Chapter 2

Organization and governance of the health system

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Abbreviations

AOP..... annual operating plan
BHCPF..... Basic Health Care Provision Fund
DAP..... department, agency and parastatal
FCT..... Federal Capital Territory
FGN ..... Federal Government of Nigeria
FMOH..... Federal Ministry of Health
FMOH&SW..... Federal Ministry of Health and Social Welfare
HRH ..... human resources for health
IRMNCAH+N.... integrated reproductive, maternal, neonatal, child and adolescent health plus nutrition
LGA..... local government area
LGHA..... local government health authority
MNCH ..... maternal, neonatal and child health
NCH ..... National Council on Health
NGO ..... nongovernmental organization
NHA..... National Health Act
NHIA..... National Health Insurance Authority
NHP ..... National Health Policy
NSHDP ..... National Strategic Health Development Plan
PHC..... primary health care
PHCUOR..... Primary Health Care Under One Roof
PPP ..... public–private partnership
SCH..... state council on health
SDG ..... Sustainable Development Goal
SHC..... secondary health care
SMoH ..... state ministry of health
SPHCDA/B..... state primary health care development agency/board
SSHDP..... state strategic health development plan
SWAp..... sector-wide approach
TB..... tuberculosis
UHC ..... universal health coverage

Chapter 2 key messages

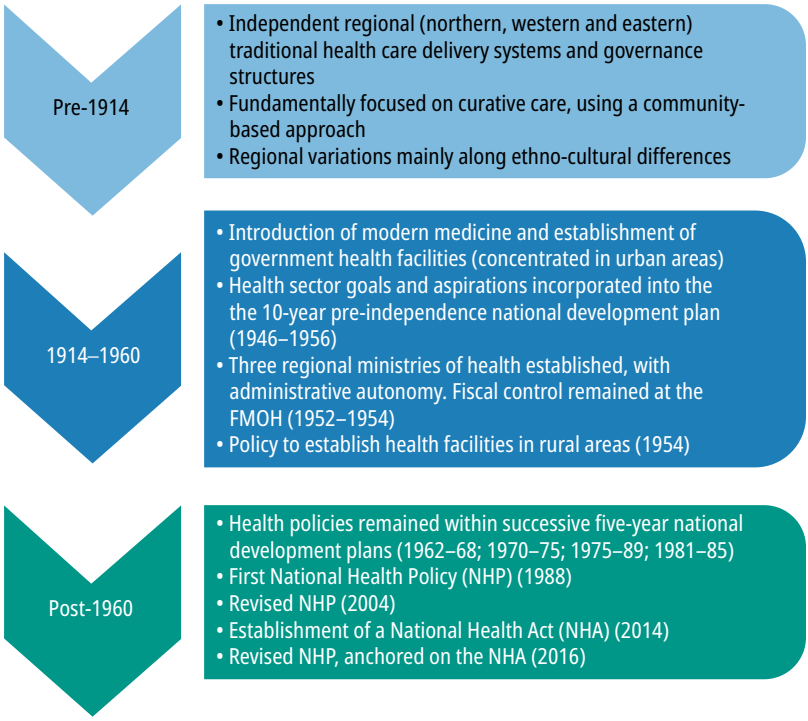
- Nigeria's three-tier (primary, secondary and tertiary) health system structure is governed by the National Health Act (2014) and National Health Policy (2016). Health governance is regionally devolved in line with the existing democratic federal governance structure.
- The federal level is primarily responsible for tertiary health services and the state level for secondary health services. State governments work with local government authorities to supervise primary health services delivered at the local or ward level, guided by the Primary Health Care Under One Roof (2013) policy. Overlaps between tiers and party or political influences weaken coordination in the system.
- Private health providers currently deliver an estimated 70% of all health care services, despite being responsible for only 35% of health facilities. Partnerships for health are recognized as building blocks of the health system, and strengthening public–private partnerships is seen as key to enhancing health system performance. However, mechanisms for engagement, regulation and accountability in the private sector remain weak.
- Nigeria has a federal governance structure with federal, state and local levels. There are 36 states and the Federal Capital Territory at state level, and 774 local government areas. Weak core governance indicators, including control of corruption, freedom of expression and the rule of law, remain causes for concern, with knock-on effects on health system governance.
- Political commitment to global health targets is strong, and reforms including the Nigeria Health Sector Renewal Investment Programme (2023) have put in place the policies and plans needed to guide health service delivery. However, policy implementation remains challenging, exacerbated by the complexity of the regionally devolved health sector and weak accountability and law enforcement at all governance levels. Consequently, progress towards universal health coverage remains slow.

2.1 Organizational structure

Historical development of the health system

The Nigerian health system has evolved through various stages to reach its current form, which aligns with the existing democratic federal governance structure (Fig. 2.1.a).

Figure 2.1.a Evolution of the Nigerian health system



Source: Etiaba, 2021

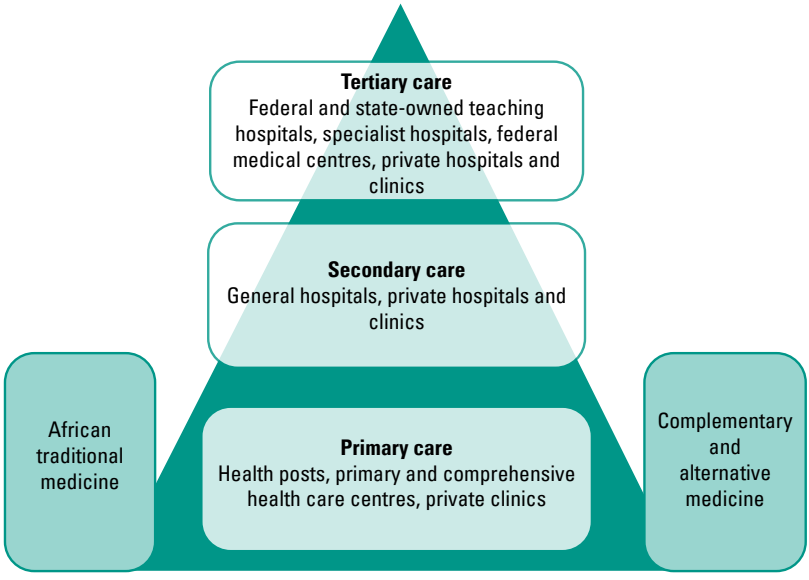
The post-independence era (post 1960) saw the introduction of the first specific national health policy in 1988, with a clear focus on primary health care (PHC). The National Health Act (NHA) entered into force in 2014 and provides a legal framework that aligns health care responsibilities with the three constitutional tiers of government: federal, state and local (FGN, 1999, 2014). Subsequent health policies, including the current National Health Policy (NHP) (FMOH,

2016) have been aligned with the NHA 2014. Presently, Nigeria's national health system comprises the following (FGN, 2014):

- the Federal Ministry of Health (FMOH), known since 2023 as the Federal Ministry of Health and Social Welfare (FMOH&SW);
- state ministries of health (SMoHs) and the Federal Capital Territory (FCT) department responsible for health care;
- parastatals under the FMOH and SMoHs;
- local government health authorities (LGHAs);
- PHC development committees;
- village health committees;
- private health care providers;
- traditional health care providers;
- alternative health care providers.

The above can be categorized into the three health system tiers, as shown in Fig. 2.1.1.

Figure 2.1.1 Overview of the health system



Source: Adapted from the National Strategic Health Development Plan II (FMOH, 2018b and Aregbeshola, 2021)

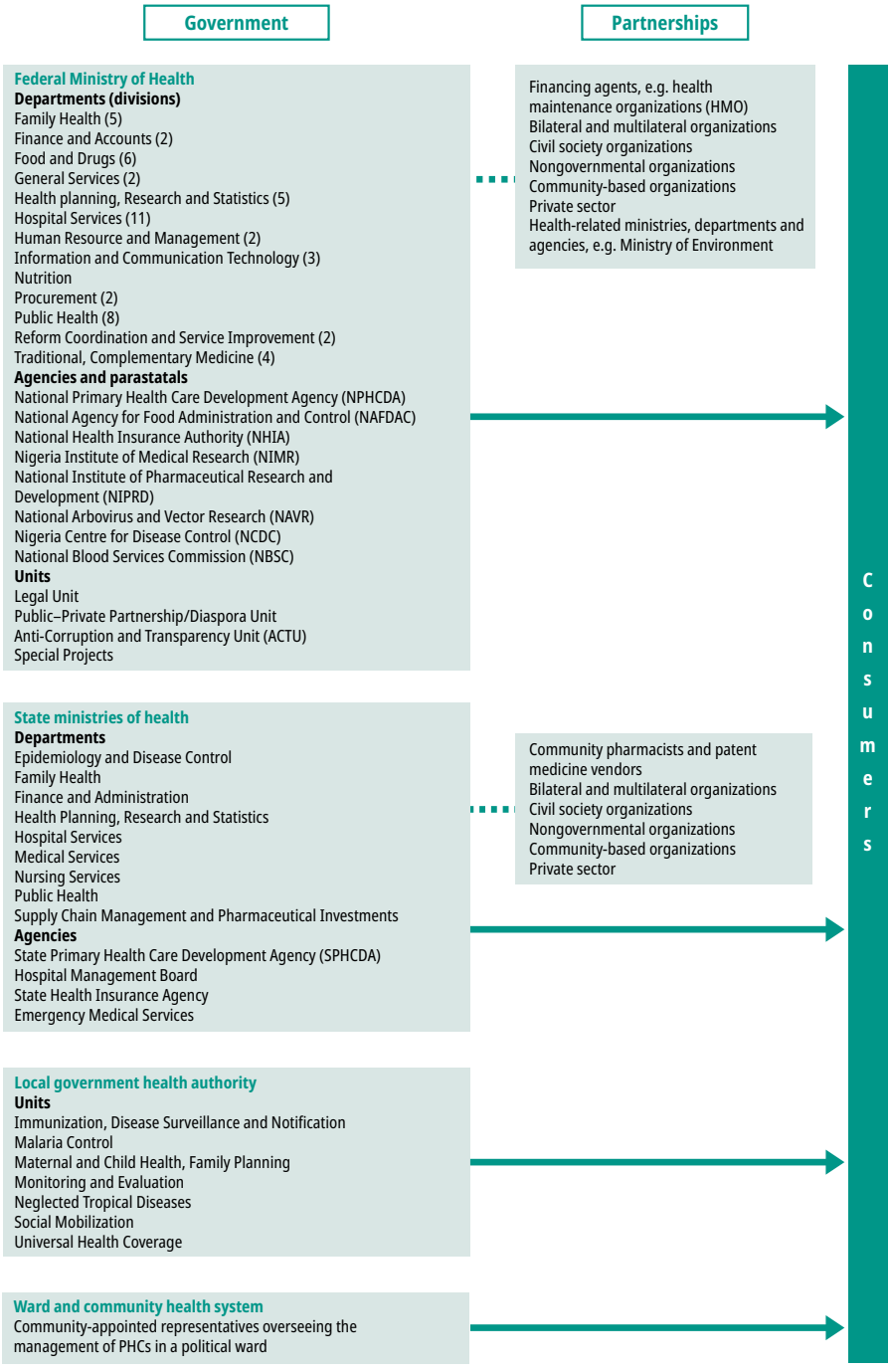
Tertiary-level health services are provided at federal teaching and specialist hospitals, federal medical centres, private hospitals and clinics. The FMOH is structured into departments, agencies and parastatals (DAPs) and units (Fig. 2.1.b). Although agencies and parastatals are domiciled outside the FMOH, departments are within the FMOH and continuously evolve with successive regimes and ministers. Presently, there are 13 departments and five units. Each department is further divided into varying numbers of divisions.

State governments govern secondary-level services, which are provided at general hospitals and private teaching and specialist hospitals in various states. In addition, some states own teaching hospitals that provide tertiary care. Each state has its own SMoH with departments and agencies organized in a similar way as those at the federal government level. The SMoHs are expected to support and supervise PHC service delivery. SMoH agencies include the state primary health care development agencies/boards (SPHCDA/Bs) and the state health insurance schemes (Fig. 2.1.1). The commissioners of health and the directors of the departments and agencies form part of the state councils on health (SCHs).

The local government health authority (LGHA) supervises PHC service delivery at PHC centres and collaborates with the SPHCDA/B to deliver community-based services. The LGHAs form part of the SCHs. They are mandated, according to the NHA 2014, to contribute no less than 25% to the total cost of PHC projects executed. Many health units at the local government area (LGA) level coordinate programme-specific activities on the front line (Fig. 2.1.b).

The political ward is the smallest administrative unit of the Nigerian Government. Wards comprise communities and villages. Each ward has a health committee that advises and supervises PHC at the community ward/village health committee level to ensure the delivery of a range of defined PHC services at the ward level, collectively known as the Ward Minimum Health Care Package (WMHCP) (NPHCDA and WHO, 2007). Ongoing reforms are intended to ensure that each community or village in a ward has at least one fully functional PHC centre.

Figure 2.1.b Organizational structure of the health system (DAPs and partnerships)



Source: Adapted from FMOH organogram (https://www.health.gov/ng/Source/42/Organogram#)
Note: Solid line = authority; dotted line = technical supervision.

2.1.1 Health care management and key actors

Table 2.1.a Health care management and key actors

	Non-state/private actors		
State/public actors	**Formal**	**Informal**	**Community**
• FMOH and its DAPs • Federal Ministry of Finance, Budget and National Planning • SMoH and its DAPs • FCT Secretariat for Health and Human Services • State ministries of budget and planning • Legislators at the federal (the Senate and House Committees on Health), state (state houses of assembly and house committees on health) and local government levels	• Private sector (for profit) • Private (formal) provider groups • Nongovernmental organizations/civil society organizations (non-profit) • Development partners (non-profit) • Formal faith-based organizations (non-profit), e.g. health facilities provided by faith-based organizations • Academia and public health experts • Chambers of commerce • Economic institutions and enterprises • Professional councils and associations	• Multiplicity of health providers/ faith healers and traditional, complementary, alternative and patent medicine vendors • Philanthropists • Labour unions • Clubs/societies	• Health care consumers as individuals, families and community members • Ward development committees

State and non-state actors are identified as key management actors (Table 2.1.a) (FMOH, 2018b). National policy documents set out structures and roles across levels of governance (FGN, 2014; FMOH, 2016c).

Federal public sector management

The FMOH is responsible for defining the overall policy framework for the health system with the participation of the 36 federal states and the FCT. It is also responsible for strengthening technical and managerial competences at the state level in delivering secondary health care (SHC) services, and for defining

norms, standards and protocols in relation to medicines, vaccines, research, hospital services, PHC and health workforce training. The FMOH performs its policy-making and oversight roles through its DAPs.

As stipulated by the NHA 2014, the National Council on Health (NCH) is the highest decision-making body of the Nigerian health system. Membership comprises the Minister of Health (chair), the Minister of State for Health, the Permanent Secretary of the FMOH (secretary), the commissioners of health for each of the 36 states, and the Secretary of Health and Human Services of the FCT (FGN, 2014). See Section 2.3 for details of the NCH's role in stakeholder engagement.

In addition, the Ministry of Finance, Budget and National Planning plays a key role by linking the FMOH with other ministries for planning health and health-related projects.

State public sector management

The SMoHs are responsible for developing and implementing state-level health policies, norms and protocols in the health sector. This may take the form of adopting and implementing national policies and/or initiating state-level policies. In addition, they oversee SHC service delivery and support their LGAs in delivering PHC services. The SMoHs supervise secondary and tertiary health care service delivery, SPHCDA/Bs, schools of health technology, nursing and midwifery, and private health organizations (Fig. 2.1.b).

Governors are the ultimate decision-makers at the state level. They confer with the state executive council, which comprises political appointees of the governor (including the deputy governor, the secretary to the state government and all commissioners). The political and decision-making structure made by the autonomy of the states overrides any national-level decisions taken at NCH meetings (ASMoH and FHI 360, 2013; Eboreime et al., 2017; ESMoH, 2018). This misalignment in governance structure means that, despite the provisions of the NHA 2014, the constitutional executive powers of state governors can create conflict in relation to the transfer and adoption of national policies (Eboreime et al., 2017). The fledgling autonomy of the states is an evolving challenge within the health system.

Before the inauguration of the SPHCDA/Bs, the SMoHs were also responsible for overseeing LGAs health departments and supervising in delivering services at PHC centres. The SPHCDA/Bs were set up to mirror the function of the NPHCDA in coordinating all PHC activities. Their central role is to coordinate

the implementation of the Primary Health Care Under One Roof (PHCUOR) policy, a health system governance reform described in detail in Section 2.5.

Local government health management

Local governments manage the bulk of service delivery points, with fiscal allocations from the state-level government (Ozohu-Suleiman and Chima, 2015; FMOH, 2016c). Legislatively, the LGHAs are managed by the Local Government Service Commission and the SPHCDA/Bs. The LGA PHC director has direct oversight of PHC services. They work with health programme managers in the health department and report to the chairperson of the LGA through the supervisor for health. However, under the present structure, local governments have poor administrative capacity and fiscal autonomy (FMOH, 2016c).

Non-state/private actors

The non-state/private sector is made up of the formal private health care sector, which includes private not-for-profit organizations (operated by faith-based organizations and nongovernmental organizations (NGOs)) and private for-profit organizations, and the informal sector, which includes traditional medicine providers (TMPs), patent medicine vendors, medicine stores, and complementary and alternative practitioners (FMOH, 2018b). The private sector provides an estimated 70% of the health care services in the country despite being responsible for only about 35% of the health facilities (Presidential Health Sector Reform Committee, 2023). It also plays a role in health personnel training and health insurance provision.

Private for-profit providers

The formal for-profit private sector provides predominantly primary and secondary care. In addition, it provides teaching hospitals affiliated with private medical universities and diagnostic and allied health services.

Private not-for-profit providers (faith-based providers, development partners and nongovernmental organizations)

Faith-based health organizations are important private, not-for-profit providers of health care services. Although their activities are mostly

community based and aim to reach the poorest and most vulnerable groups through engagement with local networks (Ayandele et al., 2021), they contribute significantly to various health system functions, notably service delivery. Over 400 health facilities across Nigeria are funded by Catholic organizations alone (Catholic Secretariat of Nigeria, 2020). The recent *Lancet* Nigeria Commission report recognizes the contributions of faith-based health organizations to enhancing complementary access to basic health services (Abubakar et al., 2022).

Bilateral and multilateral organizations have partnered with Nigeria in health emergency management, health care delivery and economic development. These actors influence health programme design and implementation standards and are involved in setting priorities linked to their global mandates or resource inputs. For example, the United Nations Children's Fund's mandate of protecting children allows it to shape immunization policies, programmes and related interventions. The Bill and Melinda Gates Foundation also invests directly in immunization programmes and therefore plays a significant role in immunization governance committees, with advisory and technical functions.

In addition to offering technical and financial assistance in health policy-making and implementation, bilateral agencies channel funds through the World Health Organization and other United Nations agencies to health-related projects (Anamene, 2020). In 2020, the Development Assistance Committee of the Organisation for Economic Co-operation and Development spent US$ 186.5 million on health in Nigeria (OECD, 2020).

Many national and international civil society organisations and NGOs work to fill the gaps in the health system left by absent or insufficient public sector provision; this work typically involves holding governments accountable and ensuring transparent health system governance. These organizations play a role in decision-making by initiating reform agendas in the sector. For instance, the Health Sector Reform Coalition, an indigenous NGO, led a broad range of stakeholders, including professional bodies, between 2004 and 2014 and advocated for the development and passage of the National Health Bill into law. The Health Reform Foundation of Nigeria and similar organizations at the national and state levels also sit on high-level decision-making panels that aim to strengthen the health system or improve the delivery of specific health interventions.

Informal non-state actors

These include the multiplicity of informal health providers (traditional/complementary/alternative providers and patent medicine vendors), labour unions, and other clubs and societies. They engage more visibly at the community level than at other levels and are usually for-profit organizations.

Community

Individuals and their families are the consumers of health services and play a role in planning, managing, monitoring and evaluating health interventions. More than 70% of health expenditure is accounted for by out-of-pocket expenses, paid directly by the consumers (WHO, 2023b). Communities have played leadership roles in some community-based health insurance schemes (Onwujekwe et al., 2009). In addition, some PHC facilities have been renovated by community members.

Communities are involved in health management through the ward/village/community development committee structure. The political ward is the smallest governance unit, usually comprising 10 000 to 30 000 people. Each ward is meant to have one PHC centre and at least one health post (NPHCDA, 2010). The committees in these wards comprise a chairperson, three community representatives and the officer in charge of the health facility. They provide accountability for PHC management on the front line. In addition, community members hold some decision-making powers through their participation in the National Tertiary Health Institution Standards Committee and the National Health Research Ethics Committee, as stipulated by the NHA 2014.

2.2 Governance

2.2.1 Planning

The NHP 2016 guides activities in the health system, and the strategic health development plans operationalize programmes across the federal, state and local government levels. Health plans are mostly developed independently, but the Ministry of Finance, Budget and National Planning is a hub for the development of intersectoral plans. For instance, the Federal Government of Nigeria (FGN), through its policy on nutrition, stipulates that nutrition is a

multisectoral thematic area. There is no budgetary allocation for intersectoral collaborative projects, but political commitment to adopting a Health-in-All-Policies approach is developing as understanding of this approach grows. The NHA 2014 provides the overarching legal framework for all national policies, plans and programmes (FGN, 2014).

Federal planning

National Health Act

The NHA 2014 provides a framework for establishing, regulating and managing the national health system. It sets out the standards for providing health services and related matters in the country (FGN, 2014). It was passed in 2014 to support the realization of universal health coverage (UHC). The details of the NHA regulatory provisions are outlined in Section 2.2.2.

National Health Policy

The first comprehensive health policy was launched in 1988 and subsequently revised in 2004 and 2016. These policies were developed to capture global mandates and development goals and adapt them to national priorities. The current policy, the NHP 2016, aims to address the unfinished agenda of the Millennium Development Goals, aspirations of the Sustainable Development Goals (SDGs) and other emerging health issues, especially epidemics and climate change. It also reassesses the national targets set out in the NHA 2014. The NHP 2016 envisages UHC for all Nigerians and lays out a foundation for stakeholders in health to achieve the SDGs. It provides objectives for 10 policy areas, namely the following: governance; health service delivery; health financing; human resources for health (HRH); medicines, vaccines, commodities and health technologies; health infrastructure; health information systems; health research and development; community ownership; and partnerships for health (FMOH, 2016c). The details of these objectives, organized by health system function, are described in Chapters 3–8.

National health policies are developed by a consensus of stakeholders from the FMOH and its DAPs, and by representatives from the private sector, academia, NGOs, development partners and regulatory bodies. These actors form a technical working group that reviews the success of previous NHP implementation and proposes new themes and objectives.

National Strategic Health Development Plan

The National Strategic Health Development Plan (NSHDP) is the overarching implementation plan guiding the health system, developed based on the National Health Policy. Nigeria has had two NSHDPs, namely NSHDP I (originally covering 2010–2015) and NSHDP II (originally covering 2018–2022). The implementation period of the first was extended to 2017, and the second expired in 2022. A successor plan (NHSDP III) is in the process of being developed ; in the meantime, the NHA 2014 provides guidance. NSHDP II was anchored in the NHP 2016. Its key purpose was to address long-standing and emerging health sector challenges and build on the progress made through implementation of NSHDP I towards achieving UHC. Programme-specific plans and plans related to the health system's building blocks have also been developed using these NSHDPs. For example, Table 2.2.1 summarizes the specific plans for malaria, HIV/AIDS, tuberculosis (TB) and maternal, neonatal and child health (MNCH), highlighting their linkages to global targets and goals.

NSHDPs are developed through an inclusive and participatory process involving both government and nongovernment stakeholders. The FMOH statutorily leads the development of an NSHDP every five years. Planning starts by developing a framework following validation by all stakeholders; this framework guides states, the FCT and actors at the federal level in the production of their plans. These plans, which are costed, are then aggregated into the NSHDP and validated by stakeholders (FMOH, 2018b).

State planning

The SMoHs are mandated to provide advisory and oversight roles to the government in policy formulation, regulation and implementation in relation to health matters by adapting the NHP to their contexts (state health policies). They develop long- and medium-term sector strategies and short-term annual operating plans (AOPs) for the state. They also develop plans for the training of nurses and PHC workers.

State strategic health development plans (SSHDPs) are developed by the SMoHs, with support from the FMOH, development partners and community members, in a participatory process and in line with the overarching national plan. The development of a monitoring and evaluation framework for each state follows the national framework.

Local government planning

Local government areas are guided by the state's interpretation and implementation of the NHP. They develop AOPs in the last quarter of the year, collating work plans from local government area health programme managers. The costed plans are compiled by the local government area PHC director and approved by the health supervisor and the local government area chairperson. The AOPs are part of the NSHDP and each SSHDP.

Implementation of programme-specific national plans

Programme-specific national plans and policies are shown in Table 2.2.1. The extent of implementation of strategies in key areas is discussed below.

HIV/AIDS

The HIV/AIDS programme has two policy documents that are in line with the recommendations of NSHDP II for the integration of HIV care into an essential package of health care services (FMOH, 2018b), the SDGs and the 90–90–90 targets (Table 2.2.1). The Nigeria HIV/AIDS Indicator and Impact Survey conducted in 2018 showed a 40% reduction in HIV prevalence from the 2017 level; however, the country was not on track to achieve the 90–90–90 targets by the end of 2020 (Adebowale-Tambe, 2020). The National Health Accounts 2022 show that total government expenditure on HIV/AIDS amounted to 94.6 billion Nigerian naira (US$ 211 million) in 2022 (WHO, 2023b).

Malaria

The National Malaria Programme has had several strategic plans: 2001–2005, 2006–2010, 2010–2013 and 2014–2020 (FMOH, 2020f). The most recent plan represented a transition from a control programme to an elimination programme, which was facilitated by increased government expenditure as stipulated in the 2010–2013 plan (FMOH, 2014b). The 2014–2020 plan aimed to eliminate malaria-related deaths in Nigeria and focused on integrated vector and malaria case management (FMOH, 2020f). A steady decrease in the number of malaria cases from 2010 to 2018 shows that this national programme was effectively implemented (FMOH, 2020f).

Table 2.2.1 Programme- or system-specific health strategies and linkages to national health plans and policies

Specific health programmes or strategies	Key policy	National target	SDG/global target
HIV/AIDS	National HIV and AIDS Strategic Plan 2017–2021 (FMOH, 2017d)	Fast-track national response towards ending HIV/AIDS in Nigeria by 2030	**SDG 3.3:** to end the epidemics of HIV/AIDS, TB, malaria and neglected tropical diseases by 2030, and to continue combating hepatitis, waterborne diseases and other communicable diseases (UN, 2015a) **UN 90–90–90 agenda:** this required that 90% of all people living with HIV would know their HIV status, 90% of all people with diagnosed HIV infection would be receiving sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy would have viral suppression by 2020 (UNAIDS, 2017)
Malaria	National Malaria Strategic Plan 2021–2025 (FMOH, 2020f)	Reduce mortality attributable to malaria to fewer than 50 deaths per 1000 live births Extend UHC from 5% to 25% by 2025 and ensure all routine and campaign data are added to the National Malaria Data Repository	**SDG 3.3:** to end the epidemics of HIV/AIDS, TB, malaria and neglected tropical diseases by 2030, and to continue combating hepatitis, waterborne diseases and other infectious diseases
TB	National Strategic Plan for Tuberculosis Control 2021–2025 (FMOH, 2021g)	Accelerate efforts at ending the TB epidemic in Nigeria by ensuring access to comprehensive, high-quality, patient-centred and community-owned TB services for all Nigerians	**SDG 3.3:** to end the epidemics of HIV/AIDS, TB, malaria and neglected tropical diseases by 2030, and to continue combating hepatitis, waterborne diseases and other infectious diseases

Table 2.2.1 Continued

Specific health programmes or strategies	Key policy	National target	SDG/global target
MNCH	RMNCAH+N Strategy (2021) (FMOH, 2021) Nigeria Every Newborn Action Plan (FMOH, 2018a)	End preventable neonatal deaths and stillbirths by 2030	**SDG 3.1:** to reduce the global maternal mortality rate to less than 70 per 100 000 live births by 2030 **SDG 3.2:** to end the preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least 12 per 1000 live births and under-five mortality to at least 25 per 1000 live births by 2030
HRH	National Human Resources for Health Strategic Plan 2021–2025 (FMOH, 2020e)	To address the most critical health workforce challenges, across multiple intervention areas and through five strategic objectives	**SDG 3.1:** to substantially increase health financing and recruitment and retention, together with the number of development and training programmes, for the health workforce in developing countries, especially in the least-developed countries and in small island developing states

Note: IRMNCAH+N = integrated reproductive, maternal, neonatal, child and adolescent health plus nutrition; UN = United Nations.

Tuberculosis

The National Tuberculosis, Leprosy and Buruli Ulcer Control Programme of the FMOH produced three strategic plans from 2013 to 2021. This control programme aims to achieve a 50% reduction in the TB prevalence rate and a 75% reduction in TB mortality (excluding HIV-related TB mortality) in Nigeria compared with 2013 levels by 2025 (FMOH, 2015a). In addition, the National Tuberculosis Strategic Plan 2015–2020 aimed to "ensure universal access to high-quality patient-centred TB prevention, diagnosis and treatment services for Nigerians with all forms of TB, regardless of geographic location, income, gender, age, religion, tribe or other affiliation" (FMOH, 2015a). However, the target of the most recent TB strategic plan (2021–2025), providing TB patients with preventive therapy, has not been met (FMOH, 2021g).

Maternal and child health

The Integrated Maternal, Neonatal and Child Health Strategy was launched in 2007. Since then, for each programmatic area in the integrated reproductive, maternal, newborn, child and adolescent health plus nutrition (IRMNCAH+N) spectrum, thematic working groups have been established (FMOH, 2017e). The NHP 2016 and NSHDP II emphasize the importance of reducing maternal and child mortality (FMOH, 2018b). Moreover, the IRMNCAH+N investment case (2017–2030) targets poor and rural populations, considering that they are most affected by maternal and child mortality. It prioritizes providing free MNCH services with strategic purchasing (FMOH, 2017e). Notably, the services are outlined in the NHA 2014 as the Basic Minimum Package of Health Services (FGN, 2014). The IRMNCAH+N Strategy (2018) stipulates that high-impact interventions should be implemented to improve MNCH outcomes, reduce associated costs and reduce maternal mortality (FMOH, 2018a). There has been continued political commitment to MNCH programmes at all levels of governance. Remarkable strides have been made in eradicating polio, but utilization of skilled birth attendants is still suboptimal due to the inadequate supply and inequitable distribution of health care workers, who are concentrated mainly in the south, and to health-seeking patterns. There is still a high prevalence of home deliveries in northern Nigeria (NPC and ICF Macro, 2019).

Human resources for health

Nigeria's focus on HRH is outlined in its National Human Resources for Health Policy (2020) and National Human Resources for Health Strategic Plan 2021–2025 (FMOH, 2020d,e). Implementing HRH policy objectives has been slow, and the health workforce continues to be poorly distributed. Although the policy stipulates collaboration among nongovernment stakeholders, there is little evidence of an intersectoral approach to HRH issues.

2.2.2 Legal and regulatory processes

The overall legal framework for the health system is detailed in the NHA 2014, which also contains an overarching regulatory framework (FGN, 2014). The NHA 2014 defines the organization of the health care system, the service providers

and the relationship between the various tiers. It outlines the framework for the standardization and regulation of health services. It describes the regulations related to responsibility for the following: health, health establishments and technologies; rights and obligations of users and health care personnel; national health research and information systems; HRH; and control of the use of blood, blood products, tissue and gametes in humans (FGN, 2014). The NHA is also notable for its focus on public health priorities.

Federal health acts and regulations

Health laws in Nigeria also include acts establishing the DAPs of the FMOH. The FGN ratifies these acts and describes the legal functions of each DAP. The NHA 2014 confers the right to maintain standards of practice on several professional regulatory bodies. These regulatory bodies are established by acts detailing their functions and legal status. A comprehensive list of regulatory bodies is available on the FMOH&SW website. Representatives of health professional regulatory bodies also serve as members of the technical committee of the NCH, which has an advisory role.

State health laws

States adapt the NHA 2014 to their context for the development of state health laws, which describe the roles of the stakeholders in health in each state. States also have acts establishing the agencies and parastatals of the SMoH. Public health laws are enacted by states for the protection and preservation of the health of the population. They detail the description of a medical officer or environmental health officer and other key aspects of public health, including infectious diseases, vaccination, water, streets and open space trading; the laws differ across states.

Law-making process

As with any law in Nigeria, health laws originate from the executive or the legislature and are presented as bills to the legislature. Bills pass through two readings and are then referred to the relevant committee for deliberation, which may include a public hearing. Thereafter, they are returned to the House of Representatives for a third reading. Following a successful third reading, bills are sent to the Senate for concurrence and transmitted to the President for

assent. The law is then gazetted on assent by the President. A law may still be passed with a presidential veto if a two-thirds majority of the two chambers agrees. At the state level, the process is as above, except that only one state house of assembly can approve a bill and send it to the governor for assent before it becomes a law.

The actors involved in law-making are the legislature, the public and stakeholders in health, who contribute to drafting the proposed bill and to the public reading. At the federal level, these actors include the FMOH, professional/regulatory bodies and development partners. These actors influence laws and regulations by introducing international best practices, with the FMOH and the legislature acting as stewards in implementing different regulations. The stewards' use of informal norms and values is useful in programme design but does not influence legal processes. At the state level, the actors mirror those at the federal level, except that the SMoH, instead of the FMOH, acts as the steward. This arrangement leads to political tensions, especially in policy processes, where subnational policy implementation can depart from the original intent of federal-level policy (Eboreime et al., 2017).

2.3 Stakeholder engagement and partnerships

Stakeholders and their roles are outlined in Section 2.1.1. Stakeholder engagement enables agenda-setting, policy-making, policy adoption, policy implementation, evaluation of health policies and the provision of feedback.

Stakeholder engagement and coordination mechanisms

Public/state health sector engagement is primarily intra-sectoral, occurring among the various units and departments in the FMOH, and coordinated by thematic technical groups and task teams at the federal and state levels. Cross-sectoral engagement and collaboration range from minimal to robust, depending on the committee. For example, the One Health intersectoral committee provides a platform for robust engagement on One Health issues, although this is currently minimal (FMOH, 2023c). Cross-sectoral engagement is more robust during health crises, as seen during the COVID-19 pandemic (FGN, 2020).

National Council on Health

The NCH provides an umbrella health stakeholder engagement platform that meets annually or can be convened by the Minister of Health to address urgent issues. Meetings involve all national and subnational health stakeholders, including professional groups, the private sector and development partners. Engagement activities can be issue based or programme specific. A technical committee chaired by the Permanent Secretary advises the NCH on its functions and any other matters that the council may refer to it. A key challenge with the NCH is that state governors, who retain executive powers at the subnational level, have not historically engaged with NCH meetings; rather, they are represented by the commissioners for health. However, what the commissioners commit to at the meetings, through memoranda of understanding or other means, is not automatically accepted by the absent governors (Eboreime et al., 2017).

State councils on health

In addition to biannual meetings, state actors are encouraged to hold SCH meetings in their various states, specifically to engage the following actors on state-specific issues: state actors, LGA stakeholders, non-state sector actors, community groups and community-based organizations and their development partners. Several states across Nigeria have adopted the practice of holding SCH meetings, as provided for in the NHA. However, the frequency of meetings varies across states, probably because they are held at the behest of the executive governors, who may have divergent priorities.

Other coordination mechanisms

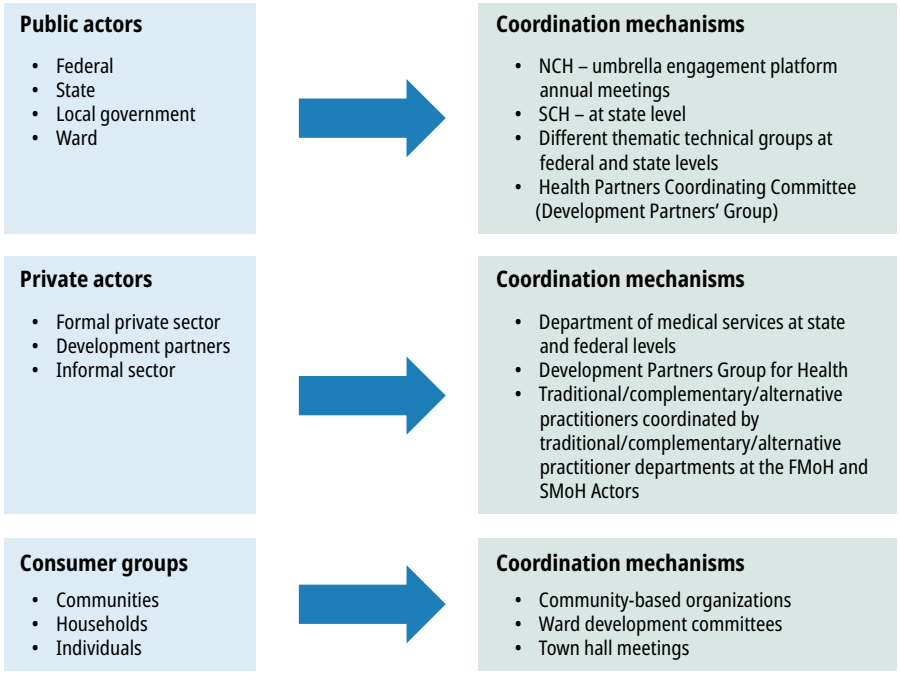
At the federal and state levels, the Development Partners Group for Health, as defined by NSHDP II, is a single engagement point for joint funding agreements, sector-wide approaches (SWAps) and health sector multidonor budget support (FMOH, 2023c). At the federal level, this group operates through smaller technical working groups, known as interagency coordinating committees, which focus on specific programmes. The Health Partners Coordinating Committee coordinates development partnerships at the state and LGA levels (FMOH, 2018b). At these levels, the platforms are geared towards coordinating the activities of the development partners in line with government plans. These

coordination platforms, however, are less efficient than those at the federal level and have overlapping functions.

Community engagement

In the ward health system, a ward development committee (WDC) is responsible for organizing, managing and assessing implementation of health policies and plans at the PHC level. However, the Nigeria Health Sector Renewal Investment Programme (2023) envisages greater involvement of communities in health through the creation of a community health care system. During the COVID-19 pandemic, community leaders were engaged and identified women as critical stakeholders and intermediaries in the deployment of vaccines, given their familiarity with infant immunization (FGN et al., 2021). However, there are no data on whether or not these structures have been sustained post COVID-19. Further details on community-led action on health are discussed in Chapter 7.

Figure 2.3.a Health actors and coordination mechanisms involved in improving public health



Partnerships for health

The Nigerian health sector identifies partnerships for health as a health system building block in recognition of the pluralism of the sector and the need for strategic partnerships. It describes a partnership as a "collaborative relationship based on mutual understanding for the achievement of common goals" (NPHCDA, 2022). The NHP 2016 and NSHDP II recognize that partnerships among the private sector, NGOs, communities, development partners and other social and economic institutions are essential for the comprehensive delivery of the sustainable health services needed to meet the population's needs (Fig. 2.3.a). This section describes the two models of partnerships in health, namely public–private partnerships (PPPs) and private sector-led initiatives.

Public–private partnerships

A national policy on PPPs for health in Nigeria was developed in 2005, within the broader framework of national health sector reform (2003–2007), as part of efforts to attain the Millennium Development Goals and the NHP targets (FMOH, 2005b). It defines PPPs for health in Nigeria as "a collaborative relationship between the public and private sectors aimed at harnessing and optimizing the use of all available resources, knowledge, and facilities required to promote efficient, effective, affordable, accessible, equitable and sustainable health care for all people in Nigeria" (FMOH, 2005b). Subsequently, Nigeria became a signatory to the Global Compact of the International Health Partnerships and Related Initiatives in 2008 and joined a complementary country compact with development partners in 2010 (FMOH, 2018b; NPHCDA, 2022).

The national policy on PPPs outlines two types of PPP: contractual and alternative partnerships (Table 2.3.a).

The private/non-state sector's engagement in partnerships does not involve a complete transfer of public assets to private/non-state owners; rather, private resources are leveraged to improve public health. Engagement methods include contracting or outsourcing, leasing, providing concessions, social marketing, franchising mechanisms and providing incentives such as health commodities or free technical support (FMOH, 2010).

Table 2.3.a Types of partnerships set out in the national policy on PPPs

	Alternative partnerships	
Contractual partnerships	**Public/state-driven partnerships**	**Private/non-state-driven partnerships**
• Private/non-state (for-profit and not-for-profit) organization performs functions on behalf of the government • May be employed by all tiers of government • Responsibilities of public/state and private/non-state bodies explicitly negotiated at the onset • Agreement documented in a contract or memorandum of understanding	• Initiated by the public/state sector • Public/state sector owns more than 50% of shares and retains decision-making power	• Initiated by the private/non-state sector (for-profit and not-for-profit organizations) • The private/non-state sector owns more than 50% of shares and retains decision-making power • Profit orientation may or may not be a primary goal • Public/state sector acts as a monitoring and standard-setting body

Private/non-state sector-led initiatives

There have been some health initiatives that draw on health and infrastructure donations, developed primarily by the private/non-state sector. The private sector includes the banking sector, businesses, faith-based organizations and community leaders. The initiatives are usually not for profit and involve the government, which plays a supervisory role.

Since the inception of the PPP policy, the FMOH has facilitated several PPPs across the country (FMOH, 2018b). The involvement of the private sector in COVID-19 testing very quickly led to the ramping up of daily testing rates (Nachega et al., 2021; Kabwama et al., 2022). However, inadequate coordination and regulation of the private sector remains a persistent challenge (FMOH, 2018b). NSHDP II (2018–2022) sets out strategic objectives and activities aimed at strengthening PPPs, but their effectiveness has not yet been evaluated.

2.4 Accountability measures

Accountability measures are in place to ensure that responsibilities for carrying out activities are clearly defined in line with health sector plans. Accountability measures for actors in the private/non-state sector are less well defined and implemented than those for actors in the state/public sector.

Federal level

The FMOH conducts periodic reviews of all policies and programme guidelines to assess the country's progress towards achieving its health objectives (FMOH, 2016c). To ensure financial accountability, a tracking and verification system is used (Table 2.4.a) (Uzochukwu et al., 2018). The costs associated with all activities are carefully documented, and funds and expenditure are reconciled against budgetary allocations. The DAPs of the FMOH and SMoHs produce data from administrative and programmatic reports, facility assessments, population-based surveys and joint annual reviews (FMOH, 2018b). The data associated with these activities are presented in biannual and annual reports, briefs, factsheets and mid-term and end-term reports for key audiences, including the NCH (to ensure technical accountability for implementation), the Senate and House Committees on Health and State houses of Assembly committees on Health (to ensure political accountability), non-state actors, community leaders (to ensure social accountability) and PPPs (FMOH, 2018b). In these forums, feedback is received and then reflected in the next planning cycle (FMOH, 2016c). Non-state actors are demanding more social and political accountability, considering existing limitations. The coordination and regulation mechanisms for the non-state/private sector, however, remain inadequate (FMOH, 2018b).

State level

At the state level, SPHCDA/Bs supervise PHC centres as part of external accountability mechanisms. This supervision involves monitoring the quality of care and HRH training that PHC centres provide, assessing PHC centres' organization of public health programmes, performing periodic audits and monitoring PHC centres' use of public funds and community engagement levels (Uzochukwu et al., 2018; NPHCDA, 2022). Secondary health facilities are overseen

by state hospital boards, which hire staff and can impose sanctions and give rewards. The SMoH conducts health facility assessments and carries out the supportive supervision of primary facilities, supporting staff to continuously improve their practice (FMOH, 2016c).

Local government level

Local government authorities develop AOPs based on national strategic development plans and SSHDPs (FMOH, 2016c). They also conduct periodic reviews and prepare reports. Integrated supportive supervision is carried out quarterly by state and national authorities (NPHCDA, 2022). In addition, local government funds are managed by experienced treasurers and auditors, finance officers and a general memorandum committee (Uzochukwu et al., 2018).

Primary health care (ward) level

Health care providers are held accountable by each primary health facility's WDC (NPHCDA, 2010). To facilitate this process, health committee members (a subcommittee of the WDC) meet with the facility officer in charge to address financial management, maintenance and community mobilization. However, there is some evidence that these committees tend to focus on government priorities instead of highlighting the community's priorities (Abimbola et al., 2022). The facility heads also report to the LGHAs. For communities that receive support from the Basic Health Care Provision Fund (BHCPF), business plans are drawn up quarterly and vetted by local and state health authorities (FMOH et al., 2018).

Accountability measures for development partners

At the federal level, the Ministry of Finance, Budget and National Planning has consultatively developed a country framework agreement for development partners. It also conducts joint reviews to monitor and evaluate programmes alongside the relevant ministries. However, this country framework agreement is not consistently implemented by all partners.

Table 2.4.a Accountability roles in the Nigerian health system

Accountability mechanisms	Federal	State	Local government	Health facility	Community	Non-state
Planning	• Defining implementation guidelines and role specifications	• Defining implementation guidelines and role specifications	• Defining implementation guidelines and role specification	• Defining implementation guidelines and role specification	• Presenting interests and mandates to WDC before policy formulation	• No explicit mechanisms in place
Monitoring and supervision	• Oversight role • External auditors monitor implementation • Results linked to revenue dispersal process • Also involved in supportive supervision	• Oversight role • External auditors monitor implementation • Supportive supervision • Results linked to revenue dispersal process	• Oversight role • External auditors monitor implementation • Supportive supervision • Results linked to revenue dispersal process	• Oversight role • External auditors monitor implementation • Monitoring by WDCs	• Monitoring the release of funds, their allocation and the implementation of associated activities • Participating in WDCs • Regulatory bodies supervise the standards of practice of members	• No explicit mechanisms in place
Reporting	• Online financial reporting	• Online financial reporting • Qualified financial managers carry out the separation of accounts	• Qualified financial managers carry out the separation of accounts	• Financial record-keeping • Providing online payment system for health services	• Publishing project reports	• No explicit mechanisms in place

Systems set up for health system performance

Health system performance is monitored by the FMOH through joint annual reviews (FGN, 2014). Statutorily, national and state strategic plans contain monitoring and evaluation frameworks that track progress towards achieving national health targets, usually in tandem with tracking progress towards achieving global targets. Implementation of available policies and guidelines remains suboptimal, and there is still little involvement of the private sector in health planning and service delivery processes, where its input on strategic interventions to improve access to high-quality health care is required (FMOH, 2023b).

2.5 Recent reforms

The key health system organization and governance reforms developed in the last decade are summarized below. An overarching national plan intends to accelerate these reforms and close gaps, to achieve the health-related SDGs and UHC (FGN, 2021a).

Primary Health Care Under One Roof (2013)

This reform aims to partially recentralize governance, to address the poor management capacity of local government authorities by integrating PHC structures and programmes into a single state-level body, the SPHCDA/B, using the "one management, one plan, and one monitoring and evaluation system" principle (NPHCDA, 2010). The initial concept was endorsed as a national policy agenda in 2011, and implementation guidelines were developed in 2013. As a result, each state was required to institute its own agency or board. The PHCUOR reform has nine domains (NPHCDA, 2015).

A scorecard-based evaluation of these domains in 2015 showed wide regional variation in implementation, with the lowest score (19%) observed in the south-eastern zone and the highest score (55%) observed in the north-western zone (NPHCDA, 2015). A subsequent assessment in 2018 showed that performance scores had increased to 50% and 57%, respectively, in these zones. The details of these assessments are outlined in the 2018 scorecard assessment report (NPHCDA, 2018). The implementation of this reform is ongoing, and

stakeholders are optimistic that the next, long overdue, assessment will show continuing improvement.

Basic Health Care Provision Fund of the National Health Act (2014)

The BHCPF is a PHC-financing reform, predominantly financed through an annual grant from the FGN, of not less than 1% of the Consolidated Revenue Fund. Approximately 25% of BHCPF funding comes from state and local government grants from international donors, and funds generated from innovative sources such as tax levies on specific activities or goods, such as tobacco or alcohol, deemed harmful to individuals or society. These funds are expected to ensure that good-quality PHC is affordable, accessible to all and thus equitable (Uzochukwu et al., 2018). Details of this reform and its implementation are provided in Chapter 3.

National Health Insurance Authority Act (2022)

This act replaces the National Health Insurance Scheme Act 2004 and its predecessor the NHIS Act 1999 (see Chapter 3, Section 3.1). The new act aims to establish the National Health Insurance Authority (NHIA) (overseen by a governing council), implement a state health insurance and contributory scheme for all citizens, ensure that the BHCPF is administered in every state and set aside a vulnerable group fund to cater for the health care needs of vulnerable populations. States are required to register all residents in a mandatory social health insurance scheme (KPMG, 2022). The new NHIA Act empowers the NHIA to regulate and provide (or manage) prepayment insurance schemes, which presents a conflict of interest. Implementation of NHIA guidelines, released on 10 October 2023, has yet to be assessed. This issue is further discussed in Chapter 3.

Health Sector Reform Committee (2021)

This committee was established in 2021 and concluded and published its report in May 2023, in which it made six recommendations for health system

governance and leadership as requisites for the country's progress towards UHC (Presidential Health Sector Reform Committee, 2023). Its recommendations, however, have yet to be fully implemented.

The federal government has initiated an ambitious reform agenda and the necessary regulation and structures to facilitate meaningful health system strengthening are largely in place. For many of the reforms, it is too early to evaluate their effectiveness, but signs suggest that implementation challenges are widespread. The complexity of the health sector, the fledgling operation of the devolved federal system, party political influence between governance tiers and weak enforcement of law and regulations contribute to these implementation challenges. In addition, many of the policies and strategic plans, including the overarching NHP, need to be revised and updated to align with current health system trends.

Government of Nigeria strategic vision for the health sector (2023–2026)

The FGN has set out a strategic blueprint for the health sector with the goals of saving lives, reducing physical and financial pain and delivering health to all Nigerians. The strategic vision is anchored in four core pillars: effective governance; efficient, equitable and high-quality health systems; unlocking value chains; and health security. The blueprint also identifies cross-cutting enablers that will facilitate the achievement of strategic objectives: data and digitization, financing, and culture and talent within ministries, departments and agencies.

Sector-wide approach

The adoption of a SWAp to deliver these reforms was approved by the NCH in November 2023 and further endorsed by the President. The SWAp will leverage the redesigned BHCPF as its foundational basis and aims to build a more unified, effective and sustainable health sector. To ensure the successful implementation of the SWAp, health sector players (states and development partners) signed an agreement in 2023, committing to fiduciary responsibility, transparency and delivery of impact against targets. This approach translates into one plan, one budget, one report and one conversation for the health sector:

- **One plan** ensures a common understanding of cross-cutting priorities that will dovetail into the development of an AOP for implementation across all states.
- **One budget** ensures the visibility of sources and flow of funds against plans; agreement on pooled fund options and how funds relate to performance; strengthened accountability systems (e.g. performance-linked funding) such as disbursement-linked indicators; and agreement on pooled technical assistance and funding.
- **One report** ensures agreement on indicators to track progress on priorities and joint annual reviews.
- **Coordinated** missions and site visits will be carried out by development partners and the capacity and responsiveness of monitoring, evaluation, research and learning systems will be strengthened.
- **One conversation** establishes forums for routine sector-wide dialogue (e.g. quarterly performance dialogues) and sets up technical working groups to facilitate subsectoral strategic dialogue, coordination of inputs and prioritization of needs.

Nigeria Health Sector Renewal Investment Programme

The new single plan for the health sector, known as the Nigeria Health Sector Renewal Investment Programme, was proposed by the new Minister of Health and approved by the NCH as part of the SWAp in November 2023. Its main objectives relate to:

- financing and organizing services, namely decentralizing facility financing, operationalizing a vulnerable group fund, strengthening community-based health services, improving the quality of care and harmonizing technical assistance support for the BHCPF initiative;
- mobilizing systems for improved outcomes, namely by improving commodity security, implementing a national emergency medical service and ambulance scheme, and increasing the use of digital technologies in the health sector;
- health security;
- governance, financing and accountability, namely by defragmenting sector financing for improved efficiency, establishing federal–state

partnerships for improved ownership and accountability, and improving citizen engagement and social accountability.

Implementation of these policies is still in progress, making it too soon to evaluate their effectiveness.

Chapter summary

Chapter 2 provides an overview of how the Nigerian health system is organized, governed, planned and regulated. Nigeria has a three-tier health system organized across federal, state and local levels, with each level having substantial autonomy in principle, although less so in practice, over the allocation and utilization of resources. The federal level is primarily responsible for tertiary health services through a network of teaching and specialist hospitals, although several states also own tertiary health care facilities. The FMOH, through its DAPs, supervises national programmes and provides technical support to states. State governments control secondary health care facilities through SMoHs and health management boards. The SPHCDA/Bs and LGHAs supervise PHC delivery at the local or ward level, guided by the PHCUOR (2013) policy.

In line with partnerships for health being a crucial building block of the Nigerian health system, harnessing health resources holistically through partnerships is a key focus of stakeholder engagement efforts. However, the monitoring and accountability mechanisms for partnership activities remain ineffective.

An ongoing programme of health sector reform initiated by the FMOH has ensured that policies, guidelines and implementation plans are in place to guide health service delivery, most recently via the 2023 Nigeria Health Sector Renewal Investment Programme. State and non-state actors develop and implement these guidelines, frameworks and plans in line with their common interests and defined coordination platforms and mechanisms. However, implementation challenges are widespread across policies, exacerbated by the complexity of the health sector and its federal operating system and weak accountability and law enforcement at all governance levels.

References

Abimbola, S., Drabarek, D. & Molemodile, S. K. (2022). Self-reliance or social accountability? The raison d'être of community health committees in Nigeria. *International Journal of Health Planning and Management*, 37, 1722–1735.

Abubakar, I., et al. (2022). The Lancet Nigeria Commission: investing in health and the future of the nation. *The Lancet*, 399, 1155–1200.

Adebowale-Tambe, N. (2020). World AIDS Day: why Nigeria missed 2020 HIV/AIDS target. *Premium Times*, 1 December.

Anamene, B. U. (2020). External actors, good governance and health care delivery in Africa. *Austral: Brazilian Journal of Strategy & International Relations*, 9, 267–288.

Aregbeshola, B. S. (2021). Towards health system strengthening: a review of the Nigerian health system from 1960 to 2019. *SSRN*, 1–42.

ASMoH & FHI 360 (2013). *Anambra state-wide rapid health facility assessment*. Anambra State Ministry of Health and FHI 360, Nigeria.

Ayandele, O., Okafor, C. T. & Oyedele, O. (2021). *The role of Nigeria's faith-based organisations in tackling health crises like COVID-19.* Africa Portal. Available online: https://www.africaportal.org/features/role-nigerias-faith-based-organisations-tackling-health-crises-covid-19/ (accessed 15 November 2022).

Catholic Secretariat of Nigeria (2020). Directory of Catholic Health Facilities in Nigeria. (unpublished)

Eboreime, E. A., et al. (2017). Evaluating the sub-national fidelity of national initiatives in decentralized health systems: integrated primary health care governance in Nigeria. *BMC Health Services Research*, 17, 227.

ESMoH (2018). *Ebonyi State Strategic Health Development Plan (2018–2022)*. Ministry of Health, A. Abakaliki.

Etiaba, E. (2021). *Sub-national implementation of national health policy: a case study analysis of the Integrated Maternal, Neonatal and Child Health Strategy in Nigeria* [thesis]. University of the Western Cape, Cape Town, South Africa.

FGN (1999). Constitution of the Federal Republic of Nigeria 1999. Federal Government of Nigeria, Abuja, Nigeria.

FGN (2014). National Health Act. Act No. 8 of 2014. Federal Government of Nigeria, Lagos, Nigeria.

FGN (2020). *National COVID-19 Pandemic Multisectoral Response Plan*, 1st ed. Federal Government of Nigeria, Abuja, Nigeria.

FGN (2021). *National Development Plan 2021–2025*. Federal Ministry of Finance, Budget and National Planning, Abuja, Nigeria.

FGN, FMOH & NCDC (2021). *Updated Stakeholders' Engagement Plan Nigeria; COVID-19 Preparedness and Response Project (P173980); and Nigeria COVID-19 Preparedness and Response Project Additional Financing With Restructuring (P177076)*. Federal Government of Nigeria, Federal Ministry of Health & Nigeria Centre for Disease Control, Abuja, Nigeria.

FMOH (2005). *National Policy on Public Private Partnership for Health in Nigeria*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2010). *The National Strategic Health Development Plan 2010–2015*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2014). *National Malaria Strategic Plan 2014–2020*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2015). *National Strategic Plan for Tuberculosis Control 2015–2020*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2016). *National Health Policy*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2017a). *National HIV and AIDS Strategic Plan 2017–2021*. Federal Ministry of Health. Available online: https://naca.gov.ng/wp-content/uploads/2018/05/National-HIV-and-AIDS-Strategic-Plan-FINAL1.pdf (accessed 1 July 2022).

FMOH (2017b). *Reproductive, maternal, newborn, child and adolescent health and nutrition 2017–2030*. Investment Case. Federal Ministry of Health. Available online: https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Nigeria-Investment-Case.pdf (accessed 30 June 2022).

FMOH (2018a). *Second National Strategic Health Development Plan 2018–2022*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2018b). *Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition Strategy for Nigeria: 2018–2022*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2020a). *National Malaria Strategic Plan 2021–2025*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2020b). *National Human Resources for Health Strategic Plan 2021–2025*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2020c). *National Human Resources for Health Policy*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2021). *National Strategic Plan for Tuberculosis Control*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2023a). *Nigeria health system assessment*. Federal Ministry of Health, Abuja, Nigeria.

FMOH (2023b). *Second Nigeria Strategic Health Development Plan Review – Revised Situational Analysis*. Federal Ministry of Health, Abuja, Nigeria.

FMOH, NHIS & NPHCDA (2018). *Basic Healthcare Provision Fund operations manual*. Federal Ministry of Health, National Health Insurance Scheme and National Primary Health Care Development Agency, Abuja, Nigeria.

Kabwama, S. N., et al. (2022). Private sector engagement in the COVID-19 response: experiences and lessons from the Democratic Republic of Congo, Nigeria, Senegal and Uganda. *Globalization and Health*, 18, 60.

KPMG (2022). *Commentaries on the National Health Insurance Authority Act, 2021*. Available online: https://assets.kpmg/content/dam/kpmg/ng/pdf/commentaries-on-the-national-health-insurance.pdf (accessed 10 August 2022).

Nachega, J. B., et al. (2021). Contact tracing and the COVID-19 response in Africa: best practices, key challenges, and lessons learned from Nigeria, Rwanda, South Africa, and Uganda. *American Journal of Tropical Medicine and Hygiene*, 104, 1179.

NPC & ICF Macro (2019). *Nigeria Demographic and Health Survey 2018*. National Population Commission and ICF Macro International.

NPHCDA (2010). *Minimum standards for primary health care in Nigeria*. National Primary Health Care Development Agency.

NPHCDA (2015). *Primary Health Care Under One Roof implementation scorecard III report*. National Primary Health Care Development Agency.

NPHCDA (2018). *Implementation status of Primary Health Care Under One Roof (PHCUOR): scorecard 4*. National Primary Health Care Development Agency.

NPHCDA (2022). *Standards and regulatory framework for primary health care practice in Nigeria*. National Primary Health Care Development Agency. Available online: https://nphcda.gov.ng/resources/ (accessed 14 November 2024).

NPHCDA & WHO (2007). *Ward minimum health care package in Nigeria, 2007–2012*. National Primary Health Care Development Agency & World Health Organization.

OECD (2020). Creditor Reporting System. Organisation for Economic Co-operation and Development. Available online: https://stats.oecd.org/index.aspx?DataSetCode=CRS1# (accessed 11 November 2022).

Onwujekwe, O., et al. (2009). Is community-based health insurance an equitable strategy for paying for healthcare? Experiences from southeast Nigeria. *Health Policy*, 92, 96–102.

Ozohu-Suleiman, A. & Chima, P. (2015). Local government administration in Nigeria: the search for relevance. *Commonwealth Journal of Local Governance*, 18, 185–195.

Presidential Health Sector Reform Committee (2023). *Presidential Health Sector Reform Committee Report*. Federal Government of Nigeria, Abuja, Nigeria.

UN (2015). *The Millennium Development Goals report 2015*. United Nations, New York.

UNAIDS (2017). *90–90–90 – An ambitious treatment target to help end the AIDS epidemic.* Available online: https://www.unaids.org/en/resources/documents/2017/90-90-90 (accessed 6 November 2024).

Uzochukwu, B., et al. (2018). Accountability mechanisms for implementing a health financing option: the case of the basic health care provision fund (BHCPF) in Nigeria. *International Journal for Equity in Health*, 17, 1–16.

WHO (2023). National Health Accounts 2022 – country notes. World Health Organization. Available online: https://www.who.int/countries/#N (accessed 15 November 2024).