



Opportunities to align supply chain, market shaping and health financing functions and policies **NIGERIA**



Access to essential medicines and other health products is fundamental to achieving Universal Health Coverage (UHC) and improving population health¹. To successfully ensure that people receive the medicines and health products they need, governments must take a complex set of actions that span health financing, supply chain and market shaping policy. They must:

- Set priorities about which services and products they will fund
- Forecast the amount of products to buy based on population health needs
- Use market shaping tools to promote adequate supply of quality products at the best prices
- Ensure that enough resources are allocated in budgets
- Ensure that funds flow effectively through the various health financing arrangements to cover the costs of medicines and products
- Ensure that the procurement and distribution of commodities functions well and the products reach the end users
- Ensure the flow of funds, pricing and payment to providers align with the flow of products through supply chains

This brief examines how Nigeria's health financing, supply chain, and market shaping functions align and intersect — and where they fall short in reinforcing each other and working together — to inform strategies, policies, and learning aimed at ensuring more reliable, better-financed access to essential medicines and health products.

Strengthening alignment between health financing, supply chain, and market shaping functions and policies is vital to ensure that the flow of financing aligns with the flow of products for reliable and affordable access to quality primary health care (PHC).



GOVERNANCE

Nigeria's flagship supply chain framework is laid out in the National Health Products Supply Chain Strategy and Implementation Plan (2021 – 2025)¹, under the National Product Supply Chain Management Program (NPSCMP), prioritizing governance, integration (via National Supply Chain Integration Plan²), workforce professionalization, optimized procurement (including e-catalog), and last-mile distribution.

While the strategy references sustainability and calls for greater state investment, financing is not a central, operational pillar. Financing remains dispersed across federal and state budgets, donor programs, and facility-level Drug Revolving Funds (DRFs), with limited system-wide alignment of cash flows to quantified essential medicine needs. In practice, financing is treated more as an enabling reference than a focused design element. Several states are piloting or expanding DRFs and co-financing for commodities and distribution; the national strategy signals more state domestic financing but leaves capitalization rules, tariff alignment, and reimbursement modalities to state policy design.

Nigeria maintains an up-to-date Essential Medicines List (EML) (7th ed. 2020; 8th ed. 2025 issued)^{3,4}, aligned to treatment guidelines and used to steer public procurement. On medicines pricing, the National Drug Policy⁵, commits to affordability and has moved toward greater price transparency/ benchmarking (e.g., plans to publish prices for most EML items), and complementary initiatives like pooled purchasing (e.g., MediPool⁶), at the federal level have been announced. However, a fully institutionalized national pricing regime with systematic controls and uniform enforcement is not yet in place, and price governance remains fragmented across federal, state, and market actors.

SOURCES OF FINANCING FOR ESSENTIAL MEDICINES

Nigeria's essential medicines financing landscape at the state level includes a mix of state government allocation, health insurance payments from federal and state insurance schemes, out-of-pocket payments (OOP), and donor contributions. Health facilities maintain a DRF in which essential medicines funding is maintained. Estimates of the total funding envelope or the share of funding across these sources are not available. The various funding sources differ in their predictability, flexibility, and vulnerability to delays – creating fragmentation and undermining supply chain efficiency.

Methods

Results for Development (R4D), with support from the Gates Foundation, conducted a multi-country rapid analysis in Ghana, Ethiopia, Nigeria and Tanzania to examine existing linkages between supply chain, health financing, and marketing shaping functions and policies.

An opportunistic qualitative analysis was conducted guided by a set of analytical questions focused on the following themes: forecasting and budget formulation, budget execution, pricing, funds flow and provider payments, and data systems. Data was gathered through document reviews and key informant interviews with technical state from Federal and State Ministries of Health (MOH, SMOH) departments, Nigeria's state level pooled procurement entities, regulatory authorities, health financing agencies, and health care facilities.

ESSENTIAL MEDICINES FINANCING SOURCES

State Government Allocations

SMOH – Drug Management Agency (DMA)

- Funds are allocated through SMOH to state DMA (state level public pooled procurement entity).
- Allocations are based on historical ceilings rather than forecasted need, undermining planning.
- Releases are often delayed, partial, and unpredictable, driven by state-level cash flow challenges, rigid public financial management rules, and weak Treasury operations.

Basic Health Care Provision Fund (BHCPF)

- The BHCPF is a federal and state-funded initiative established by the 2014 National Health Act to provide free basic health services to the poorest and most vulnerable populations through accredited PHC facilities. It provides direct financial investments to upgrade PHC infrastructure and ensure a sufficient supply of medicines and health commodities, through the National Primary Health Care Development Agency (NPHCDA) gateway, and to purchase essential services from PHC centers for the covered population, through the National Health Insurance Agency (NHIA) gateway.
- *NPHCDA gateway*: PHC facilities receive capitation-based payments they can use for operations, infrastructure, staffing support, and essential medicines procurement, with 20% of the facility allocation earmarked for medicines.
- *NHIA gateway*: PHC facilities receive capitation-based payments for delivering services in the benefits package to vulnerable populations. The payments can be used to procure essential medicines, but there is no earmarked share for essential medicines.

State Health Insurance Schemes

- Expanding across states, state health insurance schemes pay facilities capitation payments for delivering services in the benefits package to enrolled individuals (vulnerable and non-vulnerable populations).
- There is no mandatory earmark for medicines, benefit packages vary by state.

Out-of-Pocket Payments

- OOP spending accounts for a very high share of total health expenditure in Nigeria (over 75% of total health spending, World Bank Group 2022), and although data are not available, it is also likely that the majority of funding for essential medicines comes from out-of-pocket payments.
- Patient payments for medicines at the facility level are supposed to be deposited into DRFs, but actual practices vary, and accountability is weak.

Donor Funding

- Development partners finance a large share of program commodities — HIV, tuberculosis (TB), malaria, family planning (FP), vaccines, maternal and child health, and nutrition.
- These funds are typically earmarked and managed under national-level co-financing agreements.
- Donor flows are not consistently reflected in state budgets or DMA procurement schedules, creating parallel systems and duplication.

There is no integrated financing framework for essential medicines and health products across financing sources. State health budgets allocated to DMAs, BHCPF payments, and state health insurance schemes operate through separate budgeting and disbursement processes with little coordination across them. This fragmentation undermines the ability of the system to assess the adequacy of the current financing flows, identify gaps, and advocate for improved allocations, as well as leverage the potential for market shaping and strategic purchasing across the health system.

Despite persistent fragmentation in Nigeria's health financing and procurement systems, several bright spots are emerging. The NHIA Act (2022) established a mandatory insurance framework, creating a pathway to pool financing streams and send clearer demand signals to the supply chain. The BHCPF is channeling federal resources into state-level primary care with earmarks for essential medicines, while new state health insurance schemes are beginning to shape procurement through facility contracts under NHIA oversight. Donor-funded programs for HIV, TB, malaria, and vaccines are also transitioning into the NPSCMP to reduce parallel systems. Finally, a pilot digital consignment model in tertiary hospitals directly links procurement, supply, and financing through automated orders, verified deliveries, and weekly reimbursements — demonstrating how financing reforms can be embedded into supply chain operations. Although insurance coverage in Nigeria remains very low, these system improvements are laying the groundwork for strategic purchasing — including for essential medicines — in the near future.

FORECASTING AND BUDGETING



Forecasting

In Nigeria, essential medicine needs are forecasted through a bottom-up quantification process. PHC facilities begin by projecting requirements based on historical consumption, morbidity profiles, and population estimates. These forecasts are compiled and validated at higher levels, with the SMOH and the DMA playing a central role in consolidating data and finalizing quantification.

While this approach incorporates inputs from facilities and reflects state-level disease burden, it remains heavily consumption data driven, and forecasting for program commodities such as HIV, TB, malaria, FP, and vaccines is often managed separately at the national level with donor support. Weak data systems, incomplete rollout of electronic Logistics Management Information System (eLMIS) tools and limited technical capacity at the facility level continues to constrain the reliability of forecasting across states.



Budgeting

Budgeting for essential medicines in Nigeria also follows a bottom-up approach, with facilities estimating revenues from patient out-of-pocket payments, state and national insurance payments, and the BHCPF. These revenues, together with state allocations for essential medicines, are expected to flow into facility DRFs. However, in practice the DRF is not ring-fenced and is subject to weak governance, undermining the ability to guarantee consistent funding for medicines.

At the state level, maternal, newborn, and child health (MNCH) budget allocations are typically transferred to the DMA from the SMOH and are earmarked 100% for essential medicines. Facilities are meant to contribute 20% of their BHCPF allocations coming to them through the NPHCDA gateway. There is no specified earmark allocation for essential medicines for BHCPF funding coming through the NHIA gateway. Ultimately, the budget process at the state and federal levels remains constrained by macro - fiscal ceilings set by the Ministry of Finance (MOF), with allocations pushed into rigid line items that do not adequately reflect forecasted need.



Misalignments Between Forecasting and Budgeting

Despite bottom-up planning, a persistent disconnect remains between facility - level forecasts and actual budget ceilings and releases. Facilities and states generate quantifications and track spending on commodities, but these data are inconsistently captured in logistics systems and rarely drive Medium - Term Expenditure Framework (MTEF) ceilings or in - year cash releases.

Instead, allocations tend to follow historical baselines and political priorities, with forecasts routinely trimmed to fit tight fiscal envelopes and then further eroded by delayed cash-flows. State-level capacity gaps (uneven use of eLMIS tools and incomplete state quantification calendars) weaken the evidence base for budgeting and forecasting, while national budget-credibility issues (underspending and late releases) break the planning-budget-procurement chain. Vertical programs sometimes align better – where guidelines explicitly link forecasting to state-funded procurement – but this remains uneven and program-specific.

BUDGET EXECUTION

Delays in the release and execution of funds for essential medicines and health products are widespread across Nigeria’s financing streams. Funds flows are slowed by late state budget approvals, cash-release bottlenecks, compliance-heavy BHCPF processes, irregular state health insurance payments, and donor cycles that are out of sync with domestic timelines. Although domestic rules earmark resources (e.g., 20% of BHCPF via the NPHCDA gateway for medicines, DRF deposits from NHIA payments, patient out-of-pocket payments, and state budget lines for DMAs), fragmented planning and siloed revenue streams mean allocations are often partial, delayed, or poorly aligned with quantified need – making comprehensive, cross-stream planning and execution difficult.

These constraints leave DMAs and facilities with cash-flow gaps, weaken DRF performance, and force emergency open-market procurement at compromised quality – eroding value for money and widening inequities in access.

Source	Key Constraints
State Government Budget	Delays in approval and cash release; limited visibility; allocations not linked to forecasted need.
BHCPF (NHIA Gateway)	Delayed disbursements; weak reporting and accountability systems.
BHCPF (NPHCDA Gateway)	20% earmarked for medicines, but weak DRF governance and poor revenue retention undermine execution.
State Health Insurance	Low coverage; variable benefits; payment delays create arrears and liquidity stress at facilities.
Outof-Pocket Payments	Inconsistent revenue; regressive; weak DRF governance and accountability.
Donor Funding	Parallel processes; poor coordination with state budgets and DMA procurement timelines.

Table 1: Sources of essential medicine financing in Nigeria and budget execution delays

Delayed budget execution drives stockouts through late procurement and disbursement, while inflation erodes purchasing power when funds arrive late. As a result, DMAs and facilities increasingly resort to emergency private purchasing, which in Nigeria comes in at typically below DMA benchmark rates — raising questions about quality, but also exposing patients to out of pocket payments, and disrupting services, including at primary care where consistent medicine availability is essential.

POOLED PROCUREMENT: DRUG MANAGEMENT AGENCIES

DMAs serve as the primary public sector institutions responsible for public pooled procurement, warehousing, and distribution of health commodities in most Nigerian states. They procure commodities using a combination of state budget allocations (through the SMOH), drug revolving fund (BHCPF, user fees and state insurance), and occasionally donor contributions. Although there are published national guidelines, the structure, authority, and capacity of DMAs vary across states.

Key Functions of DMAs

- Aggregate state-level essential medicines and health products demand.
- Conduct public pooled procurement — often through framework contracts, restricted tenders, or approved vendor lists.
- Store and distribute commodities to public health facilities, typically on a push basis using budget allocations from the State meant for facilities.
- Supply on a pull basis with facilities using own source revenues from the DRF.

Challenges

- **Limited visibility into total available financing:** DMAs do not have comprehensive essential medicines and health products financing estimates, missing data from donor-funded programs and facility-level revenues such as user fees and insurance payments.
- **Fragmented planning and budgeting processes:** Coordination between DMAs and state budget offices is often weak, limiting accurate demand estimation and timely resource allocation.
- **Inadequate market intelligence:** Many DMAs lack the capacity to routinely analyze market data to update their price catalogs, leading to outdated procurement benchmarks.
- **Delayed and partial budget releases:** Unpredictable cash flow from the state treasury hampers pooled procurement and pushes DMAs to adopt small-batch or emergency purchases, often at higher prices, furthermore, when DMAs are out of stock health facilities procure from the open (private) market, further limiting efficiency gains.

- **Limited access to real-time data:** Often DMAs do not have full visibility on facility consumption patterns and funding availability, which constrains demand forecasting and supply planning.
- **Misalignment with insurance tariffs:** In states where contributory health insurance schemes are active, provider payment rates for essential medicines often do not reflect the prices in DMA procurement catalogs, complicating cost recovery for the health facility.

In Nigeria, facilities are permitted to procure from the open (private) market when DMAs are stocked out, upon obtaining a certificate of non-availability. This policy serves as an important “release valve” to maintain service continuity and prevent stock-outs — particularly under direct facility financing arrangements that allow facilities to use their own funds to fill urgent gaps. However, in practice, these procurements are often uncoordinated, with facilities purchasing from private vendors at prices lower than DMA rates but without the regulatory oversight or quality assurance guaranteed through DMA contracts. While this approach helps sustain availability in the short term, it undermines centralized procurement, weakens DMA negotiating power, and exposes patients to potential quality risks. Moving forward, facility-level procurement could remain an option but be systematically aligned with pooled procurement mechanisms, ensuring transparency, quality control, and consistent pricing across the supply chain.

PRICING

Price Setting

Essential medicines pricing in Nigeria is decentralized, with wide variation across states and public and private channels. In the public sector, state DMAs set prices independently — drawing on bids from pre-qualified suppliers, past procurement data, and limited market surveys — and typically apply ~16.5–20% mark-ups to cover operating and distribution costs. Because there is no national pricing framework or registry, catalogs, and mark-ups differ by state, and updates often lag inflation and foreign-exchange movements. When DMAs are stocked out or releases are delayed, facilities purchase directly from the open market (private wholesalers and pharmacies); these transactions bypass DMA quality and pricing oversight, increasing safety, accountability, and value-for-money risks. Emerging national levers — such as NHIA reimbursement price lists, e-catalog purchasing, and the MediPool pooled-purchasing initiative — offer reference points, but are not yet uniformly adopted across states.



When DMAs are stocked out, health facilities can procure from the private market with a certificate of non-availability. This policy acts as a crucial release valve, ensuring uninterrupted services and sustained patient care.

Drivers of Price Variation

Several factors continue to drive significant variation in essential medicine prices across Nigeria’s public and private markets, as summarized in Table 2 below.

Challenge	Description
Fragmented pricing governance	No national reference price/registry; each DMA sets prices independently, producing large state-to-state variation and weak purchasing consistency.
Procurement timing & cash-flow constraints	Unpredictable cash releases force emergency/small-batch buys, pushing up unit prices and disrupting planned tender cycles.
Market volatility (inflation/FX)	Price lists and catalog are often outdated and do not adjust quickly to inflation, exchange-rate movements, or rising logistics costs.
Weak regulation/enforcement	Limited mechanisms to regulate or enforce uniform prices across public and private channels; hidden mark-ups persist even for basic EML items.
Tariff/provider payment misalignment	NHIA payment rates are not systematically aligned with DMA catalogs, creating gaps and underfunding at facility level.
Limited price intelligence	Infrequent, non-standard market surveys and the absence of a national price database hinder benchmarking and supplier negotiations.
Geographic/last-mile cost variation	Higher transport and distribution costs in remote areas drive uneven final prices and reduce availability.

Table 2: Drivers of price variation

Nigeria has taken positive steps toward stronger pricing governance — maintaining an up-to-date Essential Medicines List (2025), publishing NHIA medicines price lists for provider payment rate-setting reference, committing in the National Drug Policy to biennial publication of prices for $\geq 90\%$ of EML items, expanding e-catalog use, and launching MediPool to aggregate demand and negotiate lower, standardized prices. To translate these gains into system-wide impact, Nigeria will need to institutionalize a national price registry and routine price intelligence, align NHIA tariffs with state DMA catalogs, and standardize DRF mark-up policies — so pricing becomes predictable, equitable, and resilient to market shocks.

FUNDS FLOW AND PROVIDER PAYMENT

Health facilities in Nigeria receive funds for essential medicines from multiple sources each with its own rules and payment modalities. Depending on the source, payments for medicines are made separately (e.g., state budget to DMAs; donated commodities) or bundled within service payments (e.g., BHCPF/NHIA capitation, state health insurance capitation). Fragmented budgeting and disbursement processes across these streams complicate cross-source planning, weaken visibility of the total essential medicines envelope, and limit strategic purchasing.



Bright spots in Nigeria's essential-medicines pricing

Up-to-date EML: The Federal Ministry of Health issued the 8th-edition (2025) Essential Medicines List, keeping selection current for procurement and price referencing.

Policy push on price transparency: The National Drug Policy commits to publishing prices for $\geq 90\%$ of EML medicines biennially by end-2025 — a concrete step toward national price benchmarking.

National reference prices for reimbursement: The NHIA Medicines Price List is publicly posted and periodically updated, providing a payer-level reference for price negotiations and benefit design.

Pooled purchasing to lower prices: The Federal Executive Council approved “MediPool,” a national group-purchasing organization to aggregate demand and negotiate lower, standardized prices for essential health products.

Regulatory stance on affordability: National Agency for Food and Drug Administration and Control (NAFDAC) has publicly prioritized making medicines more affordable, complementing price transparency and pooled-purchasing reforms.

Funding Source	Payment Mechanism	Are payments for medicines bundled into service payments?	Notes
SMOH financing - DMAs	State budget allocation to DMA	No	Funds are allocated prospectively for medicines (100%); budgets are often inadequate, and releases delayed or incomplete.
BHCPF (NHIA Gateway)	Capitation	Yes	No explicit earmark for medicines; disbursements to PHCs are unpredictable and accountability is weak.
BHCPF (NPHCDA Gateway)	Capitation	Yes	20% intended for essential medicines and deposited into DRFs; actual practice varies by state due to weak DRF governance.
State Health Insurance	Capitation (primarily)	Yes	Benefits for medicines vary by state; coverage is low and payments are frequently delayed.
Out-of-pocket	Fee-for-service	No	Collected at point of service and supposed to flow into DRFs; governance gaps and leakage are common.
Donor programs	Donor Programs	No	HIV, TB, malaria, vaccines, FP, maternal and child health, nutrition commodities flow in parallel to domestic financing and bypass state budget execution.

Table 3: Provider payment mechanisms for essential medicines in Nigeria

DATA SYSTEMS

Multiple Data Systems for Financing, Supply Chain and Service Delivery

For health systems to effectively manage a robust portfolio of essential medicines and health products, managers need visibility across financing, supply chain, and service delivery functions. In Nigeria, multiple platforms exist to capture these data streams. Below are a few of the key systems currently in use:

- **State IFMIS (Integrated Financial Management Information System):** Digital budgeting, expenditure tracking, and payment processing for state-level procurement.
- **NHLMIS (National Health Logistics Management Information System):** Used for consumption reporting purposes and provides data for forecasting and quantification across states and health facilities but has incomplete coverage.
- **State LMIS:** Used to report into NHLMIS, implemented unevenly across states.
- **mSupply:** Warehouse inventory management software deployed in some State DMAs with donor support to manage inventory, coordinate procurement and distribution, but high annual subscription cost limits access and there is no interoperability with State IFMIS. Available in 15 states.
- **OpenLMIS:** Mainly used to track vaccine supply chain, capture orders, stock transactions, resupply for end-to-end visibility.
- **DRF Tools:** Used in some states to track DRF performance, but systems are often manual or Excel-based, health facilities and DMAs are ideally manually tallying monthly.
- **District Health Information System (DHIS2):** Aggregates service delivery data and provides essential medicines and health products demand estimation based on population need.

Gaps

- **Fragmented systems, poor interoperability:** State IFMIS, NHLMIS/State LMIS, OpenLMIS (vaccines), mSupply (DMA warehouses), DRF tools (often Excel), and DHIS2 operate in silos with no standardized crosswalks — blocking end-to-end visibility from budgets - procurement - stock - service delivery.
- **Incomplete coverage & inconsistent reporting:** NHLMIS/State LMIS coverage is patchy; reporting quality/timeliness varies widely across states and facilities.
- **Limited tracking of patient OOP:** Routine systems do not capture OOP for essential medicines, hampering full demand/cost visibility.

- **Warehouse system constraints:** mSupply is only in ~15 states and carries high subscription costs; it is not integrated with State IFMIS and is not routinely interfaced with NHLMIS.
- **Manual DRF management:** DRF tools are mostly manual/Excel, with weak audit trails and irregular monthly tallies by facilities/DMAs.
- **Planning – execution gap persists:** Lack of linkage between forecasting/quantification tools and budgeting cycles means forecasts rarely drive ceilings or in-year releases, sustaining the planning-execution disconnect.
- **Analytics blind spots:** Without integrated data, decision-makers lack routine key performance indicators (e.g., forecast vs. funds released, on-time delivery, stockout days, price variance) to guide course correction.



Strengthening Nigeria's data ecosystem requires a shift from fragmented, siloed systems toward interoperability and integration. Establishing a consensus-driven approach — such as a unified dashboard that brings together financing, supply chain, and service delivery data — would create end-to-end visibility of the essential medicines process. Coupled with investments in data quality and alignment across platforms, such integration would enable managers to reliably track gaps between forecasted needs, budget allocations, procurement, and actual service delivery. Without these reforms, Nigeria risks continued inefficiencies and missed opportunities to optimize resources and secure consistent access to life-saving medicines.

RECOMMENDATIONS



Establish an integrated essential medicines and health products financing framework: Nigeria's commodity financing is fragmented across government budgets, insurance, out-of-pocket, and donor sources. States could align these streams under a unified essential medicines and health products planning and budgeting process, with aligned provider payment rules and digital tracking across all sources.



Institutionalize forecast-to-budget linkages: State-level commodity forecasts are often disconnected from budget allocations. Embedding structured forecast reviews in budget planning and explicitly identifying gaps would ensure needs are reflected in budgets and strengthen advocacy for domestic and donor funding.



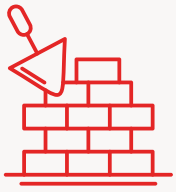
Advocate for timely budget and provider payment disbursements: Delayed and incomplete releases from state treasuries disrupt procurement timelines and limit DMA performance. States could implement routine tracking of disbursement timelines, quantify the cost of delays (e.g., stockouts, emergency procurement), and use the data to advocate for timely releases.



Harmonize public procurement costs with provider payment rates: To create a more financially viable system, DMA prices should be systematically aligned with provider payment rates — whether through reimbursement tariffs for essential medicines and health products or capitation allocations. Such alignment reduces facility-level financial risk and incentivizes providers to procure through DMAs rather than unregulated private vendors, ensuring both affordability and sustainability.



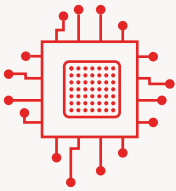
Establish a national price governance mechanism: Create a coordinated essential medicines and health products pricing and market intelligence platform to manage a national price registry, conduct regular cost and market analysis, and publish benchmark pricing and markup guidelines. This would reduce price variability and support more equitable, cost-effective procurement practices. A market-shaping strategy implemented through demand aggregation, supply planning, transparent pricing, and coordination with key financing and procurement actors can unlock system-wide savings and improve access.



Strengthen DMAs capacity to ensure procurement efficiencies: DMAs are central to public procurement but operate with limited visibility into funding flows and have inconsistent pricing practices across states. State governments should invest in building DMA capacity to conduct independent market research, develop evidence-based price catalogs, and consolidate demand across financing sources. Clear mandates for DMAs to contribute to shaping the essential medicines and health products market — through procurement, framework contracting, and coordinated price setting — can unlock savings, improve efficiency, and ensure financial sustainability.



Assess capitation allocation for essential medicines and health products: BHCPF disbursements through the NHIA gateway require at least 20% of capitation payments to be spent on essential medicines, while BHCPF through NPHCDA gateways and state health insurance scheme prospective payments have no clear earmarking requirements. The impact of these varied practices on provider behavior and the availability of essential medicines and health products remains unclear, including whether facilities are investing sufficiently in the same. Nigeria should assess the optimal allocation, considering pricing variability, operational costs, and facility-level demand.



Integrate data systems across the supply chain: Link siloed information systems to enable end-to-end visibility of financing, supply chain and service delivery data. A unified dashboard should enable real-time monitoring of commodity needs, financing flows, stock levels and service delivery gaps — improving transparency, accountability, and timely decision-making.



Fully integrate donor supported program commodities forecasting and budgeting processes into government systems: With shifts in the global health financing landscape, donor support for program commodities (HIV, TB, malaria, family planning, vaccines, maternal and child health, and nutrition) is likely to vary. This creates an opportunity to harmonize donor-funded support with national forecasting and budgeting for essential medicines and health products, ensuring full integration into country systems.



Leverage peer learning platforms: While each recommendation will require country-specific dialogue and stakeholder engagement, there is also a unique opportunity for countries such as Nigeria to share experiences, assess effective practices, and co-create solutions through forums like the Joint Learning Network, fostering evidence-based learning and best practice development.

Theme	Key Finding	Recommendation	Intended Outcome
Essential Medicines Financing Framework	Financing fragmented across government budgets, insurance, donors, and OOP	Establish a coordinated framework integrating all essential medicines funding streams with harmonized rules, planning, reporting, and procurement	Improve efficiency, reduce duplication, and enable unified, transparent procurement
Forecast-to-Budget Linkages	Forecasting not integrated into state budget allocations	Institutionalize structured forecast reviews during budget planning and explicitly identify commodity gaps	Ensure budget allocations reflect quantified needs, highlight gaps, and strengthen advocacy for domestic and donor funding
Budget Execution	Delayed/incomplete treasury releases disrupt procurement	Track disbursement timelines, quantify costs of delays, and automate fund-flow monitoring	Enhance predictability, accountability, and procurement timeliness
Insurance Tariffs & Provider Payments	Reimbursement tariffs and capitation payments not aligned with DMA prices	Harmonize tariffs and capitation allocations with DMA prices	Reduce facility-level financial risk, incentivize use of DMAs, and ensure affordability
Pricing & Market Governance	Significant price variation, weak national coordination on pricing	Establish a federal pricing and market governance platform with standardized guidance and a national reference price list	Enhance transparency, improve value for money, and shape pharmaceutical markets
DMA Capacity	DMAs under-resourced, limited visibility into funding flows, inconsistent pricing practices	Invest in DMA capacity for market research, evidence-based price catalogs, framework contracting, and demand consolidation	Strengthen procurement efficiency, unlock savings, and promote financial sustainability
Capitation Allocation	Current facility allocations for essential medicines may not reflect actual facility needs	Measure current allocation and assess adequacy of allocation to essential medicines within capitation, considering pricing variability, costs, and demand	Ensure sufficient resources for essential medicines and rational facility-level investment
Digital Systems	Poor visibility across financing, supply chain and service delivery information systems	Digitize and link or create a dashboard with key indicators across demand, procurement, financial management, logistic and service delivery systems	Improve visibility, coordination, and responsiveness across the supply chain
Donor Integration	Donor-funded program commodities managed in parallel processes	Fully integrate donor-supported forecasting and budgeting and procurement into national systems	Harmonize donor and domestic financing, improve alignment, and ensure sustainability
Peer Learning Platforms	Limited cross-country exchange on essential medicines and health products financing reforms	Leverage platforms such as the Joint Learning Network for peer exchange and joint problem solving	Foster evidence-based learning, co-create best practices, and accelerate reform

Table 4: Recommendations summary

ENDNOTES

- ¹ [Federal Republic of Nigeria. National Health Products Supply Chain Strategy and Implementation Plan \(2021-2025\).](#)
- ² National Oversight Framework for Reconciliation, Triangulation and Accountability of Health Products. Federal Republic of Nigeria.
- ³ Nigeria Essential Medicines List 2020 7th Edition. Federal Ministry of Health.
- ⁴ NIGERIA ESSENTIAL MEDICINES 8TH EDITION 2024 Federal Ministry of Health and Social Welfare LIST FOR ADULTS. Federal Ministry of Health.
- ⁵ Nigeria National Drug Policy 2021. Federal Ministry of Health.
- ⁶ [Nigeria's FEC approves health financing policy through Medipool. P4H Social Health Protection Network.](#)

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