

Z! CITIZEN

The Nigerian Life Compendium

HEALTH EDITION



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Foreword

With health, governance becomes personal

There are questions that follow Nigerians through every stage of life. Will a mother survive childbirth? Will a child receive the vaccines they need? What happens when someone is injured and an ambulance does not arrive? Where does a young person go when their mind becomes a difficult place to live? Can a family afford the cost of illness without losing everything else? And when the next epidemic or pandemic comes, will we be ready?

These are questions about health, but they are also questions about power, dignity and the value we place on human life.

Health is where governance becomes deeply personal. It is where policies leave government documents and enter our bodies, our homes and our most vulnerable moments. It is also where the quality of institutions can determine whether a person lives, recovers, receives care or is left behind.

This is why Health is the first edition of *The Nigerian Life Compendium* by Zikoko Citizen.

We begin here because health is not only one part of the Nigerian condition. It touches every part of it. It affects whether children can learn, whether adults can work, whether women can exercise autonomy over their bodies, whether families can build financial security, and whether communities can face crises without being broken by them.

For many Nigerians, being unwell goes

beyond the illness itself and stretches towards the search for money, the journey to a facility, the absence of equipment, the uncertainty of finding qualified care, and the fear that help may come too late. It is about calling family members, borrowing from friends, turning to social media, or relying on the kindness of strangers to stay alive. It is learning, again and again, how much survival can depend on what you have, where you live and who you know.

We often praise Nigerians for their resilience and we celebrate the people who find a way to hold families together, build informal support systems and keep going despite conditions that ask too much of them. But resilience should never become an excuse for institutional failure. People should not have to be extraordinary to receive ordinary care. Survival should not depend on luck.

The Nigerian Life Compendium was created from the newsroom's need to help everyone understand these realities more honestly. It is a civic and cultural record of how Nigerians live, and of how politics and governance shape that life. Across Health, Justice and the Judiciary, Education, and Economy and Labour, we are asking what our systems make possible, what they prevent, whom they protect, and whom they repeatedly fail to see.

This Health edition begins with the understanding that poor health outcomes do not emerge from nowhere but are

shaped by choices. They reflect how public resources are distributed, how institutions are built and maintained, whose voices influence policy, and whether commitments are carried through after the speeches and announcements have ended. The contributors to this edition help us see these connections with greater clarity.

Chime Asonye examines the painful distance between the promise of mental health legislation and the reality experienced by people seeking care. Hassana Maina asks who truly holds power over women's bodies and what that reveals about sexual health, policy and autonomy in Nigeria. Temie Giwa-Tubosun shows us that during an emergency, survival depends not only on individual skill or courage, but on systems that communicate, coordinate and respond in time.

Adam Abdullahi looks ahead to the next epidemic and asks whether Nigeria is investing in preparedness before crisis arrives. Oyeronke Oyebanji considers the country's long-standing ambition to manufacture vaccines and the cost of repeatedly beginning without building the structures required to sustain progress. Luke Alade reflects on two decades of donor-supported health projects, asking what Nigeria has learned about dependence, continuity and local ownership. Omei Bongos connects fiscal policy to the unequal realities of healthcare access, showing how public finance can either reinforce exclusion or bring care closer to the people. Vivianne Ihekweazu confronts the question at the heart of this edition: if health is a political choice, is Nigeria finally prepared to choose differently?

These essays do not offer a single account of Nigeria's health system, instead, they

show us the system from multiple points of contact: law, gender, emergency care, disease prevention, manufacturing, donor support, public finance and political leadership. Together, they reveal a country with knowledge, expertise and ambition, but also one that struggles to turn these assets into systems that people can depend on.

They also remind us that health is not experienced equally. The consequences of a weak system are often most severe for women, young people, low-income families, rural communities, people living with disabilities, and those whose conditions remain stigmatised or poorly understood. To speak honestly about health in Nigeria is therefore to speak about inequality, voice and whose suffering is permitted to remain invisible.

As Nigeria moves towards another general election, we must resist the temptation to allow political conversation to remain only about personalities, performance and promises. We must ask more grounded questions. What kind of life do our political choices make possible? What should Nigerians be able to expect from the institutions funded and empowered in their name? What would it mean to build a country in which care is not a privilege, an emergency does not automatically become a tragedy, and wellbeing is treated as a public responsibility?

This Compendium does not ask readers to become experts in every area of health policy. It asks us to become more attentive citizens. It invites us to recognise the connection between private pain and public decisions, to understand where responsibility lies, and to imagine what accountability could look like.

Our hope is that this edition becomes more

than something people read once. We hope it becomes a resource for classrooms, newsrooms, community conversations, advocacy spaces, policy rooms and homes. We hope it gives language to experiences many Nigerians know but struggle to explain. We hope it helps citizens ask sharper questions and helps those in power understand that behind every statistic is a life, a family and a future.

Most of all, we hope this edition affirms that Nigerians deserve more than the ability to endure. We deserve systems that see us before we are in crisis. We deserve care

that is accessible, humane and reliable. We deserve institutions that learn, prepare and act. We deserve a country in which good health is not reserved for the fortunate, but protected as part of the dignity of every person.

Welcome to the Health edition of *The Nigerian Life Compendium*. So, we begin with this body, with dignity, and with the belief that a healthier Nigeria is not only necessary, but possible.

Thank you for reading.

Anita E. Eboigbe
COO/Social Impact Lead,
Big Cabal Media

Methodology

The Nigerian Life Compendium examines important national issues from the viewpoints of subject-matter experts, practitioners, academics, and policy actors using an editorial and evidence-based methodology.

Each edition is intended to provide a thorough overview of a significant area of development while producing useful suggestions for individuals, civil society, and politicians. Contributors were approached based on a framework that prioritised diversity in expertise, geography, and especially lived experience.

We gave particular attention to ensuring representation across Nigeria's six geopolitical zones, urban and rural contexts, gender, and generational perspectives. We recognise that national challenges often manifest differently across locations and populations.

To ensure consistency across contributions while preserving each author's perspective, all essays followed a common analytical framework.

When we reached out to our contributors, we asked them for one thing: An essay on a given topic that:

- Provides historical and contemporary context for the issue;
- Identifies the principal institutions, stakeholders, and actors involved;
- Assesses both the immediate and long-term implications of existing policies and practices;
- Proposes actionable policy recommendations at the federal, state,

and local government levels; and

- Concludes with clear recommendations and calls to action for policymakers, practitioners, advocates, and citizens.

Every submission underwent a structured editorial process that included desk review, substantive editing, line editing, and fact-checking. Data, statistics, and policy claims were verified where possible, while recommendations were assessed for evidence, feasibility, and relevance to their intended level of government. Throughout the editorial process, contributors' arguments were refined for clarity, accessibility, and coherence without altering the substance of their positions.

The Nigerian Life Compendium is intended not only as a record of Nigeria's current realities but also as a practical civic resource. The aim is simple: To educate the public and support evidence-based policymaking both before and after the 2027 general elections for a better nation. And this we have done by blending thorough analysis with approachable writing and practical policy propositions.



#01 *by* Chime Asonye

Is Nigeria ready to support our mental health?

CLOSING THE GAP BETWEEN LAW AND REALITY.



A Sector in Transition

Nigeria's mental health framework is undergoing its most significant transformation in decades. [The 2023 National Mental Health Act](#) replaced the 1958 Lunacy Act, shifting the country from a colonial-era detention model to a rights-based approach that prohibits forced treatment and imposes severe penalties for abuse. Yet while the legal framework has been modernised, the physical and operational infrastructure required to deliver mental healthcare has changed far more slowly. Integrated mental health services remain scarce in state health facilities, psychotropic medicines are often unavailable at the local level, and national systems for monitoring mental health outcomes remain underdeveloped. The result is a widening gap between what the law promises and what millions of Nigerians can access in practice.

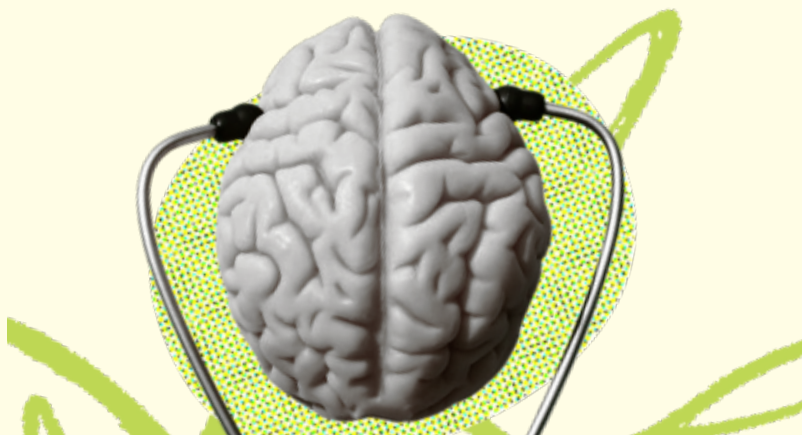
One of the most significant barriers to effective mental health policy in Nigeria is the absence of reliable and up-to-date data. The last comprehensive nationwide survey was conducted over 20 years ago, making it nearly impossible to address current realities with precision. Without accurate data on prevalence, treatment gaps, and service needs, planning remains largely reactive rather than strategic.

The [lack of accurate data is also compounded by mental health being treated in isolation](#) from broader disability discussions, a critical failure, given that mental health conditions are the leading cause of disability worldwide. This detachment means mental health is routinely excluded from accessibility and disability conversations. This absence

shows up in institutional representation. The flagship National Commission for Persons with Disabilities, established to advance the rights and welfare of persons with disabilities, currently has no board member with lived experience of a mental health condition.

Financing also remains one of the system's greatest weaknesses. Historically, mental health has received less than 5% of the national health budget, itself a chronically underfunded sector. This lack of investment, coupled with the continued migration of health professionals, [has left Nigeria with just 0.86 mental health workers per 100,000](#) people, far below the World Health Organisation ([WHO](#)) [global median](#) of 13 specialised mental health workers per 100,000 population.

The continued loss of mental health professionals is driven by a combination of poor remuneration, deteriorating hospital infrastructure, and limited opportunities for career advancement, prompting many specialists to seek employment in more supportive healthcare systems abroad. The [resulting workforce shortage has significantly constrained access to care](#), leaving more than 80% of people who need mental health support without formal care.



The System Beneath the Surface

Understanding Nigeria's mental health landscape requires looking beyond policy to how care is actually delivered. At present, the system remains heavily centralised, with specialised services concentrated in nine federal neuropsychiatric hospitals nationwide, leaving 28 of Nigeria's 36 states and the Federal Capital Territory (FCT), with no federal psychiatric presence.

Located almost exclusively in major urban centres, these hospitals provide critical care but are unable to serve the grassroots. For individuals outside these few metropolitan hubs, who must often cross multiple state lines for a single appointment, seeking professional help is not just a medical choice; it is a logistical nightmare involving long-distance travel, prohibitive costs, and significant delays. Primary Healthcare Centres (PHCs), which should serve as the foundation of a decentralised behavioural health system, are not equipped to fill this gap.

Many PHCs lack trained personnel to identify and manage mental health conditions, have limited access to essential psychotropic medications, and operate without clear referral pathways. As a result, early-stage conditions frequently go undetected. The National Mental Health Act addresses this by mandating the integration of mental health services into primary healthcare through training PHC workers to provide basic care and conduct mental health screenings during routine health checks. However, these provisions are yet to be implemented, leaving many to rely on informal systems—family networks, traditional healers, and religious institutions—which often act as the first point of contact for individuals experiencing psychological distress. Taken together, these dynamics reveal a system that is not simply under-resourced, but skewed toward metropolitan areas, reactive where it should be preventive, and inaccessible to formal medical support.

Inequality in Access and Experience

These systemic failures are not felt equally. They mirror deep inequalities in age, gender, socioeconomic status, and geography. While the urban–rural divide determines physical access to care, stigma and cultural expectations determine who feels safe enough to seek help.

This is especially true for young people. Half of all mental health conditions begin by age 14, yet Nigeria—home to one of the world's youngest populations—offers its youth little support. Despite our celebrated communal

culture, 12.7% of African adolescents experience chronic loneliness, more than double the rate in Europe. For many young Nigerians, this isolation is worsened by economic pressure, academic stress, and a digital environment that promises connection but often delivers comparison.

National assessments by UNICEF indicate that 85% of young Nigerians feel greater pressure to succeed than previous generations—the highest percentage globally across 21 surveyed countries.

Even as 1 in 6 reports feeling anxious or depressed, the system remains silent. Mental health is still missing from school curricula, and on-campus support is virtually non-existent. This institutional silence does more than make help-seeking difficult—it actively discourages it. In a society that continues to treat isolation and struggle as personal failings rather than systemic challenges, many young people are left to suffer alone.

Socioeconomic status further compounds these disparities, as individuals with higher incomes are more likely to access private care, while those with limited financial resources rely on overstretched public services or informal support systems. For women, mental health is often weaponised. [Between the rise in gender-based violence \(GBV\)](#) and intense social expectations, the psychological strain is immense, [yet a diagnosis can be used to threaten a woman's marriage or her agency as a mother](#). This is compounded by a dangerous colonial relic: the criminalisation

of attempted suicide.

While the United Kingdom abolished this law in 1961, just one year after Nigeria gained independence, Nigeria continues to criminalise attempted suicide, imposing a prison sentence of up to one year. This approach not only penalises individuals in distress but also undermines public health objectives. [Evidence suggests that suicide rates are higher in countries where attempted suicide is criminalised](#), with women often experiencing the most severe consequences.

Crucially, this law creates a data blackout. To avoid the ex-convict label and legal sanction, families and hospitals do not report these incidents; they are forced to hide the truth. This ensures a critical public health challenge remains undercounted and invisible, making it impossible to fund the gender-specific support women need. By treating a crisis as a crime, we are not just blocking help-seeking; we are making sure the most traumatised among us stay in the shadows.

The Cost of a Fragmented System

The consequences of these gaps extend beyond individual well-being, affecting households, communities, and the broader economy.

At the economic level, untreated mental health conditions reduce productivity, increase absenteeism, and limit workforce participation. Globally, depression and anxiety alone [cost the global economy US\\$1 trillion annually in lost productivity](#). Nigeria's youthful population—projected to remain among the youngest in the world through 2050, with a massive cohort

entering the workforce—makes these costs especially devastating for our future. We are sitting on a demographic and economic time bomb: a mentally drained generation, meant to power national growth, is instead struggling to function.

At the household level, in the absence of accessible formal services, the burden of care falls on families. Relatives provide long-term support, often at the cost of their own income and educational opportunities. This leads to sustained financial strain and limited savings, as resources meant for

long-term stability are frequently diverted to cover the high out-of-pocket costs of emergency treatment and medication.

At the health system level, delayed care increases pressure on limited specialist services. Hospitals and psychiatric facilities must manage cases that could have been addressed earlier in the community. This not only increases costs but also reduces system efficiency.

There are also broader social implications. A critical systemic failure is that mental health is not integrated into national health surveillance. Unlike infectious diseases such as typhoid or cholera, which automatically trigger the Integrated Disease Surveillance and Response (IDSR) system and mobilise resources, spikes in psychological distress go largely untracked. This leaves the government and humanitarian actors unable to detect mental health outbreaks, direct resources to high-need areas, or respond effectively to trauma linked to conflict, flooding, or economic shocks.

During the 2025 World Mental Health Day commemorations, the Coordinating Minister of Health, Prof. Muhammad Pate, publicly acknowledged this gap and called for urgent integration of mental health into emergency care. Yet, despite this high-level recognition, meaningful action remains stalled. Mental health continues to sit outside national surveillance systems, meaning we still cannot detect regional trauma the way we track physical disease outbreaks. A system blind to these spikes stays dangerously fragile—lacking the real-time data needed to prevent crisis-level consequences.



From Policy to Practice: What Needs to Change

Addressing these challenges requires a shift from policy commitments to operational change.

At the federal level, the priority must shift from legislation to implementation. The National Mental Health Act needs dedicated funding, clear guidelines, and strong accountability mechanisms. Immediate steps include: establishing the stipulated Department of Mental Health Services within the Federal Ministry of Health to operationalise the Act; creating the mandated Mental Health Fund to inject much-needed financing into the sector; publishing the Act's roadmap, which civil society actors like Nigerian Mental Health (NMH) helped create to provide a framework for implementation; and establishing a comprehensive, costed national mental health action plan.

Furthermore, transparent monitoring and reporting systems are essential. Without reliable data on rollout progress across states, accountability will remain impossible. The National Assembly should also pass the National Suicide Prevention Bill that would decriminalise attempted suicide, which NMH, working with the Nigerian Suicide Prevention Advocacy Working Group, helped introduce in the legislature in 2025. Finally, expanding mental health coverage under the National Health Insurance Authority (NHIA) is critical to reducing catastrophic out-of-pocket costs and making care truly accessible.

At the state level, integration and domestication are essential; currently, the 2023 Act has been domesticated in Lagos,

Ekiti, Kaduna, and Ogun states, leaving the majority of the country without a localised legal mandate for implementation. Mental health must be embedded within state health plans rather than treated as a standalone speciality, ensuring that services are accessible in both urban and rural areas. At the local level, PHCs provide the most viable pathway for scale. Using tools such as the WHO Mental Health Gap Action Programme (mhGAP) [Intervention Guide](#), a version of which has been domesticated in Nigeria, non-specialist health workers can be trained to identify and manage common mental health conditions. Task-shifting, where community health workers provide basic psychosocial support, can significantly expand access while reducing pressure on specialist services.

Financing reforms are also critical. Today, most Nigerians pay for mental health care out of pocket. We must move toward pooled funding—a system that collects money from taxes, insurance contributions, and other sources into a shared national fund. This spreads risk across the population so that the healthy and wealthier help cover the costs for those who need support, rather than individuals paying the full cost at the point of care. This must be combined with strategic purchasing, where the pooled money is used deliberately to buy the most effective services at reasonable cost.

However, it is not enough to simply change how we pay. We must also change what we are paying for. Today, nearly 100% of federal government funding for mental health is directed toward biomedical

interventions focused on hospital-based treatment and medication. To truly meet the scale of the crisis, Nigeria must begin funding psychosocial support—community-based initiatives such as peer support groups, counselling services, school-based programmes, and culturally relevant wellness approaches that treat mental health as a social and emotional reality, not just a medical condition.

Beyond the health sector, a broader ecosystem approach is required. Employers can introduce workplace mental health programmes, schools can integrate psychosocial support into student services and the curriculum, and community organisations can promote mental health literacy and reduce stigma.

Digital tools also present a unique

opportunity to leapfrog traditional infrastructure barriers. Tele-mental health services, mobile applications, and digital screening tools can expand reach, particularly in underserved areas where specialists are absent. We are already seeing this shift within the NMH network, where a growing segment of member organisations is now dedicated to health-tech startups. Innovators like SereniMind, Nexavue Africa, and Mindwellnest are using AI-driven diagnostics and remote counselling to bridge the treatment gap and assist mood regulation. However, these digital solutions must be integrated into the broader public health system to ensure quality and continuity of care. Technology is a powerful enabler, but its success depends on a regulated framework that protects patient data and maintains clinical standards.

Reframing Mental Health as a Public Good

Nigeria has made meaningful progress in recognising mental health as a rights-based issue. The challenge now is to translate this recognition into systems that deliver care at scale. Doing this successfully requires a shift in perspective.

Mental health must be understood not as a niche or specialised issue, but as a core component of public health, economic development, disability justice, and social stability. Improving mental health outcomes is not only about treating illness but also about enabling individuals to participate fully in society, contribute productively, and maintain social connections. It is about building systems that respond early, reduce

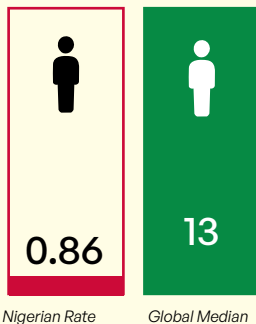
suffering, and promote resilience.

Nigeria now has the legal and policy foundation for progress. The next phase will depend on implementation: whether services can reach communities, whether care can be made affordable, and whether stigma can be reduced. Ultimately, the success of Nigeria's mental health system will not be measured by the laws it passes, but by the lives it improves.

Until mental health is properly mainstreamed, true disability justice will remain an unfulfilled promise, with accessibility continuing to focus only on what we can see, while leaving the invisible majority behind.

Chime Asonye is a public policy advisor and mental health advocate. Currently, he serves as the Founder of Nigerian Mental Health, the country's largest multidisciplinary community of practitioners, comprising over 50+ mental health-focused organisations that work to advance policy advocacy, research, wellness programming, and disability justice. His organisation played a central role in coordinating advocacy efforts that helped pass Nigeria's National Mental Health Act in December 2022, the country's first human rights-focused mental health reform since independence. His thought leadership on psychosocial issues is featured in Harvard Africa Policy Review, CNBC Africa, and the World Economic Forum, among others.

Key Insight #1



Nigerian Rate

Global Median

Nigeria has just 0.86 mental health workers per 100,000 people. The global median is 13. That's a shortfall of over 90%. Simply put, If 100,000 Nigerians needed mental health support today, they wouldn't even have one mental health worker to turn to.

Key Insight #2



More than

80%

who need mental health support get no formal care at all, and yet attempting suicide is still a crime that can land you in prison for a year.

#02 *by* Hassana Maina

Who controls women's bodies?

SEXUAL HEALTH, POWER, AND POLICY IN NIGERIA



In recent years, through both my work and the realities I continue to observe, I have been drawn to a recurring question: who controls women's bodies? Is it the state, society, or women themselves? These questions lie beneath many of the issues we confront, yet they are rarely addressed directly. In Nigeria, this tension is most visible in how sexual health is understood, accessed, and governed.

In 2019, I coordinated [standstill rallies across eight northern states](#) under the #NorthNormal campaign, pushing for the domestication of the [Violence Against](#)

[Persons Prohibition \(VAPP\) Act](#). In Sokoto, the police withdrew our permit. In Bauchi, the Speaker of the State House of Assembly, wearing an orange #ArewaMeToo shirt, received us and pledged support. In Borno, after sustained engagement with state lawmakers, we received a copy of a proposed VAPP domestication bill. These experiences taught me that the tensions around sexual health in Nigeria are not abstract policy debates. They play out in the everyday lives of women and girls, shaped by power, geography, and whether anyone with authority is willing to act.

The State of Sexual Health in Nigeria

Sexual health is often treated as a private or moral issue, something to be managed within families or avoided in public discourse. Yet the realities across the country tell a different story. For many women and girls, access to accurate information, reproductive health services, and protection from sexual violence remains uneven and, in some cases, entirely out of reach. These gaps are not accidental. They are shaped by policy limitations, cultural expectations, and systems that do not consistently centre women's lived realities.

Nigeria continues to carry a high burden of maternal mortality, while adolescent pregnancy remains prevalent, particularly in rural and conflict-affected regions. Access to contraception is inconsistent, and conversations around sexuality are often constrained by social and religious sensitivities. At the same time, gender-based violence continues to shape women's health outcomes in profound ways. Sexual

violence is not only a violation of rights; it is a public health issue with lasting consequences for physical health, mental well-being, education, and economic participation.

The numbers are stark. According to the 2018 National Demographic and Health Survey, the maternal mortality ratio stands at 576 deaths per 100,000 live births, the fourth highest globally. In the North West, 36% of girls aged 15 to 19 have begun childbearing, compared with 6% in the South West. Modern contraceptive prevalence nationally is just 12%, dropping to as low as 3% in states like Sokoto. These are not just statistics. They represent [the compounded consequences of systems](#) that do not prioritise women's reproductive autonomy.

What this reveals is that sexual health in Nigeria is not simply about individual choice. It is about systems—who has access, who is

excluded, and who bears the consequences of that exclusion.

These systems are shaped by a wide range of actors. At the national level, the Federal Ministry of Health sets policies on reproductive and adolescent health, while agencies like the National Primary Health Care Development Agency

drive implementation. Yet much of the responsibility for service delivery rests with state governments, leading to stark differences in access across the country. A young woman in rural Bodinga, Sokoto, faces a very different reality from one in urban Lagos, not only in terms of available services but also in what is socially acceptable when seeking care.

Who Holds the Power, and Who Is Held Accountable?

Civil society organisations play a critical role in bridging these gaps, particularly in areas where formal systems fall short. In my work with the Anti-Sexual Violence Lead Support Initiative (ASVIOL), I have seen how survivors navigate not just trauma, but systems that are difficult to access, inconsistent, or, at times, unresponsive. For many women and girls, support does not come as a coordinated system but as fragmented interventions—a health facility in one place, legal support in another, and community stigma everywhere in between. This reality underscores the gap between policy and lived experience, and the critical role that community-based organisations continue to play in bridging it.

Development partners, including the World Bank and other international institutions, provide financing and technical support for programmes on maternal health, family planning, and gender-based violence. The private sector contributes through healthcare delivery and digital health platforms, although affordability remains a significant barrier. Across all of this, community and religious leaders continue to shape how sexual health is understood

and whether services are accepted or not.

In 2025, ASVIOL launched the [Seeds of Hope project](#) in Tudun Biri, Kaduna State, a community devastated by the December 2023 military drone strike that killed over 100 residents. The project trains 50 women, survivors of conflict and gender-based violence, in climate-smart agriculture, addressing the root causes of vulnerability that make women susceptible to sexual violence in the first place. It is funded by the French Embassy and represents the kind of intervention that connects sexual health to economic empowerment at the community level.

The consequences of these intersecting systems are both immediate and long-term. In the short term, limited access to sexual and reproductive health services contributes to preventable maternal deaths, unsafe abortions, untreated infections, and poor mental health outcomes. Young women and girls are particularly affected. Many are forced to leave school due to early pregnancy or early marriage, disrupting their education and limiting their future opportunities.

The Cost of Exclusion: Short-Term Crisis, Long-Term Damage

Over time, these outcomes compound. Women who lack access to health services are less able to remain in school, enter the workforce, or build sustainable livelihoods. Gender-based violence deepens this reality. Survivors often face stigma, limited access to justice, and long-term trauma that affects their ability to participate fully in society. The result is not only personal harm, but a broader economic cost.

As Nigeria confronts the challenge of creating jobs for a rapidly growing youth population, this cost becomes even more significant. Economic participation is not just about skills or access to finance; it is also about whether individuals can safely exist in the spaces where opportunities are created. Increasingly, those spaces are digital. Platforms that enable learning, networking, entrepreneurship, and employment are also becoming sites of harassment and abuse. Online gender-based violence, from threats to image-based abuse, is pushing many women into silence or withdrawal. When women are forced out of these spaces, they are excluded from emerging economic opportunities. A 2023 Paradigm Initiative study found that 58% of Nigerian women and girls surveyed had experienced some form of online gender-based violence, ranging from unsolicited sexual content to doxxing and image-based abuse. Yet Nigeria has no comprehensive legal framework to address online gender-based violence. The Cybercrimes Act of 2015 does not specifically address gender-based digital harms, and platform accountability remains minimal. This is not a peripheral concern. As the digital economy becomes central to

Nigeria's youth employment strategy, [the safety of women in digital spaces is an economic development issue](#), not merely a social one.

Sexual health, in this sense, is deeply connected to development. It shapes whether women can complete their education, work, build businesses, and create jobs for others. When women are excluded, whether through policy, social norms, or unsafe environments, the effects ripple through households, communities, and the broader economy.

Addressing this requires more than isolated interventions. It requires a coordinated approach that recognises sexual health as central to national development. At the federal level, this means enforcing the 2018 National Reproductive Health Policy and the National Strategic Health Development Plan, with dedicated budget lines for reproductive health services that currently receive less than 2% of the health budget, increasing funding for primary healthcare, and integrating gender-based violence response into health systems. It also requires acknowledging emerging risks, including online gender-based violence, and developing frameworks to address them. Specifically, the National Assembly should amend the Cybercrimes Act to explicitly criminalise online gender-based violence, including image-based abuse, doxxing, and technology-facilitated sexual harassment. Digital platforms operating in Nigeria should be required to establish local content moderation capacity and transparent reporting mechanisms.

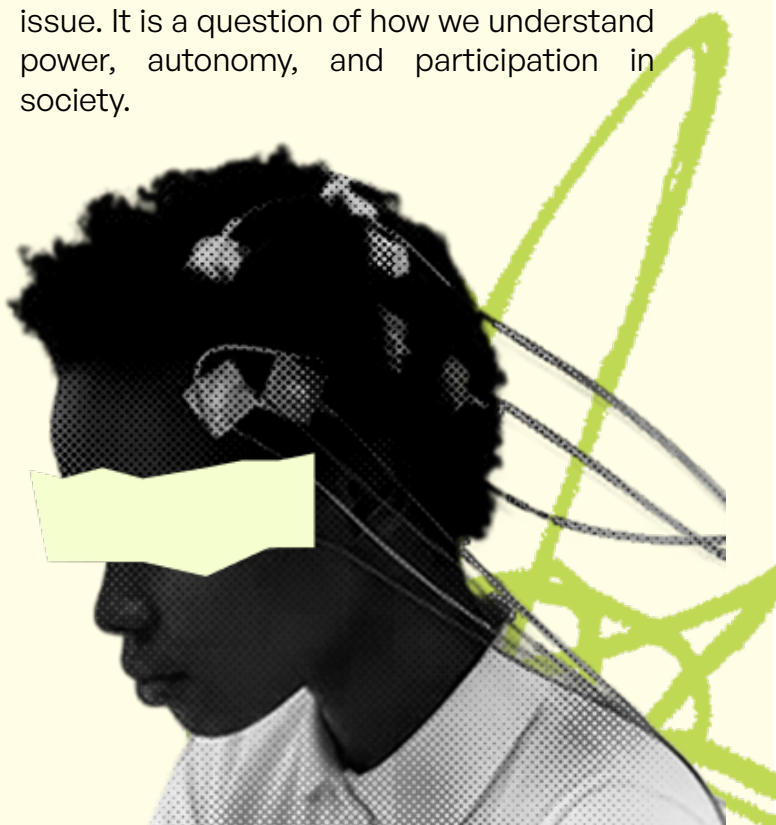
What Must Change: Policy Recommendations

At the state level, there is a need to expand access to services in rural and underserved communities, invest in adolescent-friendly healthcare, and strengthen systems that connect health services with legal and social support for survivors. Local governments also have a critical role to play in community engagement—working with traditional and religious leaders to shift harmful norms and ensure that services are both accessible and acceptable. During my work with UN Women across multiple communities, I saw how deeply social norms shape women’s access to health, safety, and decision-making. In many cases, service availability was not the primary barrier—acceptance was. Efforts to strengthen sexual health outcomes must therefore engage directly with the cultural and social structures that influence behaviour at the community level.

Civil society must continue to provide survivor-centred support and drive accountability, while development partners can support data, financing, and programme design. The private sector has

an important role in improving access to affordable services and ensuring that digital platforms are safer for women.

Ultimately, however, this is not only a policy issue. It is a question of how we understand power, autonomy, and participation in society.



Beyond Policy: A Question of Power

When women and girls are unable to make decisions about their own bodies, the consequences extend far beyond health. They shape education, economic opportunity, and the ability to participate fully in public life. As Nigeria approaches the 2027 elections, there is an opportunity to move beyond surface-level conversations and focus on the systems that shape

everyday realities.

Sexual health must be recognised as central to those systems.

Because the question is not only whether women can access healthcare.

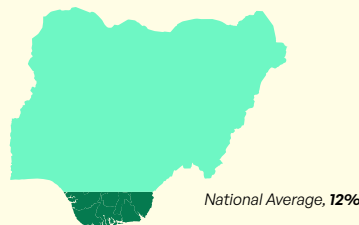
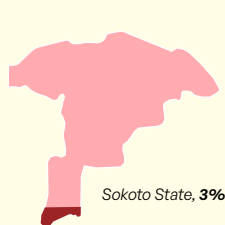
It is whether they can live, participate, and

contribute fully — without their bodies being sites of control. The answer to the question this piece began with is uncomfortable but necessary: in Nigeria today, women's bodies are controlled by a convergence of systems, policies, norms, and silences that no single intervention can dismantle.

What is required is sustained political will, dedicated financing, and the kind of coordinated action that treats sexual health not as a sensitive topic to be managed but as a development priority that determines whether half the population can participate fully in the nation's future.

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Key Insight #3



In Sokoto State, only 3% of women use modern contraception, compared to a national average of 12%

Key Insight #4



36% of girls aged 15-19 in North West Nigeria have already started having children versus just 6% in the South West.

Key Insight #5



58% of Nigerian women and girls surveyed have experienced online gender-based violence yet Nigeria has no law that specifically criminalizes it.

#03 by Temie Giwa-Tubosun

Emergency response in Nigeria:



WHY SYSTEMS AND COORDINATION DECIDE SURVIVAL



Background

In emergency healthcare, the most dangerous assumption is that availability equals access. In reality, survival is rarely determined by whether medical supplies exist within a health system, but by whether the system can coordinate their delivery, identify where care can actually be administered, and move patients quickly through a fragmented network of providers. In Nigeria and many similar contexts, emergencies are often not just clinical events but coordination failures measured in minutes.

Across global health literature, delays in accessing appropriate care have consistently been identified as a major contributor to preventable mortality in low-resource settings, particularly in maternal and trauma-related emergencies, often emerging from fragmented procurement systems, weak real-time visibility of hospital readiness, and the absence of structured emergency routing between facilities.

It is within this gap between presence and access that lives are lost.

Where Emergency Systems Break First

The first time the fragility of emergency systems becomes visible is rarely in data; it is in experience.

One of the earliest moments that shaped my founding perspective came during a field trip in Kaduna, Northern Nigeria. A young woman, Aisha, had just delivered a baby but developed severe postpartum haemorrhage. Blood was urgently required. Her family moved between facilities searching for a unit that could respond. The blood existed somewhere in the system, but there was no coordinated visibility of where it was available or how quickly it could be accessed. By the time compatibility and availability were resolved, the delay had already become irreversible, and Aisha lost her life.

Years later, a second, more personal experience reinforced the same structural truth. During childbirth in a highly resourced

healthcare system outside Nigeria, my experience was still difficult and high-risk, but fundamentally different in one respect: coordination was immediate, protocols were clear, and escalation pathways were already mapped. The contrast exposed a stark inequality, not necessarily in medical knowledge, but in system readiness.

These two experiences became foundational to a single question that stayed with me: why should survival depend so heavily on where an emergency happens?

This was not simply a shortage problem. It was a systems problem, defined by fragmented information, delayed decision-making, and a lack of coordinated emergency response pathways. It also featured a lack of considered investment and structure within Nigeria's broader emergency response ecosystem. In 2016, LifeBank was founded to address this gap

by building the infrastructure required to make lifesaving medical supplies visible, accessible, and deliverable in real time.

When Systems Are Fragmented, Emergencies Fail

Nigeria's emergency healthcare challenges are often described in terms of shortages and lack. You hear patients and their loved ones say things like:

"...they said there is no blood."

"...the hospital said oxygen had finished,"

"...we were told they don't have antivenom."

In many cases, these are accounts of what families were told at the point of care. But that is not the full story.

In many situations, these supplies do exist within the broader system. The challenge is that they are not always visible or accessible when needed most. As a result, families and even health workers are left searching, calling, and moving from one facility to another, trying to find what should have been reachable in minutes.

Emergency care fails most critically at the intersection of coordination and time. Facilities may have capacity, but not visibility into each other's readiness. Supplies may exist, but not in the location where they are urgently required. Decisions are often made without real-time data on hospital capability, leading to avoidable delays.

Global evidence on emergency care systems reinforces this. Studies on trauma and obstetric mortality consistently show that delays in receiving appropriate care

are more strongly associated with system inefficiencies than with absolute resource absence. In other words, emergencies are often not supply failures; they are system routing failures.

In addition to coordination gaps, three other structural constraints deepen the problem. First is affordability. Many healthcare facilities operate under liquidity constraints that prevent the timely procurement of essential emergency supplies. Even when demand is urgent, financial barriers delay procurement decisions, introducing avoidable risk into time-sensitive care.

Second is infrastructure readiness, including equipment downtime. Across many facilities, critical machines required for emergency care are non-functional due



to lack of maintenance support or access to biomedical engineers. This creates silent failures within the system; capacity that appears available on paper but is non-operational in practice.

Third is the safety and quality of medical supplies, particularly blood. Weak screening systems, reliance on rapid diagnostic tests with limited sensitivity, and gaps in traceability increase the risk of transfusion-transmissible infections and compromised care. While some health systems, supported by stronger government policy

and regulatory oversight, are improving screening and transfusion safety, others still face significant gaps, which means that in emergency situations, the safety of available blood cannot always be guaranteed. In such moments, ensuring both access and safety becomes critical, because unsafe transfusion can create additional risk rather than resolve the emergency.

Together, these constraints create a layered failure: visibility, affordability, readiness, and safety all interact to determine whether a patient survives an emergency event.

Plugging the gap in Emergency Healthcare Infrastructure

At LifeBank, we operate at the intersection of logistics, technology, and healthcare systems design. We are constantly building systems to reduce the time between an emergency need and a clinical response at the healthcare centres in the communities we serve.

At our core, we focus on three things: making essential supplies accessible in time, ensuring they are safe, and helping reduce the cost barriers that slow emergency care.

Strengthening Access to Emergency Supplies: Through our medical supplies marketplace (Nerve), LifeBank enables healthcare centres to access and coordinate the delivery of essential emergency supplies, including blood, oxygen, and antivenom. We recently introduced antivenom access on our marketplace to address one of the most persistent challenges in emergency care: delays in treatment for snakebite

cases. In one case in Ibadan, a patient was moved between multiple hospitals over an extended period in search of antivenom, which ultimately took about 13 hours to locate. In a similar case in Abuja, a widely reported incident involving a social media personality, Ifunanya, followed the same pattern, with several facilities visited before treatment was eventually found, though unfortunately, after critical delays. In both situations, what slowed the response was not a lack of effort by healthcare workers, but uncertainty about where treatment was available and when.

Strengthening access really means this: in an emergency, help is not something people have to search for under pressure.

Building Safe, Proactive Emergency Systems: Access alone is not enough without safety assurance, and we are deeply aware of this and continuously working to improve through innovation

and partnerships. LifeBank's SmartBank system strengthens blood safety through structured screening and traceability, reducing the risks associated with unsafe transfusions and building greater confidence in emergency blood systems. We have seen successful implementation in Kenya and Sierra Leone through partnerships and collaboration, and we are actively working to replicate and deepen these outcomes in Nigeria by strengthening the reliability and proactiveness of blood safety systems, particularly in emergency care settings.

Addressing Affordability Constraints:

Emergency care is not only constrained by physical access, but also by financial liquidity. In many high-pressure situations, facilities are clinically ready to act, but a temporary cash flow shortage can delay the decision to procure urgent supplies. When a life is on the line, the time spent navigating administrative payment approvals is time the patient does not have.

We offer flexible payment terms, providing healthcare centres with a functional credit cushion that allows them to procure life-saving supplies immediately and defer payment for 2 to 6 weeks. We also practice a community solidarity model that leverages broader system support and resources to ensure that even the most vulnerable facilities, serving the most underserved communities, are not cut off from essential supplies during a crisis. Together, these approaches ensure that the "ability to pay" at the point of care never becomes a barrier to the "ability to save." By decoupling financial constraints from emergency response, we create a more resilient network in which care remains uninterrupted, regardless of a facility's immediate financial position.

Strengthening Equipment Readiness:

Another quiet but critical challenge in emergency care is equipment failure. The COVID-19 pandemic in Nigeria exposed this reality, with reports highlighting gaps in critical care capacity, including limited access to functional ventilators. These gaps make one thing clear: emergency care also depends on whether the equipment needed to deliver that care is actually working when it is needed most.

Through our Quip platform, we connect hospitals with verified biomedical engineers who can quickly service and repair critical medical equipment. Alongside this, training programmes like Orange Army, a Quip initiative that supports and trains female engineers, are helping to build a stronger pool of technical talent that keeps healthcare systems functioning.



The Citizen Layer: First Response

Beyond facility-based systems, emergency outcomes are also shaped by decisions made at the citizen level. In many emergency situations, bystanders, loved ones, and even first responders often lack clear visibility into which healthcare facilities are actually equipped to handle specific emergencies. The reality is that not all hospitals are fully prepared for emergencies. Some are not equipped for trauma care, others cannot manage cardiac arrest, obstetric emergencies, or paediatric crises. Yet in moments of urgency, patients are often taken to the nearest hospital rather than the most appropriate one. This mismatch leads to repeated transfers, confusion, and avoidable delays.

We saw this reality again in a case involving a road traffic accident victim and the CTO of Bumpa. Emergency responders moved between multiple hospitals without clear knowledge of which facility could provide immediate trauma care. Each transfer added more delay, and in emergency medicine, time lost is often irreversible. Sadly, this is not an isolated case. Situations like this happen far too often, where uncertainty

at the point of decision becomes a silent contributor to poor outcomes.

This gap led to the development of First Response, a platform built around the idea of citizens as the decentralised first mile of healthcare. In emergencies, the moments before professional help arrives are often the most critical, yet communities are frequently left without the information or tools needed to act effectively. By equipping bystanders and first responders with real-time information, First Response helps bridge the gap between the onset of an emergency and access to appropriate care.

The platform enables faster decision-making by providing real-time hospital readiness mapping, GPS-based navigation, and emergency-type matching to identify the right facility for each situation. It also supports coordination between ambulances, volunteers, and healthcare providers, while providing immediate guidance to bystanders so that life-saving actions can begin before formal emergency services arrive.

Moving from Reactive to Predictive Emergency Systems

The future of emergency care cannot remain reactive. It has to be about anticipating needs before they become crises.

In practice, this means building systems that help healthcare providers see what is coming, not just respond to what has

already happened. It means using data more intelligently across different parts of the health system, from oxygen demand to blood availability, and understanding which hospitals are actually ready to respond in real time.

When these layers come together—supply,

logistics, and real-time visibility—emergency care becomes less about scrambling in the moment and more about being prepared

ahead of time. It creates a system where readiness is built in, not improvised under pressure.

Policy Recommendations

At the federal level, the government should establish a National Emergency Care Coordination Centre with real-time visibility across hospital readiness, blood bank availability, and ambulance deployment. The National Blood Transfusion Service must be adequately funded. A dedicated emergency care budget line would provide predictable funding.

At the state level, each state should publish an Emergency Care Readiness Plan to map hospital capabilities and establish inter-facility transfer protocols. At the local level, primary healthcare centres should be equipped as stabilisation points with clear escalation pathways.

Civil society, the private sector, and technology innovators have demonstrated that the tools exist. The challenge is scaling these through regulatory frameworks, public-private partnerships, and sustained investment. Citizens should know their nearest emergency-ready facility and demand that governments publish emergency care readiness plans. By creating clear regulatory frameworks that allow private infrastructure engines to securely plug their real-time data into state and national command centres, we can scale these solutions rapidly.

Conclusion

Emergency care outcomes are not only determined by the availability of medical supplies but also by how well a system is designed to respond when every minute counts. When coordination breaks down, when readiness is unclear, or when information is missing, even available resources can become out of reach. These gaps are what turn treatable situations into avoidable loss.

LifeBank's work sits within this reality, building the infrastructure that helps reduce the delay between emergency need and response, and strengthening the connections that allow healthcare systems

to function under pressure. We will continue to innovate to ensure that no one loses their life due to a lack of access to safe, affordable, and timely medical supplies.

Temie Giwa Tubosun is the Group CEO of LifeBank, Africa's healthcare supply chain engine. The company helps hospitals discover essential medical suppliers and delivers them in the right condition and on time. She has over 10 years of experience in health management with the Department for International Development (DFID), the World Health Organisation, the UNDP, and the Lagos State Government. In 2014, the BBC listed her among the 100 Women changing the world. She was also recognised as an African Innovator by Quartz and in 2025 as a social innovator of the year by the Schwab Foundation for Social Entrepreneurship.

Key Insight #6



In Nigeria, **not knowing which hospital treats which emergency can turn a survivable accident into a fatal one.** Patients are routinely rushed to the “nearest” hospital instead of the right one, causing them to be moved from one hospital to another while critical time slips away.

#04 *by* Adam Abdullahi

Preparing for the next epidemic

**INFECTIOUS DISEASE AND THE
POLITICS OF PREVENTION IN NIGERIA**



QUARANTINE

In early 2020, as SARS-CoV-2 spread across continents, overwhelming even well-resourced health systems in Europe and North America, Nigeria faced a defining question: could it build the capacity to detect and respond to a major global health security threat in real time?

For many observers, the answer seemed uncertain. Despite prior experience with Ebola, COVID-19 presented a different scale of challenge: simultaneous national spread, prolonged disruption, and the need for sustained coordination across institutions and levels of government. The response that followed demonstrated something important and often underappreciated.

Within weeks, Nigeria began scaling the core components of epidemic response. Diagnostic laboratories expanded across geopolitical zones. Surveillance systems were activated nationwide. Data reporting improved. Scientists, clinicians, and public health officials worked with a level of coordination rarely seen before. Under the leadership of the Nigeria Centre for Disease Control (NCDC) and the Federal Ministry of Health, the country assembled a team in its emergency operations centre, including key units focused on challenges ranging from risk communications to diagnostic capacity.

By mid-2021, the laboratory network had expanded from fewer than five testing centres to over [140](#) across all six geopolitical zones, millions of COVID-19 tests had been conducted, and sequencing capacity, an advanced capability that remains beyond reach for many countries with comparable resource constraints, was developed, representing a functional epidemic response architecture spanning testing, reporting, emergency coordination, and genomic sequencing to track viral evolution.

This response positioned Nigeria among Africa's leaders in pandemic management and demonstrated that Nigeria possessed scientific talent, institutional leadership when aligned and empowered, and the ability to mobilise rapidly in moments of crisis.

But this is only part of the story. Much of this capacity was built under emergency conditions, driven by urgency, [supported by external funding, and sustained by political attention](#) that is difficult to maintain outside a crisis. As case numbers declined, a familiar pattern began to re-emerge. Systems slowed, and momentum weakened, as a system built for crisis was not fully converted into one built for prevention. That tension between what Nigeria can build during a crisis and what it can sustain afterwards defines the country's epidemic preparedness challenge.



Precedence and Diagnoses

Recent outbreaks illustrate this with clarity. Recurrent Lassa fever outbreaks continue to expose uneven response capacity across states, including in places like Bauchi, where [early detection remains limited](#). Similarly, [emerging research on mpox transmission in urban Nigeria](#) suggests that silent circulation may be occurring more widely than formal case reports indicate, with exposure in individuals never formally diagnosed.

These are not failures of science, but of detection systems. Epidemics do not always announce themselves. Some spread quietly through gaps in detection, surveillance, and trust. Yet between outbreaks, prevention consistently loses to short-term priorities that carry greater political appeal but limited long-term value. As a result, Nigeria remains

caught in a reactive cycle: respond, recover, and reset without fully building a system that endures. The question is no longer whether Nigeria can respond to epidemics; it has shown that it can, but whether it can build systems that function before crises begin.

Doing this requires recognising epidemic preparedness work not only as a technical problem, but also as a political and governance problem. Epidemic preparedness depends on whether prevention is treated as a core government function, equivalent in importance to maintaining roads, providing electricity or education. It is not a single-institution function; it is a system, and over the past decade, it has developed credible technical capabilities.

Identifying Stress Points

State ministries of health carry much of the operational burden. Primary health care centres (PHCs), often under-resourced, serve as frontline detection points. Community health workers, embedded and trusted, are frequently the first to recognise unusual patterns of illness. Research institutions and laboratories provide critical scientific capacity, as demonstrated during COVID-19 through genomic surveillance. Beyond formal institutions, epidemic response depends on trust. Faith-based organisations, civil society, and the media influence how health information is understood and acted upon. During outbreaks, trust in these actors can determine whether public health measures are followed or resisted.

The challenge is not the absence of capacity, but fragmentation. Coordination across federal, state, and local levels remains uneven. While international partners have helped strengthen these systems, they have also created dependencies where key components of preparedness rely on external funding cycles rather than domestic investment. As a result, preparedness exists in pockets, not as a cohesive system.

Nigeria's epidemic risk is increasing, shaped by structural changes already underway. Rapid population growth, urbanisation, and the expansion of informal settlements create environments where infectious diseases spread quickly. Climate variability

is altering patterns of disease emergence, increasing risks of outbreaks such as cholera and vector-borne infections. At the same time, closer human–animal interaction raises the likelihood of zoonotic spillover. These dynamics suggest that Nigeria is entering a period where outbreaks may become more frequent, more complex, and more difficult to contain.

Recent work on mpox highlights both risk and opportunity.

Serological evidence suggests exposure to orthopoxviruses may be more widespread than reported case numbers indicate, pointing to ongoing low-level transmission that remains undetected. Similarly, Lassa fever response efforts demonstrate that early detection dramatically improves outcomes. Cases identified quickly are more manageable, with shorter transmission chains and reduced mortality.

From an opportunity standpoint, a large, young population represents a potential public health workforce. Urban systems offer opportunities for scalable interventions. Expanding research capacity positions Nigeria to lead in understanding emerging infectious threats. The implication is straightforward: the problem is not simply the presence of pathogens, but the reach and sensitivity of detection systems. The

solution is achievable; it requires investment in reach, not new science. Without sustained investment, the consequences are predictable. In the short term, delayed detection can accelerate transmission, increase emergency response costs, and fuel misinformation. In the long term, underinvestment risks eroding laboratory capacity, driving the loss of skilled personnel, and weakening the surveillance systems needed to identify and contain future threats.

These risks are not evenly distributed either. Rural communities face delayed detection and limited access to care. Urban populations face rapid transmission risks. Women, as primary caregivers and the majority of community health workers, bear disproportionate burdens during outbreaks, facing increased care responsibilities and disrupted access to maternal health services. Young people, who constitute over 60% of the population, face both direct health risks and broader socio-economic consequences, including school closures, disrupted livelihoods, and economic scarring. If current patterns persist, Nigeria will face not isolated epidemics but overlapping and recurring syndemics — multiple disease outbreaks within already strained systems.

The Architecture of Actors

Addressing these requires a shift from reactive response to sustained prevention. This shift is not abstract thinking. Consider early detection: a suspected Lassa fever case in rural Plateau State may currently take weeks to confirm. With investment, it could be diagnosed within days, limiting the

spread, reducing mortality, and reducing economic costs. With geographic reach, diagnostics are currently concentrated in a few urban centres, but with expansion, every region could have reliable testing, eliminating blind spots. The same applies to the workforce, where trained experts

leave due to limited opportunities. With structured career pathways and competitive systems, talent could be retained and strengthened. Data systems present a similar opportunity, as current surveillance systems are fragmented. With integrated digital reporting, real-time data could guide faster and more transparent responses. Finally, there is the question of permanence. Funding often surges during crises and recedes once the immediate threat passes. Sustained financing would transform preparedness from a temporary response into permanent infrastructure, where expertise is continuously strengthened and resilience is built into the system itself.

This transition requires deliberate action. At the federal level, epidemic preparedness must be financed as a core function, with predictable funding rather than emergency allocations. Surveillance systems must be integrated across primary care, laboratories, and national data platforms. Genomic surveillance should be embedded within routine public health systems, not dependent on research cycles. State governments, for their part, must strengthen primary health care systems as frontline detection platforms, expand laboratory networks, and retain trained personnel. At the local level, community health workers must be formally integrated into surveillance systems, supported with clear reporting pathways and linked to state and national systems.

Trust-building through community engagement must be prioritised. The Africa CDC estimates that annual per capita spending of US\$1 to US\$3 on preparedness could avert billions in outbreak response costs. Epidemic preparedness is not a

government-only responsibility; it is a collective endeavour. Beyond government, private sector actors, civil society organisations, and development partners all have roles to play.

Private laboratories and healthcare providers should be integrated into national surveillance frameworks. Civil society and media organisations are essential for strengthening public health communication and countering misinformation. Development partners should transition toward co-financing models that prioritise sustainability and national ownership rather than parallel systems.

The question is political: Will our nation sustain preparedness when crises fade? COVID-19 showed that rapid mobilisation, scientific excellence, and institutional coordination are possible. The challenge is to institutionalise these gains before the next outbreak.

Citizens must demand accountability by asking fundamental questions: How is epidemic preparedness funded? How are rural communities protected? What systems are in place before outbreaks occur? Policymakers must embed preparedness into national planning and provide consistent funding. Scientists must lead from within. Communities must remain engaged. International partners must support systems that are locally owned and sustainably financed.

The next epidemic is not a question of if, but when. The real question is whether Nigeria will be ready. Will we continue responding to crises as they emerge, or build the systems needed to prevent them from becoming crises in the first place?

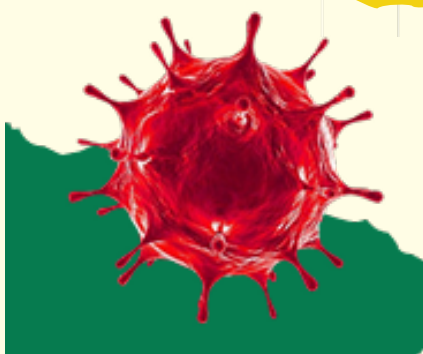
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Key Insight #7



African CDC estimates that spending just \$1 to \$3 per person per year – between ₦1,410 to ₦4,230 by current market rates – on epidemic preparedness could avert billions of dollars in outbreak response cost.

Key Insight #8



At the outbreak of COVID-19 saga and in under 18 months, Nigeria's COVID-19 lab network exploded from fewer than 5 testing centres to 140 across all six geopolitical zones.

Key Insight #9



The system built to combat the COVID-19 crisis was not converted to one that can tackle present infectious diseases or prevent future epidemics.

#05 *by* Oyeronke Oyebanji

Will Nigeria finally build what it once had?

**VACCINE MANUFACTURING AND
THE COST OF RECURRING AMBITION**



The COVID-19 pandemic and the race to develop vaccines rewarded countries with strong, proven research capabilities. It also provided a chance for Nigeria, [whose Federal Vaccine Production Laboratory, Yaba](#), was a frontline space for Nigeria's epidemiological capacity.

Established from the [Rockefeller Yellow Fever Laboratory in 1925](#), it produced vaccines against smallpox (1930s), rabies (1948), and yellow fever (1952), reaching a peak of 500,000 yellow fever vaccines in 1987, before closing in 1991 for renovations and upgrades that remain unfinished. Its closure stands as a monument to years of underinvestment, shifting policy priorities, and a system that struggles to sustain alignment across institutions.

By the time COVID-19 arrived, Nigeria was no longer producing vaccines. Instead, like much of Africa, it was working to secure access within a global system where supply, timelines and priorities were largely shaped elsewhere. Still, the pandemic triggered a renewed ambition to restart local vaccine

manufacturing in Nigeria, but this was not the first attempt.

In 2005, the Nigerian Government, in partnership with May & Baker Nigeria Plc, established BioVaccines Nigeria Limited (BVNL) to rebuild [Nigeria's domestic vaccine manufacturing capacity and reduce import dependence](#). Despite this, Nigeria still lacks local vaccine manufacturing, with BVNL remaining a "work in progress," as the agreement broke down and was revived in 2017, [before stalling due to financing gaps and political interference](#). In 2018, there were [other attempts to revive the Yaba laboratory](#). That, too, was not successful.

Nigeria's population and strategic role as West Africa's hegemon mean that any future regional outbreak or pandemic will require a strong, effective response. It will need a system that is resilient and prepared to handle the weight of an expectant and sceptical public. But can Nigeria build the kind of system that makes it possible?

The Gap Between Agenda and Action

In 2023, the Presidential Initiative for [Unlocking the Healthcare Value Chain \(PVAC\) was established](#). The existence, for the first time, of a presidency-mandated committee signalled high-level political commitment and the inclusion of vaccines, as well as drug and test manufacturing, firmly in Nigeria's policy agenda. The PVAC has launched two strategies, established committees, and announced partnerships, in line with [Nigeria's 2021 vaccine policy](#), which set an expectation that local manufacturing would begin by 2026.

Regrettably, such promises with unrealistic timelines have proven to be a precursor to disappointment. Vaccine manufacturing is not a discrete project that can be delivered within a single political cycle and requires concerted buy-in across presidential transitions and leadership changes at the Ministry of Health. It necessitates sustained alignment across financing, regulation, organisational capability and market structure. That the 2021 vaccine policy target was not met is unsurprising; it does, however, highlight the level of transformation needed.

The Opportunity Cost of Failure

Nigeria carries a high burden of infectious diseases, many of which have implications beyond its borders. Outbreaks that begin locally can quickly become regional or global concerns. Lassa fever, for example, continues to affect communities annually, spreading from 20 to 34 of Nigeria's 36 states and the Federal Capital Territory, yet Nigeria lacks a licensed vaccine.

At the same time, Nigeria records [an estimated eight million births annually](#), each child requiring a full course of routine immunisation. With one of the highest birth cohorts in the world, and a direct and predictable demand for vaccines, Nigeria still has over 2.1 million zero-dose children: [infants who have not received any routine vaccines](#) — the [highest number on the African continent](#). These children and the women who care for them, concentrated mostly in rural communities in Northern Nigeria, where health systems are weakest, and mothers face the greatest barriers to accessing immunisation services, will bear the sharpest consequences of a system that has not yet learned to protect its most vulnerable.

In Nigeria, where health needs are extensive and outbreaks recurrent, it is reasonable to question whether scarce public resources should be directed toward manufacturing. The answer lies not in government funding production outright, but in its role in shaping the conditions that make it viable: predictable procurement, regulatory strength, targeted risk-sharing, and coordination of actors across the value chain.

In countries where vaccine manufacturing

has taken root, such as Senegal, South Africa, and India, from which Nigeria procures much of its supply, it has not been a purely government-driven endeavour. The scale, cost and uncertainty involved demand a mix of public and private participation. Vaccines are not products that can be manufactured on demand, but the outcome of a system that must function reliably over time. That system covers regulation, financing, industrial policy, scientific capability and public health delivery, and its success depends on how well these elements are aligned and sustained. The challenge, therefore, is how to build and maintain a coherent system that can deliver.



Strong Parts, Fragmented System

Nigeria has relatively strong institutions, and if they functioned well together, they would result in a strong healthcare system with a robust vaccine development structure. But they are subject to internecine turf battles and clashes over resources and influence, leaving the entire system vulnerable.

The Federal Ministry of Health provides policy direction and oversees its agencies. The National Primary Health Care Development Agency (NPHCDA) procures and delivers vaccines. The National Agency for Food and Drug Administration and Control (NAFDAC) regulates their use, while the Nigeria Centre for Disease Control and Prevention (NCDC) generates data that informs what is needed and where. Research institutions such as the National Institute for Pharmaceutical Research and Development (NIPRD) and the Nigerian Institute of Medical Research (NIMR) contribute to the development of scientific and clinical research capacity. [Local pharmaceutical companies are exploring entering the vaccine manufacturing market](#) in partnership with global firms. Meanwhile, international partners are engaged and willing to support. On paper, all the necessary components appear to be in place.

Sadly, in practice, the system is fragmented. Responsibilities overlap, coordination is uneven, and decision-making can be slow. We see this in basic research, when clinical trials or other scientific materials are stuck at the port of entry with no clarity on where the bottleneck exists or accountability for resolving such situations. There is a tendency to focus on creating new structures rather than ensuring that existing

ones are aligned and function effectively. Vaccine manufacturing cannot be built with such misalignment.

It is a complex undertaking within any health system, requiring long-term financing, credible and trusted regulatory systems, a skilled and sustained workforce, reliable demand, and coordination across sectors that do not always naturally align. Vaccine manufacturing requires discipline, consistency and a level of institutional coherence that is often difficult to achieve.

If these foundations are not addressed, the consequences will accumulate over time. In the short term, Nigeria will continue to depend on imported vaccines. During periods of stability, this dependence may not appear problematic. But mass outbreaks, as we saw in 2020, do not occur under stable conditions. When global supply is constrained, countries, especially those in Africa, which [import more than 70% of the continent's medicines and lack production capacity](#), will be faced with limited options.

In the medium term, Nigeria risks missing a critical window of opportunity. There is currently significant global momentum for vaccine manufacturing in Africa. The European Union, for instance, [has partnered directly with Nigeria to boost local manufacturing in the health sector](#), supported by increased political attention and rising financing.

This momentum could also improve investment interest in other parts of the health ecosystem and significantly improve Nigeria's capacity to leverage its weight in the regional and continental economy.

However, this momentum is not evenly distributed. Countries that can offer clarity through strong regulatory systems, coordinated policies, and predictable markets are moving ahead more quickly. Nigeria has the potential to be part of this group, but that outcome is not guaranteed.

Over time, the greater risk is that Nigeria

remains engaged in discussions and present in partnerships, but unable to translate that engagement into sustained domestic capacity. Perhaps, most importantly, repeated gaps between ambition and delivery risk eroding confidence not only among external partners and investors, but also among Nigerians.

Alignment before Ambition

What would it take to change this trajectory? The answer is to make existing systems work more effectively, starting with clarity. There must be a clear locus of responsibility for driving the vaccine manufacturing agenda. Coordination cannot remain a shared responsibility without ownership. Someone, or some institution, must be accountable for ensuring that the different parts of the system are aligned and moving in the same direction. For example, Ghana has set up a National Vaccine Institute [with a dedicated institutional anchor](#) for vaccine development and manufacturing. Nigeria's [PVAC is a time-bound initiative](#), but within its short lifespan, it has already made tangible progress in coordinating across ministries, mobilising investment and aligning stakeholders around a shared vision for local production. One positive step would be for PVAC to evolve into a more permanent institutional platform to sustain and consolidate these gains.

It also requires a more honest engagement with the economics of vaccine manufacturing. Vaccines are expensive to develop and produce, require long timelines, and operate within tightly regulated environments. They cannot be sustained without a predictable and

credible market. If Nigeria is serious about local manufacturing, it must be willing to procure locally produced vaccines once they meet established quality standards. Without such commitments, private-sector participation will remain cautious, and investment will remain limited. Nigeria's experience with the Dangote Refinery offers a useful parallel. The federal government's [crude-for-naira agreement with NNPC](#), a commitment to supply domestic crude in local currency to guarantee the refinery's operations, illustrates exactly the kind of structured market commitment that vaccine manufacturing will also require. A credible government pledge to purchase locally produced output that meets quality standards reduces the risk for private investors and incentivises local actors.

At the same time, it is important to distinguish between different types of financing. Financing for vaccine procurement, which involves purchasing vaccines for use, and financing for manufacturing, which involves building and sustaining production capacity, serve different purposes. When these are conflated, it creates confusion, weakens accountability and undermines strategic planning. Both are necessary, but they must

be structured and managed differently. Regulation is another area that needs a shift in perspective. A strong regulatory system is a prerequisite. Without it, vaccines cannot move through clinical trials efficiently, be approved in a timely manner, or be trusted by either domestic or international stakeholders. NAFDAC has a solid foundation—it is one of only four regulatory agencies in Africa to achieve WHO Maturity Level 3 status, [a recognition it first earned in 2022 and retained after re-benchmarking in 2024](#)—but it needs to be further strengthened. This will go a long way in securing citizen buy-in for actual vaccine usage compliance.

Equally important is the question of human capital. Infrastructure often receives the most attention because it is visible and politically tangible. But facilities alone do not produce vaccines; people do. Scientists, regulators, technicians and quality assurance specialists form the backbone of any vaccine ecosystem. Developing this workforce requires sustained

investment, and retaining it requires creating environments in which expertise can be applied and valued. Unfortunately, [our current science curriculum is not yet aligned with the skills and competencies required](#) for vaccine development and manufacturing. Without a clear talent pipeline, companies are not incentivised to invest in the long-term structures required for vaccine development. Without this, physical infrastructure risks being underutilised.

Finally, Nigeria must be more strategic in its approach to vaccine manufacturing. Attempting to produce every vaccine is neither necessary nor feasible. A more focused approach, such as starting with fill-and-finish for established vaccines, would enable more realistic, tractable progress. This allows capabilities to be built incrementally, aligned with existing institutional and market conditions and expanded over time as system alignment and capacity improve.

The Big Picture

Vaccine manufacturing is not solely the government's responsibility. Citizens have a role in demanding accountability and engaging with how health priorities are set and funded. Civil society organisations can track progress and ensure that diverse perspectives are reflected in policy discussions. The private sector must engage in ways that prioritise long-term capacity over short-term gain. Academic and research institutions must generate evidence that informs decision-making and supports implementation.

Nigeria's vaccine ambitions have been marked by cycles of urgency and abandonment. The Yaba laboratory closed in 1991 with promises of an upgrade that never came. BioVaccines was incorporated in 2005, stalled, revived in 2017, and still has not produced a single dose. Each time a crisis arrives, the conversation restarts with the same sense of urgency, the same commitments, and, eventually, the same fade into inaction once the headlines move on. Outbreaks might once have seemed distant, but recent incidents have been close to home and the threats real. Nigeria

alone has seen Ebola in 2014, Lassa fever year after year, COVID-19 in 2020, mpox in 2022, to name a few.

What these outbreaks have made clear, repeatedly, is that vaccine security cannot be built in the middle of an emergency. It requires the kind of sustained, coordinated investment in institutions, regulation, manufacturing, and workforce that outlasts any single crisis. The question Nigeria faces is not whether it has learned this lesson, but whether it is finally prepared to act on it before the next outbreak forces the conversation again.

Nigeria's ambition to produce vaccines

locally is not new. Right now, there appears to be renewed political attention and global momentum behind it. Whether this moment translates into sustained capacity will depend on the ability to strengthen, align and discipline the systems that already exist. The political cycle is too short for any single government to deliver, but the benefits of this work are long and transformative. It will be felt by generations who will no longer depend on inequitable global vaccine supply chains. Each administration must therefore see its role as part of a larger effort that will reshape the country long after any one government has passed. Each Nigerian must see it as a larger effort to protect and preserve future generations yet unborn.

Oyeronke Oyebanji is the Head of Lassa Engagement at the Coalition for Epidemic Preparedness Innovations (CEPI), where she leads country and regional collaborations to accelerate Lassa vaccine development. With nearly ten years of global health experience. She has led and contributed to significant initiatives, including her role as an Analyst within the COVAX facility, helping to deliver 2 billion COVID-19 vaccine doses globally. She has a doctorate in public health from the London School of Hygiene and Tropical Medicine.

Key Insight #10

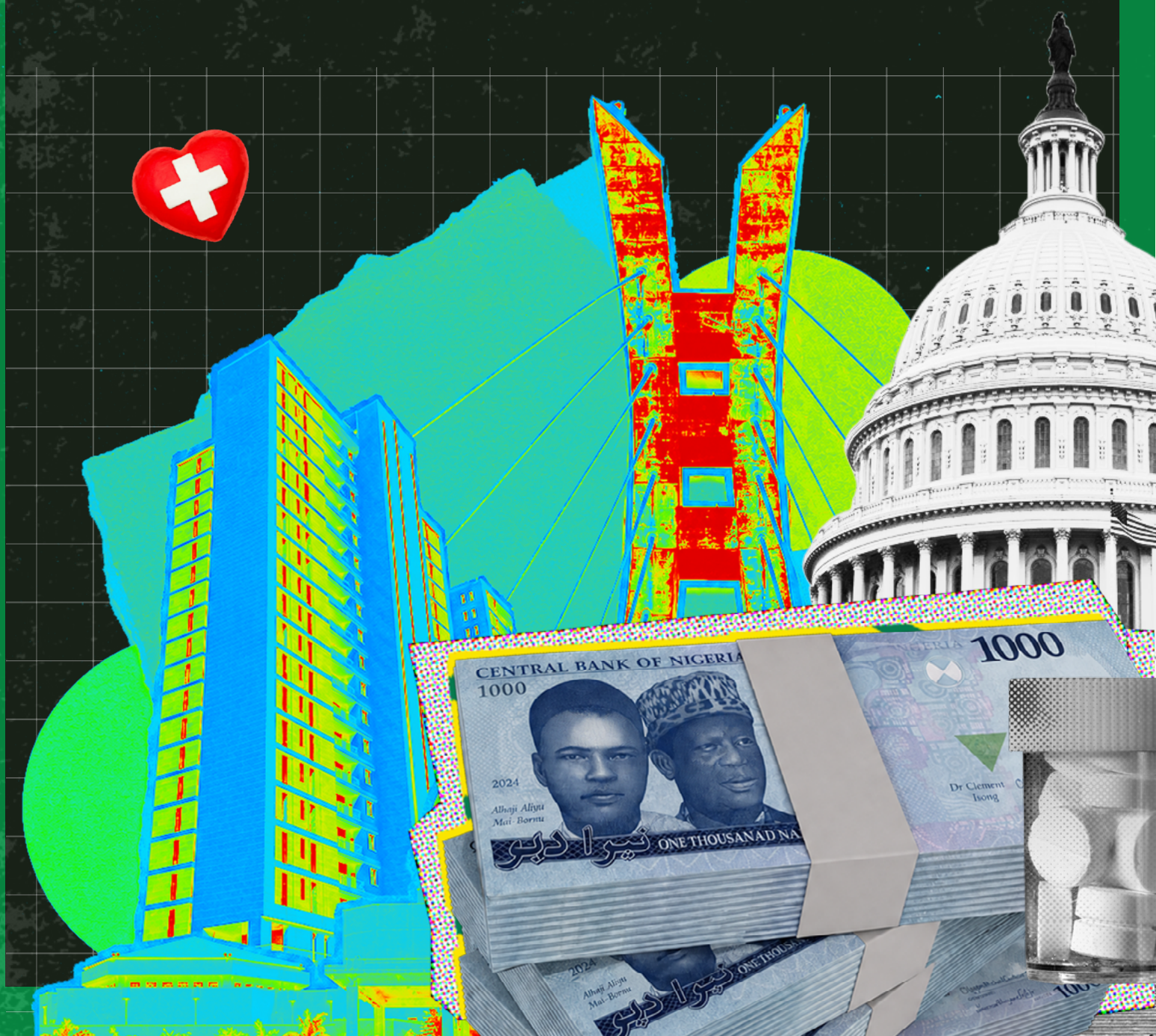


Nigeria once produced 500,000 yellow fever vaccines a year at a Lagos lab in 1987. That lab has been shut for “renovations” since 1991. So far, it's been 35 years and counting.

#06 by Luke Alade

The hands that feeds:

LESSONS FROM TWO DECADES OF DONOR-SUPPORTED HEALTH PROJECTS IN NIGERIA



There is no free lunch in free town

For over two decades, Nigeria's health system has been substantially bankrolled by external donors, among them the United States government through PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Bill & Melinda Gates Foundation, and a long list of bilateral and multilateral partners.

The numbers are staggering. Between 2021 and 2025 alone, Nigeria received more than US\$4.6 billion in international health grants from the Global Fund and USAID, with [PEPFAR contributing an additional US\\$6 billion](#) over the same period. By 2024, donor funding had risen to represent 19% of Nigeria's total health expenditure—up from 14% the year before—with most of those resources managed directly by development partners rather than routed through government systems.

Yet despite this extraordinary level of investment, Nigeria continues to record some of the worst health outcomes on the

continent. Maternal mortality stands at [576 deaths per 100,000 live births](#), among the highest in the world. Neonatal mortality sits at 41 deaths per 1,000 live births. The country has only 55,000 licensed doctors for a population of over 200 million, well below the [WHO recommendation](#) of ten physicians per 10,000 people. Government spending on health remains at roughly 0.5% of GDP, below the [African regional range of 2–12%](#) and a distant cry from the 15% commitment Nigeria made at the Abuja Declaration in 2001. In 2024, despite a federal health capital allocation of ₦434.8 billion, [only ₦65.4 billion](#)—about 15%—was actually released. In practical terms, the Federal Ministry of Health could not execute any capital project that year.

The persistence of these gaps suggests systemic weaknesses that cannot be fully understood without examining the dynamics of current funding models and their long-term implications.

Who Is Involved?

The donor health ecosystem in Nigeria is sprawling. At the top sit the behemoths: PEPFAR, which has disbursed over US\$7.8 billion to Nigeria since its inception; the Global Fund, which allocated approximately US\$933 million to Nigeria for the 2024–2026 grant cycle alone; and the Gates Foundation, which has made substantial investments across primary healthcare, polio eradication, and nutrition. These are complemented by the World Health Organisation (WHO), UNICEF, UNFPA, the World Bank, and a growing number of bilateral donors,

including the United Kingdom and the European Union.

On the government side, the Federal Ministry of Health and Social Welfare (FMOHSW) is the nominal anchor institution, supported by the National Primary Health Care Development Agency (NPHCDA), the National Health Insurance Authority (NHIA), and state ministries of health. Civil society organisations, from large international NGOs to small community-based groups, serve as the implementation layer,

often doing the actual work of reaching communities. Implementing partners such as CHAI, Management Sciences for Health (MSH), FHI 360, and APIN Public Health Initiatives bridge the gap between donor funding and on-the-ground service delivery.

In practice, this ecosystem produces a complex and often fragmented patchwork of interventions, each with its own timeline, reporting requirements, and definition of success.

The Mixed Record: Where Donor Funding Has Worked — and Where It Has Not

Any assessment of donor contributions must acknowledge the significant gains that have been achieved. Between 2012 and 2024, HIV infections in Nigeria declined by 63%. By the end of 2024, 84% of people living with HIV knew their status, and over 98% of those diagnosed were on treatment. Close to 2 million Nigerians now access antiretroviral therapy, a scale of coverage that would have been unimaginable twenty years ago. Malaria burden has also reduced meaningfully, and Nigeria has made progress in building technical working groups and coordination structures that have strengthened health system governance.

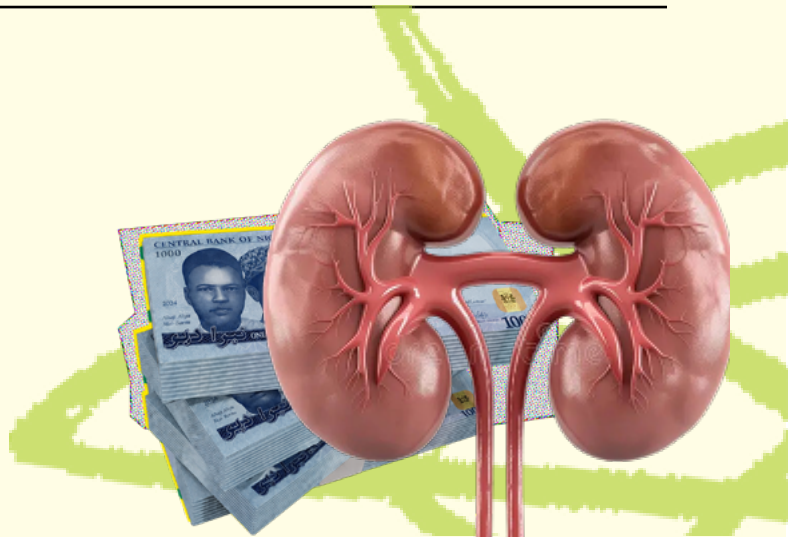
However, the picture becomes more complicated once you move away from vertical disease programmes. Maternal and child health outcomes have barely shifted. Health system strengthening—the infrastructure, workforce, and supply chains that allow a health system to function even on days when no donor programme is running—remains deeply weak. Out-of-pocket spending, at 58.3% of total health expenditure in 2024, continues to push millions of Nigerians into financial hardship every time they fall ill. Women, children, and low-income households in rural areas bear the greatest burden.

The fundamental tension is this: donor funding has been most successful in areas that align with donor interests, particularly infectious disease control, which serves both humanitarian goals and the strategic interest of preventing global epidemics. It has been far less successful in building the underlying architecture of a functional health system, which is slower, messier, and harder to measure in annual reports.

Donor timelines frequently prioritise demonstrable outputs—numbers of patients treated, facilities upgraded, health workers trained—over the slower, systemic work of ensuring those gains outlast the programme cycle. A community health worker trained in year two of a three-year grant faces an uncertain future when the grant closes. A facility renovated with donor funds can deteriorate within eighteen months if the state government does not budget for maintenance. These are not exceptional failures; they are structural ones.

There is [also the question of alignment](#). Donor priorities do not always map cleanly onto Nigeria's actual disease burden or health system needs. The allocation of resources often reflects global agenda-setting—driven by epidemics that captured

international attention, geopolitical relationships, and, yes, the market logic of pharmaceutical industries looking to expand access to their products. This is not a conspiracy; it is simply the way large institutions operate. But its consequences for a country like Nigeria, where the gap between donor priorities and population needs can be wide, are significant.



What Happens If We Don't Act Today?

The warning signs are already visible and acute. In 2025, the Trump administration's suspension of PEPFAR funding triggered an immediate crisis across Nigeria's HIV response. More than 95% of PEPFAR-funded community workers received stop-work orders. Over 80 One-Stop Shops, facilities serving key populations including adolescent girls, sex workers, and men who have sex with men, faced service disruptions. In eight countries, including Nigeria, 89% of funding for community-led HIV organisations comes from bilateral donors, with less than 0.1% from domestic sources. This is the existential vulnerability of dependency. When Washington shifts its foreign policy, clinics close in Kano.

In the short term, continued dependency means that progress on HIV, malaria, and

maternal health will remain fragile and reversible. Over the next decade, Nigeria risks approaching what researchers call donor transition—the point at which its lower-middle-income classification triggers the withdrawal of official development assistance—without having built the domestic financing systems to absorb the gap. The trajectory is clear: external funding is becoming less reliable, but domestic systems have not matured to replace it.

For women in rural Kebbi State who currently access antenatal care through a donor-funded facility, or for an adolescent girl in Borno accessing HIV prevention services through a partner-supported One-Stop Shop, the consequences of this structural failure are not abstract. They are life and death.

Policy Recommendations

The solutions are neither simple nor cheap. But they are knowable.

At the federal level, Nigeria must make a credible, enforceable commitment to the

15% Abuja Declaration target—not merely in budget allocation, but in the actual release of funds. The chronic gap between health budget appropriations and disbursements

is arguably the single greatest structural failure in Nigeria's health system. The federal government must also strengthen the National Health Insurance Authority as the primary vehicle for domestic health financing, with a clear mandate to expand coverage beyond formal sector workers. Critically, counterpart funding obligations to donors—a recurring point of failure—must be treated as a non-negotiable first-line expenditure, not an afterthought.

At the state level, governors must be held politically accountable for their states' health outcomes. Subnational variation in Nigeria's health landscape is extreme: a woman in Lagos faces fundamentally different risks and access realities than a woman in Zamfara. States must develop and implement their own health financing strategies, rather than simply waiting for federal or donor transfers. States should also build robust community health worker systems that are fully domestically funded and integrated into the civil service, ending the cycle of NGO-funded, grant-dependent community workers.

For donors themselves, the ask is structural rather than financial. Donor

programmes should be designed from day one with explicit exit strategies that include government absorption plans. Technical assistance—supporting governments in planning, budgeting, and managing their own systems—should be given greater weight than direct service delivery. Reporting requirements should be rationalised and aligned across donors to reduce the administrative burden on government partners, who currently spend significant capacity producing reports for 10 donors in 10 different formats. Specifically, at least 30% of programme budgets should be allocated to systems strengthening and government capacity building.

For civil society and the private sector, the priority is accountability and innovation. Civil society organisations must deepen their role as watchdogs over both governments and donors — tracking whether funds are released, programmes are delivered, and outcomes are achieved. The private sector, which already accounts for a significant share of health service delivery, has an underutilised role in health financing through private insurance and workplace health programmes.

Conclusion

Nigeria cannot continue to build its health system on borrowed money. The PEPFAR disruption of 2025 was a warning shot, not an anomaly. The architecture of a health system that lives and dies by the decisions of foreign governments and global fund replenishment cycles is not a health system: it is a contingency plan.

The work ahead requires three things above all: domestic political will, domestic

financing, and domestic accountability. Not because donors are malicious, but because sustainable health outcomes require ownership of the kind that persists after the project cycle ends, the kind that belongs to the communities it serves.

For citizens, the most powerful action is to demand accountability from elected officials at the local, state, and federal levels for health outcomes and health budgets.

Ask elected officials and representatives what percentage of the state budget is allocated to health care. Ask what happened to the counterpart funds that should have unlocked donor grants. Ask why the primary health centre in your community has not had running water in three years.

For advocates, the priority is to push for transparency in both government health spending and donor programme

evaluations. Nigeria needs a functioning open contracting portal for health procurement, and the political will to use it. For policymakers, the lesson of two decades is this: donor support can accelerate what domestic systems make possible. It cannot substitute for them. The investment in those systems—in buildings, in workers, in institutions, in trust—is the work of this generation.

Key Insight #11



Between 2021-2025, Nigeria received over \$10 billion combined from PEPFAR, the Global Fund, and USAID, its 2026 and Nigeria still has one of the worst maternal mortality rates on Earth.

#07 *by* Omei Bongos

Reaching people first:

**HOW EFFICIENT FISCAL POLICY CAN
BRIDGE HEALTH INEQUALITIES**



From a public health perspective, Nigeria is in two places at once. Acute infectious diseases common in underdeveloped societies have not vanished, while chronic non-communicable diseases (NCDs), once associated with Western societies, have become predominant.

A changing demographic makeup is one of several factors driving this transition. A woman who might have died in childbirth survives the birth of five children; in her fifties, she confronts cervical cancer. A child who in decades past might have died from a vaccine-preventable disease now reaches middle age, and, because of changes in risk factors such as diet and lifestyle—another driver of this transition—he encounters type 2 diabetes and grapples with the new health and economic costs of living with a long-term illness.

Even as NCDs currently account for around 29% of total deaths in Nigeria, the infectious disease burden remains high. The WHO estimates that one quarter of Nigeria's population contracted malaria in 2021. Cholera and tuberculosis outbreaks still ravage communities nationwide. Four of the five neglected tropical diseases that can be tackled through mass drug administration (MDA) are endemic in Nigeria. Despite these realities, our health systems have not adopted balanced policies that suitably confront the changing patterns of disease. The 2014 National Health Act was a commitment to investing in the health system to achieve universal health coverage. Under the Act, the Basic Health Care Provision Fund (BHCPF) covers a limited suite of health services known as the Basic Minimum Package of Health Services (BMPHS), which includes maternal health, immunisation services and the treatment of childhood illnesses like diarrhoea and

pneumonia, as well as screening and basic outpatient care for type 2 diabetes and hypertension.

While many PHCs provide key maternal and child health services, they are ill-equipped to manage NCDs. The WHO's 2018 NCD Country Profile for Nigeria revealed that primary health care centres are unprepared to handle cardiovascular disease (CVD). The Country Profile also indicated that no PHC facilities reported offering CVD risk stratification or guidelines, while essential medicines and equipment for NCD treatment were largely unavailable. No PHC could provide information on the availability of drug therapy and counselling to prevent heart attacks and strokes.

Regional disparities compound the issue. Facility readiness for NCD care is higher in Nigeria's Southern region compared to the North. Lagos, FCT and Rivers rank highest in readiness while Katsina and Gombe rank among the lowest.

Nearly 40% of Nigerians live with hypertension, the top risk factor for stroke and coronary heart disease. But with limited routine screening and subtle symptoms, it can go undiagnosed for years; patients arrive at health facilities in advanced stages of the disease.

In rural communities, where specialists are scarce, patients leave PHCs with referral slips and little relief. BHCPF coverage can extend to secondary facilities, but mainly for services defined within the minimum package: screening, diagnosis and disease management. Yet it is often insufficient to cover prolonged costs associated with chronic illness. Although the BHCPF recognises insulin as an essential medicine for managing diabetes, a coronary heart disease risk equivalent, funding and

supply chain constraints mean it is often unavailable.

Tertiary facilities offer more specialised care, but a high patient burden and infrastructure challenges impede patient outcomes. The shortage of radiotherapy machines illustrates the infrastructure gap. Despite needing at least 280 machines

to serve its current population of cancer patients, Nigeria has fewer than 10 consistently functional machines across tertiary facilities. These infrastructural and diagnostic challenges force patients to seek care in private facilities that demand high out-of-pocket costs.

State Matters

Across states, disparities in health spending are evident. Although the overall size of federal and state allocations determines the total resources available, decisions on how to fund primary health care lie with the states.

The Nigeria Health Commissioners Forum and Tekano Group analysed state budgets for 2022–2024, noting that during this timeframe, the average share of state health expenditure declined. Although overall state fiscal expenditure surged, state health spending showed wide divergence, ranging from less than 50 cents per capita to US\$5.90. This variance was not determined solely by fiscal strength, as the highest-spending states were not necessarily those with the largest resource allocations, but those that prioritised health in their state budgets.

Bauchi State, for instance, with an overall resource allocation of less than US\$50 per capita, dedicated over 14% of this share to health. In comparison, Bayelsa State, which received more than three times Bauchi's overall resource allocation, devoted only around 4% of this to health.

One of the reasons Nigeria's maternal health burden remains high, in spite of the

donor funds invested, is rural–urban, state and zonal access disparities in service availability. A woman living in an urban area is twice as likely to give birth in a health facility as a woman living in a rural area, where distance, transportation, family and traditional beliefs can pose real barriers to skilled birthing care. This disadvantage extends to the child: the infant mortality rate in urban areas is 53 per 1,000 live births; in rural areas, this figure swells to 77 per 1,000 live births.



Ramping up local financing

Over the past few decades, donor funding and external aid have largely financed disease prevention and management. However, in 2025 and 2026, at a time when longtime donors were visibly scaling back aid, the Nigerian government raised its healthcare investment [through a 60% budget increase](#) and the expansion of the BHCPF, which is projected to reach ₦298 billion by 2026. Substantial international partnerships, such as US\$515 million in [targeted US assistance](#) and a [US\\$500 million World Bank credit facility](#), also continue to bolster domestic efforts.

In late 2025, a circulating “Red Letter” announced that the Health Minister, Muhammad Ali Pate, had released ₦32.9

billion to the BHCPF, primarily urging community ownership and accountability for rural PHCs. However, domestic budget lines do not disaggregate clear line items for NCD prevention interventions, and below the tertiary and secondary health systems, health worker capacity to detect NCDs such as heart disease, cancer, and diabetes (types 1 and 2) is nearly non-existent.

Despite these increased investments, Nigeria lags behind other low-income countries by nearly 40 percentage points in health spending and out-of-pocket medical expenditure. An even more disturbing systemic issue is that high budgetary allocations do not always translate to the actual release of funds.

Why do funds get stuck?

A critical barrier to bridging NCD health inequalities is ensuring that funds reach frontline facilities. In what is known as the “paper budget phenomenon,” large sums are appropriated for capital health projects, with only minimal funds reaching health facilities. A February 2026 report reveals that while ₦218 billion was allocated for health projects in 2025, only ₦36 million was released. [This amounts to less than 1%: 0.02%, to be exact.](#)

This inefficiency points to a fragmented stakeholder landscape. The Federal Ministry of Health blames the “cash planning system” of the Accountant-General’s office for delays. Health funds reach states through three primary gateways: the National Primary Health

Care Development Agency (NPHCDA), the National Health Insurance Authority (NHIA) and the Nigeria Centre for Disease Control (NCDC). Although the NPHCDA gateway is designed for direct transfer, some states still experience delays. Funds can sit in state accounts for months before PHCs receive them.

In 2025, records in states like Kano showed that BHCPF releases for the first two quarters did not reach facilities until August. In some states, funding makes little difference. In Ogun State, where over [₦1.4 billion was received between 2023 and 2025](#), it is impossible to distinguish PHCs funded under the BHCPF from those that received no funding, as facilities are short-staffed, poorly equipped, lack safe

infrastructure, and some centres are abandoned.

Partners, like Gavi and the World Bank, are taking a firmer stance, refusing to release funds without clear governance milestones.

This is known as the [Program-for-Results \(PforR\) model](#). It places a unique focus on results and withholds disbursements until institutions can prove that they have achieved specified results.

Far-reaching consequences

This disconnect carries more than logistical consequences. Hospital upgrades are delayed. Health workers are denied basic tools. Lives are lost. For women, this gap translates into a shortage of emergency obstetric care; for young medical professionals, it means seeing no future in under-equipped facilities, fuelling brain drain. Funding alone is insufficient without a parallel commitment to accountability in disbursement processes.

NCD rates are rising, and they come with a lifetime burden. These conditions are not absent from Nigeria's most remote rural communities, yet domestic and donor funding still focuses mainly on infectious diseases. Without fiscal policies that

prioritise prevention, crushing health care costs will impact individuals forced to bear out-of-pocket expenses and national health systems.

Preventive health is foundational to the health system. Beyond the health benefits, it reduces economic losses from low productivity and absenteeism. Public health advocacy campaigns often pursue policy shifts and strong provisions that can be implemented at the state and local levels. Many policy successes, however, remain as elite-level achievements that never translate to real systemic shifts. Strong implementation, tied to political will, is often the missing link.

Recommendations

Bridging inequalities will centre on expanding essential services under BHCPF 2.0. The government's transition to BHCPF 2.0, which aims to expand direct financing from 8,000 to 13,000 facilities, must explicitly include basic NCD management, such as blood pressure medication, alongside its successful provision of emergency obstetric care to women.

To address bottlenecks to funds reaching communities, prevention-focused policies,

such as taxes on sweetened beverages, alcohol and tobacco, can directly finance community-level interventions. Mass hypertension, breast and cervical cancer screenings, prostate exams, and school-based nutrition education, for instance, can shift the focus from expensive tertiary cures to cost-effective community prevention.

Resources must be made available, whether through state-run mobile clinics that traverse LGAs to reach hard-to-reach

communities at scheduled outreach interventions, or more fully equipped frontline facilities. Strong, government-backed public awareness initiatives will counter public viewpoints that prevention costs more than treatment and normalise behaviours such as hygiene and healthy dietary practices that can keep both communicable and non-communicable diseases at bay.

Accountability must be treated as a prerequisite for investment, not an afterthought. This requires greater state-level oversight alongside community-led monitoring. Citizen-led budget tracking, where local communities verify if drugs actually arrive at their PHC, can force leakages to close organically.

Introducing financial incentives that reward proven impact can also close inequality gaps. In 2025, the Nigeria Governors' Forum named [Yobe the best-performing state](#)

[for primary healthcare](#), citing rigorous data quality and community engagement. This award secured the state \$1.2 million in performance rewards. Accountability not only prevents waste but also attracts more funding. To scale this success, the government must require the publication of financial reports on BHCPF use from the start and set transparency precedents to guide future programmes.

The HOPE-GOV Program (2025–2026) offers a model: [\\$480 million is disbursed to states](#) only after achieving specific Disbursement-Linked Indicators, such as producing audited financial statements or improving rural health worker deployment. By ensuring that allocated funds are released only upon proof of impact, this model can end the cycle of wasted paper budgets, create a fiscal environment where sorely needed funds can finally reach facilities—and people—at the last mile first, and meaningfully reduce health inequalities across Nigeria.

Omei Bongos-Ikwue is a health communications and public health advocacy specialist at Gatefield Nigeria. She is the spokesperson of the National Action on Sugar Reduction (NASR) Coalition, through which she has led national campaigns for sweetened beverage taxes and NCD prevention policy. A graduate of Oral Roberts University, her work spans health financing advocacy, tobacco control, and NCD prevention across Nigeria and West Africa.

Key Insight #12



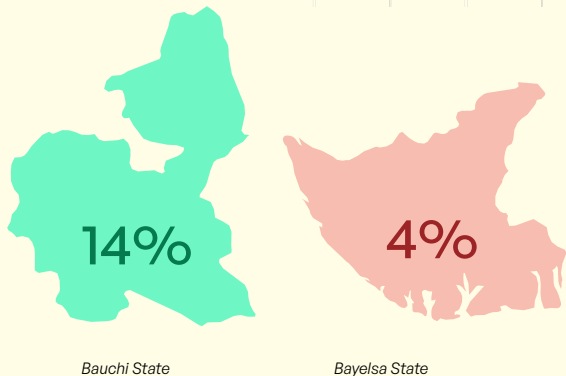
₦218 billion was budgeted for health projects in 2025. Only N36 million was released, that’s 0.02%. Meaning for every ₦5,000 budgeted for health projects, less than ₦1 actually reached them

Key Insight #13



With the current population of cancer patients in Nigeria, the country needs at least 280 radiotherapy machines. Nigeria has fewer than 10 across tertiary facilities.

Key Insight #14



Bauchi State receives less than US\$50 per person in overall resources (about ₦70,500) and dedicates 14% of that (₦9,870) to health. In comparison, Bayelsa State receives more than three times Bauchi’s overall allocation and spends just 4% of it on health.

#08 *by Vivianne Ihekweazu*

Health is a political choice:

IS THIS NIGERIA'S TURNING POINT TO GET IT RIGHT?



“

“Health is fundamentally a political choice – a choice that is made in laws, regulations and policies, but also in budgets, and decisions about how economies are structured.”

Dr Tedros Adhanom Ghebreyesus, Director-General, World Health Organisation.

Health systems are ultimately shaped by political choices. Decisions about financing, governance, and service delivery determine who can access care, when they receive it, and at what cost. In Nigeria, where an estimated population of [232 million](#) people depend on a health system facing persistent resource constraints, the consequences of those choices are increasingly visible.

While decisions about healthcare are becoming more urgent, the gap between policy intent and implementation remains significant. During the 2026 budget defence, the Coordinating Minister of Health revealed that only ₦36 million had been released from the ministry’s ₦218 billion capital allocation for 2025, highlighting the challenges that continue to undermine the delivery of health services despite ambitious commitments.

[With just over 21 million Nigerians covered by some form of health insurance, 70%](#) of healthcare-related expenses in Nigeria come from out-of-pocket payments at the point of use, placing a financial strain on households and often delaying access to care.

Recent reforms that [replaced](#) the National Health Insurance Scheme (NHIS) with the National Health Insurance Authority (NHIA) shifted health insurance from a

voluntary scheme to mandatory coverage, aimed at reducing inequality, improving accessibility, and strengthening financial protection across the system. To drive compliance, in 2025, President Bola Tinubu issued a directive mandating all Ministries, Departments, and Agencies (MDAs), along with all entities participating in public procurement, to implement health insurance in line with the NHIA.



How financing shapes access to healthcare

Compulsory insurance is expected to help reduce income inequality, which remains relatively high in Nigeria compared to peer countries. For many, especially those in rural areas or working in the informal sector, health care is something to be paid for when illness strikes rather than a service that can be readily relied on. This pattern reflects deeper structural issues that have persisted over time.

Data from the World Health Organisation (WHO) [Global Health Expenditure Database](#) shows that Nigeria's Current Health Expenditure as a percentage of Gross Domestic Product averaged around 4% between 2016 and 2023. Given the country's population, disease burden, and ambitions for universal health coverage, this level of investment remains low and points to a broader issue of how health is

prioritised within national planning, a pattern that has remained largely unchanged across successive administrations.

The consequences of these financing constraints are evident across the health system. [The Lancet Nigeria Commission](#) highlights longstanding challenges, including fragmentation across federal, state, and local levels, persistent inequities in access to care, and chronic underinvestment in primary healthcare. While reforms such as the Basic Health Care Provision Fund have sought to strengthen health financing and expand access to primary care services, progress in health outcomes has been uneven. As a result, access to healthcare in Nigeria continues to be shaped as much by an individual's ability to pay as by their health needs.

Who shapes the system, and who is accountable?

Nigeria's health system is not short of actors. Federal, state, and local governments all have a role, yet responsibilities often overlap, creating gaps in accountability and implementation. Plans made at one level do not always show up at another, contributing to persistent weaknesses in service delivery. As a result, the way the system is financed and governed continues to shape who can access care, when they receive it, and the quality of services available.

The private sector is already a [significant](#)

[part](#) of care delivery in Nigeria, and for many people, is the first point of contact for both routine and emergency care. Despite its importance, integration between private and public providers remains limited. Donors have long shaped health interventions, often reflecting their own priorities, playing a major role in immunisation, maternal health, and [nutrition](#). While these programmes have made a difference, they have also contributed to a system that feels pieced together, with initiatives running alongside

each other rather than working as one. The resulting lack of coordination contributes to variations in the quality of care, creating challenges for patients navigating different levels of the health system and making it harder to build a system people can rely on no matter where they live.

The [Sector-Wide Approach \(SWAp\)](#) seeks to address this by reducing fragmentation, aligning funding with national priorities, and moving away from programmes that duplicate efforts without strengthening the broader healthcare system. However, as donor funding shrinks and global priorities shift, broader questions about long-term financing and health sovereignty are becoming increasingly prominent.

There have been efforts to fix some of these gaps. The Basic Health Care Provision Fund, established under the National Health Act in 2014, was intended to provide direct funding to primary health care and expand access

to basic services. In October 2025, the Coordinating Minister of Health, Professor Muhammad Ali Pate—calling on Nigerians to take ownership of their health and signalling a renewed push to strengthen the system—[noted](#) that ₦32.9 billion had been released to primary health care facilities.

Despite the call, little has been done to provide clarity on how the fund was disbursed, making it hard for communities to monitor spending and hold decision-makers accountable. The Supreme Court’s affirmation of the [financial autonomy](#) of Nigeria’s 774 local governments should, in principle, mean primary health care decision-making is closer to communities and make the system more responsive. However, without greater transparency in the management and allocation of funds, it is difficult for citizens to follow the money and assess whether resources are reaching the services they are intended to support.

What happens if nothing changes?

The consequences of these governance and financing challenges are evident in health outcomes across the country. For many women, pregnancy and childbirth still come with real risks, often shaped by delays in getting care or the quality of care available when they arrive. Preventable maternal deaths and adverse [outcomes](#) continue to expose persistent gaps in the health system. In some parts of the country, children still miss routine vaccines, leaving communities exposed to diseases that should no longer be a threat. Malnutrition also remains a concern, not only because of food availability, but also because health, nutrition, and social support systems are

not working together consistently.

Young people face their own challenges. Access to sexual and reproductive health services is [still uneven](#), and many are left to navigate these issues without the information or support they need. These challenges reflect broader inequities within the health system, where access to care continues to be shaped as much by income and location as by need.

The result is that many people delay seeking care until conditions worsen or rely on the services they can afford rather than those most appropriate to their needs.

Over time, this reinforces disparities in health outcomes across regions and socioeconomic groups.

With elections approaching, there is a window to shift how health is prioritised at the federal, state, and local levels. But without stronger coordination, greater

accountability, and more effective use of available resources, progress is likely to remain uneven, leaving many Nigerians excluded from the benefits of a health system intended to protect and improve their well-being.

What needs to be done?

In many countries, [elections](#) are [shaped](#) by public expectations on issues like health. In Nigeria, this link is not always as strong. Ahead of the 2019 elections, Nigeria Health Watch, in collaboration with NOI Polls, carried out a survey under the [#Vote4HealthNaija](#) campaign to understand what drives voting decisions. Despite health ranking high among the priorities Nigerians care about, it has not consistently translated into clear or detailed health commitments in political manifestos.

The COVID-19 pandemic brought health to the centre of national attention. It showed what happens when systems are stretched and why preparedness matters. It would be easy to assume that this experience would shift how health is prioritised. But subsequent budget allocations and releases paint a different picture. During the 2026 budget defence, the Coordinating Minister of Health and Social Welfare confirmed that only ₦36 million was [released](#) from the ₦218 billion capital allocation for the ministry in 2025.

If the goal is to avoid repeating the same patterns, then it is not enough to allocate funds on paper; change has to begin with how health is treated within the broader political and economic system, where it is no longer peripheral but central to

decision-making, with funding released and accountability built into its delivery.

There are several areas where practical action could shift outcomes if health is to be treated as central to governance rather than peripheral to it.

Financing must become more predictable and transparent. A key starting point would be a commitment by the federal government to release at least 50% of capital health budget allocations within each fiscal year, supported by quarterly public reporting. The issue is not only the overall level of health spending, but whether allocated funds are actually released and used for their intended purposes. Strengthening public financial management systems and improving reporting clarity will be essential to ensuring accountability beyond government institutions.

Primary healthcare must also be repositioned as the foundation of the system rather than an afterthought. This requires sustained investment in frontline facilities, adequate staffing, and reliable access to essential medicines and supplies. It also depends on ensuring that existing reforms, including the Basic Health Care Provision Fund, translate into visible improvements in service delivery at the community level.

Improved coordination across actors is equally critical. Stronger alignment is needed between federal, state, and local governments, alongside more deliberate integration of the private sector, which already plays a central role in service delivery. The objective should be not only the presence of multiple actors within the system, but their ability to function in a more coherent and complementary way.

Finally, accountability must be embedded as a routine feature of the health system rather than treated as an external requirement. While policy frameworks already exist, the key challenge lies in ensuring consistent implementation, effective monitoring, and timely adjustment when interventions are not delivering intended results.

What people can do

Change cannot come from government alone. Citizens, advocates, and other stakeholders all play a role.

For citizens, this starts with recognising that health is not only a service but a right that can be demanded. Asking questions about local health facilities, tracking whether services are available, and engaging with local leaders are all part of this. With local government autonomy, there is now a greater opportunity for communities to be more involved and hold those closest to them accountable. This would, of course, require transparency in fund disbursements. Elections also provide an important moment to push for clearer commitments on health and to hold leaders accountable for them.

For civil society and health advocates, staying consistent and visible is essential. Advocacy cannot only happen during crises or around major events. It needs to be sustained, evidence-based, and connected to what people are experiencing on the ground. There is also a role in translating complex policy and financing issues into language that communities can understand and act on.

For policymakers, the task is to move beyond

statements of intent. This means making decisions that reflect the importance of health, ensuring that funds are released and used effectively, and creating space for feedback from those who rely on the system.

At its core, this is about recognising the political economy of health. Decisions about health are shaped by priorities and trade-offs. Changing outcomes will require shifting those choices so that health is treated as a shared responsibility and a long-term investment in the country's future. This goes to the heart of why health is a political choice that is ultimately shaped at its core by how resources and priorities in the country are set, and where citizens demonstrate their agency, and as Chude Jideonwo stated in his 2014 [TEDxEuston](#) talk, the most important office in a democracy is the “office of the citizen”.

Vivianne Ihekweazu is the Managing Director of [Nigeria Health Watch](#), leading strategy and advocacy to improve health access in Nigeria. She works at the intersection of policy, communication, and public engagement, focusing on inequities affecting women and underserved populations and how trust, evidence, and narratives shape health outcomes, accountability, and decision-making.

Key Insight #15



Only 21 million Nigerians (out of 232 million) have any form of health insurance. Everyone else pays out of pocket, every single time they're sick.



Conclusion

by **Vera Njote**

More often than not, Nigeria's health story is told through crises: maternal deaths, disease outbreaks, underfunded hospitals, workforce shortages, and unequal access to care. This compendium reveals an obvious yet deeper truth: these outcomes are not inevitable. They are the product of political, institutional, financial, and social choices.

Across mental health, fiscal policy, emergency response, donor financing, sexual and reproductive health, governance, and vaccine manufacturing, what we found is a common thread. Nigeria does not lack ideas, expertise, or capable people; what it lacks is consistent implementation, sustained investment, accountability, and the political will to build systems that serve everyone.

And so our contributors did more than just diagnose problems: they demonstrated that solutions already exist. Some are policy reforms waiting to be implemented; others require stronger institutions, better coordination, improved financing, or renewed public trust. The common denominator, however, is that all require citizens who demand accountability and leaders who are willing to act beyond

electoral cycles. A country that cannot realise its full potential, and where millions remain unable to access safe, affordable, quality healthcare, is not one we should stay silent about.

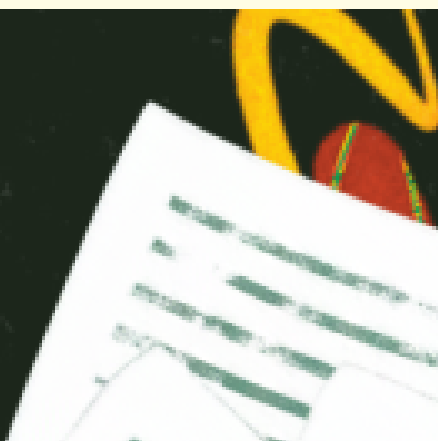
As Nigeria approaches another defining period in its democratic journey, the choices made today will shape the health outcomes of future generations. This compendium is therefore more than a collection of essays. It is an invitation to policymakers, practitioners, civil society, researchers, the private sector, and citizens to move from analysing the problem and speculating online to taking action.

The future of Nigeria's health system will not be determined by the policies we write alone, but by the institutions we strengthen, the budgets we honour, the lives we protect, and the collective decisions we make to ensure that quality healthcare is not a privilege, but a right enjoyed by every Nigerian. To Nigerians, power belongs to the people, and we owe it to ourselves and to future generations to demand what we are owed.

POSTSCRIPT

An Unhealthy State of affairs

by **Afolabi Adekaiyaoja**



When we started working on this compendium in January 2026, the issues dominating Nigerian commentary concerned which parties would produce which candidates for which elections. Several months on, that conversation has barely moved. In the intervening period, Nigerians have lived through a fuel subsidy hangover that has not fully resolved, rising food prices that have pushed more households into poverty, and a federal health ministry that received ₦36 million of a ₦218 billion capital budget. The opportunity cost is not the political activities that will inevitably happen as we trudge towards the 2027 elections, but the actual welfare systems that millions of Nigerians depend on to survive.

This issue examines the different elements of seeking health in an unhealthy situation. It has tried to look at the people left on the margins of these systems, whether it is the sick resident of Makoko seeking care, the young man in Makurdi seeking mental health support, or the clinic in Maiduguri trying to make ends meet in difficult circumstances. These voices are unlikely to shape the forthcoming election, but they will be affected by its outcome.

The Health Edition brings together eight contributors — researchers, advocates, lawyers, entrepreneurs, and public health specialists — writing about the dimensions of Nigeria's health landscape that rarely make it into political manifestos but shape the everyday realities of millions. Their pieces cover pandemic preparedness, mental health, sexual health, emergency response, health financing, vaccine development, donor dependency, and non-communicable diseases.

We were more ambitious in scope than what appears here. We know there are stories out there covering maternal and reproductive healthcare, disability support, access to essential medicines, the health workforce, and crumbling medical infrastructure among them. It was interesting to realise that, despite these issues being well documented in commentary and online, it was still difficult to find active contributors and institutions that we could work with to develop contributions. If the voices best placed to shape health policy in Nigeria struggle to find platforms, time, or institutional backing to engage with these questions in depth, that is part of the problem that warrants more active and intentional solutions. Hopefully, this

compendium adds to that.

A thread runs through nearly every piece: the gap between what Nigeria allocates and what it actually spends. In 2025, the Federal Ministry of Health received ₦36 million of a ₦218 billion capital budget. That single fact sits behind stories of women who die in childbirth because blood is unavailable, of children who go unvaccinated because supply chains are broken, of mental health facilities concentrated in nine cities for a country of over 230 million people. It also sits behind a harder story: the resilience and remarkable capacity Nigeria has shown in moments of crisis, from the COVID-19 response to the NCDC's laboratory expansion, only to let it fade when the headlines moved on.

The PEPFAR disruption of 2025 brought this into sharper focus. When the US government changed its foreign policy priorities, programmes closed. Communities lost services without a domestic backstop. The contributors who write about donor dependency and health financing are not arguing against international partnership but are making the case for domestic will, systems, and accountability that make any partnership sustainable.

Several contributors also write about something harder to budget for: power. Who controls whether a woman in rural Sokoto can access contraception; who can seek mental health support without criminalisation or stigma; whether a community in Borno knows where to go when an emergency strikes at night. These concerns determine whether health systems serve people or merely exist alongside them.

This compendium is not a government report or a donor brief. We hope it will be a resource for citizens, journalists, advocates, and policymakers who believe that an election year is an opportunity to demand something more specific than vague promises of better health. The contributors here have worked in these realities, and their recommendations are practical, evidence-based, and sometimes uncomfortable.

The most important office in a democracy, as one contributor reminds us, is the office of the citizen. That office comes with responsibilities to ask questions, to follow the money, to hold leaders accountable not just at the ballot box but in the years between. This edition is an attempt to give that work better ammunition.

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