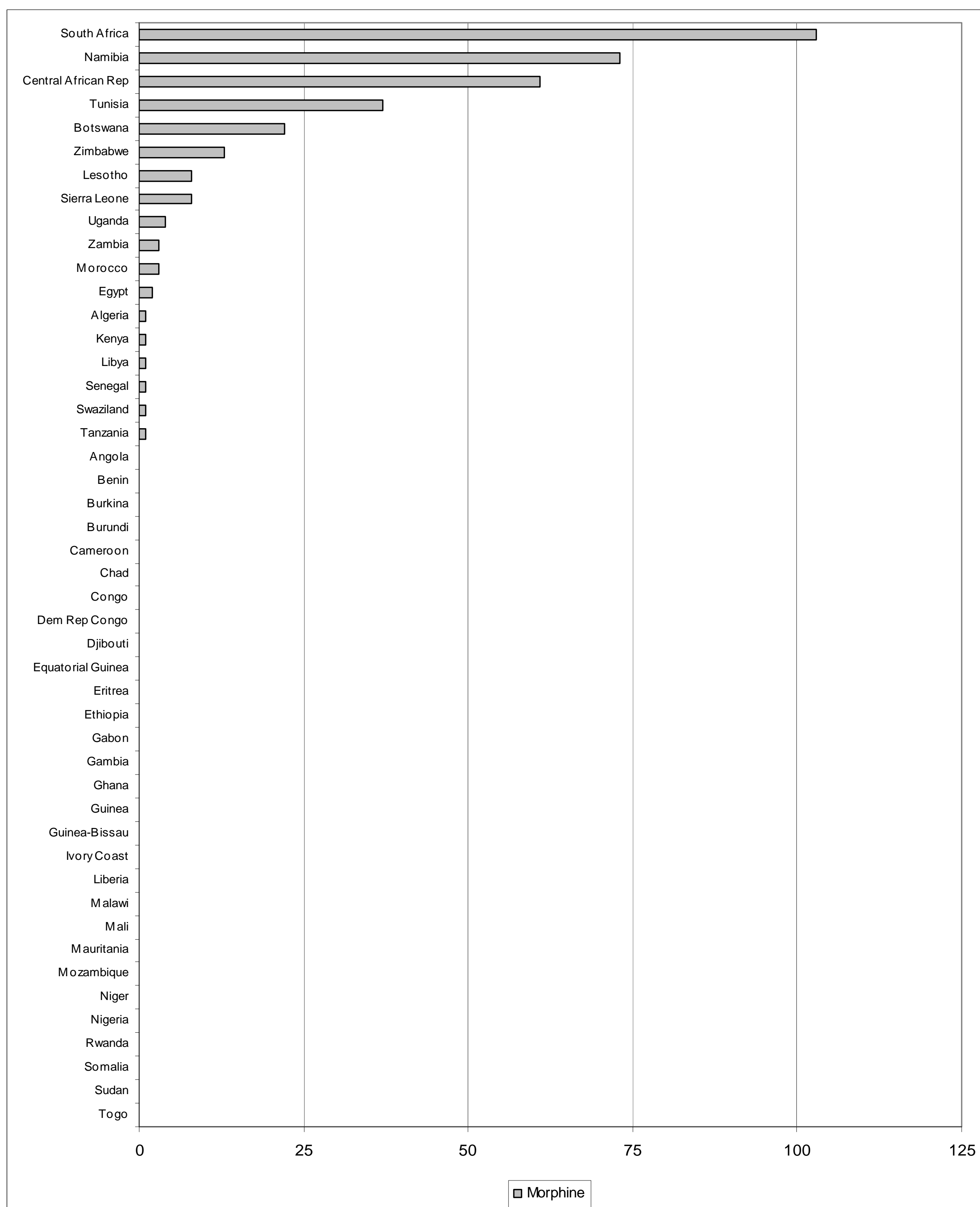
National and professional organisations

The following organisations feature prominently in Nigeria:

African Palliative Care Association (APCA)

The African Palliative Care Association was formally inaugurated at a conference in Arusha in June 2004. The concept was born in 2002 in Cape Town, South Africa at a meeting to look at issues of palliative care education in Africa. The desire to link knowledge, resources and networks throughout Africa formed the motivation to form the association. Steering committee members were drawn from: Kenya (Zipporah-Merdin Ali), South Africa (Kath Defilippi), Tanzania (Mark Jacobson) Uganda (Anne Merriman) and Zimbabwe (Sambulo Mkwananzi).[11]

Table 2 Average daily consumption of defined daily doses (for statistical purposes) of morphine per million inhabitants, 2000-2002: countries of Africa



Source: International Narcotics Control Board *Narcotic Drugs: Estimated World Requirements for 2004. Statistics for 2002*. New York: United Nations, 2004.

In summary, APCA aims to:

- promote study, knowledge, training and research in palliative care
- foster networks and links at all levels of palliative care
- address ethical issues
- establish an international communication network
- sponsor publications
- disseminate achievements
- promote access to resources

Objectives include:

- promotion of standards
- advocating for palliative care at governmental level
- securing the availability of drugs
- encouraging the development of national associations within Africa
- promotion of training programmes
- devising standard guidelines
- advocacy

Representatives of APCA presented papers at a workshop convened in Ibadan in January 2005 to promote advocacy for palliative care in Nigeria.

President's Emergency Plan for AIDS Relief (PEPFAR) [12]

During his State of the Union address in 2003, President Bush announced his PEPFAR initiative; this groundbreaking intervention encompasses HIV/AIDS activities in more than 75 countries and focuses on 15 countries worldwide – of which Nigeria is one of 12 in Africa – to develop integrated care and treatment programmes (Table 5). Over the next 5 years, PEPFAR is donating a total of US $15billion, of which 15% is earmarked funding for palliative care. This has dramatically changed the palliative care landscape in Africa, as bids for new initiatives are attracting the funding for implementation. Four main areas are targeted:

- prevention of HIV transmission
- treatment of AIDS and associated conditions
- palliative care for HIV infected individuals
- care for AIDS orphans and other vulnerable children

Hospice Africa Uganda

This NGO was founded in 1993 to care for cancer and HIV/AIDS patients and give support to family members.[13] In the past, most referrals came from hospitals; now, an increasing number originate from community vigilantes (trained carers who identify patients in the community in need of the hospice's services). Hospice Africa Uganda also incorporates Mobile Hospice Mbarara and Little Hospice Hoima, both established in 1998.[14]

In Central and East Africa, Hospice Africa Uganda became the Diana Fund's partner agency in a 3 year project which attracted funding of £300,000. During this period, Hospice Africa Uganda would:

- provide technical support and advice on the identification of countries with the capacity and political will to initiate palliative care services
- provide guidance and training to such countries
- set up and run a Distance Learning Diploma in Palliative care for African countries
- set up a resource centre of palliative care materials for Africa, at Makindye, Kampala
- improve services within Uganda so that a model can be developed that works for the poorest and that can be duplicated in other African countries.

Anne Merriman comments:

> In 2001, the Diana, Princess of Wales, Memorial Fund in London, invited Hospice Africa Uganda to be their technical experts in assisting other African countries to start or strengthen palliative care services using the public health approach and integrating with existing health systems. Working with World Health Organisation, this initiative has brought the Hospice training programmes to several other African countries.[15]

As part of this vision Hospice Africa Uganda has assisted PCIN in its efforts to introduce palliative care into Nigeria.

There is no national association in the country. This has been identified as a priority by the participants of the palliative care workshop held in February 2005 in Ibadan.

UK Forum for Hospice and Palliative Care Worldwide[16]

This NGO, formed in 2001 to support the development of palliative care in resource poor countries, falls under the umbrella of Help the Hospices (UK). The following grant has been awarded top Nigeria:

- PCIN - a 2 day regional advocacy workshop involving health professionals, policy-makers and others from the south west of Nigeria: £2,000

Palliative care coverage

Palliative Care Initiative, Nigeria

There are approximately 3000 patients per year who attend the radiotherapy unit at the University College Hospital in Ibadan either as inpatients or outpatients. About 30 cancer patients admitted to the hospital each year are referred to the PCIN team.

Hospice Nigeria

The majority of patients seen by this home based care programmes are Nigerians recently returned home from abroad. Very few local Nigerians utilise the service.

Education and training

In the absence of formal palliative care policies, palliative care education has been undertaken by individuals.

Palliative Care Initiative, Nigeria

Olaitan Soyannwo uses her position as lecturer and senior academic to spread knowledge of palliative care.

> Right now at Ibadan we have a new group in the College of Medicine and we've introduced palliative care into the curriculum of medical students and nursing students. The proposal has been sent from the Faculty, it's now awaiting, you know, confirmation at the College level so that once that is passed it can go into the curriculum.[17]

From April 2005 an oncology nurse from PCIN will undertake an 8 week course at Hospice Africa Uganda.

Hospice Nigeria

This home based care programme has identified the model of training used by Hospice Africa Uganda as appropriate for its training development.

> I now know that the Uganda model is much, much more to relevance to us in Africa, I mean in terms of setting up something because one can then, you know, the facilities are much limited here, and I'm thinking that it would be easier to incorporate, what palliative care training and teaching into existing healthcare model that is within the country, so that if everybody, even right up to the village health workers, are trained, because like now in terms of malaria for example they are training people to give home care, so if people are trained at every level to, on palliative care, so that even if the patients are discharged to distant places you can have some contact point and so that you, after training a few experts in palliative care, I mean in terms of doctors, nurses, social workers, they can now train the others locally. So that you send a few out for training, maybe to other centres in Africa, and then those can go back home and train more, that's the way.[18]

Palliative care workforce capacity

There are no full time palliative care workers in Nigeria[19].

HISTORY AND DEVELOPMENT OF PALLIATIVE CARE

Narrative history of palliative care

Palliative Care Initiative, Nigeria

As Professor of Anaesthesia and Dean of Clinical Sciences at the College of Medicine Olaitan Soyannwo developed an interest in pain management, especially of patients undergoing acute surgery and trauma. Expanding her interest to cancer pain she attended the World Pain Congress in 1996 and thereafter established a palliative care

team in her home country. The Palliative Care Initiative, Nigeria is being registered as a non-governmental organisation. 3 members of the group have experience in palliative care.

Hospice Nigeria

Olusola Fatunmbi is a nurse and became aware of international hospice programmes during the 1990s. A combination of training courses at St Christopher's Hospice in the UK and a visit by Anne Merriman to Nigeria provided her with the confidence to establish a home based care programme in Lagos for people living with terminal illness.

Hospice success stories

No data available

Life/oral histories

Olaitan Soyannwo – *Professor of Anaesthesia, Dean of Clinical Sciences, College of Medicine, University of Ibadan*: interviewed by David Clark 4 June 2004. Length of interview (West Africa group): 40 minutes.

Professor Olaitan Soyannwo explains how her interest in pain management arose out of seeing the suffering of surgical and trauma patients. Realising that cancer patients received no pain management at all, she attended the World Pain Congress in 1996 and returned to Nigeria inspired to establish a palliative care team at the University Teaching Hospital. That team, now known as the Palliative Care Initiative, Nigeria, is affiliated to the International Association for the Study of Pain. She lists the fora through which she spreads the word of palliative care principles, including the West African College of Surgeons and the Faculty of Anaesthesia. Advocacy for palliative care and accessibility to oral morphine is a priority. Introduction of palliative care methods into the curriculum for medical and nursing students has been presented for ratification by the university authorities. Hospice Uganda has been the model for training health professionals. Without oral morphine in the country, health professionals do what they can with injectable morphine. Beginning with cancers of the breast and cervix, this group of professionals are developing a protocol of holistic care that can be applied to other conditions, including HIV/AIDS. The hospital is already registered for antiretroviral therapy and prevention of mother to child transmission. She hopes that palliative care will be implemented by these programmes. Turning to the African Palliative Care Association (APCA) and her role as board member, Olaitan Soyannwo reflects on Anne Merriman's efforts to introduce palliative care to Nigeria before moving to Kenya and Uganda. She hopes that APCA will give the necessary impetus to the implementation of palliative care by both the public health system and the private sector in Nigeria. She identifies the need to form a national palliative care association in the country in order to gain an accurate picture of the various services.

Olusola Fatunmbi – *nurse, founder of Hospice Nigeria:* interviewed by David Clark 4 June 2004. Length of interview (West Africa group): 40 minutes.

Olusola Fatunmbi attended the Sixth International Conference at St Christopher's Hospice in 1991 and was inspired to return to Nigeria to implement home based palliative care. Having met Anne Merriman at the conference she invited her to Nigeria in 1993 to advocate with the Ministry of Health for the necessary systems to be put in place for palliative care. Talks were held at the Lagos Teaching Hospital but there was little political will at the time to embrace this medical speciality. Having attended further palliative care courses at St Christopher's Hospice, she began to network with an oncologist in the region who shared her vision of home based care for the needy. Establishing a home based care service with her husband and other interested professionals, she facilitates palliative care for many Nigerian patients referred from St Christopher's Hospice. She describes how oral morphine is unavailable in Nigeria, necessitating patients arriving from the UK with their own supply of palliative drugs. Referrals of patients from the diaspora continue to account for the majority of her patients. Olusola Fatunmbi gives a moving account of one of her patients whose symptoms were well controlled using locally available vegetables. She concludes by sharing her vision for palliative care education to be incorporated into existing health care systems in Africa in general and Nigeria in particular, using the model championed by Hospice Africa, Uganda.

PUBLIC HEALTH CONTEXT

Population

Nigeria, which is Africa's most populous country (137.25 million), is composed of more than 250 ethnic groups; the following are the most populous and politically influential: Hausa and Fulani 29%, Yoruba 21%, Igbo (Ibo) 18%, Ijaw 10%, Kanuri 4%, Ibibio 3.5%, Tiv 2.5%

Religious groups include: Muslim 50%, Christian 40%, indigenous beliefs 10% [20]

Epidemiology

In Nigeria, the WHO World Health Report (2004) indicates an adult mortality[21] rate per 1000 population of 453 for males and 392 for females. Life expectancy for males is 48.0; for females 49.6. Healthy life expectancy is 41.3 for males; 41.8 for females.[22]

HIV/AIDS is a huge burden for sub-Saharan Africa. Throughout the region in 2003, an estimated 23-27 million people were thought to be living with the disease which also caused up to 2.5 million deaths. This represents a huge loss and impacts significantly on health systems and social and family structures.

Nigeria is one of the worst HIV/AIDS affected countries in Western Africa. Estimates suggest that in Nigeria, between 2.4 and 5.4 million people were living with

HIV/AIDS at the end of 2003. In the same year, up to 490,000 adults and children are thought to have died from the disease (Table 2).

Table 2 Country HIV and AIDS estimates, end 2003

Adult (15-49) HIV prevalence rate	5.4% (range: 3.6%-8.0%)
Adults (15-49) living with HIV	3 300 000 (range: 2 200 000-4 900 000)
Adults and children (0-49) living with HIV	3 600 000 (range: 2 400 000-5 400 000)
Women (15-49) living with HIV	1 900 000 (range: 1 200 000-2 700 000)
AIDS deaths (adults and children) in 2003	310 000 (range: 200 000-490 000)

Source: 2004 Report of the global AIDS epidemic

UNAIDS reports:

> While Nigeria's infection rate is lower than those of neighbouring countries, it nonetheless represents higher number of infections, given the large population; the country now has the highest number of HIV/AIDS-infected adults in West Africa. HIV/AIDS was first reported in Nigeria in 1986. Since then, the epidemic has been growing rapidly. In 2002 alone, more than 200 000 AIDS-related deaths occurred, and it was estimated that Nigeria had more than one million children orphaned by AIDS. Many factors that favour a rapid spread of the virus are prevalent in Nigeria, including high mobility, trafficking of young girls, marginalization of women, poverty, social and economic inequality, and specific socio-cultural practices. The "Next Wave of HIV/AIDS" report of the US National Intelligence Council predicts an estimated 10 million–15 million people living with HIV in the country by 2010.
>
> Nigeria has put in place the necessary coordinating and decision-making bodies: the Presidential AIDS Council is chaired by the president of the country and includes the main line ministries. The federal coordination mechanism, the National Action Committee on AIDS (NACA), has been fully established with adequate infrastructure and capacity. Civil society participation in the fight against HIV/AIDS has been institutionalized through the establishment of coordination mechanisms such as the Network of People Living with HIV in Nigeria (NEPWAN), the Civil Society Consultative Group on HIV/AIDS in Nigeria (CiSCGHAN), the Faith-based Forum on HIV/AIDS, and the Nigeria Business Council on HIV/AIDS (NIBUCAA). The timeframe of the HIV/AIDS Emergency Action Plan (HEAP) 2000–2003 has elapsed and a review of the HEAP is being planned in the context of the participatory development of the new National HIV/AIDS Strategic Framework 2005–2009. Preparations for the drafting of the National Health Sector Strategic Plan and an advocacy strategy are well under way. [23]

Health care system

In 2001, the total per capita expenditure on health care was Intl $31 (3.4% of GDP).[24]

Among the countries of Africa, this figure falls within a spending range of Intl $652 in South Africa (8.6% of GDP) and Intl $12 in the Democratic Republic of Congo (3.5% of GDP). At 2.0% the smallest spending as a percentage of GDP is in Equatorial Guinea (Tables 3 and 4).

The WHO overall health system performance score places Nigeria 187/191 countries. This composite measure of overall health system attainment[25] is based on a country's goals relating to health, responsiveness, and fairness in financing. The measure varies widely across countries and is highly correlated with general levels of human development as captured in the human development index.

Political economy

Before the colonial period, the area which comprises modern Nigeria had an eventful history. More than 2,000 years ago, the Nok culture in the present Plateau state worked iron and produced sophisticated terra cotta sculpture. In the northern cities of Kano and Katsina, recorded history dates back to approximately 1000 AD. In the centuries that followed, these Hausa kingdoms and the Bomu empire near Lake Chad prospered as important terminals of north-south trade between North African Berbers and forest people who exchanged ivory, and kola nuts for salt, glass beads, coral, cloth, weapons, brass rods, and cowrie shells used as currency. In the southwest, the Yoruba kingdom of Oyo was founded about 1400, and at its height from the 17th to 19th centuries attained a high level of political organization and extended as far as modern Togo. In the south central part of present-day Nigeria, as early as the 15th and 16th centuries, the kingdom of Benin had developed an efficient army; an elaborate ceremonial court; and artisans whose works in ivory, wood, bronze, and brass are prized throughout the world today. In the early 19th century the Fulani leader, Usman dan Fodio, launched an Islamic crusade that brought most of the Hausa states and other areas in the north under the loose control of an empire centered in Sokoto. [26]

Since independence, the economy has become increasingly under the influence of the oil industry which has moved the country away from its agricultural base. However, oil has affected the way in which successive military regimes have approached economic management as well as investment and consumption patterns.[27] The capital-intensive oil sector provides 20% of GDP, 95% of foreign exchange earnings, and about 65% of budgetary revenues. The largely subsistence agricultural sector has failed to keep up with rapid population growth - Nigeria is Africa's most populous country - and the country, once a large net exporter of food, now must import food. The IMF have proposed a number of market-oriented reforms, such as modernization of the banking system, the curbing of inflation by blocking excessive wage demands, and the resolution of regional disputes over the distribution of earnings from the oil industry. During 2003, the government deregulated fuel prices and announced the privatization of the country's four oil refineries. GDP growth will probably rise marginally in the future, led by oil and natural gas exports. The country faces the daunting task of rebuilding a petroleum-based economy and institutionalizing democracy if it is to build a sound foundation for economic growth and political stability.[28]

Tables 3 and 4 Total health expenditure (Intl $) per capita and as a percentage of GDP: countries of Africa, 2001

Table 3
Health expenditure (Intl $) per capita: Africa

Country	Per capita
South Africa	652
Tunisia	463
Botswana	381
Namibia	342
Libya	239
Morocco	199
Gabon	197
Algeria	169
Swaziland	167
Egypt	153
Zimbabwe	142
Côte d'Ivoire	127
Liberia	127
Kenya	114
Equatorial Guinea	106
Lesotho	101
Djibouti	90
Gambia	78
Angola	70
Senegal	63
Guinea	61
Ghana	60
Central African Republic	58
Uganda	57
Zambia	52
Mozambique	47
Mauritania	45
Togo	45
Rwanda	44
Cameroon	42
Sudan	39
Malawi	39
Benin	39
Guinea-Bissau	37
Eritrea	36
Nigeria	31
Mali	30
Burkina Faso	27
Sierra Leone	26
Utd Rep of Tanzania	26
Congo	22
Niger	22
Burundi	19
Chad	17
Ethiopia	14
Dem Rep of the Congo	12
Somalia	

Source WHO World Health Report 2004

Table 4
Health expenditure (Intl $) as a percentage of GDP: Africa

Country	%GPD
South Africa	8.6
Kenya	7.8
Malawi	7.8
Namibia	7.0
Djibouti	7.0
Botswana	6.6
Tunisia	6.4
Gambia	6.4
Zimbabwe	6.2
Côte d'Ivoire	6.2
Mozambique	5.9
Uganda	5.9
Guinea-Bissau	5.9
Zambia	5.7
Eritrea	5.7
Lesotho	5.5
Rwanda	5.5
Morocco	5.1
Senegal	4.8
Ghana	4.7
Sudan	4.5
Central African Republic	4.5
Utd Rep of Tanzania	4.4
Angola	4.4
Benin	4.4
Mali	4.3
Sierra Leone	4.3
Liberia	4.3
Algeria	4.1
Egypt	3.9
Niger	3.7
Ethiopia	3.6
Mauritania	3.6
Burundi	3.6
Gabon	3.6
Guinea	3.5
Dem Rep of the Congo	3.5
Nigeria	3.4
Cameroon	3.3
Swaziland	3.3
Burkina Faso	3.0
Libya	2.9
Togo	2.8
Chad	2.6
Somalia	2.6
Congo	2.1
Equatorial Guinea	2.0

There has been a long-term, halting diffusion of the liberal democratic state. Key contextual factors of transition include: international pressure for democratization, geo-political dynamics of pro-democracy coalitions, and local and trans-local political economic relationships. Nigeria, under the military governments of Babangida and Abacha (1985–1998) was in a perpetual half-hearted state of transition to democracy. The country's status as a major oil exporter allowed it relative immunity from international pressure for democratization. Mobilization for state creation served to divide opposition to military government because it focused attention at the local scale, as new state movements competed for access to centrally controlled resources and political recognition of their ethno-regional group(s).[29] In 1999, following 15 years of military rule, a new constitution was adopted and a peaceful transition to civilian government was eventually completed; the first civilian transfer of power in Nigeria's history.

GDP per capita is Intl $915. This falls within the range of $8,272 (Libya) and $346 (Democratic Republic of the Congo) in the countries of Africa (Table 5).

Table 5 GDP per capita (Intl $): countries of Africa, 2001

Country	GDP per capita (Int $)
Libya	8272
South Africa	7538
Tunisia	7183
Botswana	5747
Gabon	5514
Equatorial Guinea	5239
Swaziland	5029
Namibia	4918
Algeria	4104
Egypt	3901
Morocco	3887
Liberia	2965
Zimbabwe	2271
Côte d'Ivoire	2045
Congo	1936
Lesotho	1844
Guinea	1752
Togo	1608
Angola	1578
Kenya	1452
Senegal	1323
Central African Republic	1289
Djibouti	1288
Ghana	1272
Cameroon	1269
Mauritania	1257
Gambia	1214
Sudan	1112
Uganda	964
Nigeria	915
Zambia	906
Benin	888
Burkina Faso	886
Mozambique	805
Rwanda	799
Mali	700
Chad	656
Guinea-Bissau	630
Eritrea	629
Sierra Leone	606
Niger	604
Utd Rep of Tanzania	599
Burundi	529
Malawi	501
Ethiopia	382
Dem Rep of the Congo	346
Somalia	

Source WHO

ETHICAL ISSUES

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[9] 'The term *defined daily doses for statistical purposes* (S-DDD) replaces the term *defined daily doses* previously used by the Board. The S-DDDs are technical units of measurement for the purposes of statistical analysis and are not recommended prescription doses. Certain narcotic drugs may be used in certain countries for different treatments or in accordance with different medical practices, and therefore a different daily dose could be more appropriate'. International Narcotics Control Board. *Narcotic Drugs: estimated world requirements for 2004. Statistics for 2002.*

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[20] See: http://www.cia.gov/cia/publications/factbook/geos/ni.html

[21] This refers to adult mortality risk, which is defined as the probability of dying between 15 and 59 years.

[22] See: WHO statistics for Nigeria at: http://www.who.int/countries/nga/en/

[23] http://www.unaids.org/en/geographical+area/by+country/nigeria.asp

[24] Total health expenditure per capita is the per capita amount of the sum of Public Health Expenditure (PHE) and Private Expenditure on Health (PvtHE). The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of currency conversion constructed to account for differences in price level between countries.

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