budgIT

# Health Financing in Nigeria

A Public Finance Analysis at Federal and Subnational Levels

# About BudgIT

BudgIT is a civic organisation that uses creative technology to simplify public information, stimulating a community of active citizens and enabling their right to demand accountability, institutional reforms, efficient service delivery and an equitable society.

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*The roles of development partners and actors are crucial to leading health advocacy, transparency, advocacy and the dissemination of lessons is vital to strengthening healthcare/service delivery. A strong collaboration between the government and these stakeholders boosts the taxpayers confidence in their willingness to participate and improve the health sector. Access to budgetary documents, expenditure documents, and budget implementation reports that cover both Government aids and grants and other sources of domestic resource financing will improve accountability and transparency.*

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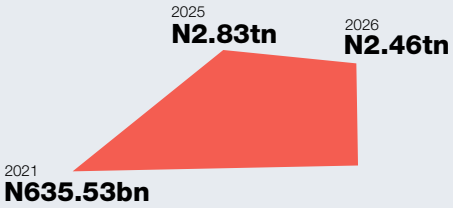
# Abbreviations

**AIDS** – Acquired Immunodeficiency Syndrome
**BHCPF** – Basic Health Care Provision Fund
**BMPHS** – Basic Minimum Package of Health Services
**COVID-19** – Coronavirus Disease
**CRF** – Consolidated Revenue Fund
**DFF** – Decentralised Facility Financing
**DRM** – Domestic Resource Mobilization
**EMT** – Emergency Medical Treatment
**FGN** – Federal Government of Nigeria
**FMoF** – Federal Ministry of Finance
**FMoH** – Federal Ministry of Health
**HIV** – Human Immunodeficiency Virus
**LGAs** – Local Government Areas
**LGHA** – Local Government Health Authority
**MDAs** – Ministries, Departments and Agencies
**MOC** – Ministerial Oversight Committee
**NAFDAC** – National Agency for Food and Drug Administration and Control
**NACA** – National Agency for the Control of AIDS
**NASS** – National Assembly
**NCDC** – Nigeria Centre for Disease Control
**NCDs** – Non-Communicable Diseases
**NEMTC** – National Emergency Medical Treatment Committee
**NEMSAS** – National Emergency Medical Services and Ambulance Systems
**NHIA** – National Health Insurance Authority
**NHIS** – National Health Insurance Scheme
**NHSRII** – Nigeria Health Sector Renewal Investment Initiative
**NIMR** – Nigerian Institute of Medical Research
**NIPRD** – National Institute for Pharmaceutical Research and Development
**NPHCDA** – National Primary Healthcare Development Agency
**NSHDP II** – National Strategic Health Development Plan II
**ODA** – Official Development Assistance
**OECD** – Organisation for Economic Co-operation and Development
**OOP** – Out-of-pocket

**PHC** – Primary Health Centres
**RESMAT** – Rural Emergency Services and Maternal Transportation
**SHIA** – State Health Insurance Agency
**SHIS** – State Health Insurance Scheme
**SOC** – State Oversight Committees
**SPHCDA** – State Primary Health Care Development Agencies
**SPHCB** – State Primary Health Care Boards
**TSA** – Treasury Single Account
**UHC** – Universal Health Coverage
**USAID** – United States Agency for International Development
**VAT** – Value Added Tax
**WDC** – Ward Development Committee
**WHO** – World Health Organisation

# Report Insights

### FG Allocations to Health




Federal allocations to the health sector nominally increased from N635.53bn in 2021 to a peak of N2.83tn in 2025 before declining to N2.46tn in the proposed 2026 budget.

## ₦17.88tn

The 34 states (Akwa Ibom and Rivers were excluded due to unavailable 2025 Q4 budget implementation reports) approved a combined budget of N26.52tn in 2025 but expended N17.88tn.

## 61.74%

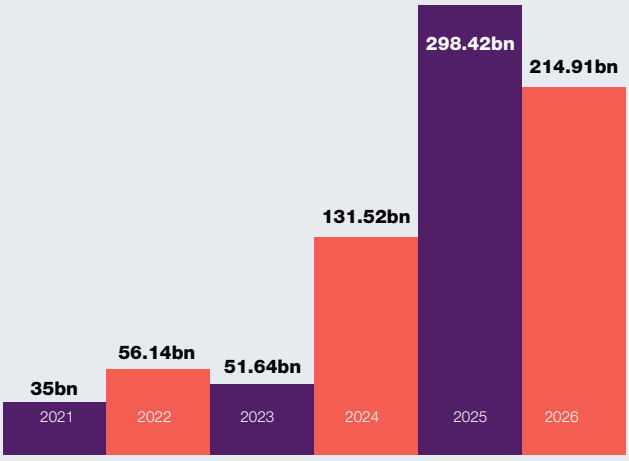
Of the N1.97tn allocated to health by the States in 2025, only N1.18tn was expended, resulting in a 61.74% performance rate.

## 6.98%

With health accounting for just 6.98% of total actual subnational expenditure in 2025, indicating limited sectoral prioritisation.

### FG Allocations to BHCPF

*Unit in naira*




The BHCPF has seen significant nominal increases in allocation and an expansion in facility coverage.

## ₦3.33 trillion

**In 2026, health budget allocations across the 35 Nigerian states* reveal significant disparities in sectoral prioritisation, expenditure structure, and fiscal commitment.** Out of a combined N35.51tn total state budgets, about N3.33 trillion was allocated to health. States allocated N1.2tn to recurrent expenditure and N2.12tn to capital expenditure in the 2026 budget.

*excludes Rivers State

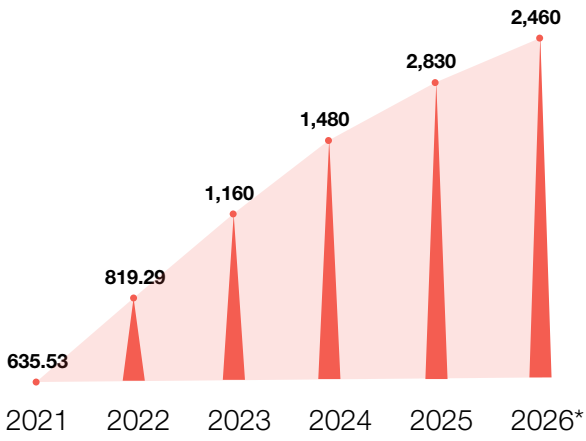
## 40%

Federal Government Capital Expenditure utilisation in the health sector reportedly did not exceed 40% across 2021–2025.

# Report Insights

### Federal Government Allocation to Health

*Unit in billions naira*



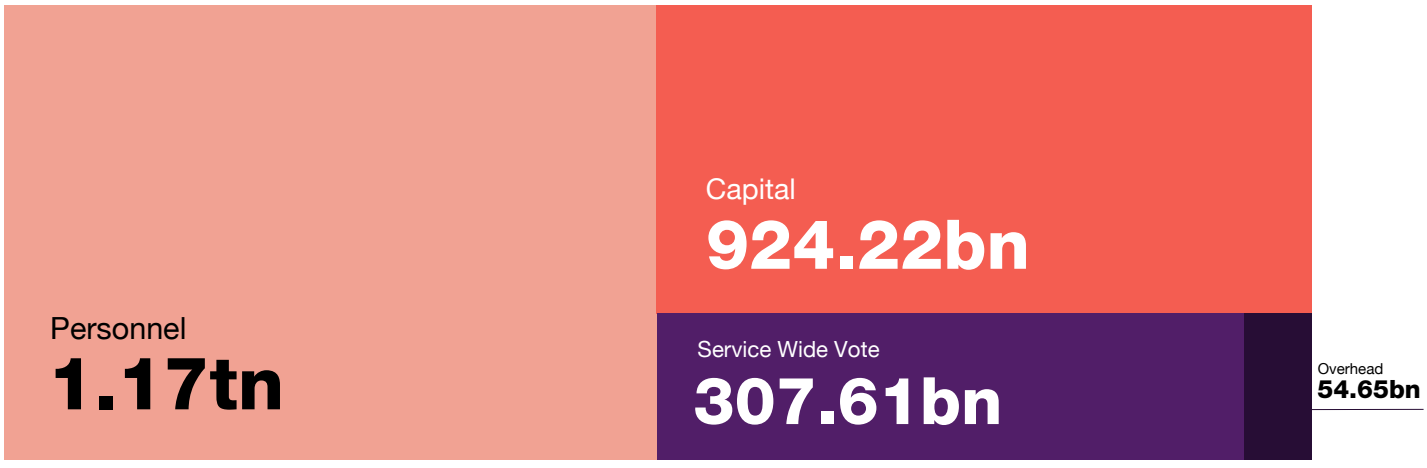

**₦34bn**

An in-depth review of the federal government's 2026 proposed budget, N34bn was apportioned to immunisation and vaccination.

### 2026 FG Proposed Budget

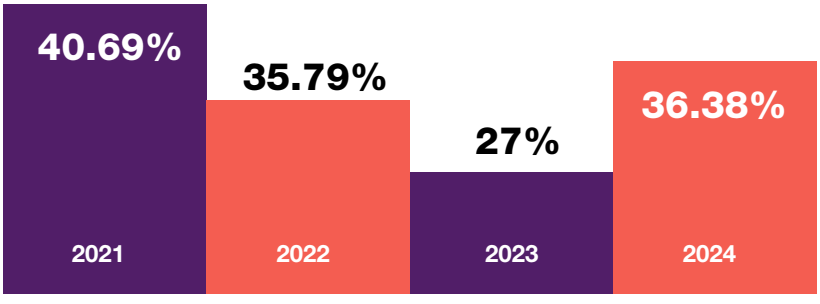
Health

Total Budget
**2.46tn**




### Federal Government Health Capital Expenditure Performance

Utilization Rate*




*Note that the utilisation here is as a percentage of budget actually utilised and not released.

# Report Insights 

| State | Health Budget Performance 2025 |
|---|---|
| Katsina | 140.92% |
| Yobe | 99.89% |
| Delta | 96.79% |
| Benue | 90.76% |
| Bayelsa | 89.15% |
| Edo | 85.30% |
| Lagos | 83.52% |
| Ondo | 82.61% |
| Bauchi | 80.56% |
| Ekiti | 74.37% |
| Osun | 70.99% |
| Nasarawa | 64.61% |
| Kogi | 64.03% |
| Gombe | 61.32% |
| Jigawa | 58.54% |
| Imo | 57.93% |
| Kano | 57.46% |
| Niger | 52.56% |
| Anambra | 49.43% |
| Kwara | 48.29% |
| Plateau | 45.49% |
| Borno | 43.11% |
| Kaduna | 42.56% |
| Sokoto | 41.81% |
| Adamawa | 41.10% |
| Oyo | 40.67% |
| Ebonyi | 39.24% |
| Zamfara | 39.06% |
| Ogun | 37.86% |
| Abia | 34.77% |
| Taraba | 34.28% |
| Enugu | 30.69% |
| Kebbi | 26.08% |
| Cross River | 11.90% |

# Report Insights

| State | 2026 Health Budget as a share of Total Budget |
|---|---|
| Sokoto | 16.40% |
| Bauchi | 15.05% |
| Abia | 15.00% |
| Yobe | 15.00% |
| Borno | 14.81% |
| Kaduna | 14.66% |
| Kano | 14.54% |
| Kwara | 13.55% |
| Ogun | 12.76% |
| Ondo | 11.35% |
| Gombe | 11.27% |
| Akwa Ibom | 11.10% |
| Plateau | 10.81% |
| Zamfara | 10.04% |
| Anambra | 9.56% |
| Kogi | 9.39% |
| Oyo | 8.96% |
| Jigawa | 8.81% |
| Osun | 8.19% |
| Adamawa | 8.17% |
| Lagos | 8.15% |
| Benue | 7.62% |
| Katsina | 7.53% |
| Kebbi | 7.52% |
| Edo | 7.19% |
| Bayelsa | 7.13% |
| Niger | 6.98% |
| Nasarawa | 6.87% |
| Taraba | 6.15% |
| Enugu | 5.92% |
| Delta | 5.54% |
| Imo | 4.77% |
| Ekiti | 4.73% |
| Cross River | 4.25% |
| Ebonyi | 4.21% |

**Note that Rivers data was unavailable as of the time of publishing.*

# Executive Summary

In a less comprehensive manner, the report also assesses the budgeting framework of the states, with a view to appraise spending performance for the 2025 fiscal year and projected performance for the next year. The objective is straightforward: BudgiT seeks to situate the federation's health financing ecosystem within Nigeria's broader fiscal reality and identify where reform must be urgent, practical and measurable.

The health budget trend analysis reveals a pattern of nominal growth followed by contraction. **Federal allocations nominally increased from N635.53bn in 2021 to a peak of N2.83tn in 2025 before declining to N2.46tn in the proposed 2026 budget.** Despite this growth, health spending remains below 6% of the federal budget and far short of the 15% Abuja Declaration benchmark. More troubling is the disconnect between approved budgets and actual releases. **Capital expenditure utilisation did not exceed 40% across several years and in 2025 only N36mn was reportedly released out of N218bn appropriated for capital projects for the Federal Ministry of Health (Headquarters).** The result is predictable: infrastructure deteriorates, facilities remain incomplete and citizens bear the cost through out-of-pocket spending that exceeds 70% of total health expenditure.
The report further interrogates the composition of spending. Recurrent expenditure consistently outweighs capital investment, reflecting a system focused on maintaining operations rather than expanding capacity. While recurrent spending is necessary to keep facilities functional: persistent underinvestment in capital projects limits long-term system resilience. Service Wide Votes (SWV), which grew significantly in recent years, introduce flexibility but raise transparency concerns since funds are not initially tied to specific implementing agencies.

In examining the health financing framework, the report places emphasis on domestic resource mobilisation (DRM). Nigeria's current financing model remains vulnerable due to oil dependence, limited tax capacity and continued reliance on donor funding. With global Official Development Assistance (ODA) projected to decline, Nigeria cannot assume stable external financing. According to The Economist, "Nigeria must add $3bn to its health budget over five years" in the new aid framework being developed by the current US government, in order to increase financing. There is a compelling need to expand fiscal space through improved tax collection, insurance pooling and innovative financing as the problem is compounded.

Critical federal government health frameworks are assessed, particularly the Basic Health Care Provision Fund (BHCPF), the National Primary Health Care Development Agency (NPHCDA), the National Health Insurance framework, the National Emergency Medical Treatment (NEMT) initiative and the Nigeria Centre for Disease Control (NCDC). **The BHCPF has seen significant nominal increases in allocation and an expansion in facility coverage (from N35bn in 2021; N56.14bn in 2022; N51.64bn in 2023; N131.52bn in 2024; N298.42bn in 2025; to N214.91bn in 2026).** However, performance

remains contingent on timely releases, state-level compliance and robust monitoring. The insurance framework, despite legal reforms, still covers a small fraction of the population. The NCDC and emergency services show expanded allocations, but sustainability will depend on domestic funding stability rather than episodic increases.

The 34 states (Akwa Ibom and Rivers were excluded due to unavailable 2025 Q4 budget implementation reports) approved a combined budget of N26.52tn but expended N17.88tn, reflecting a persistent gap between fiscal projections and execution. Of the N1.97tn allocated to health, only N1.18tn was expended, resulting in a 61.74% performance rate, with health accounting for just 6.98% of total actual expenditure indicating limited sectoral prioritisation.

Institutional transparency and accountability mechanisms are reviewed across executive and legislative structures. The report identifies three major accountability gaps:

**Financial Accountability:** Financial inefficiencies reduce the impact of scarce resources, leaving health facilities underfunded and citizens exposed to high out-of-pocket costs.

**Weak capital releases:** Due to delays or partial disbursement, funds earmarked for infrastructure, equipment, or workforce expansion were not fully utilized in the approved health budgets creating a disparity between planned and actual spending.

**Fragmented financial flows:** With limited operational coordination, the funding from multiple funding streams (federal, state, donor and private) leads to duplication in some thematic areas and neglect across others.

**Performance Accountability:** Without robust performance monitoring, inefficiencies persist and policymakers lack evidence to guide reforms or reallocate resources effectively.

**Fragmented data systems:** Comprehensive monitoring of outcomes are difficult to achieve due to siloed health information systems across ministries, agencies and states.

**Weak linkage between financing and results:** Budget allocations were not consistently tied to measurable performance indicators, therefore spending did not always translate into measurable service delivery improvements.

**Political Accountability:** Political interference undermines efficiency and equity, with health financing decisions serving short-term political goals rather than long-term system strengthening.

**Political interference:** Budget priorities-especially at the subnational level-were often influenced by political considerations rather than health needs, leading to misallocation of resources.

**Legislative oversight gaps:** While the legislature has a role in approving budgets, weak oversight and enforcement mechanisms means that deviations from approved allocations go unchecked.

**Citizen exclusion:** Communities and civil society have limited opportunities to participate in budget processes or hold leaders accountable for health financing decisions.

The combination of financial leakages, weak performance monitoring and political interference creates a cycle of inefficiency. Even when funds were allocated; delays, fragmentation of disbursements, poor tracking and political interference erode public trust, weaken health outcomes and slow Nigeria's progress toward Universal Health Coverage (UHC). Without improved disaggregation of budget data, stronger legislative oversight and enhanced citizen engagement, fiscal increases alone will not translate into better outcomes. This is a critical component of public transparency, accountability and development.

# N26.52 trillion

*The 34 states (Akwa Ibom and Rivers were excluded due to unavailable 2025 Q4 budget implementation reports) approved a combined budget of N26.52tn but expended N17.88tn, reflecting a persistent gap between fiscal projections and execution. Of the N1.97tn allocated to health, only N1.18tn was expended, resulting in a 61.74% performance rate, with health accounting for just 6.98% of total actual expenditure indicating limited sectoral prioritisation.*


*Despite the impacts of this scheme and Nigeria declared free of wild polio, Nigeria continues to grapple with the virus, through campaigns like Outbreak Response 3 (OBR3) and community mobilisation following the emergence of a circulating variant poliovirus type 2 (cVPV2) which poses a threat to children in the northern Nigeria.*

# Background

1

*In fact, approximately 70% of total health expenditures in 2025 were still paid directly by households at the point of service, accounting for one of the highest rates globally and placing a heavy financial burden on families.*

Despite numerous policies and interventions, Nigeria faces a complex cascade of challenges in achieving its desired health outcomes for its citizens. It has been reported that 114 for every 1000 children under five years old die,[1] in addition to 8,200 maternal deaths and a maternal mortality ratio of 1,047 per 100,000 livebirths.[2] As a nation, Nigeria accounts for 10% to 16% of the global burden of maternal and child mortality[3] with a significant proportion of maternal deaths resulting from poor care during critical periods (Antenatal care) of pregnancy, from poorly controlled diseases in pregnancy (such as hypertension, diabetes to pre-eclampsia and eclampsia, hemorrhages) and complications from unsafe abortions-especially in rural communities.

While the federal government's role is centered around providing a regulatory framework for the health sector to address its underlying challenges, public spending has failed to address these issues through prioritization of critical and essential commodities/expenditure, capable of contributing immensely to improving public health outcomes. This is all the more concerning as the annual budget has grown nominally; especially the health allocation (from N635.53bn in 2021 t0 N2.83tn in 2025). The health related spending by the Nigerian government accounts for approximately 5.18% (as at 2025), while the gap created is filled both by private funding and Nigerians that opt for out-of-pocket payments (with the latter paying the most). In fact, approximately 70% of total health expenditures in 2025 were still paid directly by households at the point of service, accounting for one of the highest rates globally and placing a heavy financial burden on families.[4] The October 2025 World Bank Poverty and Equity Brief for Nigeria indicates that 75.5% of rural Nigerians are living below the poverty line, with 30.9% of Nigerians living below the international extreme poverty line of $2.15 per person per day in 2018/2019, before the COVID-19 pandemic.[5]

At the state level, the 36 states and local governments who are directly responsible for the service delivery and management of primary and secondary health care facilities (through the state and hospital management

1.Okoroiwu, H.U., Edet, U.O., Uchendu, I.K., Echieh, C.P., Nneoyi-Egbe, A.F., Anyanwu, S.O., Umoh, E.A., Nwaiwu, N.P., and Mbabuike, I.U. (2024) Causes of infant and under-five (under-5) morbidity and mortality among hospitalized patients in Southern Nigeria: A hospital based study. J Public Health Res. Feb 24;13(1):22799036241231787. doi: 10.1177/22799036241231787.
2. Dogbanya, G. (2025). Maternal Mortality in Nigeria: Holding the Line in Uncertain Times. Ann Glob Health. Mar 25;91(1):16. doi: 10.5334/aogh.4710.
3. UNICEF. (2025). Nigeria: Demographics, Health & Infant Mortality. Country Profiles. Available at: https://data.unicef.org/country/nga/
4. Hassan, B.I. (September 12 2025). Financing Nigeria's health future: NHIA's bold plan to end out-of-pocket healthcare costs. In Business Day (Online) Newspapers. Available at: https://businessday.ng/interview/article/financing-nigerias-health-future-nhis-bold-plan-to-end-out-of-pocket-healthcare-costs/
5. World Bank.Nigeria Poverty and Equity Brief: October 2025 (English). Poverty and Equity Brief Washington, D.C. : World Bank Group. http://documents.worldbank.org/curated/en/099253204222517873

boards) are also lagging in addressing these health issues/challenges. States and Local governments appear to be directing their expenditures towards correcting systems, as opposed to growing to meet capacity-which results in significant impact on the health sector. This is evident by the majority of both urban and rural dwellers (especially the less privileged and those with competing priorities for resources) resorting to non-orthodox methods of treatment, further worsening Nigeria's health indicators.[6]

## 1.2 Introduction

Nigeria's health sector sits at the intersection of a 'rock' and a 'hard place'. On one side, the country continues to carry an unacceptably heavy burden of maternal and child mortality, preventable infectious diseases, and rising costs of non-communicable diseases.[7] On the other, the nation's public funding regime is both small (relative to existing demand) and unreliable in execution. Between 2021 and 2025, the Federal Government cummulatively budgeted almost N10tn for health, yet the central question remains whether these allocations translated into actual spending and improved outcomes. **Where summary budget implementation information is available, the pattern is worrying: capital expenditure utilisation in the health sector reportedly did not exceed 40% across 2021–2025.**[8] In fact official summaries for 2024 and 2025 Federal Government spending were incomplete, further limiting public visibility into what was released, what was spent and what was achieved. In practical terms, this points to a persistent gap between policy, budgets and the governance system meant to deliver results.

This report is written against a shifting global context that makes Nigeria's domestic choices more compelling. As global Official Development Assistance (ODA) faces mounting pressures and cuts are projected in several donor countries, health financing in developing countries is likely to be among the hardest hit. The report emphasises this as a warning signal, fortunately heeded by the current Minister for Health: "Over-reliance on donor support threatens long-term sustainability and national health security".[9] In essence, Nigeria cannot plan its health system around the assumption that donor support will remain stable. This is particularly for programmes historically supported by external financing such as: immunisation, HIV/TB/Malaria, maternal and child health and key commodity supply chains. The Federal government has increasingly understood the limits of donor dependence. However, it is not yet matched by a financing structure that is predictable, adequate and accountable.

Global political dynamics have created a significant shift in old, tried and true institutions and perceptions of how the international system worked for developing countries. With the share of ODA trending towards a decline (France, Germany, the United Kingdom and the United States being the countries with the largest cuts), health financing in developing countries will be the hardest hit (OECD, 2025).[10] It has been acknowledged that: "Bilateral ODA for health is projected to decline by 19%-33% in 2025 over 2023 levels, marking further falls from previous high levels related to COVID-19 support. ODA for health in 2025 is projected to fall below pre-COVID-19 levels" (OECD, 2025). The Nigerian government has appeared to have accepted this, as in 2025 both the Ministry of Health and Social Welfare and the National Health Insurance Authority held that Nigeria could not afford to continue to rely on donor funding for its health needs (Vanguard, September 2025).[11] This was even as the Minister of State for Health stated that Nigerian citizens bear about 60% of the total cost of healthcare (Vanguard, September 2025).

BudgiT is of the view that this urgency is not abstract. Available estimates suggest that Nigeria loses tens of thousands of children under five annually and thousands of women during pregnancy and childbirth.[12] Nigeria's share of global maternal and child mortality remains disproportionately high. Even worse, a

6. Yisa, S.S., Ogunniyi, T.J., and Dine, R.D. (2025). Strengthening primary health care in Nigeria: a means to achieve universal health coverage. BMJ Global Health. 2025;10:e018486. Available at: https://doi.org/10.1136/bmjgh-2024-018486
7.Oweibia, M., Elemuwa, C.O., Egbenipou, T., Timighe, G.C., Sylvanus, P., and Wilson, T.R. (2025). Maternal and Child Health Trends in Nigeria: A Scoping Review of NDHS 2018 vs. NDHS 2023. medRxiv 2025.05.18. Available at: https://www.medrxiv.org/content/10.1101/2025.05.18.25327864v1.full & Oso, A. (2023). Non-communicable Diseases: An Emerging Epidemic in Nigeria. Tropical Journal of Nephrology Vol.18 Nos 1 & 2, June & Dec., 2023. Available at: https://tjn-online.com/index.php/tjn/article/download/259/221
8. Joseph, P. (February 25 2026). Stakeholders Raise Alarm Over Underfunding of Nigeria's Health Sector; Warn of Stagnation in Capital Growth. National Assembly Library Trust Fund. Available at: https://naltf.gov.ng/stakeholders-raise-alarm-over-underfunding-of-nigerias-health-sector-warn-of-stagnation-in-capital-growth/
9. Dera. (February 10, 2026). All Pate Calls for More Local Funding of Mass Immunisation. In Nigerian Eye (Online). Available at: https://www.nigerianeye.com/2026/02/all-pate-calls-for-more-local-funding.html
10. OECD (2025), Cuts in official development assistance: OECD projections for 2025 and the near term. OECD Policy Briefs, No. 26, OECD Publishing, Paris, https://doi.org/10.1787/8c530629-en
11. Erunke, J. (September 2 2025). Nigeria cannot continue to rely on foreign aid for healthcare system — Pate. News. In the Vanguard (Online) Newspapers. Available at: https://www.vanguardngr.com/2025/09/nigeria-cannot-continue-to-rely-on-foreign-aid-for-healthcare-system-pate/
12. United Nations Children's Fund. (n.d). Situation of women and children in Nigeria. Nigeria. Available at: https://www.unicef.org/nigeria/situation-women-and-children-nigeria

significant portion of deaths are linked to gaps in antenatal care, poor management of conditions such as hypertension and diabetes and complications including pre-eclampsia/eclampsia, haemorrhage and unsafe abortions-especially in rural and underserved communities.[13] At the same time, extreme poverty and rural deprivation mean millions of households cannot withstand health challenges and fall deeper into poverty. With out-of-pocket spending reportedly accounting for around 70% of total health expenditure,[14] the financing model is effectively impotent: it asks the poorest Nigerians to bear the largest risks at the point of care.

Within this context, the report has five core objectives. First, it provides a birds-eye view of the federal health financing ecosystem by tracking allocations, spending where data is available and overall trends in health budgeting. The intention is not only to present numbers, but to clarify the size and pattern of the budgeting gap to be filled if Nigeria is to stabilise health service delivery in a tighter global financing environment. Second, it appraises the federal health sector's institutional architecture to identify strengths, pressure points and structural weaknesses that limit performance. Third, it examines key financing and service delivery anchors, particularly the: Basic Health Care Provision Fund (BHCPF), National Primary Health Care Development Agency (NPHCDA) and the national health insurance framework, as these institutions ought to serve as buffers against external shocks while supporting a growing population. Fourth, it interrogates transparency, oversight and accountability mechanisms to determine whether they are fit-for-purpose in a time where 'doing more with less' will be forced by fiscal reality. Fifth, it looks into subnational health budget credibility and share of expenditure issues, showing weakness in the urgency for healthcare across states. Sixth, it offers a structured assessment of strengths, weaknesses, threats and opportunities within the federal health budgeting system to guide government, private sector actors, philanthropists, development partners and citizens on what must change.

## 1.3 Methodology

The Health Financing Report employs an 'action research' orientation and mixed methods approach involving desk review of the federal government's health sector (core/specific Ministries, Departments and Agencies) and its budget data from the 2021 to 2026 Appropriation Acts. It adopts a more quantitative approach (including comparative and trend analysis) towards the health sector as regards the BHCPF, NPHCDA, NHIS and specific allocations to service delivery in health care. Comparative evaluations were conducted against previous fiscal years to identify shifts in funding priorities and cross-sectoral funding (highlighting fragmentation and systemic challenges). This health financing report was also supported by review of secondary literature and global set standards, such as journal articles, relevant media reports, the Abuja Declaration and the National Health Act of 2014, to ensure a contemporary (but also a legal and policy) foundation.

## 1.4 Limitations

Reports written on health finance ecosystems, like many written in developing countries (on what some refer to as 'human capital development concerns') do not cover the full scope of issues. This means that attention was directed to areas that BudgiT believes are critical and speak to the report's objectives. Firstly, in terms of the fiscal and financial data analysed: preference was for 6 years. This enabled access to comprehensive budget documents even though it minimised the depth of trend analysis. Secondly, this report provides a narrow analysis of budget performance (this did not impact the section on subnational health spending, however). It could be argued that a health financing report without an emphasis on performance provides

13. Anumudu, S.I., Uhegwu, C.C., Anumudu, C.K. (2025). A scoping review of maternal mortality, its health determinants, and factors that influence care utilization in women of child-bearing years in Nigeria. Global Health Journal, Volume 9, Issue 3, 2025; pages 185-199. Available at: https://doi.org/10.1016/j.glohj.2025.10.004.
14. Aniebo, C.L., Lawani, L.O. and Eze, P. (2025). The Burden and Socioeconomic Inequality in Catastrophic Out-of-pocket Health Expenditure in Post-Pandemic Nigeria. Glob Soc Welf. https://doi.org/10.1007/s40609-025-00423-4

*This report is written against a shifting global context that makes Nigeria's domestic choices more compelling. As global Official Development Assistance (ODA) faces mounting pressures and cuts are projected in several donor countries, health financing in developing countries is likely to be among the hardest hit.*

*The report emphasises this as a warning signal, fortunately heeded by the current Minister for Health:* ***"Over-reliance on donor support threatens long-term sustainability and national health security".***

a bounded view of the health system. Be that as it may, the disaggregated data on health budget performance-published by the federal government-is noticeably absent. Thirdly, the report being a desk assessment of the financing record of the federal and state budgets, means a focus on numbers. This means the direct experiences and impacts on the lives of people (via interviews and spot assessments) are not highlighted. However, this emphasizes the need for health sector advocacy to use this report, to speak to the people and listen to what they have to say. This report, in and of itself, is an advocacy tool.

This report aims to situate the Nigerian federal health budgeting ecosystem, as a component of the broader governmental system. This report is for health practitioners, government officials, Non-governmental Organisation (NGO) workers, staff of donor organisations, the private sector and the general public to comprehend the dynamic nature of the federal government's spending. Ultimately, this report is meant to serve as a launching pad for deeper conversations about the fundamental changes needed to be made in a country where the federal government is proposing to spend slightly under N9,000.00 per person in 2026.[15]

15. This figure was arrived at by dividing the 2026 proposed total federal government health budget (N2,149,365,867,131.00) by the estimated 2026 population (240 million persons). The proposed Health budget, i.e., Federal Ministry of Health and Social Welfare budget only, was used as a proxy. Population estimates were taken from Worldometer, available at: https://www.worldometers.info/world-population/nigeria-population/

# 2

# Overview of Nigerian Health Financing Framework

## (Revenue and Expenditure)[16]

*Importantly, the Nigeria Health Sector Renewal Investment Initiative (NHSRII) has mobilised significant external and domestic resources (over $3bn) and has seen rapid upgrades of primary healthcare facilities and expansion of insurance coverage, reflecting more operational momentum than NSHDP II experienced in parts of its lifecycle.*

Nigeria's health financing framework is a complex interplay of revenue-generation mechanisms and expenditure patterns that significantly affect healthcare delivery across the country. Despite being Africa's most populous nation, with over 200 million people, Nigeria continues to battle with severe underfunding of its health sector, marked by high out-of-pocket expenditures and inadequate government allocations.[17] Understanding this framework is critical for developing sustainable solutions to achieve UHC.

The Nigerian healthcare system is financed through multiple channels, including government budget allocations, out-of-pocket payments, health insurance schemes, and donor funding. However, the dominance of out-of-pocket payments, which account for approximately 70%-76% of total health spending,[18] exposes millions of Nigerians to catastrophic health expenditures and impoverishment. This reality underscores the urgent need for comprehensive reforms in Domestic Resource Mobilisation (DRM) and efficient expenditure allocation.

The federal government's approach to health financing in Nigeria has evolved over the years, with increasing emphasis on DRM as a pathway to sustainable healthcare funding.[19] DRM is vital to achieving sustainable healthcare financing in Nigeria, where dependence on external funding and oil revenues has long hindered progress in the health sector. The mechanisms for domestic resource mobilization include general tax revenue, social insurance systems, community-based health insurance and innovative financing approaches.

## 2.1 Federal Government Financing Framework: A Focus on Domestic Resource Mobilisation

### 2.1.1 Architecture and Sustainability[20]

The federal government funds healthcare through statutory revenue mechanisms, budget appropriations from consolidated revenue and policy instruments, including the National Health Act (2014) and the National Health Insurance Authority Act (2022). Primary revenue sources include:

16. Abuja Declaration https://www.medbox.org/document/abuja-declaration-on-hivaids-tuberculosis-and-other-infectious-diseases
https://www.premiumtimesng.com/features-and-interviews/760982-low-insurance-coverage-inadequ
17. Ozor, O., Nwokolo, C., Teixeira de Siqueira, N., Odii, A., Hicks, J.P., Li, S., Ezenwaka, U., Dawkins, B., and Onwujekwe, O. (2025). Inequities in Household Out-Of-Pocket Spending Among Urban Slum Dwellers in Southeast Nigeria. Int. J. Public Health 70:1607969. doi: 10.3389/ijph.2025.1607969
18. Ozor, O., Nwokolo, C., Teixeira de Siqueira, N., Odii, et al. Inequities in Household Out-Of-Pocket Spending Among Urban Slum Dwellers in Southeast Nigeria, op.cit.
19. Onyedika-Ugoeze, N. (September 1 2025). FG to boost domestic health financing. In the Guardian (Online) Newspapers. Available at: https://guardian.ng/features/health/fg-to-boost-domestic-health-financing/
20. Fidelis, S. (2023). Analysing the Pathways and Linkages Between Health Financing Arrangements In Nigeria and Universal Financial Protection. Master's Thesis. KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam Amsterdam, Netherlands. Available at: https://www.bibalex.org/baifa/Attachment/Documents/SaUxILI0IZ_20231127130343320.pdf?

**Tax Revenue and Federal and State Budget Appropriations:** The federal government generates revenue through direct and indirect taxation, including Value Added Tax (VAT) and federation account distributions. These funds are allocated to health through the annual federal and state budget process.

**Basic Health Care Provision Fund (BHCPF):** The National Health Act mandates that at least 1% of consolidated federal revenue be dedicated to the BHCPF, which supports primary healthcare for vulnerable populations and enhances service delivery capacity.

**National Health Insurance:** The NHIA Act requires universal health insurance coverage and establishes a Vulnerable Group Fund for low-income households; however, enrollment rates remain limited.[21]

The institutional structure encompasses the Federal Ministry of Health, National Health Insurance Authority and agencies such as the NPHCDA, which oversee pooled resources, insurance programs and targeted interventions. Long-term viability of federal health financing hinges primarily on expanding domestic revenue through enhanced DRM, increasing budgetary allocation priorities for health, strategically distributing funds across care levels and establishing robust financing mechanisms (such as insurance schemes and consolidated risk pools). Nevertheless, constrained government revenue driven by economic downturns, oil dependence and competing fiscal demands (including debt repayment) makes sustainability challenging without structural reforms to strengthen domestic revenue generation. While the new tax laws can potentially provide an increase in revenue for the federation, this increased revenue must be accompanied by transparent, digital and effective revenue collection. In addition, states must take the high road and invest more in the 'unexciting' (compared to big infrastructure projects that can be completed in less than 2 years) but absolutely crucial human capital development projects.

### 2.1.3 Medium-Term Sector Strategy Planning for the Health Sector

The federal Ministry of Health has since completed its strategy, which began in the 2018 fiscal year. The National Strategic Health Development Plan II (NSHDP II) 2018–2022 placed Strategic Pillar Five (Predictable Financing and Risk Protection), at the centre of moving Nigeria closer to UHC, by addressing how health services are paid for and how financial barriers can be reduced.[22] The main goal was to ensure all Nigerians could access health services without financial barriers at the point of care, a core principle of UHC and a response to the ongoing challenge of high out-of-pocket spending in Nigeria's health system.

Within this pillar, health financing was structured around strategic objectives to strengthen governance of financing reforms, increase sustainable and predictable funding, enhance financial risk protection through pooled mechanisms and improve transparency and accountability in strategic purchasing. For example, NSHDP II set targets to: ensure more states had functional health financing units; approved financing policies and updated health accounts; and increased allocations to primary health care and expanded risk protection mechanisms such as the National Health Insurance Scheme (NHIS).[23]

Importantly, the Nigeria Health Sector Renewal Investment Initiative (NHSRII) has mobilised significant external and domestic resources (over $3bn) and has seen rapid upgrades of primary healthcare facilities and expansion of insurance coverage, reflecting more operational momentum than NSHDP II experienced in parts of its lifecycle. In contrast to the earlier plan's broad strategic language, NHSRII ties financing reforms to tangible infrastructure outcomes and workforce investments, seeking to translate strategic intent into measurable health system performance gains.[24]

21. Eze, O.I., Iseolorunkanmi, A., and Adeloye, D. (2024). The National Health Insurance Scheme (NHIS) in Nigeria: current issues and implementation challenges. Journal of Global Health Economics and Policy. 2024;4:e2024002. doi:10.52872/001c.120197
22. Federal Ministry of Health. (2018). National Strategic Health Development Plan II. Federal Republic of Nigeria. Available at: https://extranet.who.int/countryplanningcycles/sites/default/files/public_file_rep/NGA_Nigeria_Second-National-Strategic-Health-Development-Plan_2018-2022.pdf
23. Federal Ministry of Health. National Strategic Health Development Plan II, op.cit.
24. (January 1, 2025). Inside Nigeria's plan to overhaul healthcare. African Business. https://african.business/2025/01/politics/inside-nigerias-plan-to-overhaul-healthcare

Nevertheless, continuity between the two frameworks is clear: both prioritise governance, pooled financing and financial risk protection as enablers of equity and access. Where NSHDP II provided the policy architecture, NHSRII is attempting to deliver the implementation engine, but success will depend on sustained political commitment, efficient use of funds and robust monitoring to ensure the ambitious goals translate into real improvements in financial protection and health outcomes.[25]

One notable limitation of the plan was that, despite ambitious targets, NSHDP II faced ongoing implementation challenges, particularly with funding. The plan estimated significant funding needs and projected a large gap even under moderate scale-up scenarios. Without enough budgetary commitment from federal, state and local governments, many targets remained aspirational. This gap reflected longstanding issues in Nigeria's public finance, where health ranks low in budget priority and out-of-pocket spending remains high. Another weakness was that, while the plan promoted risk-pooling mechanisms such as state social insurance schemes, coverage expansion remained slow. Insurance penetration remained limited by administrative, logistical and financial hurdles: leaving many Nigerians still facing substantial financial risk at the point of care.

As part of a broader Renewed Hope Agenda to reinvigorate health sector reforms, NHSRII builds on the foundations of NSHDP II by maintaining an emphasis on predictable financing, strategic coordination and financial protection, while further embedding these within a sector-wide approach. The SWAp (Sector Wide Approach) Initiative is a development cooperation framework between the government and its development partners, including donors, NGOs, and international organisations, to align their efforts under a single sector policy, expenditure program, and a coordinated management system overcoming fragmentation and inefficiency of project-based aid delivery contributing to a unified sector plan.[26] SWAp aims for "one plan, one budget, one report, one conversation." This framework is intended to reduce fragmentation across federal, state and development partner investments and accelerate implementation through unified planning and accountability.[27]

25. (n.d.). National Health Insurance Scheme Strategic Framework. https://p4h.world/app/uploads/2023/02/Final20copy20of20the20NHIS20SP20reviewed2020and20validated.pdf
26. Agbaoye, K. (April 10 2024). What Does Nigeria's Sector-Wide Approach Mean for the Health Sector? Thought Leadership. In Nigeria Health Watch (Online). Available at: https://articles.nigeriahealthwatch.com/what-does-nigerias-sector-wide-approach-mean-for-the-health-sector/
27. Federal Ministry of Health and Social Welfare. (December 20 2025). Nigeria and United States Sign Landmark Agreement To Strengthen Health Security, Expand Primary Care, And Drive Self-Reliance. Federal Republic of Nigeria. Retrieved February 16, 2026, from https://health.gov.ng/press-statement-2

# 3

# Health Budget Trend Analysis

*In the 2026 proposed budget, the health sector has N1.23tn allocated to recurrent expenditure while N924.22bn was allocated to capital expenditure.*

## 3.1 Federal Government Health Sector Budget: 2021 to 2026

The Federal Government of Nigeria's allocation to the health sector followed a generally upward trajectory from 2021 to 2025, before declining in the proposed 2026 budget; reflecting shifting fiscal priorities, public health demands and broader macroeconomic conditions. The allocation increased nominally from N635.53bn in 2021 (amid post-COVID-19 recovery efforts aimed at strengthening healthcare infrastructure, disease surveillance and emergency response), to N819.29bn in 2022, representing a 28.9% increase. In 2023 and 2024, the figure increased by 41.6% and 27.6% respectively. This increment can be partly attributed to inflation and exchange rate pressures that raised the nominal cost of medical inputs and capital projects. A dramatic nominal surge occurred in 2025, when the allocation increased to N2.83tn, representing a 91.2% increase from the previous year. This is the largest percentage rise in the six year period. However, the 2026 proposed budget shows the figure decreasing to N2.46tn, giving a 13.1% decrement. Unlike previous years, this signals a contraction rather than growth. Since the 2026 figure is proposed and not yet approved, it remains subject to legislative adjustments. While allocations have increased nominally over the years, the real value of these increases must also be assessed against inflation, exchange rate fluctuations and population growth.

In 2001, African Union member states, including Nigeria, pledged to devote at least 15% of their national budgets to improving healthcare systems. However, twenty-five years after the landmark Abuja Declaration, Nigeria still falls significantly short of the agreed benchmark of allocating at least 15% of its annual budget to health. This clearly reflects a weak political commitment to health financing and a substantial gap between policy commitment and practical implementation.

Table 2: 2021 - 2026 Federal Health Sector Budget as a Percentage of Total Budget (In billions of Naira)

| Year | Health Budget | Total Budget | % Increase/ Decrease | % of Total Budget |
|---|---|---|---|---|
| 2021 | 635.53 | 13,590 | - | 4.68% |
| 2022 | 819.29 | 17,220 | 28.9% | 4.76% |
| 2023 | 1,160 | 21,830 | 41.6% | 5.33% |
| 2024 | 1,480 | 28,780 | 27.6% | 5.15% |
| 2025 | 2,830 | 54,990 | 91.2% | 5.14% |
| 2026* | 2,460 | 58,470 | - 13.1% | 4.20% |

*Source: 2021-2025 Appropriation Act, Budget Office of the Federation; 2026 Appropriation Bill, Budget Office of the Federation*

### 3.1.2 Federal Government - Capital versus Recurrent Expenditure

In the 2026 proposed budget, the health sector has N1.23tn allocated to recurrent expenditure while N924.22bn was allocated to capital expenditure. This reflects the government's priority to sustain ongoing health services, pay medical personnel and keep public hospitals and primary healthcare centres functioning. Capital investment on the other hand, refers to spending on long-term investments such as building new hospitals, upgrading medical equipment, constructing primary healthcare centres and expanding research and training institutions. While the N924.22bn allocated for capital projects is significant, it is still lower than recurrent expenditure. This may indicate a structural tension between maintaining existing services and investing in future capacity.

Table 3: 2026 Federal Health Sector Budget - Capital versus Recurrent Expenditure (in Billions of Naira)

| Sector | Personnel | Overhead | Capital | Total | % of the 2026 Proposed Budget Size |
|---|---|---|---|---|---|
| Health | 1,170 | 54.65 | 924.22 | 2,460 | 4.20% |
| *Ministry of Health (and 125 departments, agencies & parastatals)* | 1,170 | 54.65 | 924.22 | 2,150 | 3.68% |
| *Service Wide Vote* | | | | 307.67 | 0.53% |

*Source: 2026 Appropriation Bill, Budget Office of the Federation*

There is a noticeable dynamic between both expenditures; without adequate capital investment, facilities may deteriorate, technology may become obsolete and the system may struggle to meet rising health demands. Yet without sufficient recurrent funding, even newly built facilities cannot function effectively. This imbalance can result in overcrowded hospitals, outdated equipment, limited access to quality care, and continued reliance on private or overseas treatment. In a country with a large and growing population like Nigeria, recurrent spending is essential to prevent service disruptions, strikes and shortages that could immediately endanger lives. However, when recurrent expenditure consistently outweighs capital investment, it suggests that much of the health budget is being consumed by operational costs rather than expanding or modernising infrastructure.

### 3.1.3 Capital Expenditure Performance

The performance of Nigeria's health sector capital expenditure between 2021 and 2023 reflects persistent underfunding and implementation gaps, though with a slight improvement in utilisation efficiency in 2023. In 2021, only N90bn was released out of the budgeted amount of N134.59bn; however, only N54.76bn was eventually utilised, representing 40.7% of the approved budget. The approved health sector capital expenditure nominally increased to N207.39bn in 2022, out of which only 59.7% (N123.77bn) was released, and about 35.8% (N74.23bn) of the total expenditure was utilised. The amount released for capital investment dipped in 2023 despite the nominal increase in the approved capital budget to N448.04bn; only 26.9% (i.e., N120.96bn) was released. However, unlike previous years, the entire amount released for capital expenditure in 2023 was fully utilised. This indicates that though there was improvement in spending efficiency but severe shortfalls in the actual release of funds.

One of the most egregious revelations came from the Minister of Finance, Prof. Ali Pate, during a February 2026 budget defence session. The Minister disclosed that, out of the N218bn appropriated for capital projects in the 2025 fiscal year, only N36mn was released to the Ministry.[28] The consequences of this weak performance in the health sector capital expenditure cannot be overlooked. The consequence is a fragile health system that struggles to meet the needs of a rapidly growing population: inadequate funding has led to the deterioration of healthcare infrastructure across the country.

Table 4: Federal Health Sector Capital Expenditure Performance (Unit in Billion)

| Year | Budget | Actual Release | Actual Utilised | Utilization Rate[29] |
|---|---|---|---|---|
| 2021 | 134.59 | 90 | 54.76 | 40.69% |
| 2022 | 207.39 | 123.77 | 74.23 | 35.79% |
| 2023 | 448.04 | 120.96 | 120.96 | 27% |
| 2024 | 543.4 | 197.7 | 197.7 | 36.38% |

*Source: Q4 Budget Implementation Reports (2021-2024) Budget Office of the Federation*

28. Yakubu, D. (February 10 2026). Only N36m released from N218bn 2025 health capital budget — Minister. In the Punch (Online) Newspapers. Available at: https://healthwise.punchng.com/only-n36m-released-from-n218bn-2025-health-capital-budget-minister/
29. Note that the utilisation here is as a percentage of budget actually utilised and not released.

### 3.1.3.1 Sector Allocations among Key Agencies

The 2026 health capital budget signals the government's direction in healthcare, revealing both its priorities and its limitations. Spending is strongly tilted toward tertiary and specialised care, with less emphasis on strengthening the primary healthcare system that serves as the first point of contact for most Nigerians. A large proportion of the highest allocations sits within the Federal Ministry of Health and Social Welfare, focusing on cancer care, nationwide drug procurement, malaria elimination, and large-scale medical outreaches. Significant funding for cancer equipment across teaching hospitals, alongside the allocation for a permanent site for the National Institute for Cancer Research and Treatment, points to a deliberate expansion of specialist and referral-level capacity. This may reflect both the rising burden of non-communicable diseases and the political appeal of highly visible, high-impact health infrastructure.

**A total of N924bn was appropriated for capital projects in the line MDA budgets. This represents about 1.4% of the entire 2026 proposed budget and roughly 2.8% of the total capital budget, indicating the limited scale of federal investment in health infrastructure.** Within this allocation, the Federal Ministry of Health Headquarters accounts for N186.5bn, while the National Primary Health Care Development Agency (NPHCDA) receives N58bn. Tertiary hospitals collectively receive about N515.02bn. The largest allocations go to the National Hospital, Abuja (N44.9bn), University College Hospital, Ibadan (N25.5bn), Nnamdi Azikiwe University Teaching Hospital (N24.5bn), and Lagos University Teaching Hospital (N18.3bn). Other notable capital allocations include the National Institute for Cancer Research and Treatment (N49.1bn), the National Blood Service Commission (N39.6bn), and the Nigeria Centre for Disease Control (N18.9bn).

**However, capital allocations to tertiary institutions are not immune from constituency-style projects.** Examples appear across their capital budgets, such as "Supply and Provision of Medical Equipment and Drugs in Selected Hospitals and Healthcare Centres in Rural Farming Communities Selected from the South South Region" for N2.1bn within the UCH budget, and "Procurement of Hospital Ambulances for Empowerment for Maternity and Health Centres in Various Areas of the South East and South South Zones" for N3.5bn. These entries illustrate how the quality of capital budgeting still requires careful scrutiny, a recurring and perplexing feature of the Nigerian budget system.

Maternal and child health also features prominently through the establishment of regional centres in federal teaching hospitals. While these facilities are important, locating them primarily at the tertiary level limits their reach and does little to address delays at the community and primary care levels. By contrast, primary healthcare receives minimal capital attention, with the NPHCDA appearing mainly in relation to cold-chain equipment.

From a service delivery perspective, the scale and complexity of many of these projects also raise questions about what can realistically be completed within the 2026 fiscal year. Overall, the budget signals a healthcare strategy focused on specialised care and national programmes, while primary healthcare remains undercapitalised and the broader system-wide impact remains uncertain.

Table 5: 15 Top Federal Capital Allocations in the Health Sector Budget

| Code | MDA Name | Project Name | Proposed Budget (NGN) |
|---|---|---|---|
| ERGP25212109 | FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE - HQTRS | COMPLETION OF PROCUREMENT OF CANCER EQUIPMENT, INFRASTRUCTURE AND TRAINING IN COLLABORATION WITH NSIA IN 6 TEACHING HOSPITALS (UBTH BENIN, UNTH, ENUGU, ABUTH, ZARIA, FETH, KATSINA, LUTH, LAGOS AND JUTH, JOS | 44.52bn |
| ERGP25233649 | FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE - HQTRS | DRUGS, CONSUMABLES, EQUIPMENT, LAB REAGENTS, TEST KITS: TARGETING 10 MILLION VULNERABLE NIGERIANS | 42.18bn |
| ERGP25234153 | FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE - HQTRS | MULTILATERAL/BILATERAL TIED LOAN - LIVES AND LIVELIHOOD FUND (LLF) IN SUPPORT OF MALARIA ELIMINATION | 25.89bn |
| ERGP25237142 | NATIONAL INST. FOR CANCER RESEARCH AND TREATMENT (NICRAT) | DESIGNING, CONSTRUCTION, FURNISHING, EQUIPPING, SUPERVISION AND COMMISSION OF THE NATIONAL CANCER INSTITUTE NICRAT PERMANENT SITE IN NATIONAL INST. FOR CANCER RESEARCH AND TREATMENT (NICRAT) | 15.30bn |
| ERGP25237756 | NATIONAL BLOOD SERVICE COMMISSION (NBSC) | RENEWED HOPE NATIONAL BLOOD PROGRAMME ACROSS FEDERATION | 14.00bn |
| ERGP25242215 | FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE - HQTRS | RENEWED HOPE HEALTH CONNECT: FREE MEDICAL OUTREACH | 10.50bn |
| ERGP25242221 | FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE - HQTRS | ACQUISITION OF MB SPECIALIST HOSPITAL AND CANCER CENTRE | 10.20bn |
| ERGP25247708 | NATIONAL BLOOD SERVICE COMMISSION (NBSC) | CONSTRUCTION, AND EQUIPPING OF NATIONAL BLOOD SERVICE CENTRE & STRATEGIC NATIONAL BLOOD RESERVE, ABUJA | 10.00bn |
| ERGP25233921 | FEDERAL MEDICAL CENTRE, AZARE BAUCHI | CONSTRUCTION AND EQUIPPING REGIONAL MOTHER & CHILD CENTER | 7.00bn |

| Code | MDA Name | Project Name | Proposed Budget (NGN) |
|---|---|---|---|
| ERGP25233852 | FEDERAL TEACHING HOSPITAL, KATSINA | ESTABLISHMENT OF REGIONAL MOTHER AND CHILD CENTRE | 7.00bn |
| ERGP25233382 | NATIONAL BLOOD SERVICE COMMISSION (NBSC) | NATIONAL BLOOD COLLECTION & CLINICAL SERVICES PROGRAM (MULTIPLE LOTS) | 7.00bn |
| ERGP25233750 | NATIONAL HOSPITAL | ESTABLISHMENT OF REGIONAL MOTHER AND CHILD CENTRE | 7.00bn |
| ERGP25247550 | NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY | PROCUREMENT AND INSTALLATION OF SOLAR DIRECT DRIVE REFRIGERATORS | 7.00bn |
| ERGP25233911 | NNAMDI AZIKIWE UNIVERSITY TEACHING HOSPITAL, NNEWI | ESTABLISHMENT OF REGIONAL MOTHER AND CHILD CARE CENTER | 7.00bn |
| ERGP25233940 | UNIVERSITY OF UYO TEACHING HOSPITAL | ESTABLISHMENT OF REGIONAL MOTHER AND CHILD CENTRE | 7.00bn |

*Source: 2026 Appropriation Bill, Budget Office of the Federation*

### 3.1.4 Service Wide Votes

Service Wide Votes (SWV) are funds allocated for projects across MDAs, however, these funds are housed under the Ministry of Budget and Economic Planning. The SWV for the health sector are designed to cover cross-cutting of unforeseen expenditures,[30] such as health worker hazard allowances, counterpart funding for donor-supported programmes, emergency outbreak responses and other national interventions that affect multiple agencies.

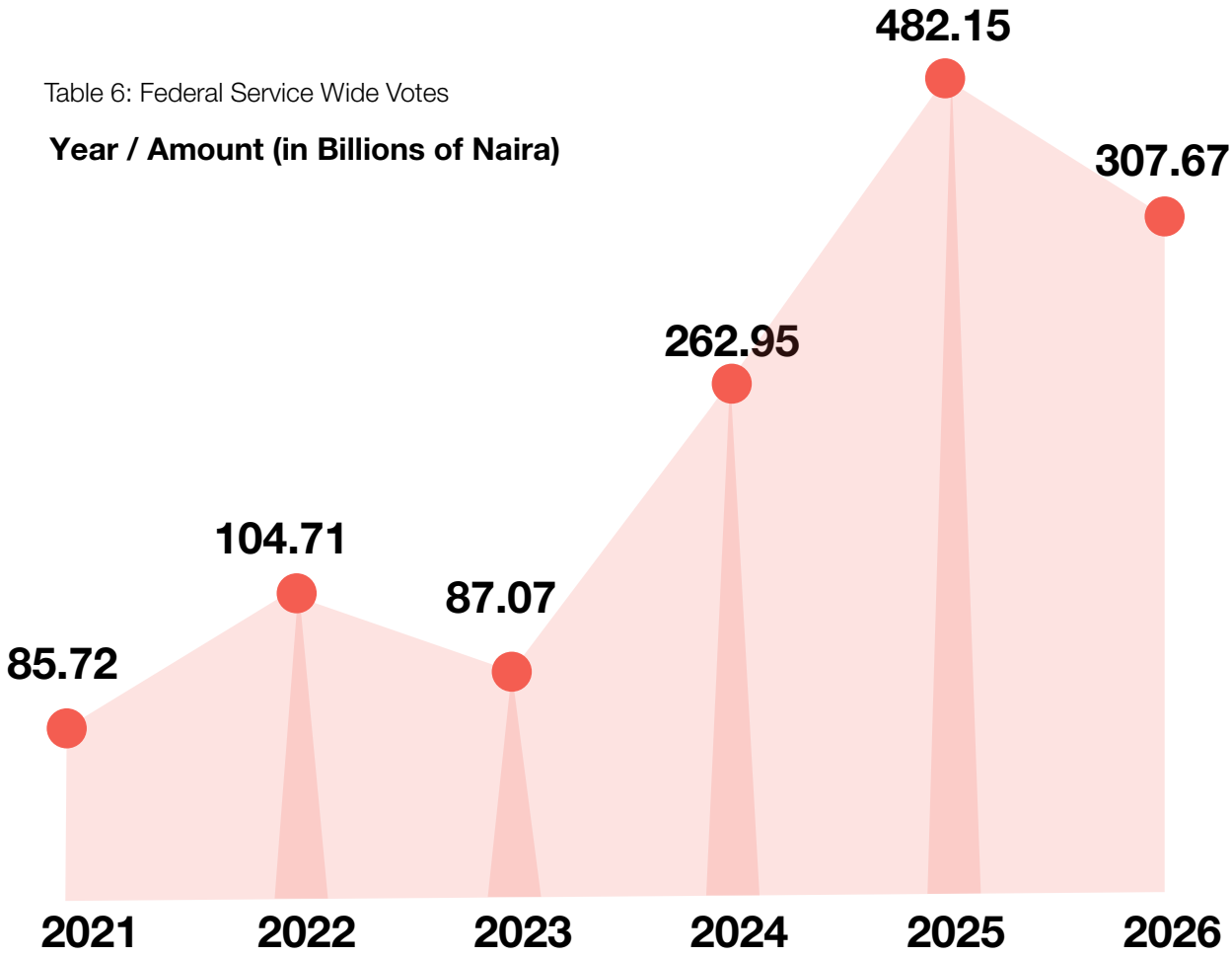
However, centralizing these allocations outside the core health MDAs gives room for transparency and accountability challenges.[31] This is because these funds are not initially tied to specific implementing agencies or programmes in the Appropriation Act: hence, tracking actual utilisation becomes more difficult for lawmakers. Allocating these funds directly to the relevant health institutions would strengthen programme-based budgeting, improve output monitoring, and enhance fiscal transparency. While SWVs provide short-term flexibility, embedding these funds within the formal budgets of implementing health agencies would likely improve transparency, accountability and efficiency in Nigeria's health sector financing.

In the breakdown of the 2026 proposed SWV, it shows some commitment of Nigeria's co-financing health for immunization with a combined allocation of N264bn counterpart fund for the Global Alliance for Vaccines and Immunization (GAVI) and the Malaria Vaccination for Infants intervention. The table below shows the nominal growth of health related SWV from 2021.

30. Inyang, W.S., Effiong, S.A., Effiong, C., and Oboh, J.O. (2019). Use of Service-Wide-Vote (Contingency Budget) for National Development: Evidence from Federal Ministries, Departments and Agencies in Nigeria. Research Journal of Finance and Accounting; 10(10):45-62. Doi: 10.7176/RJFA/10-10-06
31. Nwachukwu, A. (February 13 2026). Expert criticizes placement of health funds under service-wide votes. Health. Radio Nigeria (Online). Available at: https://radionigeria.gov.ng/2026/02/13/expert-criticizes-placement-of-health-funds-under-service-wide-votes/

Table 6: Federal Service Wide Votes

**Year / Amount (in Billions of Naira)**




*Source: 2021 - 2025 Appropriation Act, Budget Office of the Federation; 2026 Appropriation Bill, Budget Office of the Federation*

A brief evaluation of the line items below in the aggregate, shows that the federal government aims to bring a considerable amount of funding, under the scope of the Service Wide Votes and Capital Supplementation. Comparing the total amount allocated to health under the SWV & Capital Supplementation (N307.67bn) to the total proposed 2026 ministry of health budget of N2.149tn; it can be observed that the health SWV & CS takes up about 14.3% of the total proposed health sector budget. Comparing total health-related SWV & CS to the total proposed 2026 capital expenditure for the health sector, shows that health-related SWV & CS are about 33.29% of the total proposed Ministry of Health capex.

**33.29%**

*Comparing total health-related SWV & CS to the total proposed 2026 capital expenditure for the health sector, shows that health-related SWV & CS are about 33.29% of the total proposed Ministry of Health capex.*

Table 7: 2026 Federal Health Sector Related Service Wide Votes and Capital Supplementation

| Code | Health | Amount (NGN) |
|---|---|---|
| ERGP16210723 | Medical Retirees | 7.57bn |
| ERGP16210774 | GAVI/Immunisation | 250.96bn |
| ERGP25234078 | Malaria Vaccination Of Infants | 12.55bn |
| ERGP25247808 | Presidential Women's Health Transformation Initiative - Recurrent (OSSAP WH) | 1.54bn |
| ERGP25247832 | Presidential Women's Health Transformation Initiative (OSSAP-WH) | 4.46bn |
| ERGP25247834 | Domestic Cofinancing To Support The National Response To HIV/AIDS, Tuberculosis And Malaria | 22.68bn |
| ERGP30212116 | Presidential Committee On Health Sector Reform | 500.00m |
| ERGP9210830 | Counterpart Funding Including Global Fund/Health | 7.42bn |
| | Total | 307.67bn |

*Source: 2026 Appropriation Bill, Budget Office of the Federation*

# 15%

*In 2001, African Union member states, including Nigeria, pledged to devote at least 15% of their national budgets to improving healthcare systems. However, twenty-five years after the landmark Abuja Declaration, Nigeria still falls significantly short of the agreed benchmark of allocating at least 15% of its annual budget to health.*

Considering the proposed 2026 SWV & CS in more detail, a number of items are significant. For instance, the top health allocation in the table above is the Global Alliance for Vaccines and Immunization (GAVI/Immunization) allocation, at N250.95bn. This proposed allocation takes up 81.55% of the total 2026 SWV & CS. This is a significant (but nominal) increase from the 2025 approved budget allocation to GAVI/Immunization, which was N62.48bn less, at N188.47bn. It should be recalled that the federal government secured an immense grant from GAVI the Vaccine Alliance sometime in mid-2025, to the tune of $191mn.[32] The grant, meant to subsist for 4 years, is GAVI's Health Systems Strengthening (HSS-3) support to Nigeria and one of the largest ever health systems grant by GAVI. The fund aims to inoculate about 1.8 million zero-dose children and improve Nigeria's immunisation coverage to 84% by 2028.[33] Perhaps more interestingly, GAVI's Director of Health Systems and Immunization Strengthening stated that: "80% of it is supporting work at the sub-national level and more than 10% of that will flow to civil society organizations working at the community levels to ensure the funding is available and the National Traditional Leaders' Committee will be a key partner in helping to amplify these efforts at the sub-national level".[34] This shows that moving forward, the key to delivery of lifesaving vaccines is, in no small measure, put at the feet of the states-with support from CSOs.

Following this allocation to Immunization is the budget for Domestic Cofinancing to Support the National Response to HIV/AIDS, Tuberculosis and Malaria, at N22.68bn. Though just above 7.3% of the proposed 2026 SWV & CS, this line item is the second largest of the group of health related allocations. The intervention fund comes on the heels of a proposed amendment of the National Agency for the Control of AIDS Act.[35] The amendment would significantly broaden the mandate of the government agency and rename the agency to the National Agency for the Control of AIDS, Tuberculosis, and Malaria (NACATAM).[36] This, in a bid to strengthen the unified national response to infectious diseases in the context of declining donor support.

Lastly, the third largest proposed allocation is towards Malaria Vaccination of Infants. At no mean sum of N12.54bn, this is a noticeable nominal reduction of 69.64% from the 2025 allocation of N41.02bn. At 4.07% of the aggregate proposed 2026 SWV & CS, the Malaria Vaccination of Infants is supported by GAVI, the Vaccine Alliance, UNICEF and the World Health Organisation. Being an R21/Matrix-M vaccine, the schedule involves a four-dose regimen: 1st dose (5 months), 2nd dose (6 months), 3rd dose (7 months) and a booster dose (15 months).[37] It should be noted that Nigeria accounts for approximately 27% of the global malaria burden (World Malaria Report, 2022) and over 97% of Nigeria's population is at risk of malaria.[38]

Combined, the top 3 health related Other SWV & CS items make up N286.17bn, this is approximately 93.01% of the total health related Other SWV & CS items but only 13.31% of the total proposed budget of the Ministry of Health (minus SWV & CS, at N2.15tn). The imperative of addressing health care in Nigeria is not in doubt but the federal government (and the states) must transparently and fairly provide these services, for the infants, children and vulnerable groups that simply cannot do it for themselves.

32. Adebowale-Tambe, N. (May 2 2025). Nigeria secures $191 million Gavi grant to strengthen health systems. In Premium Times (Online) Newspapers. Available at: https://www.premiumtimesng.com/news/top-news/791908-nigeria-secures-191-million-gavi-grant-to-strengthen-health-systems.html?tztc=1
33. Adebowale-Tambe, N. Nigeria secures $191 million Gavi grant to strengthen health systems, op.cit.
34. Adejoro, L. (May 2 2025). Nigeria gets $191m grant from Gavi to strengthen health systems. In the Punch (Online) Newspapers. Available at: https://punchng.com/nigeria-gets-191m-grant-from-gavi-to-strengthen-health-systems/
35. Ogba, O. (November 10, 2025). House of Reps Directs Health Ministry and Partners to Submit Grant Implementation Plans for Legislative Approval Before Fund Release. In the National Assembly Library Trust Fund (Online). Available at: https://naltf.gov.ng/house-of-reps-directs-health-ministry-and-partners-to-submit-grant-implementation-plans/
36. Ogba, O. House of Reps Directs Health Ministry and Partners to Submit Grant Implementation Plans for Legislative Approval Before Fund Release, op.cit.
37. World Health Organisation (WHO). (December 5 2024). Nigeria Introduces the R21 Vaccine in a Pivotal Move for Malaria Control. WHO Africa-Nigeria. Available at: https://www.afro.who.int/countries/nigeria/news/nigeria-introduces-r21-vaccine-pivotal-move-malaria-control
38. World Health Organisation (WHO). Nigeria Introduces the R21 Vaccine in a Pivotal Move for Malaria Control, op.cit.

# 4 Critical Government Health Frameworks

*The allocation to the BHCPF, from 2021 to 2023 followed significant but comparatively minimal nominal increases (from N35.02bn in 2021 to N56.14bn in 2022 and a slight drop to N51.64bn in 2023).*

## 4.1 Basic Healthcare Provision Fund

The Basic Health Care Provision Fund (BHCPF), established by the National Health Act, 2014 was conceptualised with the aim of providing the basis for attaining UHC and by extension, improved national productivity. This was to be done by administering the following: a minimum package of health services (specifically a Basic Minimum Package of Health Services-BMPHS);[39] an expansion into the fiscal space (in terms of absolute volume and diversity of contributors) of the healthcare system; improvements in the quality and resilience of Primary Healthcare by the direct provision of running costs; and to generally provide better healthcare access to the poor and vulnerable (NPHCDA, 2026). As implied, this fund is directed towards different aspects of the health system that focus on the local (primary) provision of health care. The World Bank notes that the BHCPF is primarily dedicated to frontline services and funds 57 essential interventions covering 60% of the disease burden. These include interventions for family planning, antenatal care, delivery, postnatal care, immunization, child health, malaria, screening for Non-Communicable Diseases (NCDs) and Emergency Services such as road accident injuries (Federal Ministry of Health, 2019).[40]

In disaggregated form, the fund consists of the following fiscal components: (a) an annual grant from the Federal Government of Nigeria (FGN) of not less than one percent (1%) of the Consolidated Revenue Fund (CRF); (b) grants by international donor partners; (c) funds from any other source, inclusive of the private sector. The allocation to the BHCPF, from 2021 to 2023 followed significant but comparatively minimal nominal increases (from N35.02bn in 2021 to N56.14bn in 2022 and a slight drop to N51.64bn in 2023). However, the nominal change from 2023 to 2024 was momentous: about N79.88bn as the allocation in 2024 was about N131.52bn. This was overshadowed by the next period's change of N166.9bn i.e., between 2024 and 2025. The allocation of 2025 hit a high of N298.42bn: this difference (i.e., N166.9bn was more than the total allocations for 2021, 2022 and 2023, combined. The 2026 proposed allocation for the BHCPF appears to be in slight decline, at

39. The Federal Ministry of Health states that the BMPHS is a: "[S]et of preventive, protective, promotive, curative, and rehabilitative health services to be developed and reviewed from time to time by the Honourable Minister of Health (HMH), in consultation with the National Council on Health (NCH)". Federal Ministry of Health. (September, 2020). Guideline For the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (BHCPF), at p. 22. Federal Republic of Nigeria. Available at: https://nationalqoc.fmohconnect.gov.ng/wp-content/uploads/2023/07/BHCPF-2020-Guidelines.pdf

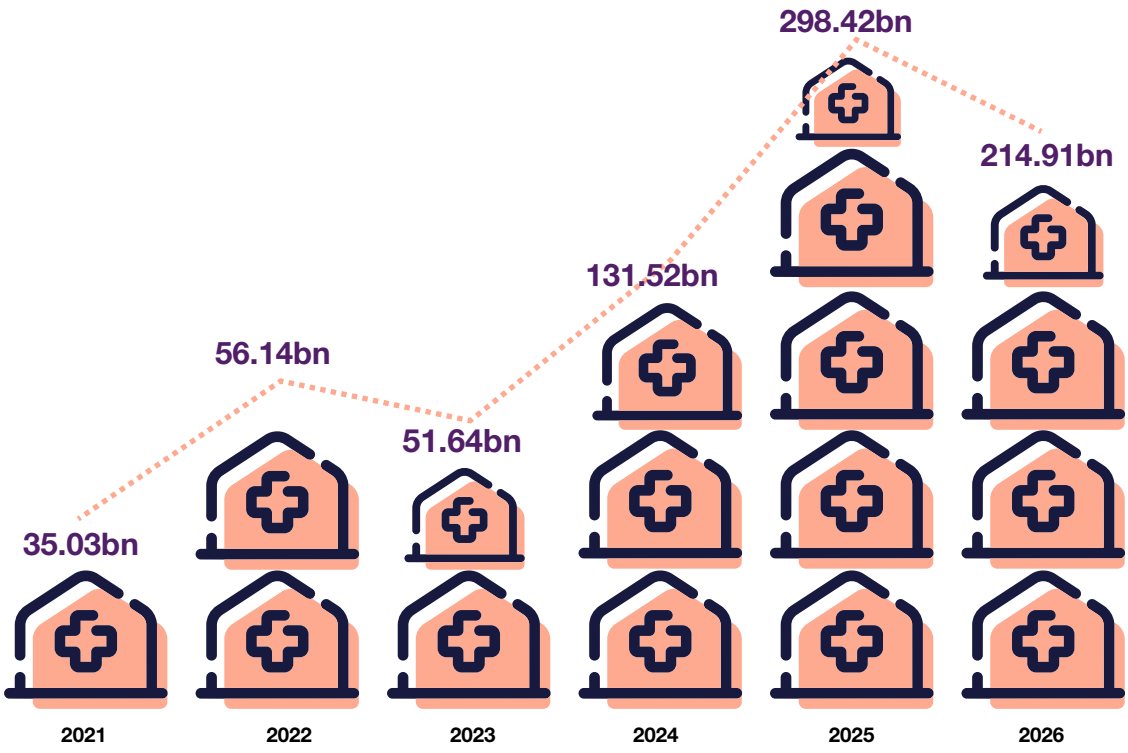
40. Financial Statements for the Period Ended 31st December, 2019. (2019). Basic Health Care Provision Fund Project - Huwe. Available at: https://documents1.worldbank.org/curated/en/385901616083076427/pdf/Nigeria

N214.9bn, though still higher than the allocations for the 2021 to 2024.

The BHCPF disbursement for 3rd quarter 2025 to the 36 States and the FCT through various gateways (NPHCDA, NCDC, EMTC and NHIA) was N27.55bn,[41] as opposed to the N29.28bn previously total disbursement for Q1 and Q2.[42] This disbursed fund is to support delivery essential to primary healthcare services and is crucial to the implementation of approved interventions in the States, Local Government Areas and facilities, in accordance with the revised BHCPF guidelines. States like Kano, Katsina, Jigawa, Borno, Sokoto and Niger states were the highest recipients accounting for 23.85% of the total disbursed funds of N29.28bn in Q3, 2025 while states such as Bayelsa, Edo, Nasarawa, Ekiti and the FCT received 9% of the disbursed funds.

The majority of the states received between N500mn and N800mn, while the FCT received N399mn (the least disbursement), and Kano received N1.52bn (the highest disbursement). Under the updated BHCPF Guideline 2.0, facilities in Nigeria would receive direct, Performance-based disbursements ranging from N600,000 to N800,000 per quarter (funding based on workload and facility size), up from the previous range of N300,750 per quarter, and the total number of facilities supported would expand from 8,000 to 13,000.

**Figure 1: Basic Health Care Provision Fund Allocation-2021 to 2026**




*Source: Budget Office of the Federation Appropriation Acts (2021 - 2026)*

41. Basic Health Care Provision Fund. (n.d). Publication of BHCPF Implementation Funds Disbursement For 3rd Quarter 2025, To The 36 States and the FCT Through The NPHCDA, NCDC, EMTC & NHIA Gateways. Federal Ministry of Health. Available at: https://bhcpf.gov.ng/_sh_files_2024_x9/3RD%20QUARTER%202025,%20BHCPF%20IMPLEMENTATION%20FUNDS%20DISBURSEMENTS_030042.pdf
42. Basic Health Care Provision Fund. (n.d). Notification of Q1 and Q2 Disbursement of BHCPF Allocation to 36 States and the FCT. Federal Ministry of Health. Available at: https://bhcpf.gov.ng/_sh_files_2024_x9/BHCPF%20IMPLEMENTATION%20FUNDS%20DISBURSEMENTS%20FULLPAGE%20ADS.pdf

### 4.1.1 Implementation Structure

**National Primary Health Care Development Agency (NPHCDA)**
Oversees PHC strengthening and service delivery.

**National Health Insurance Authority (NHIA)**
Manages insurance coverage for vulnerable groups.

**State & Local Governments**
Ensure accountability and proper use of funds at the community level.

### Distribution of BHCPF

The BHCPF is implemented through four main gateways:[43]

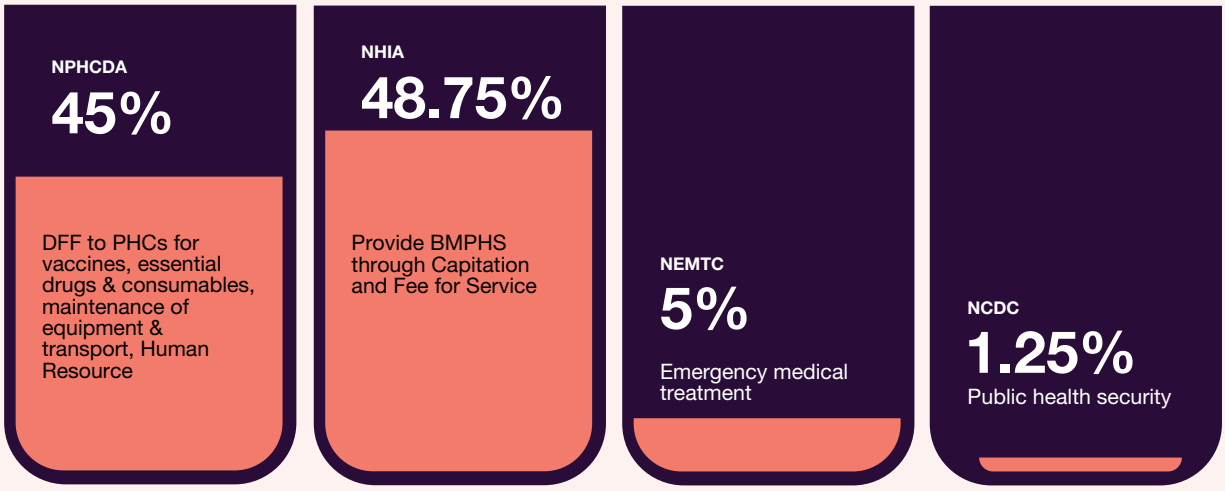
Table 8: Gateway Analysis

| Agency/Gateway | Allocations | Role/Mandate |
|---|---|---|
| National Primary Healthcare Development Agency (NPHCDA) | **45%** | Strengthens PHC Facilities, covers operational costs, and provides vaccines, drugs, and consumables. |
| National Health Insurance Agency (NHIA) | **48.75%** | Provide health insurance coverage for all, especially the poor and vulnerable, ensuring access to the Basic Minimum Package of Health Services (BMPHS). |
| National Centre for Disease Control and Prevention (NCDC) | **1.25%** | Support emergency preparedness and response to outbreaks. |
| National Emergency Medical Services and Ambulance Systems (NEMSAS) | **5%** | Funds emergency medical services and ambulance operations. |

*Source: National Primary Healthcare Development Agency*

43. Federal Ministry of Health. (September, 2020). Guideline For the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (BHCPF), at p. 20. Federal Republic of Nigeria. Available at: https://nationalqoc.fmohconnect.gov.ng/wp-content/uploads/2023/07/BHCPF-2020-Guidelines.pdf

**Figure 2: Components of the BHCPF**[44]




*Source: National Primary Healthcare Development Agency*

## 4.2 National Primary Health Care Development Agency (NPHCDA)

The National Primary Health Care Development Agency is a key structural component of the BHCPF. About 45% of the BHCPF is allocated through the NPHCDA via a pathway called the "NPHCDA Gateway". This allocation (in the ratio hereafter), is for the provision of: essential drugs, vaccines and consumables for eligible primary health care facilities (20%); the provision and maintenance of facilities, laboratory, equipment and transport for eligible primary health care facilities (15%); and the development of Human Resources for Primary Health Care (10%) (Federal Ministry of Health, 2019).

The NPHCDA budget allocation remained similar between 2021 and 2022, with a slight decline in 2023. In 2024, it increased significantly (though nominally) from N22.77bn in 2023 to N68.1bn. The allocation was followed by a marked nominal decline to N48.15bn in 2025 and a steep rise in the 2026 appropriation bill to N64.01bn. The largest proportion of the funds in the 2026 appropriation bills was allocated to Capital projects, such as routine immunisation (N13.54bn), polio eradication (N4.66bn), and the Renovation/upgrade of the NPHCDA HQ, Annex and Zonal offices (N3.15bn). Other major allocations were the provision, installation and maintenance of Solar electricity (HQ National Strategic Cold Store (NSCS), Six Zonal Cold Stores & Zonal Officers (N1.99bn) and PHC Revitalisation (N1.90bn). Other major allocations were the provision, installation and maintenance of Solar electricity (Head of Office, National Strategic Cold Store (NSCS), Six Zonal Cold Stores And Zonal Offices) (N1.99bn) and PHC Revitalisation (N1.90bn).

Additional line items identified in the 2026 Appropriation bill include: the procurement and installation of 40CBM walk-in Cold Rooms, the procurement and installation of Solar Direct Drive Refrigerators, Mobile Active Vaccine Refrigerators, cold boxes, Vaccine Carriers and Ice Packs, Temperature Monitoring Devices and Immunisation Waste Management Equipment and Supplies, which amounted to N25bn.

44. Federal Ministry of Health. Guideline For the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (BHCPF), at p. 20, op.cit.

Table 9: National Primary Health Care Development Agency Approved budgets (2021-2026) (In millions of Naira)

| Year | Personnel | Overhead | Capital | Total |
|---|---|---|---|---|
| 2021[45] | 2,980 | 209 | 21,300 | 24,450 |
| 2022 | 3,330 | 209 | 20,520 | 24,100 |
| 2023 | 3,510 | 223 | 19,030 | 22,770 |
| 2024[46] | 4,450 | 279 | 63,350 | 68,100 |
| 2025 | 5,300 | 1,000 | 41,930 | 48,150 |
| 2026* | 5,000 | 1,000 | 58,000 | 64,010 |

*2026- Appropriation bill*

## 4.3 National Emergency Medical Treatment

The National Emergency Medical Treatment, a Nigerian government initiative supported by the World Bank, is designed to strengthen emergency healthcare delivery nationwide. It focuses on bridging critical gaps in access to timely medical care, especially in rural and underserved communities. The Emergency Medical Treatment (EMT) Fund, supported by the Basic Health Care Provision Fund (BHCPF), covers emergency medical services and expands rural ambulance coverage to ensure patients can reach healthcare facilities. Programs like RESMAT (Rural Emergency Services and Maternal Transportation) aim to reduce maternal mortality by improving access to emergency care for pregnant women and infants. Between late 2024 and early 2025, 5,255 Nigerians benefited from the initiative, receiving care in tertiary hospitals and state-level facilities.[47]

## 4.4 Nigeria Centre for Disease Control

The Nigeria Centre for Disease Control (NCDC) is the country's national public health institute, established by the Federal Government of Nigeria under the Federal Ministry of Health in 2011. Its mission is to protect Nigerians from the impact of communicable diseases through surveillance, preparedness and coordinated response. NCDC is a structured gateway under the BHCPF with a portion of the funds allocated to it.

In terms of capital expenditure, the NCDC's biggest capital spend is directed towards the expansion/provision of office accommodation in its campuses. With 3 campuses across the country (two in Abuja and one in Lagos), it is clear this expansion is meant to serve additional personnel intake. This expansion could be to meet the growing importance of disease surveillance and prevention. However,

45. 2021-2023, 2025 Budget Office of the Federation
46. 2024 Federal Appropriation Act. Available at: ttps://budgit.org/wp-content/uploads/2024/01/2024-Approved-Budget.pdf
47. David, I. (March 20 2025). 5,255 Nigerians benefited from EMT fund in 6 months – NEMSAS. In Health Reporters: Online Health Newspaper for Information in Africa. Available at: https://healthreporters.info/5255-nigerians-benefited-from-emt-fund-in-6-months-nemsas/

this remains to be publicly communicated. The second highest capital expenditure allocation is geared towards both the purchase of "project vehicles for official business" at N1.52bn; and the allocation of N1.57bn to the "Redevelopment and infrastructural and equipment [sic] sustenance of the Central Public Health Lab in Lagos and other supporting laboratories as a branch of the national reference laboratory"[48]. While it is sensible for the NCDC to be fully equipped with vehicles to support monitoring and surveillance; a value for money case must be made for how these purchases are able to meet the centre's goals and objectives. In addition, while the Central Public Health Lab works with numerous regional and WHO-designated reference labs; these monies and their use must be transparently reported and must be able to yield results, via attainment of set disease targets.

Interestingly, the lowest of the top 10 largest capex allocations, of N270mn is directed towards "Equiping [sic] the headquarters on NCDC with communication and response infrastructure to achieve a 24/7 operational readiness for outbreak detection and response. The headquarters on [sic] NCDC with communication and response infrastructure to achieve a 24/7 operational readiness for outbreak detection and response". This is another indication that the government seeks to improve its surveillance equipment and technology. However, with the Ministry of Health's poor track record of having funds released, it would not be a surprise that these important allocations never see the light of day.

Table 10: Fund allocation NCDC 2024-2025 (in Millions of Naira)

| Year | Personnel | Overhead | Capital | Total |
|---|---|---|---|---|
| 2021 | 1,550 | 93.8 | 1,290 | 2,930 |
| 2022 | 1,760 | 194 | 1,890 | 3,850 |
| 2023 | 1,910 | 220 | 1,720 | 3,860 |
| 2024[49] | 1,840 | 275 | 2,230 | 4,350 |
| 2025 | 2,830 | 5,400 | 4,040 | 7,410 |
| 2026* | 2,2450 | 1,010 | 18,940 | 22,450 |

*Source: Budget Office of the Federation. 2026*- Appropriation Bill*

In the 2026 appropriation bill, N18.94bn was earmarked for capital projects. A deep dive into the budget identified the Top ten allocations, as follows:

48. Nigeria Centre for Disease Control and Prevention. (n.d). Public Health Laboratory Services. Federal Ministry of Health (Online). Available at: https://ncdc.gov.ng/departments/35/?n=public-health-laboratory-services
49. 2024 Federal Appropriation Act. Available at: https://budgit.org/wp-content/uploads/2024/01/2024-Approved-Budget.pdf

Table 11: Top Capital Allocations in the NCDC Budget

| Code | Project Name | Proposed Budget (NGN) |
|---|---|---|
| ERGP25112942 | PURCHASE OF CRITICAL INFRASTRUCTURE, LABORATORY EQUIPMENT AND COMMODITIES FOR THE NCDC LABORATORY NETWORK AND COLLABORATING LABORATORIES IN THE 36 STATES IN NIGERIA AND THE FCT. | 1.07bn |
| ERGP25112958 | REDEVELOPMENT AND INFRASTRUCTURAL AND EQUIPMENT SUSTENANCE OF THE CENTRAL PUBLIC HEALTH LAB IN LAGOS AND OTHER SUPPORTING LABORATORIES AS A BRANCH OF THE NATIONAL REFERENCE LABORATORY | 1.57bn |
| ERGP25112961 | REDEVELOPMENT, AND INFRASTRUCTURAL AND EQUIPMENT SUSTENANCE OF THE NATIONAL REFERENCE LABORATORY, GADUWA, ABUJA TO MEET INTERNATIONAL STANDARDS | 1.04bn |
| ERGP25168690 | PURCHASE OF CRITICAL LABORATORY REAGENTS AND COMMODITIES FOR THE DETECTION OF INFECTIOUS DISEASES. OF CRITICAL LABORATORY REAGENTS AND COMMODITIES FOR THE DETECTION OF INFECTIOUS DISEASES. | 1.12bn |
| ERGP25168695 | ESTABLISHMENT OF REFERENCE ZONAL PUBLIC HEALTH LABORATORIES ACROSS ALL THE SIX GEOPOLITICAL ZONES IN NIGERIA.OF REFERENCE ZONAL PUBLIC HEALTH LABORATORIES ACROSS ALL THE SIX GEOPOLITICAL ZONES IN NIGERIA. | 1.28bn |
| ERGP25205561 | EXPANSION/PROVISION OF OFFICE ACCOMMODATION AT NCDC CAMPUSES/PROVISION OF OFFICE ACCOMMODATION AT NCDC CAMPUSES | 2.17bn |
| ERGP25205608 | PURCHASE PROJECT VEHICLES FOR NCDC OFFICIAL BUSINESS | 1.53bn |
| ERGP25112946 | PROVIDING ICT INFRASTUCTURE AND SERVICES AND CAPACITY BUILDING FOR EFFECTIVENESS OF ALL CADRES OF STAFF IN NCDC. | 452.50m |
| ERGP25112962 | ESTABLISHING, PROVIDING EQUIPMENT AND INFRASTRUCTURE FOR SEQUENCING OF INFECTIOUS DISEASES AND SUPPORTING BIOINFORMATICS INFRASTRUCTURE IN NIGERIA. | 605.00m |
| ERGP25112971 | EQUIPING THE HEADQUARTERS ON NCDC WITH COMMUNICATION AND RESPONSE INFRASTUCTURE TO ACHIEVE A 24/7 OPERATIONAL READINESS FOR OUTBREAK DETECTION AND RESPONSE. THE HEADQUARTERS ON NCDC WITH COMMUNICATION AND RESPONSE INFRASTUCTURE TO ACHIEVE A 24/7 OPERATIONAL READINESS FOR OUTBREAK DETECTION AND RESPONSE. | 270.00m |

*Source: 2026 Appropriation Bill, Budget Office of the Federation*

## 4.5 Tertiary Hospitals

**The total allocations to Tertiary Institutions (comprising University Teaching Hospitals, Federal Medical Centers, Federal Teaching Hospitals and the National Hospital) amount to approximately N1.3tn, in the 2026 appropriation bill. A cost breakdown of the total allocation was N785bn for personnel cost, N34bn for overhead cost and N515.02bn for capital expenditure.** Majority of the capital expenditure were earmarked for infrastructural upgrades, construction of buildings and purchase of equipment. The total proposed allocation to these institutions is about 54% of the total proposed allocation to the entire health sector, i.e., N2.46tn.

Despite this seemingly high volume of allocation to Tertiary medical institutions, it should be noted they are confronted with several challenges relating to the efficient provision of health delivery. A common problem is the deficit between the Hospital Bed Capacity and the number of patients requiring admission: Nigeria's bed capacity stands at 0.9 hospital beds per 1000 people, a drastic discrepancy when compared to the global average of 2.3 hospital beds per 1000 people.[50] The latter deficit may be due to the self-referral practice common among Nigerians, as over 60% reportedly bypass the primary healthcare facilities to self-refer to higher healthcare levels in Nigeria.[51] An additional challenge is the continued emigration of doctors (including specialists and consultants); in the past seven years, nearly 16,000 doctors have left Nigeria and has left the doctor-to-patient ratio at just under 4 per 10,000 people.[52] Perhaps the most common but also debilitating problem is the lack of adequate power supply. Andersen notes that: "[A]t least 40% of hospitals and clinics in Nigeria lack access to reliable electricity and approximately 40,017 healthcare facilities are affected by energy challenges. This energy crisis has severe consequences such as surgeries being postponed, vaccines getting spoilt due to inadequate refrigeration, and emergency care being compromised"[53]. The most poignant instance of poor energy supply to such institutions, due its recency, is the power outage at the University College Hospital, Ibadan: allegedly the disconnection was as a result of unpaid bills in the realm of N400mn.[54] The combination of the aforementioned problems means loss of life, prolonged pain and suffering and the weakening of the health system.

A glance at the proposed budget of the Tertiary Medical Institutions in the country shows the dominant allocation towards personnel costs (about 59.2%) as a share of the total. This is not surprising as the impact of the medical brain-drain in the country is so critical that some reports claim that the United Kingdom is home to 12,000 Nigerian Doctors.[55] Yet, in addition to this proposed noticeable spend on personnel, the federal government has since embarked on its African Medical Centres of Excellence (AMCE) in Abuja in June of 2025, which aims to provide a facility for training healthcare professionals and building national capacity.[56] This was initially preceded by the National Policy on Health Workforce Migration-about a year earlier in August 2024-seeking to increase incentives for health workers, especially those in rural areas and underserved regions, meant to improve health outcomes and progress towards UHC.[57] However, equally important is the need to provide critical capital infrastructure, as noted in the paragraph above, which is 36.15% of the total proposed allocation for Tertiary Medical Institutions. The infrastructure deficit is non-trivial as some reports claim that 80% of Nigeria's health infrastructure is dysfunctional.[58] This means that the health system is confronted by twin problems that would have to be balanced not on a whim but taken contextually with evidence-based arguments made for tipping the scales in favour of either key budget component.

50. Soyemi, T.S., and Aborode, A.T. (2022). Shortage of hospital bed capacity and overcrowding in emergency tertiary healthcare centers in Nigeria. Ann Med Surg (Lond). 2022 Sep 15;82:104675. doi: 10.1016/j.amsu.2022.104675.
51. Soyemi, T.S., and Aborode, A.T. Shortage of hospital bed capacity and overcrowding in emergency tertiary healthcare centers in Nigeria, op.cit.
52. Igono, V. (September 29 2025). Filling the Tertiary Health Funding Gap in Nigeria: Realistic Options. In VerivAfrica (Online). Available at: https://www.verivafrica.com/insights/filling-the-tertiary-health-funding-gap-in-nigeria-realistic-options
53. Andersen. (May 27 2025). Addressing the Electricity Supply Crisis in Nigeria's Tertiary Healthcare Institutions with Sustainable and Affordable Renewable Energy Solutions. Andersen Tax LP. Andersen Tax LP. Available at: https://ng.andersen.com/addressing-the-electricity-supply-crisis-in-nigerias-tertiary-healthcare-institutions-with-sustainable-and-affordable-renewable-energy-solutions/
54. Eromonsele, F., and Adewale, Z. (March 7 2026). Persistent blackout at UCH sparks outrage, raises concerns over Nigeria's healthcare infrastructure. In Premium Times (Online) Newspaper. Available at: https://www.premiumtimesng.com/health/health-news/862142-persistent-blackout-at-uch-sparks-outrage-raises-concerns-over-nigerias-healthcare-infrastructure-2.html
55. Umar, A.A., Salihu, H.M., and Azuine, R.E. (2025). Crisis of Brain Drain in Nigeria's Health Sector: Challenges, Opportunities, and the Path Forward. Int J MCH AIDS. 2025 May 16;14:e011. doi: 10.25259/IJMA_11_2025.
56. Ihekweazu, V. (February 11 2025). Nigeria's health sector in 2025: Rising to the challenge. In the Guardian (Online) Newspapers. Available at: https://guardian.ng/opinion/columnists/nigerias-health-sector-in-2025-rising-to-the-challenge/
57. Chiejina, A., and Nwankwo, A. (September 16 2024). Nigeria's Health Migration Policy to Address Brain Drain Aims to Boost Local Expertise. Thought Leadership. In Nigeria Health Watch (Online) Newsblog. Available at: https://articles.nigeriahealthwatch.com/nigerias-health-migration-policy-to-address-brain-drain-aims-to-boost-local-expertise/
58. Onwujekwe, O., Etiaba, E., Ezenduka, C., Uguru, N., Okeke, C., Okechukwu, E., Uzochukwu, B., Mbachu, C., Batallack, S., and Kreling, B. (2025). Country Health Systems and Services Profiles: Nigeria. Brazzaville: WHO African Region. Available at: https://iris.who.int/server/api/core/bitstreams/1ea10753-e22e-4b05-9cea-06cfc8d33136/content

Table 12: Allocations to Tertiary Medical Centres in the 2026 Appropriation Bill

| Institution | Personnel Cost (NGN) | Overhead (NGN) | Capital (NGN) | Total Allocation (NGN) |
|---|---|---|---|---|
| UNIVERSITY COLLEGE HOSPITAL IBADAN | 29.87bn | 790.01m | 25.52bn | 56.18bn |
| LAGOS UNIVERSITY TEACHING HOSPITAL | 19.71bn | 780.68m | 18.32bn | 38.81bn |
| AHMADU BELLO UNIVERSITY TEACHING HOSPITAL | 18.35bn | 780.49m | 7.37bn | 26.49bn |
| UNIVERSITY OF NIGERIA TEACHING HOSPITAL, ENUGU | 29.48bn | 731.71m | 6.97bn | 37.19bn |
| UNIVERSITY OF BENIN TEACHING HOSPITAL | 22.05bn | 780.05m | 5.99bn | 28.83bn |
| OBAFEMI AWOLOWO UNIVERSITY TEACHING HOSPITAL | 21.06bn | 780.49m | 14.09bn | 35.93bn |
| UNIVERSITY OF ILORIN TEACHING HOSPITAL, ILORIN | 23.22bn | 769.19m | 11.56bn | 35.55bn |
| JOS UNIVERSITY TEACHING HOSPITAL | 18.68bn | 780.07m | 8.18bn | 27.65bn |
| UNIVERSITY OF PORT-HARCOURT TEACHING HOSPITAL | 21.59bn | 635.29m | 6.68bn | 28.91bn |
| UNIVERSITY OF CALABAR TEACHING HOSPITAL | 20.77bn | 733.93m | 5.57bn | 27.07bn |
| UNIVERSITY OF MAIDUGURI TEACHING HOSPITAL | 23.92bn | 631.98m | 16.13bn | 40.68bn |
| USMANU DANFODIO UNIVERSITY TEACHING HOSPITAL, SOKOTO | 15.25bn | 632.99m | 7.58bn | 23.46bn |
| UNIVERSITY OF UYO TEACHING HOSPITAL | 15.99bn | 482.47m | 17.34bn | 33.81bn |
| AMINU KANO UNIVERSITY TEACHING HOSPITAL | 22.57bn | 756.96m | 30.20bn | 53.53bn |
| FEDERAL UNIVERSITY OF TECHNOLOGY (FUTA) TEACHING HOSPITAL, AKURE | 6.49bn | 400.00m | 2.00bn | 8.89bn |
| NNAMDI AZIKIWE UNIVERSITY TEACHING HOSPITAL, NNEWI | 27.89bn | 777.24m | 24.53bn | 53.19bn |
| UNIVERSITY OF ABUJA TEACHING HOSPITAL, GWAGWALADA | 16.11bn | 698.25m | 6.94bn | 23.75bn |
| ABUBAKAR TAFAWA BALEWA UNIVERSITY TEACHING HOSPITAL BAUCHI | 10.87bn | 619.97m | 15.35bn | 26.90bn |

| Institution | Personnel Cost (NGN) | Overhead (NGN) | Capital (NGN) | Total Allocation (NGN) |
|---|---|---|---|---|
| FEDERAL TEACHING HOSPITAL, ABAKALIKI | 33.11bn | 467.23m | 6.78bn | 40.35bn |
| FEDERAL TEACHING HOSPITAL, GOMBE | 15.79bn | 470.21m | 12.40bn | 28.66bn |
| FEDERAL TEACHING HOSPITAL, IDO-EKITI | 15.39bn | 484.89m | 1.76bn | 17.65bn |
| FEDERAL TEACHING HOSPITAL, KATSINA | 14.91bn | 620.10m | 15.49bn | 31.03bn |
| DAVID UMAHI FEDERAL UNIVERSITY TEACHING HOSPITAL, UBURU, EBONYI STATE | 6.89bn | 474.21m | 6.71bn | 14.07bn |
| RASHEED SHEKONI FEDERAL TEACHING HOSPITAL, DUTSE, JIGAWA STATE | 5.30bn | 474.21m | 3.31bn | 9.08bn |
| FEDERAL UNIVERSITY OF HEALTH SCIENCES TEACHING HOSPITAL, OTUKPO, BENUE STATE | 3.42bn | 474.21m | 650.09m | 4.55bn |
| MODIBBO ADAMA UNIVERSITY TEACHING HOSPITAL, YOLA | 11.64bn | 506.06m | 6.48bn | 18.62bn |
| FEDERAL UNIVERSITY TEACHING HOSPITAL, WUKARI, TARABA STATE | 2.46bn | 474.21m | 1.41bn | 4.34bn |
| FEDERAL TEACHING HOSPITAL, OWERRI | 15.82bn | 502.44m | 2.23bn | 18.55bn |
| FEDERAL UNIVERSITY TEACHING HOSPITAL, LAFIA, NASARAWA STATE | 10.01bn | 400.00m | 7.27bn | 17.68bn |
| FEDERAL UNIVERSITY OF HEALTH SCIENCES TEACHING HOSPITAL, ILA -ORANGUN, OSUN STATE | 1.75bn | 400.00m | 2.80bn | 4.95bn |
| FEDERAL UNIVERSITY OF TECHNOLOGY (FUTA) TEACHING HOSPITAL, AKURE | 6.49bn | 400.00m | 2.00bn | 8.89bn |
| IRRUA SPECIALIST TEACHING HOSPITAL, IRRUA | 17.20bn | 471.47m | 1.70bn | 19.38bn |
| UNIVERSITY OF UYO TEACHING HOSPITAL | 15.99bn | 482.47m | 17.34bn | 33.81bn |
| FEDERAL MEDICAL CENTRE - ABUJA | 12.47bn | 446.25m | 13.67bn | 26.58bn |
| FEDERAL MEDICAL CENTRE, UMUAHIA | 12.45bn | 634.07m | 8.74bn | 21.83bn |

| Institution | Personnel Cost (NGN) | Overhead (NGN) | Capital (NGN) | Total Allocation (NGN) |
|---|---|---|---|---|
| FEDERAL MEDICAL CENTRE, OWO | 11.49bn | 500.61m | 4.13bn | 16.13bn |
| FEDERAL MEDICAL CENTRE ABEOKUTA | 17.79bn | 498.79m | 15.00bn | 35.54bn |
| FEDERAL MEDICAL CENTRE, MAKURDI | 12.45bn | 499.99m | 4.24bn | 17.19bn |
| FEDERAL MEDICAL CENTRE, NGURU YOBE | 7.85bn | 575.68m | 3.84bn | 12.27bn |
| FEDERAL MEDICAL CENTRE, ASABA | 13.25bn | 595.59m | 3.22bn | 17.07bn |
| FEDERAL MEDICAL CENTRE, BIDA | 9.21bn | 559.23m | 9.56bn | 19.33bn |
| FEDERAL MEDICAL CENTRE, GUSAU ZAMFARA | 9.08bn | 546.23m | 7.05bn | 16.67bn |
| FEDERAL MEDICAL CENTRE, KOGI | 6.67bn | 470.28m | 3.70bn | 10.85bn |
| FEDERAL MEDICAL CENTRE, AZARE BAUCHI | 9.55bn | 439.71m | 16.57bn | 26.56bn |
| FEDERAL MEDICAL CENTRE, KEBBI STATE | 9.08bn | 440.40m | 10.36bn | 19.93bn |
| FEDERAL MEDICAL CENTRE, TARABA STATE | 10.67bn | 501.49m | 3.83bn | 15.01bn |
| FEDERAL MEDICAL CENTRE, JIGAWA STATE | 7.18bn | 504.58m | 2.79bn | 10.47bn |
| FEDERAL MEDICAL CENTRE, NASARAWA STATE | 23.66bn | 487.83m | 8.89bn | 33.04bn |
| FEDERAL MEDICAL CENTRE, BAYELSA STATE | 13.97bn | 458.62m | 2.49bn | 16.92bn |
| FEDERAL MEDICAL CENTRE, EBUTE METTA | 8.58bn | 604.86m | 2.74bn | 11.92bn |
| FEDERAL MEDICAL CENTRE, HONG, ADAMAWA STATE | 3.09bn | 474.21m | 2.24bn | 5.81bn |
| FEDERAL MEDICAL CENTRE, MUBI, ADAMAWA STATE | 3.07bn | 474.21m | 1.44bn | 4.98bn |
| FEDERAL MEDICAL CENTRE, DAURA, KATSINA STATE | 2.91bn | 474.21m | 1.41bn | 4.79bn |
| FEDERAL MEDICAL CENTRE WASE, PLATEAU STATE | 1.58bn | 474.21m | 2.75bn | 4.81bn |
| FEDERAL MEDICAL CENTRE ONITSHA, ANAMBRA STATE | 2.35bn | 474.21m | 8.37bn | 11.19bn |

| Institution | Personnel Cost (NGN) | Overhead (NGN) | Capital (NGN) | Total Allocation (NGN) |
|---|---|---|---|---|
| FEDERAL MEDICAL CENTRE IKOLE-EKITI, EKITI STATE | 2.59bn | 500.00m | 2.18bn | 5.27bn |
| FEDERAL MEDICAL CENTRE MISAU, BAUCHI | 3.71bn | 500.00m | 4.10bn | 8.31bn |
| FEDERAL MEDICAL CENTRE, EPE | 2.61bn | 500.00m | 2.10bn | 5.21bn |
| FEDERAL MEDICAL CENTRE, KAFANCHAN. | 4.19bn | 500.00m | 2.00bn | 6.69bn |
| FEDERAL MEDICAL CENTRE KUMO | 4.19bn | 500.00m | 2.00bn | 6.69bn |
| FEDERAL MEDICAL CENTRES, OVWIAN UDU, DELTA STATE | 4.19bn | 500.00m | 2.00bn | 6.69bn |
| NATIONAL HOSPITAL | 15.09bn | 707.31m | 44.95bn | 60.75bn |
| **TOTAL** | **785.08bn** | **34.01bn** | **515.02bn** | **1.34tn** |

*Source: Proposed 2026 Federal Appropriation Act*

# N13 billion

*The sum of N13bn has been allocated for malaria vaccination of infants, N5.3bn for the procurement of vaccine equipments and devices, N3.2bn for the procurement of Routine Immunization (RI) vaccines, Devices and operational costs, similarly N3.2bn was allocated for Immunization waste management equipments and supplies and N2bn apportioned to the Polio eradication initiative, an investment that will undoubtedly prove critical in keeping Nigeria off the list of polio endemic countries with 270 million vaccines administered annually.*

## 4.6 Critical Thematic Issues

### 4.6.1 Routine Immunisation

Immunisation is one of the most cost-effective public health interventions for reducing mortality from vaccine-preventable diseases, especially infant and child mortality. A core responsibility of the FGN, under its immunisation policy, is to ensure immunisation coverage. As a Nation, some progress in some health-related indicators, such as reducing under-five mortality rate from 182 deaths per 1,000 live births in year 2000 to 111 deaths per 1,000 live births in the year 2021, yet Nigeria still faces significant child health challenges, contributing to one of the highest child mortality rates from vaccine-preventable diseases such as pneumonia, diarrhoea, measles, neonatal tetanus and other vaccine-preventable diseases. It is estimated that around 850,000 newborns and children under five die each year in Nigeria.[59] There are also high records, approximately 2.3 million zero-dose children in Nigeria[60] with a lack of access to immunisation, misinformation and service delivery gaps contributing to these challenges. According to Dr. Muyi Aina, the Director General of the National Primary Healthcare Development Agency, in 2024, only 21% of the allocated vaccine budget was released mid-year. Out of the N137bn appropriated, and N116bn approved, just N29bn was disbursed, creating major shortfalls in vaccine procurement and delivery.

A budgetary review for allocations for vaccines reveal a high dependency on donor/aid supports inconsistent funding and limited line items dedicated to vaccination. A trend analysis of the 2024, 2025 budget and 2026 proposed budget under the Federal Ministry of Health and Social welfare, highlighted the line items allocated to vaccination (under the FMoH and NPHCDA) in the 2024 budget was estimated at N68bn, while in the 2025 health sector budget, NPHCDA allocated N18.2bn was allocated to immunisation and vaccine delivery.[61]

An in-depth review of the 2026 proposed budget, N34bn was apportioned to immunisation and vaccination. The sum of N13bn has been allocated for malaria vaccination of infants, N5.3bn for the procurement of vaccine equipments and devices, N3.2bn for the procurement of Routine Immunization (RI) vaccines, Devices and operational costs, similarly N3.2bn was allocated for Immunization waste management equipments and supplies and N2bn apportioned to the Polio eradication initiative, an investment that will undoubtedly prove critical in keeping Nigeria off the list of polio endemic countries with 270 million vaccines administered annually. There is also the counterpart funding for GAVI/Immunization under the Service-Wide Vote with an allocation of N264bn. Despite the impacts of this scheme and Nigeria declared free of wild polio, Nigeria continues to grapple with the virus, through campaigns like Outbreak Response 3 (OBR3) and community mobilisation following the emergence of a circulating variant poliovirus type 2 (cVPV2) which poses a threat to children in the northern Nigeria.[62]

59. Ileyemi, M., and Adewale, Z. (November 13 2025). 850,000 Nigerian children die yearly from preventable causes – Health Minister. In Premium Times (Online) Newspaper. Available at: https://www.premiumtimesng.com/news/top-news/835110-850000-nigerian-children-die-yearly-from-preventable-causes-health-minister.html?tztc=1
60. Femi, E. (March 2025). Zero-Dose: 2.3m Nigerian Children Risk Preventable Death: As federal gov't, UNICEF deploy initiative to reverse trend. In Leadership (Online) Newspapers. Available at: https://leadership.ng/zero-dose-2-3m-nigerian-children-risk-preventable-death/
61. Oguntola, I., and Gbadamosi, S. (August 27 2025). Optimising Immunisation Financing Is Key to Nigeria's Child Health Goals. In Nigeria Health Watch (Online). Available at: https://articles.nigeriahealthwatch.com/optimising-immunisation-financing-is-key-to-nigerias-child-health-goals/
62. World Health Organisation (WHO). (December 22 2025). Nigeria refines Polio Eradication Strategy as WHO strengthens support toward 2026 targets. Regional Office for Africa. Available at: https://www.afro.who.int/countries/nigeria/news/nigeria-refines-polio-eradication-strategy-who-strengthens-support-toward-2026-targets

Table 13: 2026 Health Sector Budget allocation for Routine Immunization/Vaccination

| Code | MDA | Project Name | Type | Amount (NGN) |
|---|---|---|---|---|
| ERGP25112666 | NPHCDA | PROCUREMENT OF ROUTINE IMMUNIZATION (RI) VACCINES, DEVICES AND OPERATIONAL COST | ONGOING | 3.22bn |
| ERGP25112672 | NPHCDA | POLIO ERADICATION INITIATIVE (PEI) | ONGOING | 2.09bn |
| ERGP25112677 | NPHCDA | PROCUREMENT OF NON POLIO SIA VACCINE, DEVICE AND OPERATIONAL COST | ONGOING | 1.17bn |
| ERGP25112679 | NPHCDA | PROCUREMENT OF OUTBREAK (EMERGENCY) RESPONSE VACCINE, DEVICES AND OPERATIONAL COST | ONGOING | 982.31m |
| ERGP25126379 | NPHCDA | PROCUREMENT OF TRAVELERS AND PILGRIMS VACCINES | ONGOING | 999.60m |
| ERGP25126400 | NPHCDA | VACCINE DISTRIBUTION AND MOVEMENT FROM NATIONAL STRATEGIC COLD STORE (NSCS) TO SIX ZONES AND FROM THE ZONES TO THE 36 STATES PLUS FCT | ONGOING | 1.18bn |
| ERGP25126430 | NPHCDA | IMMUNIZATION SUPPLY CHAIN STRENGTHENING AT NSCS AND ZONAL COLD STORES, INCLUDING THE USE OF TECHNOLOGY FOR LAST MILE AND VACCINES AND DEVICES TRACKING FROM PRE-SHIPMENT TO LAST MILE USER | ONGOING | 2.92bn |
| ERGP25247551 | NPHCDA | MOBILE ACTIVE VACCINE REFRIGERATORS, COLD BOXES, VACCINE CARRIERS AND ICE PACKS | NEW | 5.30bn |
| ERGP25247553 | NPHCDA | IMMUNIZATION WASTE MANAGEMENT EQUIPMENT AND SUPPLIES | NEW | 3.20bn |
| ERGP25112647 | MFOH | SNAKEBITE ENVENOMING : PROCURE OF 10,000 VIALS ANTISNAKE VENOM @N190, 000/VIAL AND CONSUMABLES TO SCALING UP SUSTAINABLE SUPPLY OF ANTISNAKE VENOM IN NIGERIA | ONGOING | 92.95m |

| Code | MDA | Project Name | Type | Amount (NGN) |
|---|---|---|---|---|
| ERGP25202785 | FMoH | QUARTERLY LOCAL/INTERNATIONAL PRICE INTELLIGENCE SURVEY FOR MEDICAL EQUIPMENT/DRUGS/VACCINES AND OTHER HEALTH COMMODITIES | ONGOING | 22.31m |
| ERGP25232326 | FMoH | PROCURE 10,000 OF HUMAN ANTI-RABIS VACCINES (HARV) @ 37,000 /VIAL AND DISTRIBUTE TO 36 STATES AND FCT (NTD); CONDUCT MONITORING AND SUPERVISION OF RABIES VACCINE STORAGE FACILITIES IN 6 STATES (1 STATE IN EACH ZONE) (NTD) | ONGOING | 9.29m |
| ERGP25203410 | FMoH | NIGERIA VACCINE POLICY (NVP) AND ITS IMPLEMENTATION STRATEGIC PLAN AND GUIDELINES ON DEVELOPMENT OF EXTEMPORANEOUS PREPARATION IN TERTIARY AND SECONDARY HEALTH FACILITIES | ONGOING | 18.59m |
| ERGP25234078 | SWV | MALARIA VACCINATION OF INFANTS | ONGOING | 12.55bn |

*Source: 2026 Appropriation Bill, Budget Office of the Federation*

# N66.39m

Dropped

*As of 2024–2025, Nigeria faces significant funding shortfalls for FP programs. Federal allocations as, sourced from documents, dropped drastically from N2.23bn in 2024 to N66.39mn (FP Commodities, supply chain and services) in 2025 with the total budgetary allocation for FP placed at N552mn (approx. 75% cut).*

### 4.6.2 Family Planning

While Nigeria does not have a specific agency focused on family planning, a scan of the 2026 budget shows that the sum of N386mn is the total for the provision of family planning related in the 2026 proposed budget. The sum of N175mn was allocated for the integration of Basic Cancer Prevention Services into Family Planning activities across Comprehensive PHCs in the 36 States and FCT. N165mn was allocated for construction of the gynaecological Clinic Complex with Family Planning area and N46mn for commodities, supply chain and services. Under the Nigeria Family Planning Blueprint, achieving the projected mCPR growth and addressing unmet need in 2026 requires a minimum provision of N8bn – N11bn, covering both contraceptive commodities and essential operational support.[63]

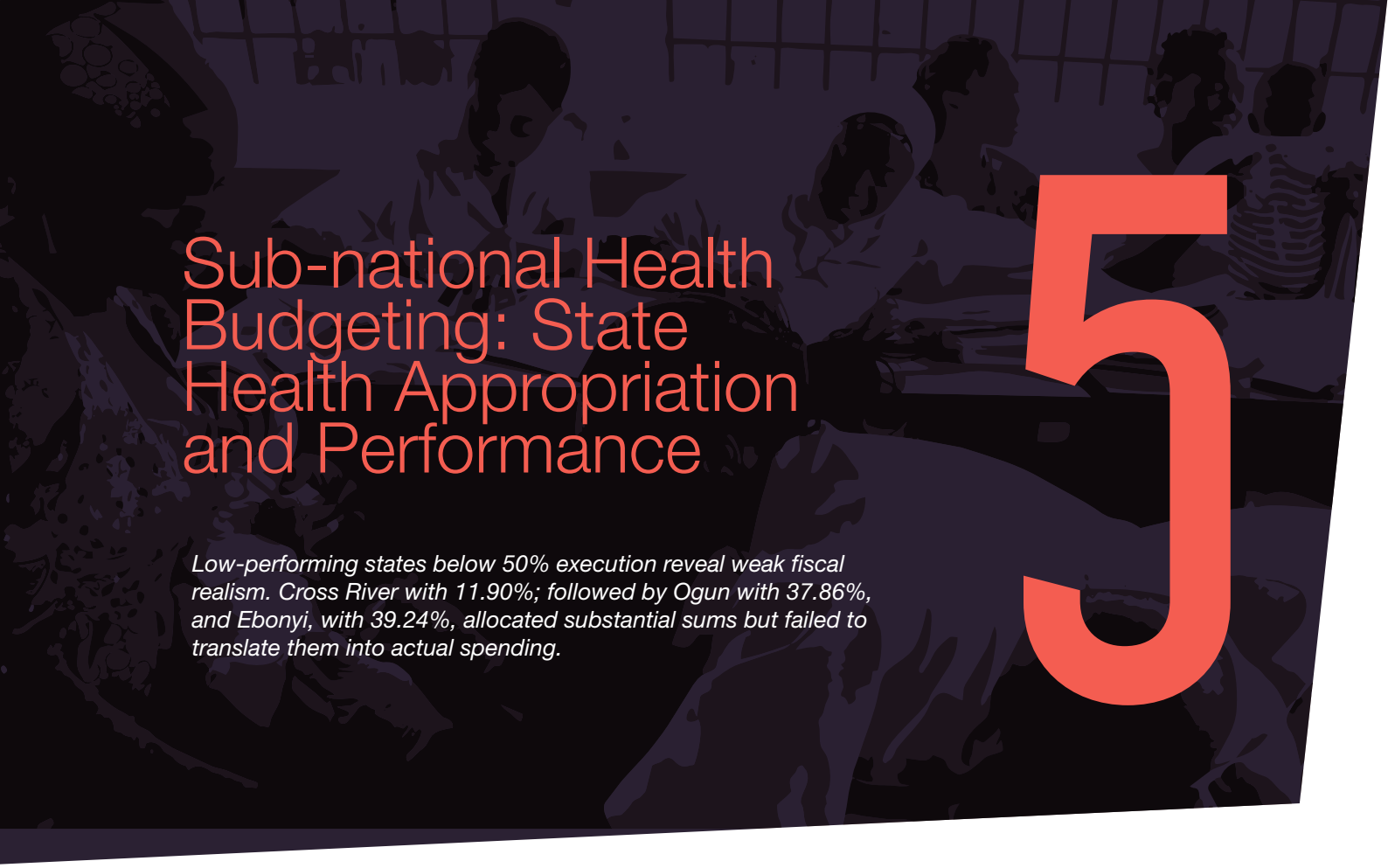
As of 2024–2025, Nigeria faces significant funding shortfalls for FP programs. Federal allocations as, sourced from documents, dropped drastically from N2.23bn in 2024 to N66.39mn (FP Commodities, supply chain and services) in 2025 with the total budgetary allocation for FP placed at N552mn (approx. 75% cut). N250mn was allocated for integration of Basic Cancer Prevention into FP activities across the 36 states and the FCT while N235mn was apportioned for the construction of a Gynaecological Clinic Complex with Family Planning Area. The Modern contraceptive prevalence rate (mCPR) is reported at 15% by 2023–24, short of the 2030 target of 27%.[64]

Table 14: 2026 Federal Budget allocation for Family planning

| Code | Line Item | | Amount (NGN) |
|---|---|---|---|
| ERGP25158195 | INCREASE ACCESS TO COMPREHENSIVE AND QUALITY FAMILY PLANNING INFORMATION, SUPPLY CHAIN AND SERVICES, INCLUDING SELFCARE INTERVENTIONS. | NEW | **46.48m** |
| ERGP25237159 | INTEGRATION OF BASIC CANCER PREVENTION SERVICES IN TO THE FAMILY PLANNING ACTIVITIES AT COMPREHENSIVE PRIMARY HEALTHCARE CENTRES IN 36 STATES AND FCT | ONGOING | **175.00m** |
| ERGP25223751 | CONSTRUCTION OF GYNAECOLOGY CLINIC COMPLEX WITH FAMILY PLANNING AREA | ONGOING | **164.68m** |

*Source: 2026 Appropriation Bill, Budget Office of the Federation*

63. FP2030. (n.d). Nigeria Family Planning Blueprint. Resources. Available at: https://www.fp2030.org/resources/resources-nigeria-family-planning-blueprint/
64. Bakare, Y.J. (May 17 2025). At the Brink: Nigeria's Current Family Planning Dilemma and the Urgent Need for Reinvestment. In Thought Leadership. Nigeria Health Watch. Available at: https://articles.nigeriahealthwatch.com/at-the-brink-nigerias-current-family-planning-dilemma-and-the-urgent-need-for-reinvestment/



# 5 Sub-national Health Budgeting: State Health Appropriation and Performance

*Low-performing states below 50% execution reveal weak fiscal realism. Cross River with 11.90%; followed by Ogun with 37.86%, and Ebonyi, with 39.24%, allocated substantial sums but failed to translate them into actual spending.*

## 5.1 An Overview of State Health Financing

This section examines how 34 out of the 36 Nigerian states financed their health sectors in 2025 and provides context for 2026 projections. (Akwa Ibom and Rivers were excluded due to unavailable detailed 2025 Q4 budget implementation reports). The 34 states approved a combined budget of N26.52tn but expended N17.88tn by reflecting a persistent gap between fiscal projections and execution. Of the N1.97tn allocated to health, only N1.18tn was expended, resulting in a 61.74% performance rate, with health accounting for just 6.98% of total actual expenditure indicating limited sectoral prioritisation. Performance varied considerably, for instance, Katsina State exceeded its health allocation by 140.92% by committing 17.17% of total spending to the sector. Delta with 96.79%, Yobe with 99.89%, and Lagos with 83.52% also demonstrated strong execution. In contrast, Ogun with 37.86%, followed by Niger with 52.56%, and Cross River with 1.29% health share reflected weaker prioritisation. Another trend from the data is that per capita spending ranged from N16,386 in Bayelsa to N808 in Cross River, underscoring deep disparities. The overall findings suggest that health financing outcomes are driven more by political will and governance discipline than by revenue size alone.

In 2025, the aggregate total health expenditure across 34 states (excluding Akwa Ibom and Rivers) reached N1.97tn, with actual health spending totalling N1.18tn. This resulted in a subnational budget average of 7.43% (i.e., comparing total subnational budget N26.51tn-to total health budget N1.18tn), falling significantly short of the 15% commitment under the Abuja Declaration. The 2025 data highlights a profound gap: the largest states (in terms of population) like Lagos and Kano, budgeted 6.44% and 11.44% as a share of total expenditure. On the other hand, states like Bauchi, Borno, Kano, Kebbi and Kwara all had a health budget above 10% of their total budget expenditure. Adamwa, Bayelsa, Gombe and Imo and Delta all had a health budget less than 5% of their total expenditure. As such, no single state in Nigeria allocated up to 15% of their budget on health; only Borno came close at 14.28% nearing the Abuja Declaration 15% benchmark. The table below provides a picture of the 2025 subnational performance.

Table 15: Overview of the 2026 Approved Budget and Health Component

| State | 2026 Total Budget (N'bn) | Health Budget 2026 (N'bn) | Health Budget as a share of Total Budget | Health Personnel Exp. (N'bn) | Other Health Recurrent Exp. (N'bn) | Health Total Recurrent Exp. (N'bn) | Health Capital Exp.(N'bn) |
|---|---|---|---|---|---|---|---|
| Abia | 1,016.2 | 152.412 | 15.00% | 16.885 | 2.67 | 19.55 | 132.86 |
| Adamawa | 583.33 | 47.638 | 8.17% | 7.767 | 1.25 | 9.01 | 38.62 |
| Akwa Ibom | 1,584.3 | 175.885 | 11.10% | 16.549 | 8.29 | 24.84 | 151.05 |
| Anambra | 766.37 | 73.282 | 9.56% | 6.438 | 2.94 | 9.38 | 63.90 |
| Bauchi | 877.05 | 132.020 | 15.05% | 18.149 | 8.49 | 26.64 | 105.39 |
| Bayelsa | 584.91 | 41.730 | 7.13% | 14.930 | 5.90 | 20.83 | 20.90 |
| Benue | 695.01 | 52.947 | 7.62% | 15.676 | 4.85 | 20.52 | 32.43 |
| Borno | 892.45 | 132.142 | 14.81% | 25.093 | 87.62 | 112.72 | 19.42 |
| Cross River | 961.62 | 40.903 | 4.25% | 3.540 | 2.22 | 5.76 | 35.14 |
| Delta | 1,729.9 | 95.828 | 5.54% | 31.180 | 3.98 | 35.16 | 60.67 |
| Ebonyi | 885.81 | 37.257 | 4.21% | 3.337 | 0.55 | 3.88 | 33.37 |
| Edo | 939.85 | 67.534 | 7.19% | 28.362 | 5.22 | 33.58 | 33.95 |
| Ekiti | 415.57 | 19.652 | 4.73% | 6.084 | 9.10 | 15.18 | 4.47 |
| Enugu | 1,617.4 | 95.674 | 5.92% | 46.055 | 2.86 | 48.91 | 46.76 |
| Gombe | 617.95 | 69.664 | 11.27% | 13.789 | 26.63 | 40.42 | 29.24 |
| Imo | 1,474.2 | 70.331 | 4.77% | 13.352 | 4.32 | 17.67 | 52.66 |
| Jigawa | 901.84 | 79.464 | 8.81% | 25.263 | 3.35 | 28.61 | 50.85 |
| Kaduna | 985.92 | 144.553 | 14.66% | 22.914 | 12.54 | 35.45 | 109.10 |
| Kano | 1,477.8 | 214.839 | 14.54% | 64.664 | 18.33 | 82.99 | 131.85 |
| Katsina | 897.87 | 67.585 | 7.53% | 14.706 | 5.14 | 19.85 | 47.74 |
| Kebbi | 642.93 | 48.375 | 7.52% | 15.975 | 4.65 | 20.62 | 27.75 |
| Kogi | 820.49 | 77.026 | 9.39% | 17.929 | 31.44 | 49.37 | 27.66 |
| Kwara | 656.60 | 88.983 | 13.55% | 9.413 | 8.69 | 18.10 | 70.88 |
| Lagos | 4,444.5 | 362.245 | 8.15% | 116.174 | 90.73 | 206.90 | 155.35 |
| Nasarawa | 545.18 | 37.462 | 6.87% | 20.296 | 10.35 | 30.64 | 6.82 |
| Niger | 1,074.0 | 74.990 | 6.98% | 14.190 | 5.21 | 19.40 | 55.59 |
| Ogun | 1,669.0 | 213.028 | 12.76% | 26.609 | 40.48 | 67.09 | 145.94 |
| Ondo | 524.41 | 59.542 | 11.35% | 24.714 | 3.79 | 28.50 | 31.04 |
| Osun | 723.45 | 59.229 | 8.19% | 24.733 | 14.49 | 39.22 | 20.00 |
| Oyo | 892.09 | 79.901 | 8.96% | 20.579 | 0.82 | 21.40 | 58.50 |
| Plateau | 817.51 | 88.363 | 10.81% | 12.501 | 9.47 | 21.97 | 66.39 |
| Sokoto | 758.70 | 124.405 | 16.40% | 15.293 | 4.47 | 19.76 | 104.64 |
| Taraba | 653.63 | 40.207 | 6.15% | 8.704 | 1.42 | 10.13 | 30.08 |
| Yobe | 515.53 | 77.350 | 15.00% | 20.213 | 6.48 | 26.69 | 50.66 |
| Zamfara | 871.34 | 87.460 | 10.04% | 8.675 | 2.58 | 11.25 | 76.21 |
| **Total** | 35,514.7 | 3,329.907 | 9.37% | 750.729 | 451.29 | 1,202 | 2,128 |

**Note that Rivers data was unavailable as of the time of publishing.*

The table below provides a colour coding of health budget performance and health budget as a percentage of the total budget. It's clear that about 7 states were able to exceed a 70% performance of their actual health budget as compared to their budgeted health expenditure. More worrying however, is the percentage of the health budget as a proportion of the total state budget. The latter item shows if the states are able to attain the status of Abuja Health Declaration status. Yet, as the evidence shows-with the exception of Borno that was just 0.72% shy of hitting the target-no state was able to do so.
Overall, the data show that per capita health outcomes at the subnational level are shaped not only by revenue size, but by execution rates, demographic pressures, and deliberate sectoral prioritisation. The contrast underscores a critical political economy lesson: health financing outcomes hinge not just on allocations, but on political will, governance discipline, and deliberate sectoral prioritisation, explaining why some states convert budgets into impact while others fail to translate resources into meaningful health outcomes.

## 5.2 Subnational Health Spending and Governance Outcomes: High- vs Low-Health-Spending States

In 2025, some states demonstrated high health spending, through both fiscal capacity and deliberate prioritisation. **An example of this is Lagos, which with a N216.71bn health budget expended N180.99bn; achieving 83.52% performance reflecting alignment between total expenditure, sectoral commitment and demonstrating that health financing was integrated into the broader fiscal strategy.** Another stand out state is Katsina, which exceeded its N58.76bn allocation and spent N82.81bn with 140.92% performance. The state dedicated 17.17% of total expenditure to health signalling a clear political choice to protect and expand health financing, despite broader budget constraints. Delta spent N63.38bn from a N65.48bn allocation with 96.79%, and Yobe achieved N27.78bn of N27.82bn with 99.89%, showing that disciplined execution and prioritisation can deliver substantial sectoral outcomes.

Following this, we found some states to be underperforming, showing weak governance and limited sectoral focus: despite available resources. Cross River allotted N34.10bn but expended only N4.06bn with 11.90%; representing just 1.29% of total expenditure. Similarly, Ogun executed 37.86% of N94.16bn, while Ebonyi spent 39.24% of N39.89bn. These examples show that high allocations alone do not guarantee spending; political will, execution discipline, and governance quality are decisive in translating budgets into meaningful health outcomes. The contrast between states highlights a critical political economy lesson: health financing success depends not merely on allocations but on deliberate prioritisation and effective governance, explaining why some states convert resources into impact while others fail.

## 5.3 Health Budget Credibility: High-, Mid-, and Low-Performance States

Health budget credibility differs significantly across states, underscoring variations in fiscal discipline, institutional efficiency, and the degree of political prioritisation accorded to the health sector.

The high-performing states from 80% and above in execution demonstrate a strong alignment between the allocation and implementation. Among them is Katsina, which exceeded its health allocation with

140.92% performance, while Yobe stood at 99.89%, followed by Delta, with 96.79%, executing nearly its full health budgets. These states send a strong credibility signal: approved budgets are treated as binding commitments rather than symbolic promises.

The mid-performing states from 50–79% execution reflect a partial credibility. Lagos, with 83.52%, sits at the upper threshold, while Niger, with 52.56% illustrates moderate follow-through. In these cases, health receives significant funding, but execution gaps suggest competing fiscal pressures or implementation inefficiencies.

Low-performing states below 50% execution reveal weak fiscal realism. Cross River with 11.90%; followed by Ogun with 37.86%, and Ebonyi, with 39.24%, allocated substantial sums but failed to translate them into actual spending. Such gaps undermine confidence in subnational planning and reinforce perceptions that budget figures are aspirational rather than operational. Ultimately, health budget credibility is not determined by allocation size but by execution consistency where implementation closely mirrors approved commitments.

## 5.4 Regional Inequality in Per Capita Health Spending (2025)

Per capita health spending across the states reveals clear regional disparities shaped by differences in fiscal capacity, population size, and governance priorities. In several southern states with relatively stronger revenue bases, spending per resident tends to be higher. For instance, Bayelsa State recorded the highest per capita spending at N16,386 from N48.46bn in actual health expenditure for a population of 2.96 million. Similarly, Lagos State, the country's largest economic hub, spent N180.99bn on health for 16.74 million residents, translating to N10,812 per person. Delta State also maintained relatively strong citizen-level investment at N8,390 per capita. However, many northern and some north central states face greater demographic pressure, which dilutes spending outcomes even when nominal allocations appear substantial. For example, Kano State spent N63.06bn on health, yet its population of 17.6 million results in only N3,583 per capita. Likewise, Kaduna State, which recorded N2,978 per capita despite spending N32.20bn. These differences illustrate how population scale can significantly reduce the real value of health spending per citizen. The implication of this is that such states will have to balance their priorities: more spending has to be made relative to the population.

## 5.5 Fiscal Capacity vs Population Pressure

The data further highlights a structural tension between fiscal capacity and demographic realities. Economically, stronger states often spend more in absolute terms, yet large populations can limit the per capita benefit of those expenditures. For instance, Lagos State leads the country in total health spending, but its large population moderates the per-person value compared with smaller states such as Bayelsa State.

Conversely, weak execution and limited prioritisation can dramatically reduce citizen-level investment. Cross River State spent only N4.06bn on health for about 5.02 million residents, resulting in just N808 per capita, the lowest in the dataset. Similarly, Adamawa State and Oyo State recorded N2,140 and N2,270 per capita respectively, reflecting how population size combined with limited execution can constrain effective health investment. Overall, the evidence suggests that equitable health outcomes depend not only on budget size but also on population dynamics, fiscal discipline, and sustained political commitment to health financing.

Table 16: 2025 Subnational Budgets, Health Budgets, Actual Health Expenditure & Performance

| Year 2025 Subnational Health Data Extraction | | | | | |
|---|---|---|---|---|---|
| State | Total Budget 2025 | Health Budget 2025 | Actual Health Expenditure 2025 | Health Budget Performance 2025 | Health Budget as % of Total Budget 2025 |
| Abia | 900,282,200,000.00 | 81,771,721,350.00 | 28,434,782,906.75 | 34.77% | 9.08% |
| Adamawa | 621,288,245,923.00 | 28,715,067,480.00 | 11,801,911,989.66 | 41.10% | 4.62% |
| Anambra | 606,991,849,118.12 | 45,317,207,630.02 | 22,399,645,011.21 | 49.43% | 7.47% |
| Bauchi | 622,013,248,317.12 | 66,395,262,723.27 | 53,490,189,465.88 | 80.56% | 10.67% |
| Bayelsa | 1,294,807,915,706.10 | 54,357,861,963.68 | 48,458,076,583.66 | 89.15% | 4.20% |
| Benue | 550,112,988,930.45 | 40,569,347,742.07 | 36,820,556,841.03 | 90.76% | 7.37% |
| Borno | 656,357,950,000.00 | 93,741,846,000.00 | 40,415,601,346.08 | 43.11% | 14.28% |
| Cross River | 642,160,250,165.67 | 34,101,582,829.61 | 4,058,026,516.19 | 11.90% | 5.31% |
| Delta | 1,179,228,818,719.10 | 65,477,340,020.51 | 63,377,065,604.50 | 96.79% | 5.55% |
| Ebonyi | 536,676,300,000.00 | 39,893,663,000.00 | 15,656,050,640.32 | 39.24% | 7.43% |
| Edo | 799,820,058,858.52 | 43,062,543,016.88 | 36,734,097,503.03 | 85.30% | 5.38% |
| Ekiti | 398,325,383,905.43 | 26,246,056,973.62 | 19,518,406,668.84 | 74.37% | 6.59% |
| Enugu | 971,084,000,000.00 | 56,473,156,804.00 | 17,333,971,842.21 | 30.69% | 5.82% |
| Gombe | 461,661,858,000.00 | 22,505,285,000.00 | 13,799,704,876.05 | 61.32% | 4.87% |
| Imo | 807,088,041,220.00 | 27,916,479,128.49 | 16,171,440,500.25 | 57.93% | 3.46% |
| Jigawa | 756,300,000,000.00 | 69,252,828,500.00 | 40,539,578,923.93 | 58.54% | 9.16% |
| Kaduna | 790,439,580,083.16 | 75,652,850,971.75 | 32,195,777,927.64 | 42.56% | 9.57% |
| Kano | 935,133,792,206.62 | 109,751,402,976.96 | 63,060,220,047.96 | 57.46% | 11.74% |
| Katsina | 692,244,449,513.87 | 58,763,962,108.68 | 82,812,942,500.09 | 140.92% | 8.49% |
| Kebbi | 580,327,469,023.80 | 68,668,677,994.31 | 17,911,288,591.46 | 26.08% | 11.83% |
| Kogi | 604,528,992,718.00 | 48,390,040,730.00 | 30,985,547,877.05 | 64.03% | 8.00% |
| Kwara | 626,646,609,582.00 | 72,559,947,114.00 | 35,040,008,680.99 | 48.29% | 11.58% |
| Lagos | 3,366,815,224,143.85 | 216,709,720,058.04 | 180,991,569,919.92 | 83.52% | 6.44% |
| Nasarawa | 476,468,074,966.91 | 35,809,364,521.03 | 23,135,981,317.11 | 64.61% | 7.52% |
| Niger | 1,091,221,295,750.60 | 68,214,234,295.70 | 35,850,891,875.00 | 52.56% | 6.25% |
| Ogun | 1,054,542,020,148.07 | 94,160,094,494.12 | 35,649,746,214.09 | 37.86% | 8.93% |
| Ondo | 489,998,360,173.48 | 47,013,077,910.77 | 38,837,510,651.56 | 82.61% | 9.59% |
| Osun | 427,746,925,170.00 | 31,936,278,180.00 | 22,672,286,721.52 | 70.99% | 7.47% |
| Oyo | 984,036,798,399.06 | 59,411,385,714.58 | 24,165,507,819.77 | 40.67% | 6.04% |
| Plateau | 609,176,525,931.13 | 32,697,776,891.26 | 14,873,929,290.86 | 45.49% | 5.37% |
| Sokoto | 526,882,142,484.39 | 41,869,252,082.91 | 17,506,884,680.90 | 41.81% | 7.95% |
| Taraba | 574,827,265,238.77 | 44,426,397,699.87 | 15,229,237,242.73 | 34.28% | 7.73% |
| Yobe | 382,137,000,000.00 | 27,816,225,000.00 | 27,784,607,814.00 | 99.89% | 7.28% |
| Zamfara | 498,683,075,000.00 | 41,367,288,499.77 | 16,157,035,220.84 | 39.06% | 8.30% |
| Total | 26,516,054,709,397.20 | 1,971,015,227,405.90 | 1,183,870,081,613.08 | 60.06% | 7.43% |

Source: Q4 Budget Implementation Reports of the 34 States[65]

65. Note that Rivers state-despite returning from the State of Emergency imposed by the federal executive-has not returned to regular governance and the publishing of basic fiscal documentation. As such, there is no Budget Implementation Report for the entire 2025 fiscal year. Akwa Ibom state, on the other hand has left the regular and comprehensive publishing of BIRs in detail and since the beginning of the 2025 fiscal year has published micro summaries of the BIR that contain zero information of spending and revenue in any of the National Chart of Account Classifications.


## 5.6 Political Economy of State Health Budgeting in 2026

The table below shows the 2026 projections for the state's total expenditure, health budget allocations and other components like personnel, overhead and capital expenditure and the projected execution ratio. Our examination is limited to 35 states out of the 36 Nigerian states: The Rivers State budget was not released as of the time of this report.

In 2026 health budget allocations across the 35 Nigerian states reveal significant disparities in sectoral prioritisation, expenditure structure, and fiscal commitment. Out of a combined N35.51tn total state budgets, about N3.33tn was allocated to health, but the distribution across states suggests that health financing remains shaped more by political incentives than by population needs or system capacity.

Looking at the data critically, we saw that a small group of states demonstrated stronger sectoral commitment. For example: Sokoto State allocates 16.40% of its budget to health, while Bauchi State, Abia State and Yobe State each allocate around 15% and approach the benchmark linked to the Abuja Declaration health financing target. However, several states allocate far less. Cross River State dedicates only 4.25%, and Ebonyi State allocates 4.21%, indicating limited fiscal priority for the sector.

Beyond allocation levels, the structure of spending reveals political incentives embedded in state budgets. Many states prioritise capital projects over operational capacity. For example, Ogun State allocates N145.94bn to capital expenditure compared to N67.09bn recurrent, while Kano State commits N131.85bn to capital investments. Such patterns suggest a preference for infrastructure projects that provide visible political returns, even though service delivery ultimately depends on personnel and operational funding.

The distribution of personnel spending further highlights systemic disparities. Lagos State allocates N116.17bn for health personnel, reflecting the scale of its health system, whereas states such as Cross River and Ebonyi allocate less than N4bn, raising concerns about workforce capacity and sustainability. Overall, the data indicate that health sector outcomes at the subnational level are shaped less by fiscal capacity and more by political choices about allocation, spending structure, and governance discipline, reinforcing long-standing inequalities in Nigeria's health financing landscape.
The table below provides a colour coding of health budget performance and health budget as a percentage of the total budget. It's clear that about 7 states were able to exceed a 70% performance of their actual health budget as compared to their budgeted health expenditure. More worrying however, is the percentage of the health budget as a proportion of the total state budget. The latter item shows if the states are able to attain the status of Abuja Health Declaration status. Yet, as the evidence shows-with the exception of Borno that was just 0.72% shy of hitting the target-no state was able to do so.

Overall, the data show that per capita health outcomes at the subnational level are shaped not only by revenue size, but by execution rates, demographic pressures, and deliberate sectoral prioritisation.

*Another major consequence of poor budgetary allocation is the persistent migration of health professionals, commonly referred to as "brain drain". Low salaries, poor working conditions and irregular funding have driven many Nigerian doctors, nurses, and other medical practitioners to seek employment abroad. Also, there is the problem of uneven distribution of health personnel across urban and rural areas. This weakens the health system, increases patient-to-doctor ratios and reduces the overall quality of healthcare delivery.*

# 6 Institutional Transparency, Oversight and Accountability Mechanisms

*Low-performing states below 50% execution reveal weak fiscal realism. Cross River with 11.90%; followed by Ogun with 37.86%, and Ebonyi, with 39.24%, allocated substantial sums but failed to translate them into actual spending.*

## 6.1 Evaluation of Mechanisms for Transparency, Oversight and Accountability at the Federal Level

Mechanisms for transparency, oversight and accountability in the allocation and utilisation of resources are vital in the Nigerian Health sector. Effective management and use of health sector funds demand transparent handling and thorough accounting. Major accountability challenges bewildering the Nigerian health system include lack of political commitment from the government in relation to release of funds for health activities, poor data management, political interference at higher levels of government, corruption, poor motivation, monitoring and supervision, weak financial management and accountability system, and weak capacity to implement suggested accountability mechanisms due to political interference with accountability structures, amongst others. These can be classified into three accountability gaps: Performance, Financial, and Political.
To close these gaps, the following are to be done:

**1.) Budget Transparency via timely and comprehensive disaggregation;**
**2.) Up-to-date Data and Reporting;**
**3.) Audits of the sector and sub-departments and ministries;**
**4.) Responsive Legislature via timely, inclusive and comprehensive oversight;**
**5.) Improved Civil Society Engagement;**
**6.) Citizens Engagement in Public Governance; and**
**7.) Digital Fund Tracking.**

## 6.2 Issues and Challenges

### 6.2.1 Budgetary and Governance Challenges

**Inadequate Budgetary Allocation:** Although Nigeria is a signatory to the 2001 Abuja Declaration, which recommends allocating at least 15% of national budgets to health, actual allocations have consistently fallen below this benchmark. In many fiscal years, the health sector receives less than 6% of the total federal budget. This underfunding negatively impacts infrastructure development, procurement of medical equipment, supply of drugs, and personnel training. As a result,

public hospitals across the country often struggle with outdated facilities and insufficient medical supplies.

**Poor Budget Implementation and Low Capital Release Rates:** There is often a delay in releasing funds for capital projects and when funds are released, they tend to be much less than the budget, which slows project execution. Allocated budgets remain underused due to delayed fund releases, inadequate planning, and weak institutional capacity. Year-end fund returns erode confidence in health sector budgeting. In the long run, this leads to incomplete/abandoned projects, particularly in rural areas where healthcare infrastructure is limited.

**Dependence on Donor Funding:** Nigeria's public health sector remains heavily reliant on donor funding, particularly for critical programmes such as routine immunisation, HIV/AIDS treatment, tuberculosis control, malaria interventions and maternal and child health services. International partners, including the World Health Organisation (WHO) and the World Bank, have played a central role in financing, technical assistance and programme delivery. While this external support has led to measurable improvements in health outcomes, it has also entrenched a financing model that poses serious risks to sustainability and sovereignty.

Heavy reliance on donor funding leaves the health sector vulnerable to external shocks. When donor priorities shift, funding cycles end, or policy considerations change in donor countries, essential health services are immediately disrupted. Nigeria has experienced funding uncertainties and programme scale-backs following changes in donor commitments, including adjustments and terminations of health-related support linked to the United States Agency for International Development (USAID). Similar vulnerabilities have appeared in other donor-supported initiatives, such as fluctuations in Global Fund–supported HIV, tuberculosis, and malaria programmes, and periodic delays or reductions in externally financed immunisation and primary healthcare interventions.

Such episodes expose weaknesses in domestic health financing and limited fiscal ownership of critical programmes. When funders withdraw or reduce support, the burden shifts to a public health system already constrained by limited budget allocations, poor execution of capital expenditures, and competing fiscal pressures. Without a transition strategy that prioritises increased domestic resource mobilisation, predictable budget funding, and stronger institutional capacity, donor dependence will continue to undermine the resilience of Nigeria's health sector and threaten the continuity of essential services.

**Weak Financial Management, Limited Revenue Generation and Accountability Systems:** Leakages, inefficiencies, and limited monitoring mechanisms reduce value for money. This is negatively propped up, in addition, by heavy reliance on oil revenues, poor tax compliance and a restricted tax base, which constrain federal health spending capacity and limit fiscal flexibility and economic stability. Procurement irregularities and poor auditing practices sometimes sabotage the effective utilization of scarce resources. Strengthening transparency and performance-based budgeting remains a critical reform need in the sector.

**Human Resource Challenges:** Another major consequence of poor budgetary allocation is the persistent migration of health professionals, commonly referred to as "brain drain". Low salaries, poor working conditions and irregular funding have driven many Nigerian doctors, nurses, and other medical practitioners to seek employment abroad. Also, there is the problem of uneven distribution of health personnel across urban and rural areas. This weakens the health system, increases patient-to-doctor ratios and reduces the overall quality of healthcare delivery.

**Funding and Access Barriers:** Simply put, low coverage/enrollment caused by money problems. The NHIS statistics indicate that less than 5% of Nigerians are enrolled in the NHIS, while 70% still finance their healthcare independently, i.e., out-of-pocket. A recent report shows that public funds account for 25% of total health spending, the private sector contributes 75%, and out-of-pocket (OOP) expenditures by families account for 95% of the private sector's share. The Federal government's commitment to the health sector is poor, as evidenced by its failure to fund an annual budget with little or no disbursement.

*Overall Assessment:* Nigeria's health financing combines tax revenues, statutory funds such as the BHCPF, and insurance contributions. While opportunities exist through tax reform, insurance expansion, and innovative financing, critical barriers remain: inadequate allocations, narrow fiscal space, accountability weaknesses, high OOP spending and inefficient fund utilization. Addressing these systemic challenges is essential for building sustainable, equitable health financing toward UHC.[66]

## 6.3 Successes and Opportunities

It should be noted that the BHCPF has a significant, multi-level governance framework for managing the various Gateways. The structure established to address the nationwide approach to health financing, is attained via the: National Assembly (NASS) Committees on Health; the Ministerial Oversight Committee (MOC); the State Oversight Committees (SOCs) and the Gateways Forum; the Local Government Health Authority (LGHA) Advisory Committee; the Ward Development Committee (WDC); and Primary Health Care Centre (PHC) Management Committees.[67] The foregoing comprise the implementers and beneficiaries across the tiers of government and the health care delivery structure.

### 6.3.1 Opportunities

Nigeria can address its health financing shortfall through four key strategies:

**Revenue Generation:** Broaden the tax base, enhance compliance and mandate targeted taxes (like sin taxes) to increase health funding. The new tax laws have significant potential to achieve this; what remains is the political will to ensure health is taken as a priority for finance.

**Private Sector Engagement:** Leverage public-private partnerships to bring in additional resources and operational efficiency. This can be in the form of Public-Private Partnerships (PPPs) and facility Concessions; Impact investing and loans (the latter, championed by PharmAccess in Lagos and Delta states, revitalises suboptimal or defunct public primary healthcare facilities in rural or hard-to-reach areas and promotes collaborations where private operators can access loans from a matching fund framework developed by the Medical Credit Fund and Delta State Contributory Health Commission);[68] and Corporate Social Responsibility (CSR) and Philanthropy initiatives, among others.

**Insurance Expansion:** Scale up the National Health Insurance Authority's coverage beyond current levels (under 10%-12%) to reduce out-of-pocket payments through sustainable prepayment systems. In addition, mandating the implementation of the NHIA is critical to reaching more policyholders: the Act requires enforcement and a move away from voluntary coverage.[69] This will require substantial intervention and commitment by subnationals and their respective health insurance arrangements, alongside consequential changes to the scope of financial allocation. There are conversations for the amount from the Consolidated Revenue Fund to be bumped up to 2%, allowing for deeper and better coverage for vulnerable groups.[70]

66. Igboanugo, F., Nwakor, O., and Kazeem, S. (November 13 2025). Driving Health Access and Financial Sustainability: Legal and regulatory solutions for advancing universal health coverage in Nigeria. In Business Day (Online) Newspapers. Available at: https://businessday.ng/news/legal-business/article/driving-health-access-and-financial-sustainability-legal-and-regulatory-solutions-for-advancing-universal-health-coverage-in-nigeria/
67. Federal Ministry of Health. (September, 2020). Guideline For the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (BHCPF), at p. 19. Federal Republic of Nigeria. Available at: https://nationalqoc.fmohconnect.gov.ng/wp-content/uploads/2023/07/BHCPF-2020-Guidelines.pdf
68. Dada, I., Osisiogu, U., and Ndili, N. (Guest Writers). (January 8 2025). Harnessing The Private Sector's Power to Revitalise Primary Healthcare in Nigeria. In Nigeria Health Watch (Online). Available at: https://articles.nigeriahealthwatch.com/harnessing-the-private-sectors-power-to-revitalise-primary-healthcare-in-nigeria/
69. Biose, S., and Oko, S. (December 12 2025). Is the BHCPF Nigeria's Best Bet for Achieving Universal Health Coverage-If It Is Properly Funded? Thought Leadership. Nigeria Health Watch (Online). Available at: https://articles.nigeriahealthwatch.com/is-the-bhcpf-nigerias-best-bet-for-achieving-universal-health-coverage-if-it-is-properly-funded/
70. Biose, S., and Oko, S. Is the BHCPF Nigeria's Best Bet for Achieving Universal Health Coverage-If It Is Properly Funded? Thought Leadership, op.cit.

**Domestic Capital Markets and Innovative Financing:** Tap domestic capital markets through instruments like health bonds and dedicated levies to fund long-term health infrastructure development. While this is yet to be applied in Nigeria, such interventions have worked in Cameroon and India, with some level of success.[71] Innovative financing models, like the Adoption model essentially, are designed to target a pool of public-spirited high-net-worth indigenes to pay premiums for low-income and vulnerable citizens.[72] This has the potential to increase the number of informal (and persons in hard to reach areas) within the scheme. In this case, the self-enlightened philanthropists do the adoption of the facility and those on whose behalf the premiums are paid are the "adoptees".[73]

71. Iroegbu, C., and Enema, P. (September 2 2025). Closing Nigeria's Insurance Gap for Maternal and Child Through Health Impact Bonds. Thought Leadership. In the Nigeria Health Watch (Online). Available at: https://articles.nigeriahealthwatch.com/closing-nigerias-insurance-gap-for-maternal-and-child-through-health-impact-bonds/
72. Onyemaechi, S.B., and Ezenwaka, U.R. (2022). Leveraging Innovative Financing Strategy to Increase Coverage and Resources Among Informal Sector for Social Health Insurance Within the Nigerian Context of Devolution: Evidence From Adoption Model Implementation. Front Public Health. Jul 14;10:894330. doi: 10.3389/fpubh.2022.894330.
73. Onyemaechi, S.B., and Ezenwaka, U.R. Leveraging Innovative Financing Strategy to Increase Coverage and Resources Among Informal Sector for Social Health Insurance Within the Nigerian Context of Devolution: Evidence From Adoption Model Implementation, op.cit.

# 7 Conclusion and Recommendations

## 7.1 Conclusion

The findings from this flagship financing report reveal that despite the federal government's intention and commitment to increase the health sector budget allocation, it is still below the 5% of the federal Budget. In the 2026 proposed budget, the health sector's allocation totals N1.23tn for recurrent expenditure and N924.22bn for capital expenditure, with a core focus on upgrading (revitalising) primary health care and cancer care, and on including vulnerable groups. With 4.20% allocated to the health sector in the 2026 proposed budget of N58.18tn. The Federal Government's spending on health care remains well below the recommended WHO and AU benchmark.[74]

Despite budgetary allocations, delays in funding releases further limit the timely commencement of health programmes,[75] compounded by the high cost of out-of-pocket payments across most healthcare facilities, a large portion 75% of the population is unable to access care due to high healthcare costs.[76] For example, of the N218bn allocated to health capital expenditure in 2025, only N36mn was released, which is 0.165%.

74. Declaration.PDF
75. Onyedika-Ugoeze, N. (February 15 2026). Budget office uncovers 10-year capital funding gap in Nigeria's health sector. In the Guardian (Online) Newspapers. Available at: https://guardian.ng/features/health/budget-office-uncovers-10-year-capital-funding-gap-in-nigerias-health-sector/
76. Omolaoye, S. (June 1 2025). Experts worry as over 75% of Nigerians pay out-of-pocket for healthcare. Guardian (Online) Newspapers. Available at: https://guardian.ng/features/health/experts-worry-as-over-75-of-nigerians-pay-out-of-pocket-for-healthcare/

## 7.2 Recommendations

Our key recommendations are as follows:

01

**Prioritise health resource allocation and utilisation**

**Implementation of the National Health Act:** The BHCPF should be drawn directly from the National Health Act, which is pegged at 1% of the Federation's Consolidated Revenue Fund (CRF).

**Increase health spending:** A multi-stakeholder advocacy engagement through the various platforms to strengthen political actions for increased government allocations and timely disbursal of funds on healthcare.

**The roles of development partners and actors** are crucial to leading health advocacy, transparency, advocacy and the dissemination of lessons is vital to strengthening healthcare/service delivery. A strong collaboration between the government and these stakeholders boosts the taxpayers confidence in their willingness to participate and improve the health sector. Access to budgetary documents, expenditure documents, and budget implementation reports that cover both Government aids and grants and other sources of domestic resource financing will improve accountability and transparency.

02

**Prioritize budgetary provisions on key programs:** During the review of the budget (2021-2025), there were challenges in tracking line items of key programs such as Immunization, family planning and MNCH, which were previously heavily donor dependent. This inconsistency in the budgetary provision significantly impacts on the availability of these commodities hence affecting the health outcomes across the nation. As part of BudgiT's recommendations, there should be a clear budget line for these programs.

03

**Strengthen the National Insurance Scheme across the various MDAs:** As efforts are targeted to reduce out-of-pocket spending to achieve Universal Health Coverage, the NHIA Gateway under the BHCPF accounts for a large portion of the allocation. Timely release of capitations to facilities especially the primary health care facilities would ensure that the standard for maintaining minimum package of health care for Nigerians are met and would also serve as a forum for advocacy for the enrollment in the health insurance scheme.

04

**Maximising Counterpart Funds:** To improve the effectiveness of the counterpart and donor funding systems for federal health programs, cash flow constraints and systemic bottlenecks must be addressed. Leveraging technology platforms to streamline central management, strengthen data efficiency and reduce administrative constraints.

05

**Leverage BudgiT's digital tools,** such as the PHC Accountability Tracka portal, to monitor PHC investment performance and gather citizen feedback for enhanced accountability and service delivery.

Strengthening Community Engagement and Accountability for Primary Healthcare Project (SCEAP)

PHC Accountability Tracka

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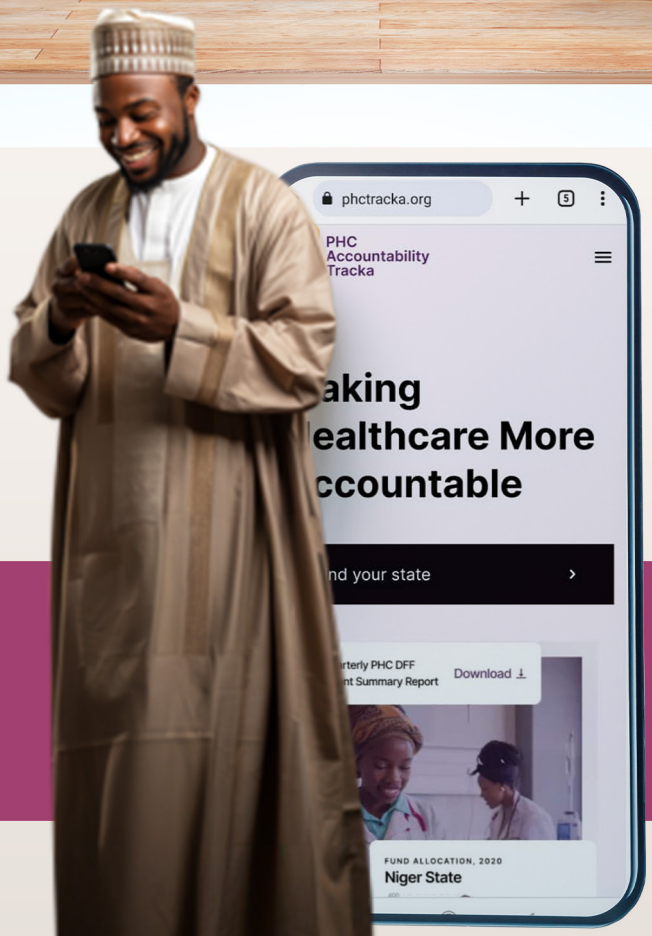


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