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SPECIAL ARTICLE



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Transforming Nigeria's Health System to Address Contextual Challenges in Child Healthcare Training and Practice

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Abstract

Nigeria bears a disproportionate burden of child mortality, accounting for approximately 17% of global under-five deaths and having one of the highest under-five mortality rates in the world, estimated at 115.6 deaths per 1,000 live births. Most children die in the first month of life, with the neonatal mortality rate estimated to remain at about 41 deaths per 1,000 live births in the 2024 Nigeria Demographic and Health Survey. The pattern of child morbidity and mortality reflects marked geographical, socioeconomic, and demographic disparities. Children living in rural communities, conflict-affected areas, and poorer households face significantly greater risks of illness and death than those in urban and wealthier settings. From primary care interventions which have been demonstrated to improve child survival, such as immunisation, adequate breastfeeding, nutrition and oral rehydration therapy, it is of note that the current child health landscape presents a paradox of progress amidst persistent challenges. Mortality rates have declined, but the magnitude of preventable child deaths remains unacceptable. To accelerate progress, the country needs to address the contextual factors that undermine child survival, growth, and development. This requires a transformative approach to health system strengthening. In fact, the National Primary Health Care Development Agency (NPHCDA), which is the government institution mandated to drive the primary health care strategy in Nigeria, needs to be strengthened to overcome the constraints caused by persistent systemic challenges, including poor access to services, an insufficient health workforce, and suboptimal financing practices. The school health programme, school feeding programme and care of children with special needs are equally important child survival needs. To achieve sustainable economic growth, reducing child mortality should be viewed as a national development strategy rather than simply a health sector objective. Therefore, child healthcare providers and child health advocates are required to double down on advocacy focused on health policymakers, financiers, and the public. These steps will energise the existing health system and boost and sustain other public health interventions that are relevant to child survival.

(Being the text of the lecture delivered at the National Postgraduate Medical College of Nigeria, Faculty of Paediatrics Day Lecture on 3rd August 2026.)

Introduction

The poor state of child healthcare in Nigeria remains a major public health challenge. The country bears a disproportionate burden of child mortality, accounting for approximately 17% of global under-five deaths and having one of the highest under-five mortality rates in the world, estimated at 115.6 deaths per 1,000 live births.[1] The majority of children die in the first month of life, with the neonatal mortality rate estimated to remain at about 41 deaths per 1,000 live births in the 2024 Nigeria Demographic and Health Survey.[2] The pattern of child morbidity and mortality reflects marked geographical, socioeconomic, and demographic disparities. Children living in rural communities, conflict-

affected areas, and poorer households face significantly greater risks of illness and death than those in urban and wealthier settings. Regional differences are particularly striking, with children in the northern regions experiencing substantially worse health outcomes than those in the southern regions. Southwest reports the best chance of survival in the country, with an under-5 mortality rate of 40.5 per 1000 live births, compared to the highest risk for child survival in the Northwest, with an under-5 mortality rate reaching 137.7 per 1000 live births.[2] This calls for a closer look at the factors, interventions and modes of execution of interventions aimed at reducing child morbidity and mortality in the different regions of the country.

Child Healthcare Trend in Nigeria

The global under-five mortality rate has declined dramatically over the past several decades. In 1990, approximately 93.5 deaths occurred per 1,000 live births globally among children under five years of age. By 2024, this had fallen to 37.4 deaths per 1,000 live births, representing an overall reduction of approximately 60%.[1] Nigeria has also recorded substantial progress in child survival. In 1975, the country's under-five mortality rate was approximately 244 deaths per 1,000 live births. By 1979, it was approximately 219 per 1,000 live births.[3] Currently, the under-5 mortality rate of about 115.6 per 1,000 live births reveals a remarkable decline, but one that still leaves the country with an unacceptably high burden of preventable child deaths.

These achievements demonstrate the impact of our collective efforts - government, healthcare professionals, development partners, researchers, and communities- through decades of investment in immunisation programs, improved control of malaria, diarrhoeal diseases and pneumonia, maternal and newborn care, and the management of common childhood illnesses. Nevertheless, the pace of progress remains inadequate.

The major contributory factors to the inadequate reduction of child morbidity and mortality include demographic issues, literacy issues, especially the inadequate education of mothers, political will instability and poor sustainability of efforts, inadequate immunisation coverage, loss of trained health workforce, nutrition inadequacies and inadequate optimisation of data generation and collation in planning, and of course, the alarming insecurity in the land.

Fast Growing Population

Nigeria's population is estimated at 237 million people,[1] with an estimated annual birth cohort of 7.64 million in 2023.[3] This rapidly growing population, with a growth rate of approximately 2.1%, results in nearly 105 million of the population being children and adolescents aged 0–17 years, representing almost half of the country's total population. This demographic profile highlights our country as a predominantly young nation and underscores the enormous responsibility placed on the paediatric healthcare providers, and indeed on our government.

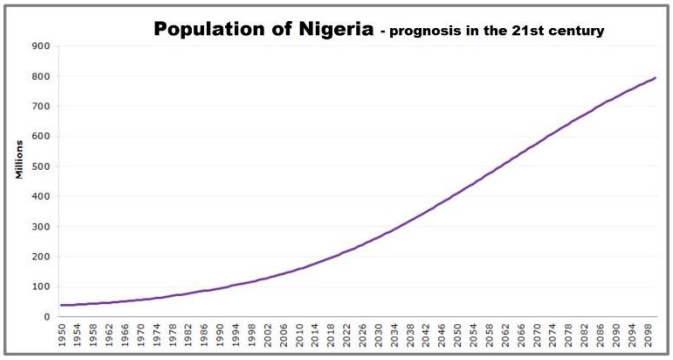


Figure 1: Population Trend of Nigeria
Source:
https://commons.wikimedia.org/wiki/File:Nigeria_population_prognosis.jpg
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Adolescent Health

Adolescence, the bridge between childhood and adulthood, constitutes a substantial proportion of our population, and the health risks and opportunities of this stage of life profoundly

shape the nation's future human capital. However, in Nigeria, this period is fraught with numerous and overlapping challenges. These include limited access to health services tailored for adolescents, malnutrition, mental health issues, substance abuse, risks related to sexual and reproductive health, gender-based violence, and the continuing problems of school dropout, child marriage, and teenage pregnancy in some parts of the country.[4] For this reason, adolescent health must no longer be treated as a peripheral concern within paediatrics or public health, but as a strategic national priority.

In our effort to sustain this reality, my colleagues and I decided to institute the Adolescent Paediatrics Society of Nigeria in 2025 (APSON). We believe that Nigeria must invest deliberately in comprehensive adolescent-responsive primary healthcare services, mental health support, and evidence-based sexuality and life-skills education, while also protecting adolescents—especially girls—from harmful social practices and structural inequities.

Registration Gaps

The births of only about 40% of children under five years of age are registered in Nigeria.[2] Consequently, a significant proportion of the large birth cohort remains unregistered, creating an important gap in population data. This undermines accurate population estimates and limits effective planning, resource allocation, and delivery of healthcare services, particularly for children. Strategic engagement with communities is therefore essential to addressing this gap. One approach worth exploring is to link birth registration and the issuance of birth certificates to access to essential services and benefits, such as eligibility for primary school enrolment at the appropriate age. Such an approach could create an incentive for timely birth registration while strengthening the government's capacity to accurately identify children and plan for and deliver essential health and social services to every child.

Disease Burden

The burden of diseases is largely due to preventable causes such as prematurity, birth asphyxia, neonatal infections, pneumonia, diarrhoea, malaria and other vaccine-preventable diseases, and malnutrition. However, there is a growing prominence of the impact of non-communicable diseases, such as congenital disorders, developmental disabilities, mental health issues, childhood cancers, injuries, environmental hazards, the growing impact of climate change, urbanisation, forced displacement due to insecurity and economic instability.

Also, malnutrition is estimated to be a direct or underlying cause of about 45% of deaths among children under five, while also contributing substantially to morbidity through stunting, wasting, micronutrient deficiencies, increased susceptibility to infection, impaired growth, and poor neurodevelopmental outcomes. In our practice, we find that the nutritional challenges in some urban settings such as Lagos are complex because of the coexistence of undernutrition and emerging childhood obesity. This calls for ongoing studies to discern the causes and to determine if this may be linked to the growing number of fast-food restaurants in such cities.

Global health emergencies have also exposed the vulnerabilities within our health system. During the COVID-19 pandemic, there was disruption of vaccine supply chains, routine immunisation, healthcare utilisation, training programs, and healthcare financing. The pandemic underscored the need for resilient health systems capable of maintaining essential child health services during crises. It was a wake-up call that we need to sustain preparedness for prompt health crisis resolution. It should never be forgotten that the

opportunity to seek superior health services in Europe and America was obliterated. In a qualitative study of healthcare workers' perspectives on preparedness of healthcare facilities for the outbreak of communicable diseases in Nigeria published in 2019, 98.4% of HCWs did not consider their health care facilities sufficiently equipped to respond to disease outbreaks.[5]

Technology and Health

There is a rapid expansion of technology in the contemporary environment in which children are growing and developing. This is an added layer of concern for us about its influence on human physical, mental, and social well-being. Consequently, several important questions arise. What are the effects of exposure to electromagnetic radiation from wireless technologies on the developing foetus, infant, and child? How does increased screen exposure influence cognitive, emotional, and social development? What impact does digital technology have on the formation of healthy relationships among children and adolescents and indeed with adults? Furthermore, how does unrestricted access to global media influence cultural values, behaviours, and identities, particularly when parents may have limited ability to monitor or regulate such exposures?

While digital technology such as social media and online communities can strengthen and expand social connection platforms where children and adolescents maintain relationships with family and friends, there is also a growing concern that the same technology can interfere with the development of healthy relationships through reduced quality of face-to-face interactions. Excessive screen use can replace conversations, play time, family activities and other experiences through which children would normally learn empathy, regulation of emotions and social skills. Ongoing research is therefore essential to ensure that policies and interventions adequately adapt to protect and promote the well-being of future generations.

Interventions that improve child survival and development

Despite these challenges, the gains recorded from several strategic interventions demonstrate that optimisation of child healthcare delivery in Nigeria is both feasible and achievable. Notable improvements in child survival and development have been associated with the implementation of the Expanded Program on Immunisation (EPI), the introduction of additional life-saving vaccines into the national immunisation schedule, strengthened malaria prevention and control strategies, adoption of the Integrated Management of Childhood Illness (IMCI) approach, improvements in essential newborn care practices, and sustained advocacy for child health. Collectively, these interventions provide compelling evidence that with deliberate policy action, adequate investment, and sustained effective implementation, substantial progress in child health outcomes can be achieved.

In this regard, professional bodies such as the Paediatric Association of Nigeria (PAN) must sustain advocacy and communication. Concerted efforts to highlight immunisation as a proven life-saving tool led to the highly visible advocacy effort: the first National Vaccine Summit, convened in Abuja on 16–17th April 2012, brought together more than 1,000 stakeholders to strengthen political commitment, financing, accountability, and ownership of routine immunisation. PAN, in collaboration with The Johns Hopkins University International Vaccine Access Centre (IVAC) and the National Primary Health Care Development Agency (NPHCDA), hosted the event with the theme, “Vaccines save lives”.[6] This was an opportunity to highlight that pneumonia is a major killer of our children and that pneumococcal conjugate vaccine is effective.

PCV was subsequently introduced into the Routine Immunisation (RI) program in Nigeria in 2014. In the 2023 publication in Human Vaccines & Immunotherapeutics, Iliya *et al.* revealed that the proportion of hospitalised pneumonia cases decreased after 3 years of PCV 10 introduction into the National Immunisation Program in Nigeria.[7]

Immunisation Coverage

However, immunisation coverage in Nigeria remains suboptimal. Using the 2024 WHO/UNICEF national immunisation estimates (WUENIC)[8], the approximate coverage rates are as depicted in Table I.

Table I: Immunisation Coverage Rates of Three West African Countries

Country	DPT3 Coverage (Penta-3) (%)	MCV1 Coverage (%)
Nigeria	67	57
Ghana	99	95
Senegal	87	87

DPT3- Diphtheria Pertussis Tetanus Third Dose; MCV1-Meningococcal Vaccine First dose

Given Nigeria's very large annual birth cohort, the country continues to bear the highest burden of zero-dose and under-vaccinated children globally. In 2023, an estimated 2.1 million Nigerian children had not received a single vaccine dose, while several million more remained only partially immunised or under-vaccinated.[9] These children are disproportionately found in hard-to-reach rural settlements, urban slums, insecure communities, nomadic populations, and border areas, where RI services are often weak or inconsistent. The National Primary Health Care Development Agency (NPHCDA) has continued to intensify efforts to identify and reach these missed children through expanded outreach, mobile vaccination services, periodic intensification of routine immunisation, and zero-dose reduction strategies, with critical support from development partners including WHO, UNICEF, Gavi, and other implementing agencies.

Oral Rehydration Therapy (ORT)

The introduction of ORT into Nigeria in 1979[10] was, in many respects, a defining moment in the history of child survival in our country. At a time when diarrhoeal diseases claimed the lives of far too many Nigerian children, ORT brought into practice a remarkably simple, affordable, and life-saving intervention that altered the trajectory of paediatric care. More importantly, it shifted the response to childhood diarrhoea beyond the hospital ward, placing into the hands of mothers, families, and communities an effective means of preventing death from dehydration.

Breastfeeding Hospital Initiative (BFHI)

The challenges to improve breastfeeding in Nigeria demonstrate a paradox: breastfeeding is nearly universal in practice, yet optimal breastfeeding (early initiation, exclusivity, and adequate duration) has remained persistently suboptimal, with exclusive breastfeeding plateauing at about 29% in recent years despite decades of promotion.[2]

The Innocenti Declaration, an international agreement adopted in Florence, Italy, in 1990, called for the protection, promotion, and support of breastfeeding worldwide.[11] Following this global commitment, the Baby-Friendly Hospital Initiative (BFHI) was launched in Nigeria in 1992, in partnership with the United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO), to promote and strengthen breastfeeding practices within health facilities.[12] This breastfeeding initiative, though widely acknowledged as one of the most cost-effective

and life-saving child survival strategies, has yet to achieve the sustained impact on infant malnutrition that was originally envisaged.

The initiative was rapidly embraced by paediatricians, particularly neonatologists, who understood the central role of optimal breastfeeding in promoting neonatal survival, preventing infection, and improving nutritional outcomes in early life. Considerable effort was invested in ensuring that health facilities, especially hospitals providing maternal and newborn services, adopted breastfeeding-friendly policies and practices in line with the principles of the initiative.



Figure 2: Breastfeeding Trend (0-6 months) in Nigeria

Yet, the enduring challenge has been the translation of this facility-based success into sustained community-level impact. While hospitals and health professionals were mobilised to champion breastfeeding promotion, the corresponding effort to carry this message to the grassroots—where many mothers live, deliver, and nurture their infants outside formal health facilities—in my opinion, was not pursued with equal vigour or continuity. This represents a critical limitation in the implementation of the initiative. In many of our communities, childbirth still occurs beyond the walls of health facilities, and a substantial proportion of young mothers remain unreached by structured breastfeeding counselling and support.

Moreover, new young women emerge each day, often with limited access to accurate information and sustained guidance. For this reason, the message of breastfeeding cannot remain confined to hospitals, nor can it be delivered as a one-off campaign. It must be institutionalised as a continuous community conversation, embedded within primary healthcare, maternal education, social support systems, and local communication structures. Only through such sustained and grassroots-driven engagement can the transformative potential of the Breastfeeding Initiative to improve child survival outcomes be fully realised.

Health Education Investment

Investment in the health education of young mothers is a critical strategic imperative for improving access to healthcare and stimulating informed demand for essential health services. By equipping mothers with the knowledge, skills, and confidence to recognise health needs, seek timely care, and engage appropriately with available services, health education becomes a central pillar for strengthening health-seeking behaviour, improving service utilisation, and ultimately enhancing maternal and child health outcomes. For instance, health education empowers parents and caregivers with the knowledge and confidence to seek and demand routine immunisation services. Sustained utilisation of routine immunisation will, in turn, optimise immunisation coverage, strengthen community ownership, and reduce reliance on periodic supplementary immunisation campaigns in the effort to improve immunisation coverage. Therefore, there is an urgent need to step up and sustain health education at the grassroots level.

Nigerian Health System

The current child health landscape therefore presents a paradox of progress amidst persistent challenges. Mortality rates have declined, but the magnitude of preventable child deaths remains unacceptable. To accelerate progress, our country must address the contextual factors that undermine child survival, growth, and development. This requires a transformative approach to health system strengthening. The challenge before us is, therefore, not merely to sustain current interventions but to transform the health system in ways that accelerate progress, reduce inequities, and ensure that every Nigerian child has an equal opportunity to survive, grow, and attain full developmental potential. I believe that the answer lies largely within the strengths and weaknesses of our health system.

The management of health is complex and requires multidisciplinary and multidimensional strategies to address the diverse socio-economic, environmental, and political determinants of health. Effective healthcare delivery depends on the strength and integration of the six core building blocks of a health system: leadership and governance, service delivery, the health workforce, health financing, access to essential medicines and health technologies, and robust health information systems.[13] Weakness in any one of these components compromises the performance of the entire health system, underscoring the need for coordinated investment and sustained policy commitment across all domains.

1. Leadership and Governance

The provision of an enabling environment for the achievement of optimal health is a fundamental responsibility of government. The health status of a population remains one of the most important indicators of good governance and national development. Nigeria operates a three-tier health governance structure. Primary Health Care (PHC) services are primarily the responsibility of Local Government Authorities, with technical oversight and support from State governments. Secondary healthcare services are provided through General Hospitals managed by State Governments, while tertiary healthcare services are delivered through Teaching Hospitals and Federal Medical Centres under the supervision of the Federal Government.

Strong leadership and governance are critical for policy formulation, strategic planning, resource allocation, accountability, regulation, and coordination at all levels of care. While the Nigeria Child Health Policy of 2022 directs the strategic management of child health in the country, the Federal Government of Nigeria,[14] with technical support from UNICEF, published an updated *Situation Analysis of Children and Adolescents in Nigeria in 2024 (SitAn)*.[9] The report examined key areas affecting the wellbeing of children and adolescents, including child rights, survival and development, education and learning, child protection, social protection, adolescent development, and the impact of climate change. The report highlighted several important achievements, including improvements in birth registration, reductions in child mortality, and increased childhood immunisation coverage. However, the desired outcomes are still inadequate due to suboptimal policy implementation and sustainability, weak accountability processes, and insufficient investment.

Transformation of the health care delivery in the country must confront a reality that is too often overlooked: child survival does not depend on the health sector alone. The quality of our roads, electricity, water supply, sanitation, housing, education, and other essential infrastructure has a profound impact on whether a sick child lives or dies. Of particular concern is the state of electricity supply to our health facilities. Reliable

electricity is not a luxury. It is not a matter of convenience. It is a basic requirement for safe healthcare. Yet, in some parts of our country, caesarean sections and other life-saving procedures are still performed under the light of lanterns or mobile phones because electricity is unavailable or unreliable. We cannot accept this as normal in a country that is determined to improve the survival and wellbeing of its children.

The consequences go far beyond the immediate danger to mothers, newborns, children, and healthcare workers. When health facilities are forced to depend on multiple generating sets, the cost of providing care rises, environmental pollution increases, essential equipment is placed at risk, and scarce resources that should be directed towards patient care are diverted to keeping the lights on. Electricity is only part of the problem. A health facility without a reliable supply of safe water cannot provide safe healthcare. Water is indispensable for infection prevention and control, sanitation, hygiene, cleaning, sterilisation, and the basic dignity of patients and healthcare workers.

2. Service delivery

The family represents the first and most important unit of child healthcare. While government has the responsibility of creating an enabling environment for child survival and development, parents also have a fundamental responsibility for the health and wellbeing of their children. Child-rearing extends beyond emotional commitment and requires adequate financial, nutritional, educational, and healthcare resources. Large family sizes in resource-constrained settings may contribute to inadequate nutrition, delayed healthcare-seeking behaviour, poor educational attainment, and increased vulnerability to disease. At the health-system level, effective service delivery requires equitable access to affordable, quality preventive, promotive, curative, rehabilitative, and palliative health-care services that are responsive to the needs of children. These are the core principles of Universal Health Coverage (UHC), a central commitment under Target 3.8 of the Sustainable Development Goals (SDGs), which calls on all countries to achieve UHC by 2030—ensuring that every person can access the health services they need, without suffering financial hardship.[15]

Primary Health Care

The Alma-Ata Declaration of 1978 emphasised Primary Health Care as the key strategy for achieving "Health for All."[16] Nearly five decades later, it is believed to be the most cost-effective strategy for improving child survival and reducing health inequalities.

The efforts of the National Primary Health Care Development Agency (NPHCDA), the government institution mandated to drive the primary health care strategy in Nigeria, deserve due recognition. Nevertheless, the effectiveness of primary health care (PHC) continues to be constrained by persistent systemic challenges, including poor access to services, inadequate availability and sustainability of proven high-impact interventions, an insufficient health workforce, and suboptimal financing practices.

Basic Healthcare Provision Fund (BHCPF)

In an effort to expand access to essential health services, reduce out-of-pocket spending, and strengthen PHC nationwide, the Basic Health Care Provision Fund (BHCPF) was initiated in Section 11 of the National Health Act, 2014[17] to provide a dedicated and predictable pool of public funds [1% of the Federal Government's Consolidated Revenue Fund (CRF)] for a Basic Minimum Package of Health Services.

The fund is shared by some agencies in FMOH, with the sharing formula being 45% to NPHCDA, 48.75% to National Health Insurance Authority (NHIA), 5% to emergency medical treatment, and 1.25% to Nigeria Centre for Disease Control and Prevention (NCDC).[18]

BHCPF is highly relevant for child survival interventions because it funds the PHC services - immunisation, treatment of common childhood illnesses, antenatal and postnatal care, nutrition services, growth monitoring, malaria and diarrhoeal disease management, and referral of sick newborns and children. However, the impact of the fund has not been significant going by the health indices.

A major World Bank-funded healthcare initiative, IMPACT Project (Immunisation Plus & Malaria Progress by Accelerating Coverage and Transforming Services), aimed at reducing under-five mortality and improving maternal care across the country, was also introduced in February 2020.[19]

This transformation is also driving the strengthening of PHC across the country. Nigeria is currently undertaking a nationwide program of PHC renovation, rehabilitation, and expansion aimed at improving access to quality essential health services. Of the country's 8,309 PHC facilities, 4,748 are functioning optimally (Level 1). However, 3,137 facilities remain sub-optimally functional at Level 1, while a further 424 are classified as sub-optimally functional at Level 2.[20] These figures highlight both the significant progress achieved and the substantial investments still required to ensure that all PHC facilities are equipped to deliver comprehensive, high-quality primary healthcare services.

The project has also driven an extensive cold-chain optimisation that promises to transform vaccine storage in the country by solar direct drive systems (SDD) replacement of old, grid-reliant or gas-powered refrigerators, thus protecting vaccines at ideal temperatures without relying on the unstable electrical grid of the country.

School Health Program

School health constitutes a critical public health intervention for promoting, protecting, and sustaining the health of children. School enrolment and attendance can serve as important entry points for strengthening birth registration, improving record-keeping, and reinforcing routine immunisation uptake. In this way, the school system becomes not merely a place of learning, but also a mechanism for ensuring that children are visible within essential health and social protection systems.

While concerns are sometimes raised that linking school attendance to health-related requirements may discourage educational participation, this assumption should not be accepted. Rather, it requires careful empirical evaluation to determine whether such measures truly constitute barriers to school enrolment, or whether, if appropriately designed and implemented, they may in fact strengthen both health-seeking behaviour and educational engagement.

School Feeding Programme

Another critical area of intersectoral collaboration lies in the partnership between the ministries of education, health, and agriculture to ensure the sustainability of school feeding programs. Several school feeding initiatives are often well conceived in the country. However, their long-term continuity has frequently been undermined by weak institutionalisation, inconsistent financing, and limited multisectoral ownership.

Beyond its nutritional value, a sustainable school feeding programme should be regarded as a strategic social investment—not simply a welfare intervention. If properly designed and consistently implemented, it can improve child health and nutrition, increase school enrolment, attendance and retention, stimulate local agricultural production, create livelihoods, and

strengthen parents' willingness and ability to keep their children in school.

School feeding therefore provides a practical convergence point for health promotion, education, social protection, and agricultural development. It is an investment in the child, the family, the community, and ultimately in the nation's human capital. This approach should progressively replace the *ad hoc* and occasional palliative interventions that too often characterise our response to poverty. Palliatives may provide temporary relief, but they rarely alter the underlying circumstances that perpetuate deprivation. A well-designed school feeding programme, by contrast, is structured, targeted, sustainable and measurable. It can put resources directly where they can have the greatest long-term impact—on children and families—while simultaneously supporting local farmers and strengthening the food system.

Children with Special Needs

Every Nigerian has the right to equitable access to healthcare and to be recognised within the health system. This principle must include the recognition and protection of Child Rights in the planning and delivery of health services. Among the most vulnerable are children with special healthcare needs—those living with developmental, intellectual, physical, behavioural, and emotional disabilities—who require continuous, multidisciplinary, and often lifelong care.

Paediatricians have consistently advocated for policies, services, and resources to meet the needs of these children. Yet, despite this sustained advocacy, the Nigerian health system continues to place much of the responsibility for their care on non-governmental organisations, faith-based organisations, charitable foundations, and private providers. While these institutions have made invaluable contributions, they cannot substitute for a comprehensive, publicly supported system of care.

What can we do differently? Are we investing in early developmental screening at the primary healthcare level? Are we training sufficient developmental paediatricians, child psychiatrists, psychologists, speech and language therapists, occupational therapists, physiotherapists, and special educators? Are we integrating developmental and behavioural services into routine child health programs? Are families protected from catastrophic out-of-pocket expenditure? Are inclusive education and social protection policies being effectively implemented?

Nigeria must move beyond advocacy to action by embedding developmental and disability services within universal health coverage, strengthening early diagnosis and intervention, expanding the specialist workforce, supporting caregivers, and ensuring that every child—regardless of ability—is afforded dignity, opportunity, and the highest attainable standard of health. The true measure of a nation's commitment to child health is not how well it serves the healthiest children, but how faithfully it protects and empowers those who need its support the most.

Private Health Sector and Child Health

The health system and services study by the Health Policy Research Group (HPRG) of the University of Nigeria, Nsukka (UNN), in collaboration with the Federal Ministry of Health and Social Welfare (FMOH&SW) and the World Health Organisation (WHO) in 2025 revealed that the private health sector contributes about 70% to the country's health sector.[21] This reality underscores the importance of the private sector as an indispensable component of the national health system. The report revealed that the government oversight in this sector needs transformation. There is a need to address the

poor utilisation of available human resources for health in the country. While the private sector has long benefited from drawing on the expertise and clinical experience concentrated within public secondary and tertiary institutions, there is a compelling case for a more reciprocal relationship—one in which the public sector also develops deliberate mechanisms to harness the underutilised skills, competencies, and service capacity that exist within parts of the private sector. A more integrated and strategically coordinated health workforce model would reduce waste, expand access to specialist care, and improve the overall productivity of the health system.

Within the public sector, the establishment of a dedicated Children's Specialist Hospital in each of Nigeria's six geopolitical zones would serve not only as centres of excellence for paediatric care, but also as hubs for training, research, innovation, and multidisciplinary management of complex childhood diseases. In this regard, the Lagos State Government under the leadership of Governor Babajide Sanwo-Olu deserves commendation for its ongoing effort to transform the first Children's Specialist Hospital in the country, Massey Street Children's Hospital, through relocation, expansion, and modernisation. This is a visionary investment in the future of child health, and the successful completion of this landmark project is expected soon.

3. Health Workforce

There have been remarkable advances in medical technology. However, healthcare remains fundamentally dependent on human resources. There is no healthcare service without healthcare workers. The availability, distribution, competence, and motivation of health personnel directly determine the effectiveness of health systems. The human resource gaps in the country continue to widen due to population growth, migration of healthcare professionals, inadequate recruitment, and limited training capacity. These shortages are particularly severe in rural and underserved communities, where child mortality rates remain significantly higher than in urban areas.

This situation constitutes a public health emergency requiring innovative solutions, including accelerated workforce training, improved remuneration, retention strategies, and strategic re-engagement of experienced retired but not tired healthcare professionals in supervisory and mentoring roles.

Healthcare training programs must continuously be context-specific to adapt to the changing disease patterns, technological advances, and emerging healthcare needs. This calls for closer and regular periodic curriculum review, strengthened continuing professional development, and competency-based training to enhance quality healthcare services. Equally important is the need to expand institutional collaboration through structured exchange programs, sabbatical opportunities, and inter-institutional partnerships within the country. These collaborative efforts could also be facilitated by technology-enabled approaches, such as telemedicine, which can enhance communication, knowledge sharing, and access to specialist expertise across geographical and institutional boundaries. Such initiatives would enrich clinical exposure, deepen professional experience, and promote the cross-fertilisation of ideas, skills, and best practices across regions and levels of care.

4. Medical products, vaccines, and technologies

The availability of safe, effective, and affordable medicines, vaccines, diagnostics, and medical technologies is essential for child survival and development. Therefore, inventory management, procurement systems, warehousing,

transportation, and cold-chain maintenance are critical components of healthcare delivery.
The increasing role of digital technologies, telemedicine, electronic medical records, and artificial intelligence also presents opportunities to improve healthcare access, quality, and efficiency. It is time for a pilot study to compare technology-driven Primary Health Care (PHC) service in a human resource-poor setting to the present PHC service delivery model.

5. Health Information Systems

Reliable health information is fundamental for evidence-based decision-making, planning, monitoring, and evaluation. A functional health information system enables policymakers and healthcare providers to identify disease trends, allocate resources effectively, monitor program performance, and respond rapidly to public health emergencies. For child health, accurate data on births, deaths, immunisation coverage, nutrition status, disease burden, and healthcare utilisation are essential. Unfortunately, weaknesses in data collection, reporting, analysis, and utilisation continue to limit effective decision-making in Nigeria.

The efforts of the Nigeria Centre for Disease Control and Prevention (NCDC) to strengthen and scale up digital health systems have significantly improved disease surveillance and the availability of timely health information. However, surveillance must be complemented by a stronger culture of research and evidence generation within our academic institutions. Government should deliberately challenge and support academia to undertake context-specific, policy-relevant research that addresses the realities of child health in Nigeria. Strengthening this research–policy interface will provide the evidence needed to improve programme planning, guide resource allocation, measure outcomes, and strengthen accountability for child healthcare programmes.

6. Health Financing

The increasing complexity of healthcare delivery demands greater attention to health economics, particularly in resource-constrained environments such as Nigeria. Adequate financing is necessary for infrastructure development, workforce recruitment, procurement of medicines and vaccines, and maintenance of healthcare facilities.

In April 2001, the African Heads of State and Government meeting in Abuja adopted the Abuja Declaration, pledging to set a target of allocating at least 15% of their annual national budgets to improving the health sector.[22] More than two decades later, many African countries, including Nigeria, continue to fall short of this target. Only about 5.2% of the national budget is allocated to health in the 2025 national budget. This is grossly inadequate for the enormous task of optimising healthcare, especially for achieving functional and equitable PHC. The issue extends beyond allocation alone. Equally critical is the timely and consistent release of appropriated funds, without which the seamless delivery and sustainability of essential services cannot be guaranteed.

Healthcare financing in the country remains heavily dependent on out-of-pocket expenditure by households. This creates significant financial barriers to healthcare access and often results in delayed care-seeking, catastrophic health expenditures, and preventable child deaths. Many families struggle to afford healthcare costs, especially for chronic illnesses, neonatal care, intensive care services, and specialised treatments.

The National Health Insurance Authority (NHIA) Act of May 2022 replaced the National Health Insurance Scheme (NHIS) Act of 2004.[23] The new Act makes health insurance mandatory for all citizens and residents and provides a framework for promoting and regulating health

insurance schemes towards achieving universal health coverage (UHC). It also provides for key funding mechanisms, including the Basic Health Care Provision Fund (BHCPF). Although enrolment has increased in recent years, significant operational challenges continue to constrain the achievement of the Act's objectives. Coverage remains concentrated largely among the formal sector, with substantial gaps in enrolment and coverage within the informal sector. A review of the current operational model, with deliberate decentralisation of oversight and implementation functions, is therefore needed to improve efficiency, reduce administrative bottlenecks, expand coverage, and accelerate progress towards UHC.

Furthermore, innovative strategies are needed to address the contextual funding gaps within our healthcare system. There is a growing need for our country to strengthen its health sovereignty and build greater domestic resilience as donor fatigue becomes increasingly apparent. Political rhetoric and policy actions in other countries are also challenging the capacity and sustainability of development partners and traditional donors to support health programs in low- and middle-income countries. These developments present an important opportunity for Nigeria to adapt, diversify, and strengthen its domestic resource mobilisation mechanisms to address current and emerging gaps in healthcare financing.

For a start, a careful review of the new tax law reveals a credible effort to enhance healthcare delivery. However, there is a need to connect environmental impact analysis of industries such as petroleum and mineral drilling companies, cigarette manufacturers, plastics industries, fume generating industries to healthcare challenges created by the environmental impact of their activities. There is a need to refine the tax of such industries and direct the funds generated accordingly to specific healthcare budgetary allocations.

Accountability is the often-invisible bedfellow of national progress, and nowhere is this more evident than in Nigeria's health sector. In my opinion, we do not lack clarity of goals and objectives, but sustained commitment to agreed priorities and continuous communication among all stakeholders to secure genuine ownership and coordinated action. We also need to step up on regular monitoring and periodic evaluation, not merely as administrative exercises, but as essential mechanisms for identifying gaps in our health system, correcting course, and ensuring that policies translate into measurable improvements in health outcomes, especially for our children, the future of our country.

Relevance of Health to National Economy

The world appears to be getting increasingly transactional and less empathetic. Appeals based solely on compassion, though morally compelling, may no longer be sufficient to drive sustained investment in child health. Consequently, as advocates for child survival, we must transform our presentation of healthcare not merely as a social service, but as an investment with measurable returns. Our training often conveys the ideal that because healthcare is a government responsibility, it ought to be free. Healthcare is never free; someone always pays.

Countries that provide "free" healthcare, such as the United Kingdom, Canada, and the Scandinavian nations, finance these services through taxation and social insurance. In contrast, countries such as the United States rely heavily on private insurance and market mechanisms. In Nigeria, a substantial proportion of healthcare expenditure is financed directly by households through out-of-pocket payments, exposing families to deepening poverty. The often-debated question of whether human capital development or economic development should take precedence presents a false dichotomy. The two

are intrinsically interconnected, as sustainable economic development cannot be achieved without investing in and strengthening human capital.

Conclusion

Children, therefore, represent not merely dependents requiring expenditure but strategic national assets. If Nigeria seeks sustainable economic growth, reducing child mortality should be viewed as a national development strategy rather than simply a health sector objective. Therefore, to secure political commitment and sustained investment, we must, as child healthcare providers and child health advocates, articulate messages that resonate with policymakers, financiers, and the public. Among all public health interventions, immunisation remains one of the most cost-effective. Vaccines have contributed to the eradication of smallpox, the near elimination of poliomyelitis, and dramatic reductions in measles, diphtheria, pertussis, tetanus, and invasive bacterial diseases. Beyond saving lives, vaccination reduces healthcare costs, prevents disability, increases school attendance, and enhances economic productivity. Immunisation is, therefore, not merely a health intervention; it is an economic development strategy to pursue with keen vigour by us all.

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