ORIGINAL RESEARCH ARTICLE

Unlocking fiscal space for reproductive health in Nigeria: A rapid assessment

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Abstract

Nigeria continues to face a persistent reproductive health (RH) financing gap despite decades of policy commitments. This rapid fiscal space analysis evaluates how the country can expand investment in RH services while maintaining macro-fiscal stability. Six domains were examined at the federal level: budget reprioritization, improvements in health sector efficiency, revenue enhancement, official development assistance, debt restructuring, and innovative financing mechanisms. The findings indicate that reallocating public expenditures, reducing inefficiencies, and introducing modest tax reforms could mobilise significant additional resources for RH by 2030. Strategic borrowing and blended finance instruments could further complement domestic funding. Realising these opportunities will depend on sustained political leadership, transparent and accountable budget execution, and stronger coordination across government and development partners. Implemented collectively, these measures provide a credible pathway to closing Nigeria's RH financing gap and advancing the country's demographic dividend. *(Afr J Reprod Health 2026; 30 [7s]: 83-93).*

Keywords: Fiscal space analysis, Reproductive health financing, Domestic resource mobilization, Health sector budget execution, Nigeria

Résumé

Le Nigéria continue de faire face à un déficit persistant de financement de la santé reproductive (SR), malgré des décennies d'engagements politiques. Cette analyse rapide de l'espace budgétaire examine comment le pays peut accroître les investissements dans les services de SR tout en maintenant la stabilité macro-budgétaire. Six domaines ont été évalués au niveau fédéral : la réaffectation budgétaire, l'amélioration de l'efficience du secteur de la santé, l'augmentation des recettes publiques, l'aide publique au développement, la restructuration de la dette et les mécanismes de financement innovants. Les résultats indiquent que la réorientation des dépenses publiques, la réduction des inefficiences et l'introduction de réformes fiscales modestes pourraient mobiliser des ressources supplémentaires importantes pour la SR d'ici 2030. Des emprunts stratégiques et des instruments de financement mixte pourraient également compléter les fonds nationaux. La réalisation de ces opportunités dépendra d'un leadership politique soutenu, d'une exécution budgétaire transparente et responsable, ainsi que d'une meilleure coordination entre le gouvernement et les partenaires au développement. Ensemble, ces mesures offrent une voie crédible pour combler le déficit de financement de la SR au Nigéria et faire progresser le dividende démographique du pays. *(Afr J Reprod Health 2026; 30 [7s]: 83-93).*

Mots-clés: Analyse de l'espace budgétaire, Financement de la santé reproductive, Mobilisation des ressources nationales, Exécution budgétaire du secteur de la santé, Nigéria

Introduction

Nigeria remains at the epicentre of the global maternal health crisis. With a population approaching 237 million as of 2025[1] and a total fertility rate of 4.8 children per woman,[2] the country accounts for nearly 30% of all maternal deaths worldwide.[3] Each year, approximately 75,000 women die from preventable pregnancy-related causes,[3] and around 60% of pregnancies are affected by severe obstetric complications.[4] Adolescents face particularly high risks, with about 15% of girls aged 15–19 experiencing pregnancy.[2] Coverage of sexual and reproductive health and rights (SRHR) services remains low and deeply inequitable: fewer than half of births are attended by a skilled provider and less than 40% occur in a health facility, with rural, adolescent, and poorer women facing the greatest barriers.[2-5] These gaps fuel preventable maternal and perinatal deaths, unsafe abortions, and long-term morbidities that undermine education, productivity, and social participation.

Chronic underinvestment in health—and in SRHR in particular—is a central driver of this crisis. Nigeria's health system depends heavily on out-of-pocket (OOP) spending, which accounts for more than 70% of total health expenditure.[6] Weak financial protection exposes households to catastrophic costs, delays care-seeking, and exacerbates poverty. Expanding public and pooled funding for SRHR is therefore both a rights-based obligation and an economic necessity for protecting households and strengthening human capital.

Nigeria formally recognises SRHR as central to national development, yet this policy commitment has not been matched by adequate financing. Federal health allocations have remained below 5% of the national budget for more than a decade, despite the Abuja Declaration target of allocating at least 15%.[7] As a result, per capita public health spending has stagnated at approximately USD 12 in recent years,[7] far below the World Health Organization (WHO) benchmark of USD 86 per person—the estimated minimum required to deliver essential primary health care services in low-income settings.[8]

These financing gaps are mirrored in service outcomes. Modern contraceptive prevalence among married women remains roughly 17%,[9] and the annual resources required to satisfy demand for modern methods exceed available funding by more than USD 500 million between 2025 and 2030.[10] While external assistance continues to play a role, it is declining and too volatile to serve as a reliable substitute for sustained domestic investment.

Nigeria has adopted several strategic instruments—including the FP2030 Commitment,[9] the National Family Planning Blueprint,[11] and its Communication Plan[12]—to expand contraceptive access, integrate family planning into universal health coverage (UHC), and increase domestic spending. Yet implementation remains constrained by fiscal pressures, competing priorities, and persistent public financial management (PFM) bottlenecks.[6,7,10] These challenges became even more pronounced when the modest ₦2.225 billion allocation for family planning in the 2024 federal budget was reduced by 97% in the approved 2025 budget,[13] effectively eliminating direct government financing. Against this backdrop, expanding fiscal space is essential for sustainably financing priority reproductive health (RH) services. Fiscal space refers to the budgetary room a government has to fund desired interventions without compromising macroeconomic stability.[14] Global guidance typically frames fiscal space across four avenues—revenue generation, external grants, borrowing, and expenditure efficiency.[15] This analysis applies an expanded version of that framework to RH,[16] aiming not only to document gaps but to identify politically feasible, sustainable pathways for expanding and better structuring public and pooled RH financing while supporting national development goals and FP2030 targets.

The remainder of the article outlines the analytical approach and data sources, presents results across key fiscal space domains, synthesises priority actions and political considerations for 2026–2030, and concludes by calling for a national compact on RH financing to translate fiscal possibilities into measurable gains for women and girls.

Methods

Framework

This study examines options for expanding public financing for RH services in Nigeria while preserving macro-fiscal sustainability. It adapts the United Nations' official methodology for fiscal space assessment in the social sectors,[16] organising potential avenues into six domains: reprioritising the federal budget, reprioritising the health budget, increasing government revenue, mobilising additional official development assistance (ODA), pursuing borrowing or debt restructuring, and piloting innovative financing mechanisms for the health sector. Each domain was evaluated for its alignment with national policy commitments, the potential scale of resources, the expected implementation horizon, and both political and technical feasibility. RH was defined as the package of services necessary to meet family planning needs and reduce preventable maternal deaths.

The assessment proceeded in four steps. First, relevant fiscal, macroeconomic, and expenditure data were extracted from national and international databases. Second, trends were analysed to assess their implications for fiscal space across the six domains. Third, preliminary findings and an initial list of options were shared with development partners for technical validation. Fourth, feedback was incorporated to refine the narrative and prioritise a shorter list of feasible and high-impact options.

Data sources

Federal expenditure figures were sourced from Nigeria's Federal Appropriation Bills for 2020–2025[17] and were used to calculate sectoral shares of total approved spending. Because fuel subsidies have played a major role in constraining fiscal space, estimates from International Monetary Fund (IMF) Country Reports[18,19] were used to capture their scale. These subsidies do not appear in Appropriation Bills because the Nigerian National Petroleum Company (NNPC) deducts their cost off budget from oil revenues before they enter the federal accounts, thereby avoiding legislative scrutiny and deficit limits.[20,21]

Macro-fiscal indicators and projections through 2030—including real GDP growth, inflation, revenue and expenditure ratios, and gross public debt—were taken from the IMF World Economic Outlook (October 2025)[22] and complemented by recent IMF country assessments. Public health expenditure data, disaggregated by financing source, function, and economic classification, were obtained from the WHO Global Health Expenditure Database.[7] These were used to estimate the public share of total health expenditure, the balance between recurrent and capital spending, and the portion devoted to RH-related functions. ODA flows were drawn from the OECD-DAC's International Development Statistics database,[23] while estimates of illicit financial flows and trade value gaps were sourced from Global Financial Integrity.[24]

Data management and analysis

Data from all sources were collated and harmonised to ensure comparability. National budget documents served as the primary source for federal allocations, while IMF and WHO datasets were used for internationally comparable macro-fiscal and health indicators. The analysis was primarily descriptive, using time-series trends to assess changes in sectoral budget allocations, revenue performance, and debt indicators from 2020 to 2025. Nigeria's performance was compared with regional peers to contextualise results.

For selected high-potential fiscal space options, simple scenario exercises were conducted. These applied hypothetical policy adjustments—such as raising the health share of the federal budget or increasing a tax rate by a percentage point—to the most recent baseline data. These were not intended as precise forecasts but as order-of-magnitude estimates of potential fiscal space. For each domain, the evidence was used to construct a long list of options, which were then qualitatively assessed according to macro-fiscal consistency, alignment with national strategies, implementation complexity, and potential to generate RH-specific resources. Options were subsequently ranked from easiest to hardest for the government to pursue.

Results

This rapid analysis identifies multiple avenues for sustainably increasing public investment in RH services in Nigeria. Options are presented in order of immediate practicality, beginning with measures that can be implemented through executive decisions and progressing toward those requiring deeper structural reforms or political negotiation.

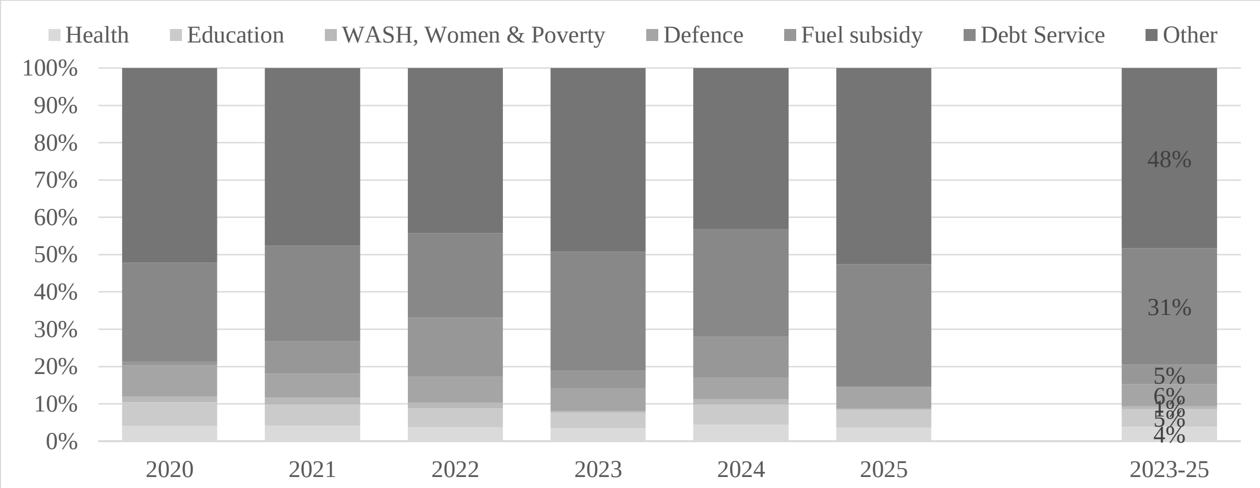
Reprioritising the federal budget

Reallocation within the existing federal budget presents the most realistic short-term opportunity. Between 2023 and 2025, health received an average of only 3.9% of total federal spending—far below the Abuja Declaration target of 15% and well under the West and Central Africa (WCA) average of 6.4% (Figure 1). Defence, debt servicing, and fuel subsidies meanwhile absorbed more than 40% of total expenditure. Combined allocations to education, health, WASH, women's affairs, and poverty reduction remained below 10%.

Raising the health share of the budget to 10% by 2030—through gradual reallocation of fuel subsidies, defence overheads, and low-impact capital projects—emerges as a fiscally credible strategy. Simulations indicate that increasing health's share by 2–3 percentage points annually could generate ₦1,000–₦1,500 billion per year, enough to significantly strengthen RH infrastructure and commodity security.

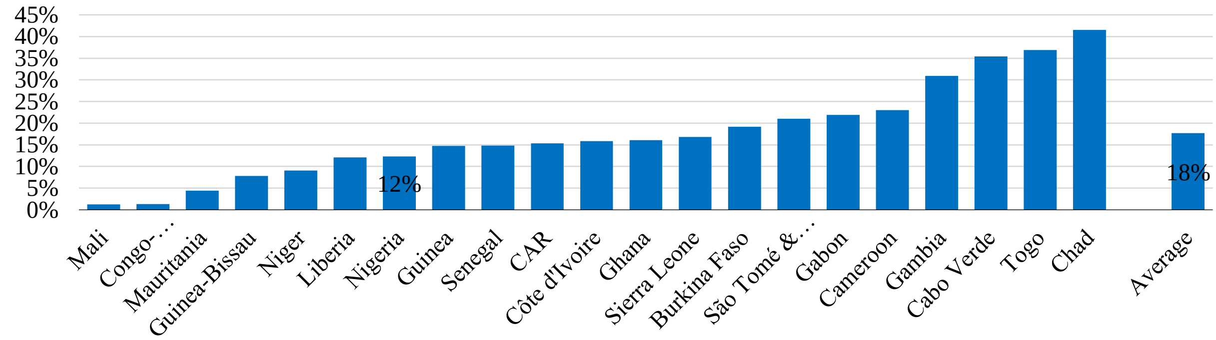
Reprioritising the health sector budget

Within the health sector, substantial fiscal room exists. Only 12% of government health expenditure currently supports RH, compared with an 18% regional average (Figure 2). Increasing this share to 20% by 2030 would directly and significantly expand access to maternal health and family planning services.



Source: Author's calculations based on Federal Government of Nigeria's Appropriation Bills 2020-2025 as well as fuel subsidy expenditure estimates in IMF Country Reports No. 25/157 (page 25) and No. 24/102 (page 25)
Notes: (i) Education includes Universal Basic Education Commission (UBEC) and Ministry of Education; (ii) Health includes Basic Health Care Provision Fund and Ministry of Health and Social Welfare; and (iii) WASH, Women & Poverty includes the Ministry of Water Resources and Sanitation, the Ministry of Women Affairs, and the Ministry of Humanitarian Affairs and Poverty Alleviation

Figure 1: Approved budget allocations in Nigeria by select sectors, 2020-25 (as % of total budget)



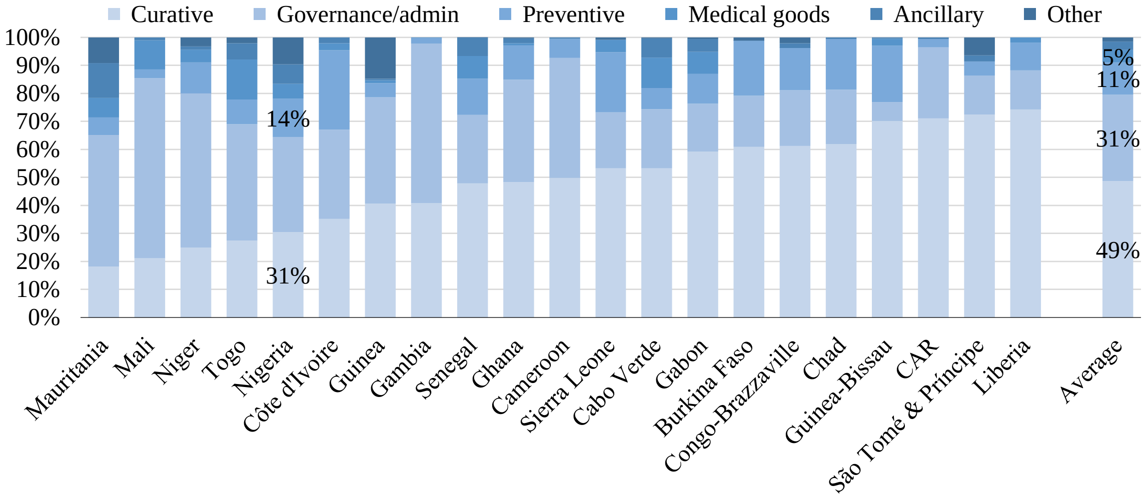
Source: Author's calculations based on WHO Global Health Expenditure Database (December 2024 Update)

Figure 2: Government expenditure on RH in select WCA countries, 2019-21 period average or latest available (as % of total government health expenditure)

The composition of spending is also misaligned. Capital investment accounts for just 4% of health expenditure, with 96% directed toward recurrent costs. Increasing capital spending to 10% by 2030—focused on infrastructure, diagnostics, obstetric equipment, and RH commodities—would help address persistent service delivery gaps. Preventive care is similarly underfunded, representing only 14% of health spending (Figure 3). Redirecting resources toward antenatal care, contraception, and community outreach would reduce downstream curative costs and improve system efficiency.

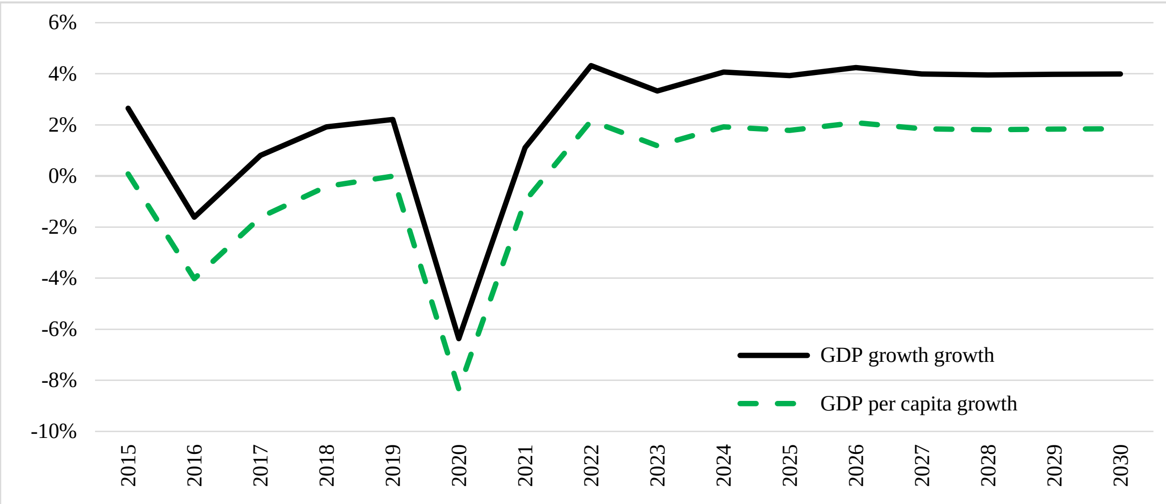
Increasing government revenue

Nigeria's medium-term economic outlook offers limited natural revenue growth. GDP is projected to rise from 3.9% in 2025 to 4.2% in 2026 before stabilising near 4%, below the regional average (Figure 4). The 2025 revenue-to-GDP ratio stands at just 9.6%, one of the lowest globally and less than half the WCA average of 19%. However, several revenue-enhancing measures are feasible. Short-term options include increasing taxes on luxury goods, harmonising excise taxes on alcohol, tobacco, and sugar-sweetened beverages with



Source: Author's calculations based on WHO Global Health Expenditure Database (December 2024 Update)

Figure 3: Government expenditure on health care functions in select WCA countries, 2019-21 period average or latest available (as % of total government health expenditure)



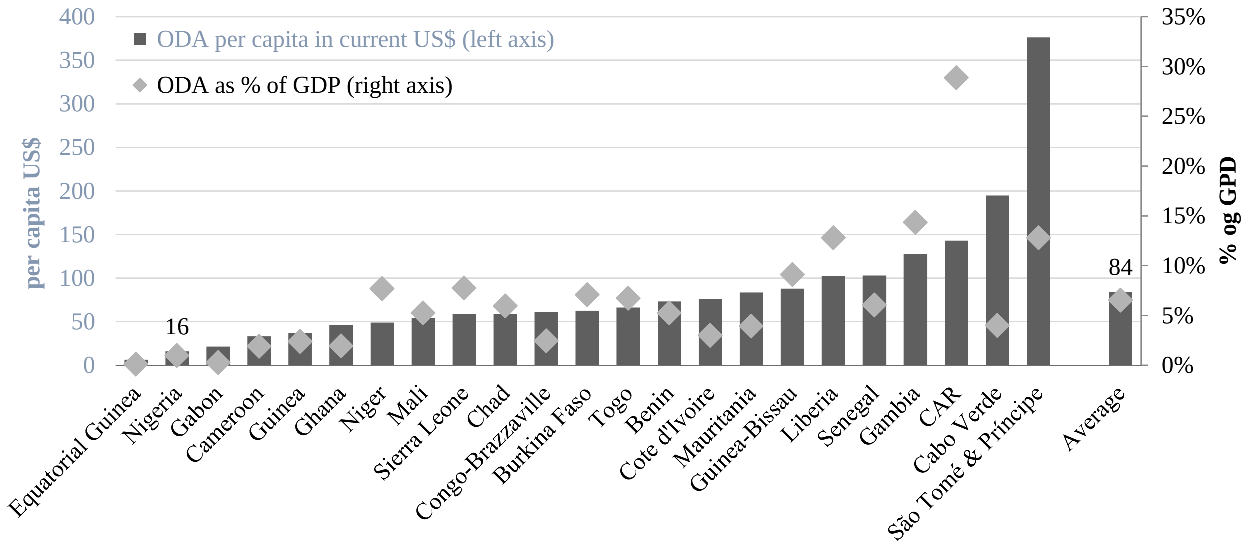
Source: IMF World Economic Outlook Database (October 2025)

Figure 4: GDP and GDP per capita growth in Nigeria, 2015-30 estimates (as %)

ECOWAS directives,[25] gradually raising the value added tax (VAT) rate from 7.5% to 10% by 2030,[18] and adjusting levies on large electronic transfers.[26] Medium-term strategies involve digitalising tax administration and simplifying compliance for small and medium enterprises (SMEs) and informal-sector operators. Over the longer term, tackling illicit financial flows—estimated at USD 5 billion annually[24]—could generate substantial fiscal gains. If combined, these measures could raise national revenue by 2–3 percentage points of GDP by 2030, yielding ₦700–₦1,100 billion annually and creating meaningful fiscal space for RH services.[27]

Official development assistance (ODA)

ODA remains central to Nigeria's RH programme, supporting contraceptive procurement, outreach, and health worker training. Between 2021 and 2023, Nigeria received USD 3.8 billion per year in ODA—0.9% of GDP or USD 16 per capita, which is among the lowest values in WCA in economic or population terms (Figure 5). Recent developments, including USAID's withdrawal from large-scale family planning support[29] and broader global reductions in health aid,[30, 31] have already resulted in delayed commodity shipments and widening state-level financing gaps.[32,33]



Source: Author's calculations based on OECD-DAC International Development Statistics database (2025)

Figure 5: Net ODA and official aid received in WCA countries, 2023 (in per capita USD and as a % of GDP)

Despite these pressures, Nigeria retains a strong case for strategic donor engagement given its demographic scale and global share of maternal mortality. Opportunities include preparing targeted investment cases for bilateral donors and international financial institutions (IFIs), maximising the UNFPA Match Fund through timely domestic commitments, and piloting a Midwife Match Fund in high-burden states with a donor-to-state matching ratio (e.g. 3:1). These approaches could stabilise commodity supply chains and maintain essential RH services during a period of tightening ODA. Figure 5

Borrowing and restructuring public debt

Following GDP rebasing in mid-2025, Nigeria's debt-to-GDP ratio is projected at 35% in 2026, declining to 33% by 2030—well below the WCA average (~60%) and under the 55% international sustainability benchmark[28] and the government's own 40% ceiling.[35] This suggests moderate room for strategic borrowing.

Prudent options include issuing long-term, Naira-denominated healthcare infrastructure bonds, which minimise foreign-exchange risk, and reviving diaspora bonds like the successful 2017 issuance.[36] Debt restructuring—through extended maturities, lower coupon rates or debt-for-health swaps—could also free fiscal resources without increasing debt stock.

Innovative financing

A range of innovative mechanisms could complement traditional public financing, including public-private partnerships (PPPs) for maternity and diagnostic infrastructure, blended finance for primary healthcare facilities, expanded community-based health insurance through the National Health Insurance Authority (NHIA), private-sector corporate social responsibility (CSR) contributions, and social impact bonds tied to outcomes such as contraceptive uptake or skilled birth attendance.

Priority scenarios and implementation constraints

Overall, 12 high-impact fiscal space options were identified as feasible between 2026 and 2030. Among those, key priorities include increasing the health budget share of the federal budget to 10%, allocating 20% of health spending to RH, raising preventive and capital spending in the health sector to 25% and 10% respectively, increasing taxes on luxury and 'sin' products, developing an investment case for greater ODA support from an IFI, and issuing a healthcare infrastructure bond.

However, several constraints may impede progress: political resistance to reallocating funds from defence and subsidies, institutional weaknesses in PFM systems, donor fatigue, and limited transparency in budget execution.

Successful implementation will require high-level political commitment, strengthened interministerial coordination, and robust monitoring frameworks to ensure that additional resources translate into measurable RH outcomes.

Discussion

This fiscal space analysis demonstrates that Nigeria's chronic underfunding of RH reflects weaknesses in allocation, governance, and prioritisation rather than an absolute scarcity of fiscal resources. Even within a constrained macroeconomic environment, multiple actionable pathways—particularly through budget reprioritisation, improved efficiency, and targeted revenue reforms—could expand public investment in RH services without undermining fiscal stability. The evidence shows that fiscal constraints are not purely financial; institutional inertia, fragmented accountability, and competing political priorities remain the more significant barriers.

The most substantial and immediately realisable gains lie within the structure of Nigeria's own budget. For over a decade, health has received less than 4% of federal expenditure, while subsidies and low-impact spending have consumed a disproportionate share of public resources. Redirecting even a modest fraction of these allocations could dramatically strengthen RH systems. International evidence consistently shows that shifting expenditure toward primary health care and family planning generates high social returns and supports long-term macroeconomic stability through reductions in fertility and improvements in labour productivity.[37,38] Within the health sector, inefficiencies further constrain progress. Nigeria's RH spending remains low relative to regional peers, and the composition of expenditure is skewed heavily toward recurrent costs, with limited investment in service delivery, infrastructure, or community outreach. A gradual rebalancing toward capital and preventive spending would improve both efficiency and resilience. Strengthened budget execution, expenditure tracking, and programme-based budgeting (PBB) are essential to ensure that allocated funds translate into measurable improvements in RH outcomes.

The results also highlight the significant potential of revenue reforms. Although Nigeria's tax-to-GDP ratio is among the lowest globally, gradual adjustments could cumulatively generate substantial fiscal space. These measures are more likely to gain political acceptance if directly linked to visible improvements in specific services (e.g. maternal health) and/or benefits (e.g. community-based health insurance schemes). Transparent communication that frames revenue measures as investments in national well-being can strengthen public trust.

However, domestic efforts alone cannot fully compensate for declining ODA. Nigeria's RH programmes have long depended on donors, and recent reductions—particularly the withdrawal of USAID's family planning support—have already resulted in stock-outs, service disruptions, and widening state-level financing gaps. Developing targeted investment cases for IFIs and bilateral partners, taking advantage of UNFPA's Match Fund, and piloting performance-based co-financing mechanisms could help stabilise commodity supply chains while Nigeria gradually increases domestic funding. Debt analysis shows moderate borrowing space that could be leveraged through strategic instruments such as long-term Naira-denominated health bonds or renewed diaspora bonds. Debt-for-health swaps present a non-debt-creating option for redirecting existing obligations toward RH priorities. Successful implementation, however, requires transparent governance frameworks and strong performance accountability.[39]

Innovative financing tools also offer potential. Expanding health insurance coverage through the NHIA provides a foundation for pooling resources and reducing out-of-pocket expenditures. Ensuring RH services within benefit packages would protect access for women and adolescents. Public-private partnerships (PPPs), blended finance structures, and CSR-supported community initiatives could complement public funding, particularly for infrastructure and supply chain strengthening, provided robust regulation safeguards equity and affordability.[40]

Overall, fiscal solutions must be paired with political commitment and institutional reform. Increases in RH financing will only be effective if accompanied by strengthened PFM systems, transparent reporting, citizen oversight, and gender-responsive budgeting. Interministerial coordination between finance, planning, and health authorities—at both federal and state levels—is essential to maintain RH as a priority amid competing demands.

A key contribution of this study is its integration of multiple, triangulated datasets—from federal budget documents to IMF macro-fiscal projections and WHO expenditure data—which enhances the credibility of the findings in a context where reporting systems remain fragmented.[41] By applying an expanded fiscal space framework tailored to RH, the analysis moves beyond narrow revenue-expenditure reviews and highlights feasible pathways grounded in Nigeria's real policy environment. This multidimensional approach aligns with global guidance emphasising the importance of efficiency gains, governance reforms, and targeted financing for accelerating progress toward UHC.[41,42] It also mirrors emerging best practice in low- and middle-income countries, where mixed-method fiscal diagnostics have been shown to improve the identification of politically viable reform options and strengthen dialogue between ministries of finance and health.[43] In addition, situating RH within a broader macro-fiscal narrative increases policy relevance, reflecting evidence that RH investments drive long-term gains in productivity, gender equity, and poverty reduction.[44]

However, several limitations must be acknowledged. The analysis relies heavily on secondary datasets that often lag by several years, constraining the precision of fiscal estimates. The focus on federal spending omits significant state-level variation in health financing, political commitment, and RH service delivery. Scenario estimates are indicative rather than predictive and cannot account for political shocks, revenue volatility, or administrative constraints. In addition, the assessment does not model distributional impacts of proposed fiscal measures on households—particularly women and adolescents—an area where fiscal incidence analysis would add value.[45]

Despite these constraints, the findings have clear implications for policy and practice. Nigeria could achieve rapid gains by reprioritising federal spending, strengthening budget execution, and framing revenue reforms as investments in maternal health. Experience from Ethiopia, Ghana, Rwanda, Tanzania, and The Gambia demonstrates that disciplined public expenditure and strong alignment with development partners can drive substantial improvements in RH outcomes even under constrained fiscal conditions.[46,47,48] Declining ODA highlights the need for targeted investment cases, performance-linked co-financing, and strategic use of blended finance to stabilise commodity supply chains. Finally, establishing a national compact on RH financing, with shared benchmarks and joint accountability, would help translate fiscal possibilities into sustained improvements in access, equity, and service quality.

Future analyses should incorporate up to date, disaggregated fiscal and expenditure data; model distributional and macroeconomic effects of RH investments more precisely; and broaden engagement to include state governments, civil society, and the private sector. Embedding routine fiscal space analysis within Nigeria's budget cycle would strengthen evidence-based decision-making and help ensure sustainable RH financing aligned with FP2030 and national commitments.

Conclusion

Nigeria has substantial but largely untapped potential to expand fiscal space for RH. Real progress will require political commitment, disciplined reprioritisation of public spending, and strengthened PFM to ensure that resources reach the frontline. By reallocating funds toward health, improving efficiency within the sector, mobilising targeted revenues, and building more resilient partnerships with development partners and private actors, Nigeria can close its RH financing gap and safeguard essential services. If implemented transparently and sustained over time, these reforms would accelerate progress toward universal access to RH care, reduce preventable maternal deaths, and support the country's broader ambition of inclusive, equitable, and sustainable development.

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Data availability

The original contributions presented in this study are included in the supplementary material. Further inquiries can be directed to the author.

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