FOR POLICYMAKERS & PUBLIC SERVANTS

Dying to Give Life

Delivering Nigeria's Maternal Health Guarantee

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Editor's Note

SimpleFix Nigeria exists because policy analysis in this country too often ends with identifying the problem. We believe that is only half the job. Our work is to translate complex policy into language citizens can understand, then place practical solutions before the people with the authority to act. Those responsibilities are often treated as separate. We see them as inseparable. If a market trader in Onitsha can understand a policy brief, a legislator should be able to use that same brief before the legislative session ends.

For Policymakers & Public Servants is where that second part of the work happens. This is not a research series. Each brief begins with a decision already on the table: a bill awaiting concurrence, an appropriation about to be finalised, or a policy that has been announced but not yet funded. From there, we ask a more focused question than policy analysis usually does: what needs to change, in which instrument, and who has to make that change for the policy to reach the people it was meant to serve?

That question shapes everything that follows. We do not recommend new programmes when existing ones remain unfunded. We cost our recommendations wherever possible, and when we cannot, we say so clearly. We identify the institution responsible and the mechanism for implementation, not simply the desired outcome. Where our figures are illustrative rather than definitive, we label them accordingly.

Nigeria has no shortage of policies. What it lacks is consistent delivery. This series is an effort to narrow that gap by producing recommendations that are specific enough to be implemented and practical enough to be legislated.

Evidence. Clarity. Action.

Chike Donald Ibewuike,
Founder & Executive Director,
SimpleFix Nigeria

Contents

Dying to Give Life

Delivering Nigeria's Maternal Health Guarantee

Addressed to	The Senate Committee on Health (Secondary and Tertiary) and the House of Representatives Committee on Healthcare Services, National Assembly
Implementing actors	Federal Ministry of Health and Social Welfare; NPHCDA; NHIA; NEMSAS; Office of the Accountant-General of the Federation
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THE MOMENT THIS BRIEF IS WRITTEN TO

On 23 April 2026, the Senate passed the National Health Act (Amendment) Bill 2026 (SB 886), increasing the Basic Health Care Provision Fund from one to two per cent of the Consolidated Revenue Fund. The bill now awaits concurrence in the House of Representatives, harmonisation between both chambers, and transmission for presidential assent.

This brief speaks to that legislative window. Doubling the earmark alone will not improve outcomes for a woman in labour. That depends on safeguards the amendment does not yet provide: a release floor, a disclosure requirement, and conditions governing how states access the funds. Section 4 proposes three provisions to address these gaps.

1. The problem

Nigeria loses a woman to a preventable pregnancy-related death roughly every seven minutes. It has both the world's highest maternal mortality ratio and the largest absolute number of maternal deaths. It is neither the world's poorest country nor its least governed. Yet, by this measure, it is the most dangerous place in the world to give birth.

In 2023, Nigeria's maternal mortality ratio reached 993 deaths per 100,000 live births, compared with a global average of 197 and a WHO African Region average of 442.[2] The country has recorded the world's highest ratio every year since 2021.[3] A Nigerian woman faces a lifetime risk of 1 in 19 of dying from pregnancy, childbirth, or postpartum complications, compared with 1 in 4,900 in the world's wealthiest countries.[4] Combined, these figures translate to about 75,000 maternal deaths each year—roughly 205 every day.[5]

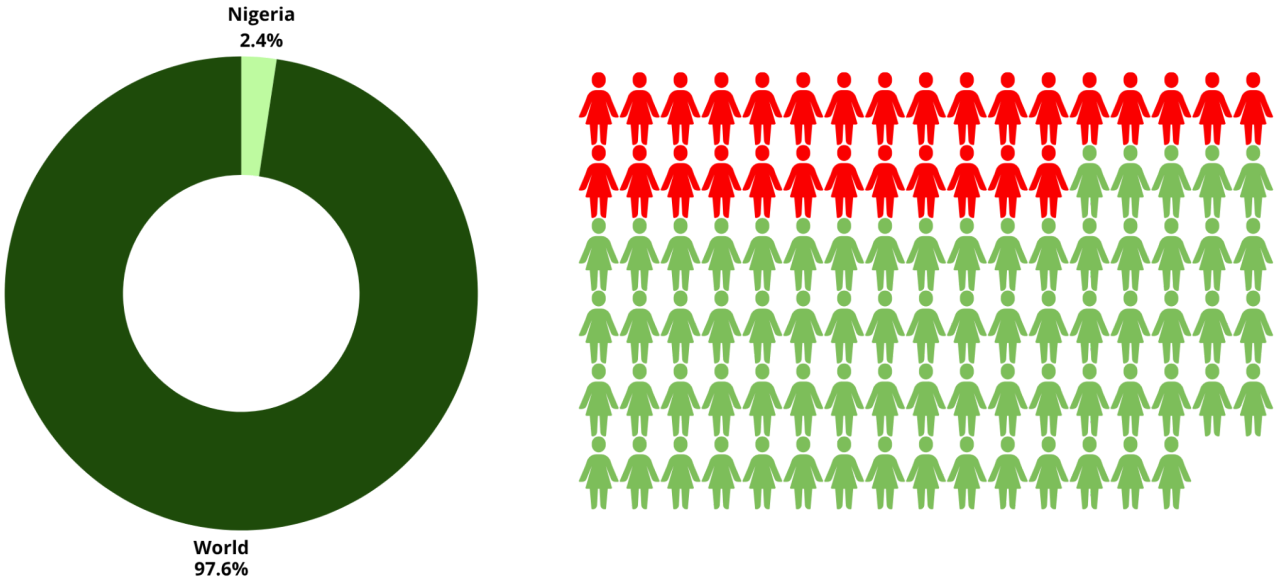
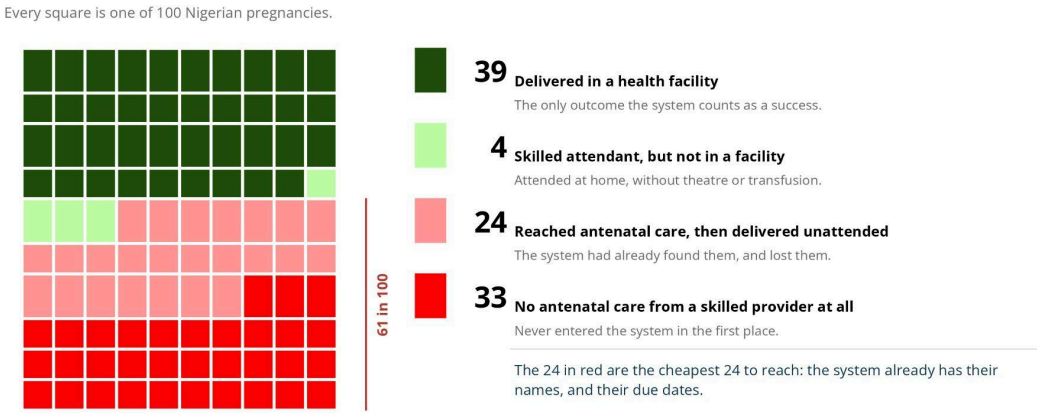


Figure 1. Nigeria's share of global maternal deaths is roughly twelve times its share of the world's population.[6]
Sources: *UN DESA, World Population Prospects 2024; WHO, UNICEF, UNFPA, World Bank Group and UNDESA, Trends in Maternal Mortality 2000 - 2023*

The care cascade

Antenatal care is the health system's most reliable opportunity to detect anaemia, hypertension, malpresentation, and infection—the leading causes of maternal death—before they become fatal. Yet a third of Nigerian pregnancies never reach that first point of contact, and losses compound at every subsequent stage.[7] Only 24 per cent of women begin antenatal care in the first trimester, when screening is most effective.[8]



Source: National Population Commission and ICF, Nigeria Demographic and Health Survey 2018; most recent live birth in the five years preceding the survey. Antenatal, skilled-attendance and facility-delivery coverage are measured separately and are presented here as a nested cascade.

Figure 2. The drop between antenatal contact and skilled delivery is greater than the drop into antenatal care. Twenty-four of every 100 women attend antenatal care but still deliver without a skilled birth attendant. The system reaches them, then loses them.[9]

The barrier is money before it is permission

It is often argued that Nigerian women are kept from maternal care principally by household permission. Survey evidence suggests otherwise. In the 2018 Nigeria Demographic and Health Survey, 85–89 per cent of women across all age groups reported no difficulty obtaining permission to visit a health facility, while about half identified the cost of treatment as a major obstacle, rising to 52 per cent among girls aged 15–19.[10] Household autonomy remains an important and unevenly distributed constraint, particularly in the North West and North East, and it warrants policy attention. But the principal barrier women themselves report is cost—and cost is the barrier legislatures are best positioned to remove.

The financing context reinforces this finding. Out-of-pocket payments account for more than 70 per cent of health spending in Nigeria, among the highest shares in the world.[11] Meanwhile, only about 35 per cent of Nigerian women hold an account at a financial institution or with a mobile money provider, compared with 56 per cent of men—a gap of some twenty percentage points.[12] In an obstetric emergency, the person least likely to have immediate access to cash or credit is often the woman who needs care.

The adolescent burden

Nineteen per cent of Nigerian girls aged 15–19 have begun childbearing: 14 per cent have already given birth and 4 per cent are pregnant with their first child.[13] They face the highest obstetric risk but the lowest coverage. Among married adolescent girls, only about 27 per cent deliver with a skilled birth attendant, against 43 per cent of women nationally.[14]

The burden is concentrated, and therefore tractable

Nigeria's own programme data locate the crisis with unusual precision. The Federal Ministry of Health has identified 172 local government areas across 33 states—about one-fifth of all LGAs—that account for up to 55 per cent of the country's maternal deaths. This concentration matters. A national problem clustered in a relatively small number of locations can be tackled with a first-year budget far smaller than a nationwide rollout. The measures proposed in Section 4 are sequenced with that reality in mind.

These facts point to neither a knowledge gap nor a technology gap. Nigeria knows what kills women in childbirth, knows where those deaths occur, and has already legislated most of the tools needed to prevent them. The challenge is no longer policy design, but is now policy delivery.

2. What already exists

Nigeria has not lacked maternal health policy. It has lacked maternal health delivery. Every instrument below is currently in force.

Instrument	Year	What it commits to	Status as at August 2026
National Health Act and the Basic Health Care Provision Fund	2014	A statutory earmark of not less than 1 per cent of the Consolidated Revenue Fund for primary healthcare, disbursed through four gateways, with a defined share for maternal and child health at primary health centres.[16]	In force. SB 886, raising the earmark to 2 per cent, passed the Senate on 23 April 2026 and awaits House concurrence and harmonisation.[17]
Midwives Service Scheme and SURE-P Maternal and Child Health	2009–2015	Deployment of midwives to underserved rural PHCs, and conditional cash transfers to raise antenatal attendance and facility delivery.[18]	Wound down. SURE-P MCH ended with the subsidy reinvestment programme that financed it, not because uptake failed.[19]
National Reproductive Health Policy	2017	National service standards and coverage targets for maternal, newborn and reproductive health.[20]	In force; coverage targets not met.
National Health Insurance Authority Act and the Vulnerable Group Fund	2022	Made insurance coverage a national objective and created a fund to subsidise cover for those who cannot pay premiums. Pregnant women are a listed vulnerable group.[21]	In force. Enrolment is not automatic. Coverage reached 22.0 million people in Q1 2026, against a population above 220 million.[22]
National Emergency Medical Service and Ambulance Scheme (NEMSAS)	2022	A BHCPF gateway funding emergency medical treatment, including obstetric emergencies, and ambulance response.[23]	Operational and expanding, from 13 states in Q1 2025 to 35 states onboarded by Q2 2026, with more than 130,000 Nigerians served since inception.[24]
Maternal and Neonatal Mortality Reduction Innovation Initiative (MAMII)	2024–	Mapping of every pregnant woman in 172 high-burden LGAs, linkage to a named care team, free delivery, free caesarean section and free treatment of complications.[25]	Rolling out. Independent reporting more than a year after launch found women in Ibadan and Abuja still paying cash for caesarean sections the policy declares free.[26]
FP2030 commitment and SDG 3.1	2015–	Expansion of modern contraceptive prevalence, and reduction of the maternal mortality ratio below 70 per 100,000 by 2030.[27]	On the current trajectory the SDG 3.1 target will be missed by a wide margin.

The architecture is close to complete. Nigeria does not need a new maternal health programme. On the evidence above, free caesarean section, free delivery, emergency obstetric transport and subsidised insurance for pregnant women are all already federal policy. Almost every recommendation in Section 4 is therefore a mechanism to make an existing commitment binding, funded and auditable, rather than a proposal to create a new one.

3. The gap diagnosis

Nigeria's maternal health instruments are not failing due to them being badly designed, but rather due to four identifiable breaks in the chain between the earmark and the bedside.

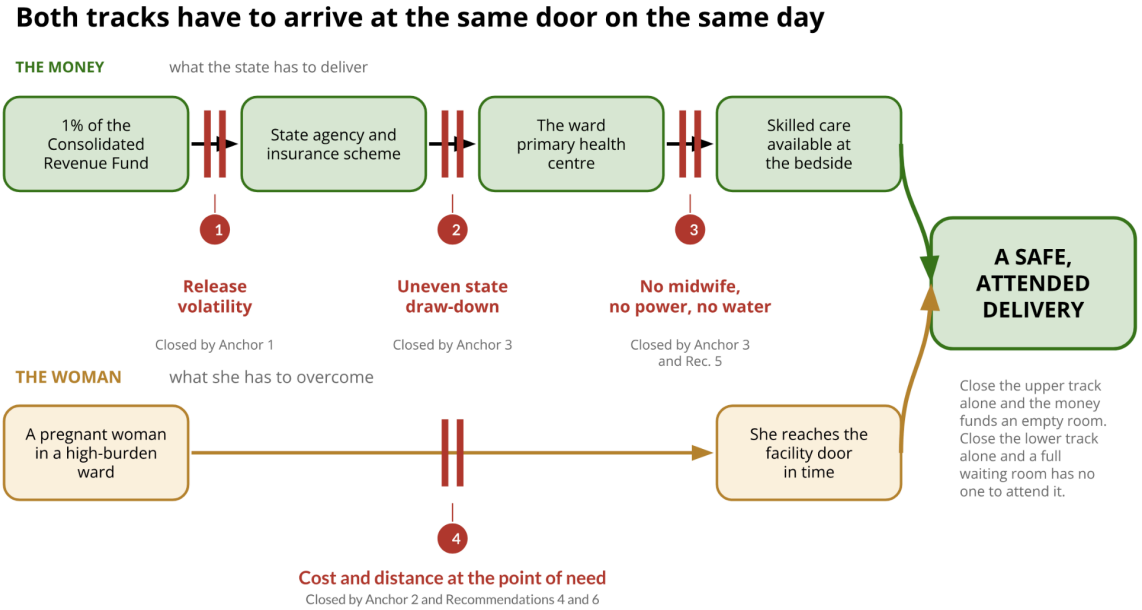


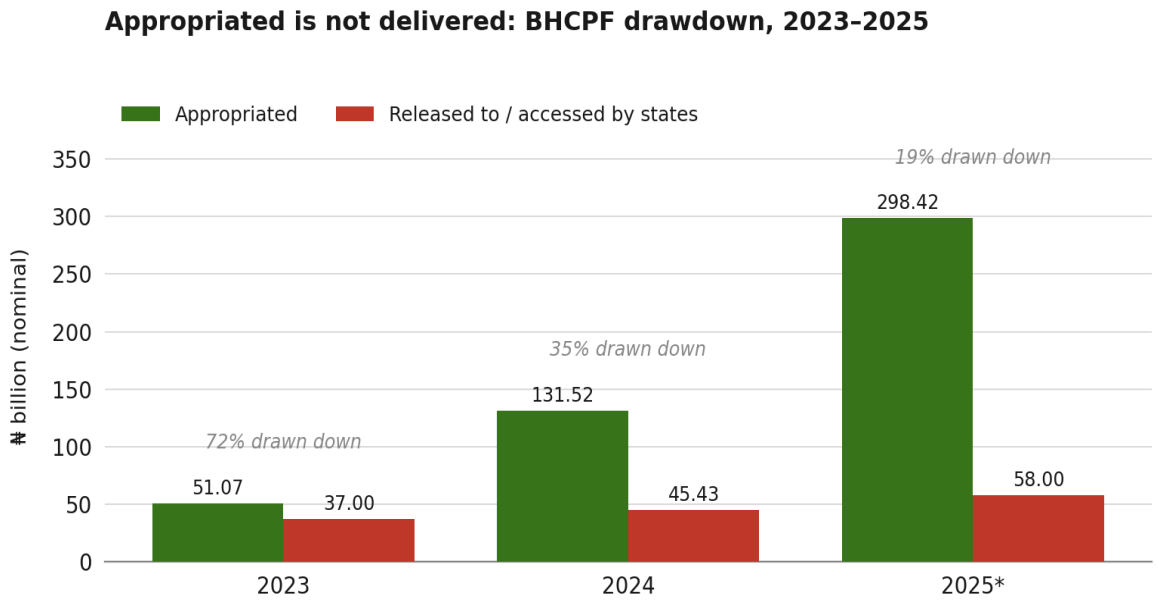
Figure 3. Money that clears the first three breaks can still fail at the fourth. A funded, functional facility cannot deliver a baby if the woman it serves cannot afford to reach it.

Break 1. Volatility, not failure, of release

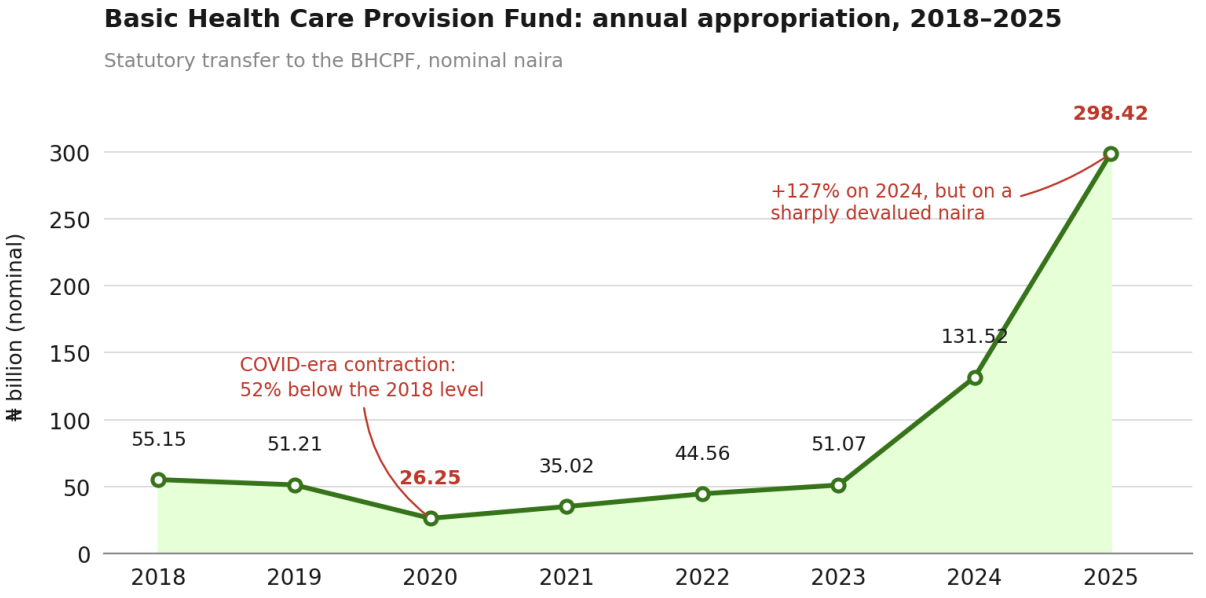
Federal release performance has improved and should be recognised as such. In June 2026, the Federal Ministry of Health reported that ₦290.7 billion of a cumulative ₦339 billion allocation had been disbursed to the implementing gateways over three years—about 86 per cent. The Office of the Accountant-General also confirmed that half of the annual Consolidated Revenue Fund allocation had been released between January and April 2026.[28] It would therefore be inaccurate to claim that the funds are simply not being released.

The problem is different, and increasing the earmark alone does not solve it. Facility managers plan against predictable minimum funding, not release rates in a good year. The statutory transfer to the BHCPF fell to ₦26.3 billion in 2020 before rising to ₦298.4 billion in 2025—a swing of more than elevenfold in five years.[29] No primary health centre can reliably staff a delivery room, maintain drug supplies, or contract ambulance services against a line of that shape.

There is a second, sharper gap inside the same year. Against the ₦298.4 billion appropriated to the fund in 2025, the amount actually released was four quarterly tranches of ₦32.88 billion, or ₦131.5 billion.[30] The distance between what the Appropriation Act promises a facility and what reaches it is the single clearest illustration of this break, and it is drawn entirely from the government's own arithmetic. Without a release floor, doubling the earmark doubles the volatility rather than closing that gap.



*2025 drawdown is year-to-date at Q3. Source: BudgIT and NPHCDA data reported in BusinessDay, 'N32bn basic health funds lie idle as PHCs struggle nationwide' (2026); appropriations per dRPC (2025). The 2023 appropriation is given as ₦51.07bn by dRPC and ₦51.64bn by BudgIT.



Source: dRPC, Understanding the Nigeria 2025 Proposed Budget: The Healthcare Sector in Focus (January 2025), Fig. 7 and Table 3, compiled from Budget Office of the Federation appropriation data. Nominal figures; not adjusted for inflation or exchange-rate moveme

Figure 4. The earmark is statutory, but the sum that appears against it is not stable. Facilities cannot plan against a line with this shape, whichever percentage sits at the top of it.
Sources: dRPC analysis of Federal Government appropriation data (2018–2025); Understanding the Nigeria 2025 Proposed Budget: The Health Sector in Focus (Jan 2025); Federal Ministry of Health and Social Welfare statements on 2025 and 2026 releases. Years without a published figure are omitted. The 2026 bar is the amount released to date, not the full-year allocation. Nominal naira, not adjusted for inflation.

Break 2. Uneven state draw-down

Access to BHCPF funds is conditioned on states operating a functioning State Primary Health Care Development Agency, a state health insurance scheme and counterpart financing, with statutory contributions of 25 per cent from states and 15 per cent from local governments.[32] States that have not built that scaffolding cannot draw funds down even when the federal allocation is

released in full. The money exists, but the pipeline to spend it does not, and the states in that position correlate with the states carrying the heaviest mortality burden.

Break 3. Facilities that are not functional

Nigeria has more than 30,000 primary health centres on paper.[33] Yet the Federal Government's target of one fully functional PHC in every political ward by 2027—about 17,600 facilities—implicitly acknowledges that much of the existing stock falls below operational standards.[34] More than 4,100 facilities have entered revitalisation over the past two years, of which some 3,000 have been fully upgraded.[35] At the same time, the migration of trained midwives and doctors out of the public health system, and increasingly out of the country, has deepened workforce shortages in the rural wards where maternal mortality is highest.[36]

Break 4. Cost and distance at the point of need

The free caesarean section policy announced in November 2024 illustrates the fourth break.[37] More than a year later, reporting from Ibadan and Abuja found women still paying out of pocket and still facing delays for a procedure the Federal Government had declared free; separate reporting found major teaching hospitals in the South West yet to implement the policy at all.[38] A policy that is free on paper but paid for at the point of care is, in one respect, worse than one that is honestly priced: households do not prepare for costs they have been told no longer exist.

4. The fixes

Three anchor measures address the system's principal breaks by strengthening instruments already in force. Three additional measures build on those reforms and are positioned explicitly downstream. None of the six proposals is experimental, and each draws on an established precedent, preferably from Nigeria where one exists.

Sequencing note. Anchor 3 deliberately precedes Recommendation 4. A successful demand-side transfer sends more women to health facilities. Those facilities must first be able to receive them. Increasing demand before strengthening service capacity turns a coverage problem into a congestion problem.

ANCHOR 1 Write a Release Floor and Quarterly Disclosure Duty into SB 886 Before Harmonisation.

Closes: Break 1.

Actor: House Committee on Healthcare Services and the conference committee on SB 886; Federal Ministry of Finance; Office of the Accountant-General of the Federation.

Mechanism: A minimum quarterly tranche expressed as a fixed fraction of the appropriated BHCPF line, and a statutory duty on the Accountant-General to report release against obligation to both Committees on Health each quarter.

Precedent: The figures already exist: the Coordinating Minister quoted the 86 per cent cumulative release rate publicly in June 2026.[39] The amendment converts a courtesy disclosure into a duty. Internationally, Ghana's National Health Insurance Levy shows that an earmark released on a predictable schedule is bankable by facilities in a way an annual budget line is not.[40]

Cost: Nil. This is a reporting duty and a payment schedule.

ANCHOR 2 Legislate automatic NHIA enrolment at first antenatal contact, funded through the Vulnerable Group Fund.

Closes: Break 4.

Actor: National Health Insurance Authority; National Assembly, for the NHIA Act amendment and the Vulnerable Group Fund appropriation.

Mechanism: Pregnancy confirmed at any accredited facility triggers enrolment automatically, with no application step and no premium. This matters because eligibility for the free caesarean section is already tied to NHIA enrolment, and the women least able to pay for the procedure are precisely those least likely to be enrolled.[41] Automatic enrolment is therefore what converts the free caesarean announcement from a ministerial policy into an entitlement with a payer attached—which is the reason it is currently being charged at the counter.

Precedent: Ghana's National Health Insurance Scheme has exempted pregnant women from premium payment since 2008.[42] We note honestly that Ghana's exemption has its own leakage where reimbursement to facilities is slow, and women continue to make out-of-pocket payments as a result.[43] That is precisely why enrolment must be automatic and claims settlement must be timed in the statute.

Cost: The Vulnerable Group Fund already exists and pregnant women are already a listed beneficiary group. See Section 5.4.

ANCHOR 3 Condition state BHCPF draw-down on published PHC functionality standards, with a ring-fenced transition fund.

Closes: Breaks 2 and 3.

Actor: NPHCDA and State Primary Health Care Development Agencies; National Assembly sets the appropriation condition.

Mechanism: Publish a ward-level functionality scorecard, condition the following tranche on it, and ring-fence a share of the BHCPF increase for states below threshold to buy the missing inputs. Conditionality without the transition fund would penalise the women in the worst-served states twice, and would be resisted for that reason.

Precedent: Nigeria's own Ward Health System already defines the standard on paper.[44] Rwanda's phased primary healthcare strengthening programme shows conditional disbursement working in a comparably constrained fiscal setting.[45]

Cost: Marginal. The transition fund is a ring-fence within the BHCPF increase, not an addition to it.

4 Appropriate a demand-side maternal health transfer, piloted in the 172 MAMII local government areas.

Downstream of: Anchor 3.

Actor: Federal Ministry of Health and Social Welfare and NPHCDA; National Assembly for the appropriation.

Mechanism: A conditional transfer paid on completion of an antenatal and skilled-delivery pathway, targeted first at the high-burden LGAs that carry up to 55 per cent of maternal deaths.

Precedent: Nigeria has run this model. SURE-P Maternal and Child Health (2012–2015) produced a statistically significant increase in the number of women completing four or more antenatal visits and in tetanus toxoid coverage, though its measured effect on skilled delivery was not statistically significant.[46] It is important to be precise about why it ended: it was financed from the fuel subsidy reinvestment programme and ended when that programme ended, not because the mechanism failed. A named appropriation line is not exposed in the same way. Indonesia's Jampersal and Kenya's free maternity policy show the mechanism at national scale; the Kenyan evidence records a 19.6 per cent step increase in normal deliveries and 28.9 per cent in caesarean sections in public facilities following the 2013 policy, alongside mixed longer-run effects that this brief does not overstate.[47]

5 Agree a national standards-based scheme to task-shift skilled birth attendance to trained Community Health Extension Workers in wards without a midwife.

Downstream of: Anchor 3.

Actor: Federal Ministry of Health and Social Welfare, NPHCDA and the Nursing and Midwifery Council of Nigeria; National Assembly for the scheme appropriation.

Obstacle, named: The binding constraint here is not money but scope of practice. Task-shifting has stalled in Nigeria before on professional body objection, which is why this is framed as a negotiated national standard agreed with the Council rather than a unilateral agency directive.

Precedent: Ethiopia's Health Extension Worker Programme closed a comparable skilled-attendance gap in a comparably under-resourced rural system.[48]

6 Fund NEMSAS to full ward-level obstetric coverage with a toll-free emergency line.

Downstream of: Anchor 1.

Actor: NEMSAS and NPHCDA with State Ministries of Health; National Assembly for the capital appropriation.

Mechanism: The architecture already exists and has expanded from a Federal Capital Territory pilot to 34 states by July 2026, with a national emergency number already in service.[49] The remaining gap is per-ward response capacity and public awareness of a single number to call, not the creation of a scheme.

Precedent: The Lagos State Ambulance Service demonstrates feasibility within Nigeria; Zambia's emergency transport referral system demonstrates it at rural scale.[50]

5. The money

The recurring objection to every recommendation above is cost. The arithmetic below answers it before it is raised, using the government's own money first and new money only where it is small, named and auditable.

5.1 Anchor 1 costs nothing

A release floor and a disclosure duty are a payment schedule and a report. They require no appropriation, and they are the precondition for every other number in this section to mean anything at facility level.

5.2 The size of the pot

The 1 per cent earmark appeared as a statutory transfer of ₦298.4 billion in the 2025 budget, of which ₦131.5 billion was released in four tranches of ₦32.88 billion.[51] SB 886 would take the appropriated figure to roughly ₦600 billion on current revenue. Set against the 2026 Appropriation Act of ₦68.32 trillion, the entire doubled fund is under one per cent of federal expenditure.[52] The scale of the ask in this brief should be read against that denominator.

5.3 The demand-side transfer

Nigeria records approximately 7.5 million live births a year, the figure implied by a ratio of 993 per 100,000 and roughly 75,000 maternal deaths.[53] About a third of pregnancies receive no antenatal care from a skilled provider, which is approximately 2.5 million pregnancies. At an indicative ₦15,000 to ₦25,000 per completed antenatal and skilled-delivery pathway, full national coverage of that group would cost ₦37.5 billion to ₦62.5 billion a year. Restricted to the 172 MAMII LGAs in the first year, the cost falls to approximately ₦21 billion to ₦34 billion.

Assumptions stated. The transfer value is illustrative and should be set by NPHCDA against its own SURE-P MCH implementation data rather than by this brief; for reference, SURE-P MCH paid up to ₦5,000 per woman across the full pathway in 2012–2015 prices.[54] No administrative overhead is included, which we would expect to add 10 to 15 per cent. Take-up is assumed at 100 per cent of the target group, which will not occur in year one; the range above is therefore a ceiling rather than a forecast.

5.4 Automatic NHIA enrolment

The Vulnerable Group Fund exists and pregnant women are already a listed beneficiary group, so the marginal cost is the premium subsidy for pregnant women not currently enrolled, not the creation of a programme.[55] Coverage stood at 22.0 million people by mid-2026.[56] This brief does not put a figure on universal pregnancy enrolment, because a responsible estimate requires NHIA's per-capita subsidy and claims data. We therefore recommend that the Committees require NHIA to table that costing at the next appropriation hearing, which is itself an auditable action with a date attached.

5.5 Who pays

Measure	Source of funds	New appropriation required
Anchor 1: release floor and disclosure	None. Existing statutory obligation.	None
Anchor 2: automatic NHIA enrolment	Vulnerable Group Fund, within the BHCPF	Costing to be tabled by NHIA
Anchor 3: functionality conditionality and transition fund	Ring-fence within the BHCPF increase under SB 886	None, subject to the ring-fence
4: demand-side transfer	New named line in the Appropriation Act	₦21bn – ₦34bn, pilot year
5: CHEW task-shifting scheme	NPHCDA human resources gateway, which already reserves a share for midwives and community health workers	Training budget only
6: NEMSAS ward coverage	Capital appropriation to NEMSAS	To be costed by NEMSAS

5.6 The cost of inaction

Roughly 75,000 Nigerian women die each year from causes related to pregnancy and childbirth. That is about 205 a day, and one every seven minutes. The pilot-year cost of the only measure in this brief that requires genuinely new money is approximately one tenth of one per cent of the 2026 federal budget.

6. The ask

This brief is addressed to the Senate Committee on Health (Secondary and Tertiary) and the House of Representatives Committee on Healthcare Services, with five specific requests.

1. **Amend SB 886 at concurrence and harmonisation** to include a minimum quarterly release tranche for the BHCPF and a statutory duty on the Accountant-General to report release against obligation to both Committees each quarter.
2. **Legislate automatic NHIA enrolment at first antenatal contact** under the Vulnerable Group Fund, with a statutory claims settlement window for facilities.
3. **Appropriate a named, costed demand-side maternal health transfer line** of ₦21 billion to ₦34 billion in the next Appropriation Act, piloted in the 172 MAMII local government areas and built on NPHCDA's own SURE-P MCH implementation data.
4. **Condition state BHCPF draw-down on published ward-level PHC functionality standards** enforced by NPHCDA, with a ring-fenced transition fund for states below threshold, reported annually to the Committees.
5. **Require a joint quarterly briefing** from the Federal Ministry of Health and Social Welfare, NPHCDA and NHIA covering BHCPF release against obligation, MAMII delivery in the 172 LGAs, and caesarean section claims paid against claims made. That last measure is the one that tests whether free is free.

Limitations

This brief relies on national averages that mask substantial state and rural-urban variation; a woman's actual risk depends heavily on where in Nigeria she lives, and the North West and North East carry outcomes materially worse than the national figures used here.

Two different measurement lineages exist for Nigerian maternal mortality. The international modelled series (MMEIG) gives 993 per 100,000 for 2023; Nigeria's own Demographic and Health Survey lineage gives 512 per 100,000 for 2018 on a different definition and method.[57] We have used the international series consistently throughout rather than mixing the two, and readers should note that both carry wide uncertainty intervals. One exception is disclosed: the lifetime-risk figures of 1 in 19 and 1 in 4,900 are drawn from the 2020 round of the international series, as the 2023 round does not report a directly comparable country figure.[58]

The coverage figures in Section 1 are drawn from the 2018 NDHS rather than from the more recent 2023–24 round. This is deliberate. The 2018 report remains the most recent source for the barrier-to-access, first-trimester-timing and married-adolescent indicators on which the argument in Section 1 turns. Where the 2023–24 round reports comparable figures, they show improvement: skilled birth attendance of roughly 46 per cent against 43 per cent in 2018, and four or more antenatal visits at 68 per cent against 57 per cent.[59] Preliminary findings from the 2026 Mini-DHS indicate further improvement in antenatal and skilled birth attendance that is not yet reflected in any published table.[60] Readers should treat the cascade in Figure 2 as the most recent fully documented picture rather than as current-year coverage. The direction of travel does not change the argument of this brief, which concerns the reliability of financing rather than the level of coverage in any single year.

The adolescent skilled-attendance figure of 27 per cent derives from the 2016/17 Multiple Indicator Cluster Survey and is restricted to married girls aged 15–19 with a live birth in the preceding two years; the 43 per cent national comparator derives from the 2018 NDHS. The comparison is indicative rather than like-for-like.[61]

The financing arithmetic in Section 5 is an illustrative national floor, not a state-by-state costed plan, and it does not cost the supply-side capacity required to absorb the additional demand that Recommendation 4 would generate. That omission is the reason Anchor 3 is sequenced ahead of it.

Notes

1. National Assembly of the Federal Republic of Nigeria, *National Health Act (Amendment) Bill, 2026* (SB 886), sponsored by Senator Ipalibo Banigo, passed third reading in the Senate, 23 April 2026; "Senate Passes BHCPF Amendment Bill after Advocacy Pressure," *Guardian Nigeria*, 3 May 2026.
2. World Health Organization et al., *Trends in Maternal Mortality 2000 to 2023* (Geneva: WHO, 2025); World Health Organization, "Maternal Mortality Ratio (per 100 000 Live Births)," Global Health Observatory, 7 April 2025.
3. WHO et al., *Trends in Maternal Mortality 2000 to 2023*.
4. World Health Organization et al., *Trends in Maternal Mortality 2000 to 2020* (Geneva: WHO, 2023), 35. See the note on measurement lineage under Limitations.
5. WHO et al., *Trends in Maternal Mortality 2000 to 2023*. The report places global maternal deaths at 260,000 in 2023; Nigeria's share is estimated at approximately 28.7 per cent.
6. United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects 2024* (New York: United Nations, 2024); WHO et al., *Trends in Maternal Mortality 2000 to 2023*.
7. National Population Commission (NPC) [Nigeria] and ICF, *Nigeria Demographic and Health Survey 2018* (Abuja and Rockville, MD: NPC and ICF, 2019), chap. 9. Sixty-seven per cent of women who gave birth in the five years preceding the survey received antenatal care from a skilled provider.
8. NPC and ICF, *Nigeria Demographic and Health Survey 2018*, table 9.2.
9. Ibid., tables 9.1 and 9.6. Antenatal care from a skilled provider, 67 per cent; births assisted by a skilled provider, 43.3 per cent.
10. Ibid., table 9.21, "Problems in Accessing Health Care."
11. African Health Observatory Platform on Health Systems and Policies, "Health Financing — Nigeria Health System and Services Profile" (Brazzaville: WHO Regional Office for Africa); World Bank, "Out-of-Pocket Expenditure (% of Current Health Expenditure) — Nigeria," World Development Indicators, accessed 6 August 2026. Estimates for recent years range from approximately 71 to 77 per cent depending on source and year.
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