From Aid Dependence to Fiscal Sovereignty

Nigeria's Country-Owned Response to Declining Development Assistance for Health and Lessons for Health System Resilience in the Post-Aid Era

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GENEVA HEALTH FORUM 2026
10–12 November 2026
Campus Biotech, Geneva

Introduction & Objectives

Development assistance for health (DAH) to Nigeria fell sharply after 2025: the US funding freeze, an ~11% mid-cycle cut to Global Fund Grant Cycle 7 (2024–2026), a Global Fund GC8 allocation of US$792m for 2027–2029 (15% below GC7), and Gavi co-financing rising from US$8m to US$57m.

Objectives: to describe how Nigeria (220m+ people; 36 states + FCT; 774 LGAs; three-tier health system) is responding, and to draw lessons for health system resilience in the post-aid era.

Methodology

- **Descriptive policy analysis**: desk review of laws, budgets, National Health Accounts, programme reports and Nigerian Health Financing Dialogue 2025 presentations
- Informed by the author's technical engagement as a member of the SWAp National Technical Working Group on Health Financing

Reforms were mapped against **six health system pillars**:

1 Governance | 2 Financing | 3 Services | 4 Digital | 5 Supply chain | 6 Partners

Results

Foundations laid before the shock, and the response since

- **2014** — National Health Act; BHCPF (≥1% of CRF)
- **2019** — BHCPF roll-out to PHCs
- **2022** — NHIA Act: mandatory health insurance
- **2023** — NHSRII & SWAp launched
- **Dec 2024** — Health Compact signed
- **2025** — US aid freeze; US$200m released
- **2026** — NHTDAO set up; GC8 US$792m

1 Leadership & Governance

- SWAp under NHSRII 2023–2027 replaces siloed donor projects
- Dec 2024 Health Compact; widened in 2025 to private sector, traditional rulers & civil society
- Joint Annual Reviews (2024, 2025); 774 Health Fellows, one per LGA, track accountability

2 Health Financing

- US$200m released for HIV, TB & malaria + US$150m/yr in-kind to PEPFAR
- NHSRII has mobilised US$3.4bn, 60% pooled (BHCPF US$796m; World Bank HOPE US$820m)
- Gavi co-financing up from US$8m to US$57m; 15% of GC8 tied to a US$935m co-financing requirement

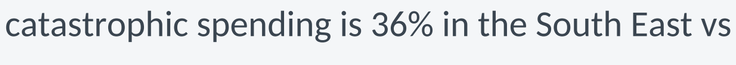
3 Service Delivery

- BHCPF: ₦194bn disbursed to 8,300+ PHCs; 1,351 PHCs revitalised, 5,500 more under way
- MAMII: 172 priority LGAs (~55% of maternal burden); 487,000 pregnant women enumerated
- Free emergency obstetric care: 32,000+ women, 1,700 newborns; 37m PHC visits per quarter

4 Digital Health & HMIS

- NHTDAO established (June 2026) to steer the digital architecture
- Data-informed AOPs in all states, linked to DHIS2; PHC Financial Management System tracks BHCPF spending

Digital PHC data capture, LGA coverage



5 Supply Chain & Commodities

- Zero tariffs, excise & VAT on inputs for local manufacturers
- MEDIPOOL pooled procurement; first domestic insecticide-treated net plant
- Better forecasting cut 2026–30 vaccine costs from US$1.5bn to US$1bn
- PIVAC: from >50% import dependence toward 70% local supply by 2030

6 Partnerships & Private Sector

- Development partners co-chair all SWAp TWGs
- Global Fund-backed ATM insurance pilot in 5 states
- Private sector alliances drive Adopt-a-PHC; CACOVID (US$55.7m) and indigenous philanthropy show domestic resources can be mobilised

Global Fund allocation to Nigeria (US$ million)

Source: Global Fund allocation letters

Who paid for health in 2022 (% of US$21.7bn)

Source: National Health Accounts 2022

People enrolled in health insurance (million)

Source: NHIA; NIN-linked enrolment

Health share of federal budget (%)

2025 budget ₦2.38tn; 2026 proposal ₦2.48tn of ₦58.18tn

Discussion

Aid cuts as an opportunity. Cuts exposed over-dependence but are accelerating domestic financing, pooling and data sovereignty under the SWAp.

Implementation fragility. Households fund 74% of health spending and ~20% face catastrophic costs; PHC spending is under US$7 per person; health's budget share fell to 4.2%.

The equity imperative. State per-capita health spending varies ten-fold (₦17k–₦183k); catastrophic spending is 36% in the South East vs 12% in the South West.

Conclusions

Aid cuts can catalyse fiscal and data sovereignty. **Universal health coverage after aid is won not by replacing donors, but by aligning governance, financing, service delivery and data under a country-owned compact**, backed by sustained equity financing for the poor.

"The question is no longer 'can we survive cuts?' but 'can we deliver equity with our own systems?'"

Acknowledgements: H.E. Prof. Muhammad Ali Pate, Coordinating Minister of Health & Social Welfare; technical teams of FMoHSW, NHIA and NPHCDA; development partners of the Nigeria Health Sector SWAp.