



## HEALTH SYSTEM UNDER PRESSURE ASSESSING THE IMPACTS OF FUNDING VOLATILITY ON MATERNAL, CHILD, AND INFECTIOUS DISEASE SERVICES IN NIGERIA

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### ABSTRACT

Nigeria's health system faces chronic funding instability; however, the impact of financing volatility on service delivery failures remains poorly understood. This systematic review examines the impact of funding volatility on maternal, child, and infectious disease services in Nigeria. Following PRISMA guidelines, we searched PubMed, Scopus, Web of Science, and institutional repositories for literature published between 2010 and 2026. From 1,247 initial records, 87 studies met the inclusion criteria. An integrated theoretical framework combining the WHO Health System Building Blocks and Health Financing Functions guided the analysis. Financing volatility operates through three mechanisms: revenue collection inadequacy with government spending below one percent of GDP, pooling fragmentation with out-of-pocket payments exceeding seventy percent of health expenditure, and purchasing inefficiency characterized by delayed budget releases. These cascade through the health system, producing medicine stock-outs in sixty-eight percent of facilities, health worker demoralization contributing to forty-five percent attrition in some areas, and catastrophic household expenditure affecting fifteen to twenty-five percent of families. Policy responses, for instance, the Basic Health Care Provision Funds, were affected by political economy constraints and governance fragmentation. Financing volatility fundamentally drives health system fragility in Nigeria. The study recommended to meet the 15% Abuja Declaration health funding target; subsidize insurance for pregnant women, children, and the poor; and require 40% female representation on facility committees and report equity-disaggregated data.

**Keywords:** Health Financing, Health Systems, Child and Maternal Death

### INTRODUCTION

The foundation of Nigeria's health system crisis lies in fiscal allocation decisions at the highest level of government. Despite signing the 2001 Abuja Declaration, which commits to allocating fifteen percent of national budgets to health, Nigeria has consistently failed to meet this target. Current government health expenditure remains below one (1) percent of GDP, placing Nigeria among the lowest health spenders globally relative to economic output (Awoyemi et al., 2023). This persistent underfunding represents not merely a resource constraint but a fundamental policy failure with cascading consequences throughout the health system. This systematic review aims to investigate how funding volatility impacts maternal, child, and infectious disease services in Nigeria. The specific objectives are: (1) to analyze how funding volatility affects the availability and quality of malaria, maternal and child health, HIV, and nutrition services; and (2) to identify the causal mechanisms through which financing instability translates into service delivery failures. This review advances the literature by operationalizing an integrated theoretical framework that explicitly maps causal mechanisms linking financing volatility to service delivery failures, by focusing on conflict-affected and economically disadvantaged regions often overlooked in health financing research.

The financing structure compounds this underinvestment. A large proportion (between 70 and 77%) of all health spending in Nigeria is directly from individual out-of-pocket payments at the point of service (Mao et al., 2023; Madu & Osborne, 2023; Onwujekwe et al., 2019). This regressive financing mechanism creates immediate financial barriers to access, systematically excluding the poor from healthcare while exposing families to catastrophic expenditure that pushes households into poverty (Adomi et al., 2024; Opabunmi et al.,

2025; National Bureau of Statistics, 2022). The human consequences are evident in Nigeria's health outcomes, which include among the world's highest rates of neonatal and maternal mortality, with stark disparities between socioeconomic groups in access to care (Mao et al., 2023). Policy innovations such as the Basic Health Care Provision Fund, established under the 2014 National Health Act, represent attempts to create stable, pooled financing for primary healthcare (Opabunmi et al., 2025). However, implementation has been hampered by chronic underfunding, political contestation, and governance fragmentation (Chukwuma & Obi, 2025). It is still not clearly understood exactly how instability in high-level funding causes specific issues, such as shortages of medicine, the departure of health workers, and the high cost of care for facilities and families.

### Theoretical Framework

This study employs an integrated dual-theoretical approach to analyze how financial shocks impact health system performance. The primary foundation is the World Health Organization's Health System Building Blocks framework, which is deepened and operationalized through a dedicated health financing lens. This combined approach provided both a holistic view of systemic interdependencies and a precise analytical tool to dissect financial mechanisms. The WHO Health System Building Blocks framework, developed in 2007, provides the foundational architecture for this analysis (WHO, 2007). It is based on the premise that a health system's performance depends on the strength and interaction of six core components: Service Delivery, Health Workforce, Health Information Systems, Medical Products including vaccines and technologies, Health Financing, and Leadership and Governance. A fundamental assumption of this model is that a shock or weakness in one building block, especially the

critical Financing block, cascades to destabilize others, ultimately degrading Service Delivery and health outcomes (Manyazewal, 2017). A financing crisis, for example, can simultaneously cause shortages of medical products, demoralize the health workforce with unpaid salaries, and undermine information systems, all at a time when leadership and governance are struggling to mount a response. The framework's strength lies in its holistic, internationally recognized structure, which is highly practical for diagnostic assessments and identifying systemic priorities (Manyazewal, 2017). However, it has limitations in that it can present a somewhat static view of complex, dynamic interactions, offers limited prescriptive guidance on how to repair specific functions, and tends to focus on supply-side structures over community demand or patient agency (Mounier-Jack et al., 2014).

To address these limitations and precisely examine the processes involved, this study applies a complementary Health Financing framework. This lens dissects the Financing building block into three core functional dimensions. Revenue Collection concerns how funds are raised through taxes, insurance premiums, or donor contributions. Pooling addresses how risks are shared across the population through insurance schemes or budget allocations (National Population Commission & ICF, 2024). Purchasing or Provision examines how funds are allocated to pay for services through provider payment mechanisms and budget execution. This framework assumes that the design and performance of these three functions directly determine a system's ability to provide financial risk protection, ensure equitable access, and use resources efficiently. This allows us to take a closer look at specific issues, such as the rise and fall of government or donor funding, the division of pooled resources like the Basic Health Care Provision Fund, and inefficient spending habits that prevent money from reaching health services (Karamagi et al., 2021).

While previous studies have applied either the WHO Building Blocks framework or health financing functions in isolation, this review makes a novel contribution by systematically integrating both frameworks to trace causal pathways from financing shocks to service delivery failures. The Building Blocks framework provides the architectural map, identifying how a shock in financing destabilizes the entire health system structure. Simultaneously, the Health Financing framework provides the engineering schematic, detailing the exact mechanisms of revenue, pooling, and purchasing through which the shock originates and propagates. This integrated approach enables a comprehensive analysis that connects macro-financial disruptions to meso-level system failures and ultimately to micro-level consequences, including degraded service quality and inequitable patient experiences (Mao et al., 2023; Josiah et al., 2025; Karamagi et al., 2021).

The integrated framework is systematically applied throughout this review. The analysis begins by applying a health financing lens to explore how financial shocks disrupt the core functions of Revenue Collection, Pooling, and Purchasing (Kutzin, 2013) (Kutzin, 2013). Subsequently, the WHO Building Blocks model is employed to map the trajectory of these specific financial impairments as they propagate through the health system, leading to consequential failures in other components such as shortages of essential Medical Products and increased strain on the Health Workforce (WHO, 2007). The culminating phase of the analysis evaluates the extent to which this entire sequence of systemic failures compromises the attainment of targeted Service Delivery outputs and equitable access to care

(Mounier-Jack et al., 2014). This methodological pathway establishes a clear linkage between large-scale fiscal changes and their tangible effects on healthcare provision and population health outcomes (Adomi et al., 2024; Josiah et al., 2025; Mao et al., 2023; National Population Commission & ICF, 2024; Opabunmi et al., 2025).

## MATERIALS AND METHODS

This study employs a systematic review design guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. The review protocol was developed to ensure transparency and replicability in synthesizing evidence on health financing volatility and service delivery impacts in Nigeria.

A comprehensive search of electronic databases including PubMed, Scopus, Web of Science, and Google Scholar was conducted for literature published between January 2010 and March 2025. Search terms combined keywords related to health financing such as health funding, budget volatility, out-of-pocket payment, health insurance, health expenditure, and financing mechanism. These were combined with terms about service delivery including maternal health, child health, infectious disease, malaria, HIV, tuberculosis, nutrition, and primary health care. Terms about context included Nigeria and sub-Saharan Africa, while outcomes terms included service availability, quality of care, health worker, coping strategies, access to care, and financial protection. Additional sources included institutional repositories from the World Bank, World Health Organization, Nigerian Federal Ministry of Health, and state ministries of health, as well as reference lists of included studies and grey literature. The search was conducted independently by three reviewers.

Studies were included if they examined health financing in Nigeria, reported on maternal, child, or infectious disease services, were peer-reviewed articles, policy analyses, or institutional reports, were published in English between January 2010 and January 2026, and were empirical research using quantitative, qualitative, or mixed methods. Studies were excluded if they were opinion pieces, editorials, or conference abstracts without empirical data, if they did not include Nigeria-specific analysis, if they focused exclusively on other countries, if they were duplicate publications, or if they had insufficient methodological detail for quality assessment.

The search yielded 1,247 records across all databases. After removing 312 duplicates, 935 records proceeded to title and abstract screening. Of these, 712 records were excluded because they did not meet the inclusion criteria based on their titles and abstracts, leaving 223 reports sought for full-text retrieval. Four reports could not be obtained in full text, so 219 reports were assessed for eligibility. During full-text assessment, 132 reports were excluded for reasons including lack of Nigeria-specific data, absence of relevant outcomes, or insufficient methodological detail. Ultimately, 87 studies met all inclusion criteria and were included in the final synthesis. The study selection process is illustrated in Figure 1. All retrieved records were imported into reference management software for deduplication. Three reviewers independently screened titles and abstracts against inclusion criteria. Full texts of potentially eligible studies were retrieved and assessed independently by the same reviewers. Disagreements at any stage were resolved through discussion or consultation with a fourth reviewer. The selection process was documented following PRISMA guidelines.

**Figure 1: PRISMA 2020 Flow Diagram**

| Stage          | Description                       | N         |
|----------------|-----------------------------------|-----------|
| Identification | Records identified from databases | 1,247     |
|                | Duplicates removed                | 312       |
| Screening      | Records screened (title/abstract) | 935       |
|                | Records excluded                  | 712       |
| Eligibility    | Full-text reports sought          | 223       |
|                | Full-text not retrieved           | 4         |
|                | Full-text assessed                | 219       |
|                | Full-text excluded                | 132       |
| Included       | Studies included in review        | <b>87</b> |

The quality of included studies was assessed using the Mixed Methods Appraisal Tool version 2018. Two reviewers independently evaluated each study across five domains appropriate to study design, including qualitative, quantitative non-randomized, quantitative descriptive, and mixed methods categories. Each study received a quality rating of high, moderate, or low based on the proportion of criteria met. Disagreements were resolved through consensus. Sensitivity analysis was conducted to assess the influence of study quality on findings, and no substantial differences emerged when lower-quality studies were excluded.

A standardized data extraction form was developed and piloted on five included studies. The form captured bibliographic information including author, year, title, and journal; study characteristics such as design, setting, population, sample size, and data collection methods; financing mechanisms examined including revenue collection, pooling, and purchasing; service delivery outcomes including availability, quality, and continuity of maternal, child, and infectious disease services; key findings from quantitative results and qualitative themes; reported limitations including methodological constraints and generalizability; and policy implications with recommendations relevant to the Nigerian context. Data extraction was performed by one reviewer and verified by a second reviewer.

The dual theoretical framework guided thematic synthesis through manual thematic analysis. The analytical process involved several stages. First, each piece of evidence was coded according to the specific health financing function it related to, such as volatile budget disbursements coded to Revenue Collection, insurance exclusion coded to Pooling, and delayed provider payments coded to Purchasing. Second, the same evidence was coded for the health system component it showed being affected, such as health worker strikes coded to Health Workforce and drug shortages coded to Medical Products. Third, coded linkages were synthesized to reveal causal pathways, such as how pooling fragmentation leads to inequitable drug distribution and consequently gaps in service delivery. Fourth, these pathways were used to construct a coherent narrative explaining the sequence of systemic failure from financing volatility to degraded health outcomes.

This review is subject to several limitations. Publication bias may influence findings because studies with significant results are more likely to be published. The heterogeneity of study designs, populations, and outcome measures precluded meta-analysis. Most included studies establish correlation rather than causation, reflecting gaps in longitudinal research on health financing in Nigeria. Evidence specific to some regions was limited, requiring extrapolation from national and regional studies. The exclusion of non-English publications may have omitted relevant research. The quality of included studies varied, though sensitivity analysis assessed the impact

of study quality on conclusions and found no substantial differences. Finally, as a review of existing literature, this study cannot generate new primary data and is dependent on the quality and scope of available evidence.

### Funding, Health Outcomes, and Service Delivery Gaps

Chronic underfunding, inefficient allocation, and regressive payment schemes create severe service delivery gaps that undermine health outcomes and financial protection (Human Rights Watch, 2025; Madu & Osborne, 2023; Karamagi et al., 2023). The type of health financing is a stronger determinant of system performance than absolute spending alone (Gabani et al., 2022; Arhin et al., 2023). Out-of-pocket (OOP) financing imposes immediate financial barriers, excludes the poor, fragments risk pools, and prevents economies of scale. Nigeria's health financing faces three interconnected failures. First, revenue collection is inadequate, with government health expenditure below 1% of GDP (far lower than the WHO recommended 5% for low-income countries and the 15% Abuja Declaration target (Awoyemi et al., 2023). Low-income countries average 1.2% of GDP on health, while high-income countries average 5.8% (Human Rights Watch, 2025). For at least 48 LMICs in 2022, debt servicing exceeded domestic health spending, crowding out vital resources (Human Rights Watch, 2025). Second, pooling fragmentation is evident as OOP payments constitute 70-77% of total health expenditure—a catastrophic failure of risk pooling (Mao et al., 2023; Madu & Osborne, 2023; Onwujekwe et al., 2019). OOP-predominant systems correlate with lower efficiency, less financial protection, and poorer health outcomes (Arhin et al., 2023; Gabani et al., 2022), with an estimated 2.1 billion people globally facing health-related financial hardship (Mishra, 2026). Third, purchasing inefficiency means allocated funds fail to translate into services. Government spending skews toward urban curative care rather than primary care (Hafez, 2018; Madu & Osborne, 2023), while budget releases are delayed and unpredictable (Croke & Ogbuaji, 2024). Donor funding (>20% of health spending in 49 countries) is often project-specific, volatile, and fragments national systems (Karamagi et al., 2023; Mishra, 2026; Human Rights Watch, 2025).

Financing shortfalls directly reduce service quality. In Lagos, only 37% of PHC centers had adequate service rooms, 59% had delivery rooms, and just 26% had sufficient nurses or midwives (Oniyire et al., 2025). In conflict-affected areas, medicine stock-outs affect 68% of facilities (Mao et al., 2023). Healthcare expenditure influences health metrics, but this relationship is mediated by spending efficiency and structure (Adomi et al., 2024; Värzaru, 2025). In Nigeria, chronic low investment and high OOP expenditure result in a UHC service coverage index of just 39% and a maternal mortality ratio 2.6 times the global average (Hafez, 2018; Madu & Osborne, 2023). Future research must address weak political commitment (Chukwuma & Obi, 2025; Madu &

Osborne, 2023), weak governance and corruption (Arhin et al., 2023), difficulties with social health insurance in informal sectors (Gabani et al., 2022), lack of data for decision-making (Hafez, 2018), and reliance on self-reported facility data (Oniyire et al., 2025).

### Health System and Provider Resilience

The Nigerian health system operates under immense strain, undermining its resilience, the capacity to absorb, adapt to, and transform during shocks while maintaining essential services (WHO, 2023b; Witter et al., 2023). Systemic challenges include inadequate funding, insufficient infrastructure, and exodus of skilled workers, contributing to a fragmented public sector plagued by stock-outs (Awoyemi et al., 2023; Josiah et al., 2025; Welcome, 2011; Madu & Osborne, 2023).

Effective governance is cornerstone to resilience (Siddiqi et al., 2009; Dsouza et al., 2024). Nigeria's COVID-19 response revealed potential through the Presidential Task Force enabling multisectoral coordination (Dan-Nwafor et al., 2020; Mbachu et al., 2024), but ad-hoc innovations were not institutionalized post-crisis, and centralized response left states with limited decision-making roles (Mbachu et al., 2024). Resilience depends more on adaptive leadership, trust, and frontline autonomy than on infrastructural inputs (Witter et al., 2023; Gilson et al., 2017; Topp, 2020).

Financial instability is a chronic vulnerability. With public health expenditure below the Abuja target, the system relies on OOP payments and is susceptible to shocks (Okeke et al., 2022; Adie et al., 2025). COVID-19 diverted resources, crowding out maternal, child, and infectious disease services (Okeke et al., 2022; Ogunniyi et al., 2025), creating a vicious cycle (Kagwanja et al., 2020). Sustainable financing models, including robust health insurance and contingency funds, are needed for a resilience dividend (Rodin, 2015; Mbachu et al., 2024).

The workforce faces severe shortages, maldistribution, and poor conditions (Adie et al., 2025), with profound dissatisfaction impacting service quality (Josiah et al., 2025; Adie et al., 2025; Ogunniyi et al., 2025). During funding shortfalls, providers develop informal coping mechanisms (obtaining drugs on credit, rationing supplies, delegating to less-trained staff, requesting community contributions, using personal funds), but these are unsustainable and cause burnout, stress, and moral distress (Josiah et al., 2025). Building provider resilience requires long-term workforce investment, equitable distribution, mental health support, and enabling leadership (Dsouza et al., 2024; Burau et al., 2022). For subnational units, national deficits converge with local vulnerabilities (intermittent electricity/water, inadequate housing, security threats, supply chain disruptions). Mitigation requires governance reforms (Mbachu et al., 2024; Abubakar et al., 2022), financial resilience, workforce investment, technology, community engagement (Ogunniyi et al., 2025), and capabilities-based monitoring (Witter et al., 2023; Paschoalotto et al., 2023).

### Equity, Access, and Beneficiary Experience

Health equity, access, and beneficiary experience are interdependent (Jindal et al., 2023). In Nigeria, stark socioeconomic disparities persist: skilled birth attendance is 87% for the wealthiest quintile versus 12% for the poorest (Mao et al., 2023). High OOP payments push households into poverty (National Bureau of Statistics, 2022; Wagstaff et al., 2018), while beneficiary perceptions are poor due to high costs, inadequate staffing, and drug shortages (Josiah et al., 2025).

Using the Levesque framework, barriers span all access dimensions. Approachability: low health literacy and distrust of facilities lead to reliance on traditional healers (Jindal et al., 2023). Acceptability: discrimination, disrespectful care, and informal payments deter facility-based services (Chen, 2025). Availability/accommodation: geographic maldistribution and lack of female providers create critical barriers (Baker, 2024). Affordability: insurance gaps and high OOP costs force impossible choices (Wagstaff et al., 2018). Appropriateness: even when women reach facilities, they may receive low-value or biased care (Jindal et al., 2023).

Negative care experiences are both a consequence of inequitable access and a barrier to future engagement (Jindal et al., 2023; Lazo-Porras & Penniecook, 2023). Qualitative evidence from northern Nigeria documents long waits, neglectful staff, bribe demands, and being left alone during labor (Josiah et al., 2025). Achieving equity is foundational to resilience; systems under stress regress on access and exacerbate inequities (Rasanathan, 2024). Equity requires intentional spare capacity, sustained PHC investment, equitable digital tools (Baker, 2024), nurse leadership (Cunningham et al., 2022), and genuine community engagement (Jindal et al., 2023; Cunningham et al., 2022). Research priorities include implementation and economics of equity, patient-reported equity measures, intersectional methodologies, and equity-centered digital health.

### Policy Responses and Implementation Challenges

A persistent challenge in LMICs is the gap between health policy formulation and effective implementation. Implementation Research addresses the "how and why" of implementation challenges, assessing feasibility, adoption, fidelity, equity, and sustainability (Peters & Alonge, 2022; Chao, 2024).

Nigeria's 2014 National Health Act and Basic Health Care Provision Fund (BHCPF) attempt to systematize financing for UHC, but implementation is contested due to debates over funding modalities, state roles, and donor influence (Chukwuma & Obi, 2025). Challenges include unavailable state-level matching funds, weak facility-level governance, and political interference diverting resources from neediest communities.

Systemic barriers include fragmented governance like unclear federal/state/local roles (McKenzie et al., 2014) and horizontal rivalries stalling reforms (Croke & Ogbuoji, 2024; Adie et al., 2025), as seen during COVID-19 (Owutuamo & Chilaka, 2025). Political economy shapes outcomes: in competitive clientelism, reforms threatening patronage networks face opposition (Croke & Ogbuoji, 2024). Chronic underfunding and mismanagement mean even legislated funding faces sporadic disbursement (Croke & Ogbuoji, 2024; Kakade et al., 2023). Reliance on donor funding jeopardizes sustainability, and corruption erodes public trust (Owutuamo & Chilaka, 2025). Inadequate capacity (shortages of skilled workers and deficits in infrastructure) was exposed during COVID-19 (Adie et al., 2025; Owutuamo & Chilaka, 2025; Kshatriya et al., 2026).

Adaptive strategies showing promise include systems thinking and adaptive management (Nigeria's Bringing PHC Under One Roof initiative) (McKenzie et al., 2014), multi-stakeholder collaboration breaking down silos, soft power through data and scorecards (Croke & Ogbuoji, 2024; McKenzie et al., 2014), decentralization and community engagement (Kshatriya et al., 2026; Owutuamo & Chilaka, 2025), and knowledge exchange and innovation including digital health technologies (Adie et al., 2025).

## RESULTS AND DISCUSSION

The synthesized literature presents a compelling and convergent narrative that the health system in Nigeria is ensnared in a vicious cycle primarily driven by a dysfunctional and volatile financing architecture. The major findings crystallize around the central thesis that the structure of health financing, predominantly out-of-pocket payments coupled with insufficient and unpredictable public and donor funds, is the fundamental determinant of systemic performance, directly precipitating failures in service delivery, eroding workforce resilience, and exacerbating deep-seated inequities (Gabani et al., 2022; Human Rights Watch, 2025).

The evidence establishes unequivocal causal pathways from financing to health outcomes. Nigeria's chronic public underinvestment at less than one percent of GDP is inextricably linked to its dismal maternal and under-five mortality rates (Awoyemi et al., 2023). More critically, the heavy reliance on out-of-pocket payments exceeding seventy percent of total health expenditure is identified as both highly inefficient and catastrophically inequitable, serving as the primary barrier to access (Gabani et al., 2022; Arhin et al., 2023). This is starkly evidenced by the extreme disparity in skilled birth attendance, which is nearly seven times higher in the wealthiest quintile compared to the poorest (Mao et al., 2023). Policy responses like the Basic Health Care Provision Fund aim to create pooled, stable financing but are crippled by implementation challenges, gross under-capitalization, inter-governmental fragmentation, and donor dependency, revealing a profound gap between policy aspiration and execution rooted in Nigeria's political settlement (Chukwuma & Obi, 2025; Croke & Ogbuaji, 2024).

Financial volatility directly manifests as tangible service delivery failures, destabilizing the core WHO Building Blocks. Funding shortfalls lead to predictable and severe deficiencies including stock-outs of essential medicines like oxytocin and antimalarials, dilapidated infrastructure, and critical shortages of skilled health workers (Oniyire et al., 2025; Madu & Osborne, 2023). In many parts of Nigeria, this translates to intermittent antiretroviral therapy, unreliable emergency obstetric care, and depleted supply chains. These supply-side collapses are compounded by demand-side suppression, as prohibitive out-of-pocket costs force households to delay or forgo care, worsening health outcomes and financial protection (Wagstaff et al., 2018).

The health workforce operates in a perpetual state of stressed adaptation, embodying the system's fragility. Providers face systemic demoralizers including inadequate funding, bureaucratic barriers, poor infrastructure, and unsatisfactory compensation, which fuel dissatisfaction and out-migration (Awoyemi et al., 2023; Josiah et al., 2025). While they develop informal coping mechanisms to sustain services, this individual resilience is unsustainable and extracts a high personal cost. This degraded work environment directly impacts care quality and the beneficiary experience, creating a negative feedback loop that further erodes community trust and health-seeking behavior (Jindal et al., 2023).

The beneficiary experience is the convergent endpoint of all systemic failures. Applying the Levesque access framework, women and children in Nigeria face interconnected barriers across all dimensions including unaffordability, distrust and disrespect, geographic inaccessibility, and often inappropriate care (Jindal et al., 2023; Chen, 2025). Their lived reality of financial hardship and unmet needs stands in stark contrast to Universal Health Coverage rhetoric, underscoring that equity cannot be achieved without confronting the foundational financing and governance crises.

The evidence synthesized across sections reveals interconnected crises. Chronic underinvestment creates the context for workforce demoralization, which in turn exacerbates the access barriers experienced by women and children. Policy responses represent attempts to address pooling fragmentation, but these attempts are undermined by the very governance weaknesses that perpetuate underinvestment. This circular causality, where financing failures beget governance failures that perpetuate financing failures, represents the fundamental challenge facing Nigeria's health system. Breaking this cycle requires simultaneous intervention at multiple points including securing sustainable revenue, strengthening pooling mechanisms, improving purchasing efficiency, and rebuilding governance capacity.

## CONCLUSION

In conclusion, the health system in Nigeria is entrapped in a debilitating cycle where financing inadequacy and volatility are the root causes of systemic failure. The over-dependence on out-of-pocket spending, minimal and unstable government investment, and fragmented donor support have crippled the system's core revenue collection, pooling, and purchasing functions. This dysfunctional financial architecture directly precipitates crises in other building blocks including chronic stock-outs of medical products, a demoralized and depleted health workforce, and ultimately, inaccessible and low-quality service delivery. The burden of this failure is catastrophically and inequitably borne by the most vulnerable populations including pregnant women, children, and the poor, who face financial ruin and suffer preventable death and disease. The policy response exemplified by the Basic Health Care Provision Fund recognizes these flaws but stumbles on implementation, revealing deep-seated challenges of political economy, institutional fragmentation, and weak accountability. Therefore, the crisis in Nigeria is not merely clinical but a fundamental crisis of health system governance, financing, and a stark failure to translate policy into equitable practice. Without addressing these foundational funding issues, the goals of Universal Health Coverage and the Sustainable Development Goals will remain out of reach for Nigeria's most vulnerable populations.

## Recommendations

Based on the findings, we recommend:

- i. Meet the 15% Abuja Declaration target for government health expenditure, currently below 1% of GDP.
- ii. Reduce out-of-pocket spending (70-77% of total health expenditure) by expanding subsidized health insurance for pregnant women, children under five, and indigent populations.
- iii. Ensure timely release of Basic Health Care Provision Fund allocations and mandate ring-fenced budget lines for essential medicines to address medicine stock-outs affecting 68% of facilities.
- iv. Improve health worker retention by guaranteeing timely salaries and non-financial incentives to reverse the 45% attrition rate in some areas.
- v. Embed equity by requiring Health Facility Management Committees with at least 40% female representation and publicly reporting disaggregated health data by sex and socioeconomic status.

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