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NIGERIA'S PUBLIC HEALTH SYSTEM: A NARRATIVE REVIEW OF KEY INDICATORS, SYSTEMIC CHALLENGES, AND COMMUNITY-BASED SOLUTIONS

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ABSTRACT

Background: Nigeria's rapidly growing and diverse population requires a resilient public health system capable of delivering equitable, high-quality healthcare. This review synthesized evidence on the current state of Nigeria's public health system and explored community-based initiatives as potential solutions to strengthen service delivery.

Methods: We conducted a comprehensive search of bibliographic databases and grey literature sources. Studies published between 2000 and 2025 reporting on the status of Nigeria's public health system, health indicators, systemic challenges, and community-based solutions were included.

Results: Findings identified persistent system-level challenges, including a high burden of communicable diseases, recurrent epidemics, and a rising prevalence of non-communicable diseases. Maternal and child health outcomes remain suboptimal: only 43% of live births occur in health facilities, and 63% of women receive antenatal care from skilled providers. Mortality rates remain high, with under-five, infant, and neonatal deaths at 110, 63, and 41 per 1,000 live births. Child nutrition is suboptimal, with 40% of children under five stunted, 27% underweight, 8% wasted, and 1% overweight. These outcomes are linked to high out-of-pocket expenditures, health-worker shortages, inequitable infrastructure, inadequate policies, and limited public awareness. Evidence highlights community-based initiatives, including community needs assessments, community engagement, community-based health insurance (CBHI), and the local recruitment and training of health workers, as viable approaches to improve access, utilisation, and system performance.

Conclusion: Strengthening and evaluating the feasibility and impact of diverse community-based health models may improve utilisation, equity, quality, and accountability within Nigeria's public health system.

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INTRODUCTION

Nigeria, with a population of 230 million, faces profound challenges in its public health system, which impede progress toward Universal Health Coverage (UHC).^{1,2} Such a large population requires a robust, well-coordinated health system to ensure equitable access to high-quality healthcare services.³ Ideally, a national health system should improve population health, provide financial protection against the costs of ill-health, and be responsive to people's expectations.^{4, 5} Although Nigeria accounts for only about 2.8% of the world's population, it bears a disproportionately high disease burden. The country accounts for approximately 20% of global maternal mortality.⁶ In 2023, Nigeria recorded the highest number of maternal deaths globally, representing about 28.7% of the world's total, with an estimated 75,000 women dying from pregnancy-related causes.⁷ While records indicate improvements in life expectancy and mortality across age groups, Nigeria's overall health indicators remain poor.⁸ Public health expenditure, despite increases, has remained low relative to total government spending over the past decades.⁹ In spite of several efforts by the government, development partners, and other stakeholders,¹⁰ the healthcare system continues to grapple with high maternal, infant, and under-five mortality rates, a dual burden of infectious and non-communicable diseases, and widespread disparities in access and quality of care. These challenges are compounded by weak infrastructure, critical shortages of health workers, and chronically low public health funding.^{6, 11} Furthermore, the country faces recurrent outbreaks of infectious diseases such as cholera, meningitis, diphtheria, and Lassa fever.^{6,11} The rising incidence of non-communicable diseases, alongside widespread reliance on direct household health expenditure, further strains the health system.^{12, 13} Access to quality public health services remains a challenge for more than half of the population, particularly in

rural areas.^{6,14} Multifaceted factors have been identified as contributing to the current state of Nigeria's public health system. These include poverty, inadequate funding, limited health insurance coverage, and a shortage of human resources for health.¹⁵ In addition, the lack of recognition and integration of private health institutions, as well as non-orthodox and traditional-based providers, further constrains the system.^{6,16} Nigeria's rapidly growing population has intensified the double burden of infectious and non-communicable diseases, resulting in increased morbidity, elevated mortality rates, and rising healthcare costs.¹⁷ These poor health indicators are compounded by stark disparities across states, between urban and rural settings, and along lines of education and socioeconomic status.^{14,16} Notwithstanding repeated reform efforts, health outcomes remain poor, particularly in rural and underserved areas.¹⁸ To address these gaps, we propose strengthening community-based initiatives specifically targeting these populations in resource-limited settings. Community-based approaches have been successfully implemented across diverse contexts, including high-income countries (HICs) such as Canada and the United States of America,^{19–22} as well as in low- and middle-income countries (LMICs) such as Ethiopia, Ghana, and Rwanda.^{23–27} These models can be adapted to meet the unique health needs and goals of Nigerian communities. This review synthesizes evidence on Nigeria's public health system and explores the scaling up of community-based initiatives to inform integrated, context-sensitive strategies for system improvement among policymakers, practitioners, and development partners. In doing so, this review underscores the importance of aligning the health indicators with local realities, addressing systemic weaknesses, and leveraging community-based initiatives to foster a more resilient, equitable, and evidence-informed health system.

Table 1. Search Terms used for PubMed Database

PCC Mnemonic	Serial Number	Search terms
Population	1	"Nigeria" OR "Nigerian" OR "Nigerian Population" OR "Communities in Nigeria"
	2	"Rural Community" OR "Urban Population" OR "Vulnerable Population" OR "" General Population "OR "Community"
	3	1 AND 2
Concept /out comes	4	"Public Health System" OR "Public Health" OR "Health Care System" OR "Health System" OR "Health Service" OR "Health Care Delivery"
	5	"Health Status Indicators" OR "Indicators" OR "Performance" OR "Outcome"
	6	"Health Services Accessibility" OR "Challenge" OR "Barrier" OR "Inequity" OR "Health System Strengthening"
	7	"Community Health Services" OR "Primary Health Care" OR "Community-Based-Based" OR "Community-based" OR "Community Participation" OR "Community Engagement" OR "Community-Based Solutions"
Context	8	4 AND 5 AND 6 AND 7
	9	"Developing Countries" OR "Sub-Saharan Africa" OR "Low- and Middle- Income Countries" OR "LMICs" OR "Resource-limited Settings" OR "Underserved Settings"
	11	43AND 8 AND 9

METHODS

We conducted a comprehensive search of the literature in bibliographic databases (PubMed, Scopus, Africa Journal Online (AJOL), and Google Scholar) and grey literature sources (Google and the websites of the World Health Organisation (WHO) and the Federal Ministry of Health and Social Welfare (FMOH&SW)). The search terms used in PubMed (Table 1) were adapted for other databases, adhering to the Population Concept Context (PPC) mnemonic. The initial database search was conducted on February 22, 2025, and the final search on August 26, 2025. The search covered sources published in English between 2000 and 2025, from December 2024 to March 2025. We included original studies and reports that focused on the public health system, health indicators, challenges affecting public health, and community-based initiatives. Studies published before 2000, research protocols, letters to the editor, and abstract-only articles were excluded. Research protocols were excluded because they outline planned studies rather than report actual findings, and thus wouldn't contribute to understanding the current public health system or community-based initiatives. On the other hand,

studies published before 2000 were excluded to ensure the relevance and timeliness of the findings, given the dynamic changes in Nigeria's health care systems in the last two decades. We used Zotero reference manager to organize the retrieved sources. The initial database search was conducted on February 22, 2025, and the final search on August 26, 2025. The search covered sources published in English between 2000 and 2025, from December 2024 to March 2025. We included original studies and reports that focused on the public health system, health indicators, challenges affecting public health, and community-based initiatives. Studies published before 2000, research protocols, letters to the editor, and abstract-only articles were excluded. Research protocols were excluded because they outline planned studies rather than report actual findings, and thus wouldn't contribute to understanding the current public health system or community-based initiatives. On the other hand, studies published before 2000 were excluded to ensure the relevance and timeliness of the findings, given the dynamic changes in Nigeria's health care systems in the last two decades. We used Zotero reference manager to organize the

retrieved sources. Two reviewers independently screened and assessed the titles and abstracts of

screened for possible inclusion by two reviewers. Disagreements arising from the assessment were resolved by discussion. We manually scanned the references of included literature for additional relevant sources. All authors appropriately contributed to the search, screening, data extraction, and synthesis, leveraging their diverse expertise in public health research, clinical practice, basic medical science, demography, administration, and urban planning to ensure the review's veracity and relevance. Extracted data were categorized into themes and presented narratively. The review was organized into two interrelated parts. The first part synthesized evidence on the structure and performance of Nigeria's public health system, encompassing governance, system organization, key health indicators, and the national burden of diseases. The second part examined community-based initiatives as strategic approaches with the potential to strengthen the performance of the public health system and improve service delivery.

ETHICS

Ethical approval was not required for this review, as we used only aggregated, fully de-identified secondary data, with no involvement of human participants or access to identifiable personal information.

Part I: The Nigerian Public Health System: Structure and Performance Governance and structure

Nigeria's healthcare system is structured across three tiers of government: Federal, State, and Local Governments (LGAs), which manage tertiary, secondary, and primary care, respectively.²⁸ However, the State government also oversees some tertiary facilities, while the National Primary Healthcare Development

Agency (NPHCDA) supports primary care operations.¹⁴ Despite the National Health Policy and National Health Bill outlining roles and responsibilities, they remain unclearly defined.¹⁴ This may contribute to poor maintenance and coordination challenges across healthcare levels.⁶ Over successive decades, the Nigerian government at the federal, state and local levels has introduced a wide range of health policies aimed at improving the quality, equity, and accessibility of public healthcare services.³⁵ Despite the breadth of these policy initiatives, their intended objectives have frequently remained unmet, largely due to weaknesses in policy design, implementation capacity, and system-level governance.¹² A prominent example is the Nigerian National Health Policy of 1988, grounded in the principles of Primary Healthcare (PHC) derived from the Alma-Ata Declaration, and emphasized universal access, community participation, and preventive care.¹⁴ However, its implementation was undermined by underfunding, inadequate decentralization, weak intersectoral coordination, and limited institutional capacity at the subnational level.¹⁴ Beyond the primary health care framework, Nigeria has adopted several sector-specific policies, including the National Blood Transfusion Policy, the National Health Promotion Policy, and the National Malaria Control Policy, each designed to address critical public health priorities.³⁵ Nonetheless, evidence suggests that persistent structural and operational constraints have limited their effectiveness. These barriers include insufficient and unpredictable financing, policy formulation that is weakly informed by empirical evidence, frequent policy reversals linked to political transitions, shortages of adequately trained human resources, low awareness of policy provisions among

implementers and beneficiaries, and misalignment between policy objectives and prevailing socio-cultural norms.^{12,35} Additional challenges, such as corruption, inadequate community

Addressing these systemic weaknesses through strengthening governance, sustained financing, evidence-informed policymaking, and inclusive implementation strategies is critical to improving public health outcomes and advancing Nigeria's progress toward equitable, high-quality, and resilient healthcare delivery.

Key Health Indicators and Disease Burden

Nigeria's public health system continues to face a complex and interrelated disease burden characterized by the persistence of communicable diseases, recurrent epidemic outbreaks, and a rapidly growing prevalence of non-communicable diseases (NCDs). Endemic conditions such as malaria, tuberculosis, and HIV/AIDs remain major contributors to morbidity and mortality, while periodic outbreaks of cholera, meningitis, and Lassa fever expose systemic weaknesses in disease surveillance, preparedness, and response capacity.⁶ At the same time, epidemiological disorders are placing additional strain on a health system historically oriented toward acute and infectious conditions. The coexistence of these disease profiles reflects a “double burden” of disease that challenges service delivery, financing, and workforce capacity.

These health challenges are exacerbated by chronic underinvestment in the public health sector. Insufficient government health expenditure has shifted a substantial share of healthcare costs onto households, with out-of-pocket spending accounting for more than 70% of total health expenditure, a level widely recognized as catastrophic and poverty-inducing.⁹ This financial vulnerability is further exacerbated by limited risk pooling, as fewer than 5% of Nigerians are enrolled in the National Health Insurance Scheme (NHIS), leaving the majority of the population responsible for direct payment at the point of

engagement, and fragmented communication and coordination among stakeholders, further impeding the translation of policy into practice.^{12 14}

care.¹⁵ The combined effects of high costs and weak financial protection undermine access to essential services and delay care-seeking, particularly among socio-economically disadvantaged groups. Key population health indicators underscore the consequences of these systemic constraints. Despite gradual improvements, maternal and child health outcomes remain suboptimal: only 43% of live births occur in health facilities, and just 63% of women receive antenatal care from skilled providers.¹¹ High fertility (4.8 children per woman) alongside low contraceptive prevalence (20% among married women) further complicates efforts to improve reproductive health outcomes. Mortality rates remain unacceptably high, with under-five, infant, and neonatal mortality estimated at 110, 63, and 41 deaths per 1000 live births, respectively. Child malnutrition persists as a critical public health issue, with 40% of children under five stunted, 27% underweight, 8% wasted, and 1% overweight, reflecting both chronic deprivation and emerging nutritional transitions.¹¹ Collectively, these indicators highlight the need for targeted, equity-oriented, and system-wide interventions to address the structural drivers of poor health outcomes in Nigeria.

Systemic Challenges Associated with Poor Health Services and Key Indicators

Available evidence indicates that multiple factors contribute to the current state of Nigeria's public health system and its associated health indicators. Key challenges include inadequate funding and high out-of-pocket expenditures, shortages of human resources for health, inequitable distribution of infrastructure and resources, and gaps in public awareness and provider conduct.

Inadequate Public Health Funding and High Out-of-Pocket Expenditure

Adequate funding is critical to the effective functioning of a public health system and to the provision of high-quality healthcare services. In Nigeria, health financing is derived from multiple sources, including tax revenue, out-of-pocket payments, health insurance schemes, donor For instance, Healthcare accounts for only 5.15% of the total 2025 budget.²⁹ As a result of inadequate budgetary allocations and resulting poor health spending, households are forced to spend out-of-pocket.^{9,12,30} This chronic underfunding has shifted the financial burden onto households, with out-of-pocket expenditure currently accounting for approximately 70% of total health spending in the country.^{9,12} As a result, nearly 40% of poor Nigerians face catastrophic health expenditures, pushing many further into poverty.^{6,14} Insufficient public investment has also limited the development of health infrastructure, contributing to inequitable resource distribution, high service costs, shortages of skilled personnel, inadequate supplies of essential drugs and equipment, and ultimately poor health outcomes across all age groups.⁶ Moreover, low government funding has created systemic inefficiencies that exacerbate dissatisfaction with services and foster corruption within the health sector.^{14,31} Addressing these funding gaps and reducing dependence on out-of-pocket payments are essential for achieving equitable access to care and improving health outcomes in Nigeria.

Human Resources for Health: Shortages and Maldistribution

A well-trained, adequately supported, and equitable health workforce is a cornerstone of an effective health system, underpinning the delivery of preventive, promotive, curative, and rehabilitative services. In Nigeria, however, persistent shortages and pronounced maldistribution of human resources for health (HRH) continue to undermine public health system performance. Across multiple cadres, including medical doctors, nurses, midwives, pharmacists, medical laboratory scientists,

contributions, and community-based funding.^{14,16} However, contrary to the 2001 Abuja Declaration, which recommended allocating at least 15% of national budgets to health, Nigeria continues to commit substantially less.¹⁶

radiographers, physiotherapists, community health workers, and other allied health professionals, staffing levels in public health institutions remain insufficient to meet population health needs.^{14,30} These deficits are most acute in rural and underserved areas, where health worker density is markedly lower than in urban centers, exacerbating existing socio-economic and geographic inequities in access to care.¹⁴ Beyond numerical shortages, qualitative gaps in workforce capacity further constrain service delivery. Evidence suggests that some available health personnel lack up-to-date competencies or specialized skills required to manage increasingly complex health needs, including the growing burden of non-communicable diseases and public health emergencies.³² This skills mismatch reflects limitations in pre-service training, inadequate continuing professional development, and weak alignment between training curricula and health system priorities. While chronic underfunding of the health sector remains a central driver of HRH shortages, multiple interrelated factors contribute to poor recruitment, retention, and distribution. Unfavorable working conditions, low and irregular remuneration, heavy workloads, and limited opportunities for career progression reduce job satisfaction and accelerate attrition, including migration to the private sector or abroad. These challenges are particularly pronounced in rural and remote settings, where the absence of basic infrastructure and social amenities, such as reliable electricity, water supply, housing, quality schools, and transportation, further discourages long-term retention.^{14,31} Health workers stationed in such environments often experience professional isolation and significant personal and social

disruptions, including prolonged separation from family and support networks.

Collectively, these structural, financial, and contextual barriers have produced a health workforce that is both insufficient in size and unevenly distributed, weakening frontline service delivery and constraining progress toward universal health coverage. Addressing HRH **Inequity in the Distribution of Health Infrastructure and Resources**

Inequities within Nigeria's health system manifest in unequal budgetary allocations, uneven distribution of infrastructure and personnel, and disparities in access to basic social amenities across regions and settings.^{14,28,32} Such inequities are particularly evident in maternal health services in rural areas, where barriers such as poor road networks, inadequate transportation, long distances to facilities, irregular operating hours, and perceptions of poor-quality care hinder access.^{3,31} Evidence further indicates that health facilities are disproportionately concentrated in urban areas, thereby limiting physical access for rural populations and reinforcing disparities in healthcare utilisation and outcomes. These inequities are reflected in major health indicators across regions and socioeconomic groups. For example, the 2023/2024 Nigerian Demographic and Health Survey (NDHS) reported a contraceptive prevalence rate (CPR) for any method among currently married women of 43.9% in the Southwest, compared to only 10.3% in the Northeast. This pattern is shaped not only by the concentration of facilities in urban centres but also by factors such as cultural traditions, educational levels, and household incomes. At the state level, 66.1% of married women in Ekiti State (Southwest) use any method of contraception, whereas the prevalence is just 3.3% in Kebbi State (Northwest). Similar disparities exist in maternal and child health. The proportion of pregnant women receiving antenatal care from skilled providers ranges from 91.8% in the Federal Capital Territory (FCT) to only 34.7% in

shortages in Nigeria will therefore require integrated strategies that go beyond workforce expansion to include improved financing, targeted rural incentives, strengthened training and continuous professional development, and investments in supportive infrastructure that make underserved postings both professionally viable and socially sustainable.

Adamawa State. Likewise, vaccination coverage among children aged 12–23 months varies dramatically, with 68.6% in Cross River State fully immunized compared to fewer than 10% in Kebbi (9.7%), Sokoto (8.4%), and Zamfara (9.6%).³²

These patterns highlight deep-seated inequities in the distribution of health infrastructure and services, which undermine progress toward equitable health outcomes and Universal Health Coverage (UHC) in Nigeria.

Socio-Behavioural Factors: Public Awareness and Provider Conduct

The behaviours and practices of both healthcare providers and service users play a critical role in shaping the performance and perceived quality of Nigeria's public health system. Empirical Evidence consistently demonstrates that a substantial proportion of the population continues to seek care from unqualified providers, including quacks, traditional healers, patent medicine vendors, and other non-orthodox health facilities, rather than from formerly trained health professionals. While factors such as limited awareness, geographical accessibility and weak referral systems contribute to this trend, structural determinants such as poverty, financial barriers and recurrent reports of unprofessional conduct within public healthcare further exacerbate the problem.^{31,33} At the institutional level, insufficient political commitment and weak governance have been widely criticized for undermining sustained investment in health system strengthening, thereby constraining service-delivery capacity and accountability. Public trust in the health system is further eroded by negative patient experiences and

entrenched perceptions regarding the inadequacy of public health facilities.

Commonly reported concerns include persistent shortages of essential medicines and consumables, perceived poor quality of care, disrespectful or abusive provider attitudes, inadequate staffing levels, frequent absenteeism, prolonged waiting times and inappropriate or delayed referrals.³¹ These perceptions, whether real or anticipated, to pay.³² Additionally, the widespread practice of dual employment, in which physicians and other health workers concurrently engage in public- and private-sector practice, has been documented as a major challenge within Nigeria's health system. This practice often results in divided professional loyalty, reduced availability of public facilities, and diminished commitment to public-sector responsibilities, ultimately compromising the continuity, quality, and reliability of care.⁵ Collectively, these demand- and supply-side behavioural dynamics interact to perpetuate systemic weaknesses, reinforcing public dissatisfaction and undermining confidence in Nigeria's public health system. A critical constraint to the effectiveness of Nigeria's public health system is the persistently low level of public awareness regarding the availability, scope and operational modalities of government health services and programs. Empirical evidence suggests that a substantial proportion of the population remains poorly informed about existing public health interventions, thereby limiting their ability to use formal healthcare services in a timely and appropriate manner. A notable example is the National Health Insurance Scheme (NHIS), which currently covers only approximately 5% of the population, underscoring a significant disconnect between policy design and population-level uptake.¹² The literature consistently demonstrates a strong association between inadequate health information and sub-optimal health outcomes, particularly in LMICs where access barriers are compounded by socio-economic vulnerabilities.¹⁷ In Nigeria, weakness in health communication

significantly influence health-seeking behaviour and contribute to delayed care utilisation, bypassing of primary care facilities, and increased reliance on informal providers. Provider-level factors also contribute substantially to system inefficiencies and inequities. Evidence indicates bias in service delivery, with differential treatment of patients based on socioeconomic status or perceived ability

systems, insufficient communication engagement, and poor dissemination or program-related information have been identified as major contributors to low service utilisation.^{32,34} Furthermore, many public health initiatives suffer from inadequate documentation, limited visibility, and fragmented communication strategies, which hinder public understanding and trust. Collectively, these information gaps constrain utilisation, diminish the potential impact of public health investments, and exacerbate existing inequities in access to essential healthcare services.

Part II: Community-Based Initiative as a Strategic Response

Rationale and Global Evidence for Community-Based Health Initiatives

While robust government interventions in funding and policy provision remain essential, community-based health initiatives (CBHIs) can serve as a complementary and sustainable approach to improving public healthcare services in Nigeria. Despite numerous strategies and interventions implemented over the years, progress in the quality of care and overall health status of Nigerians has been modest. Evidence indicates that CBHIs play a role in ensuring that grassroots populations, particularly those in rural, hard-to-reach, and resource-limited settings, benefit from improved healthcare services.¹⁵

The importance of increased health funding, improved governance, policy review, inter-sectoral collaboration, and systematic monitoring and evaluation is essential.^{6,13,16,30,35} However, CBHIs offer a targeted approach that directly engages

communities in the design and delivery of health services. Such initiatives have been successfully implemented in both high-income countries (HICs) and low- and middle-income countries (LMICs) under various models, including Community-Engaged Healthcare (CEH), Community-Based Health Planning and Services (CHPS), Community-Based Health Insurance (CBHI), and Community-Based Primary Healthcare Initiatives (CBPHI).^{19,21,26,27}

municable disease control, hygiene and sanitation, health knowledge, and care-seeking behaviours.²⁴ CBHIs empower community members to advocate for their health and actively participate in designing interventions with support from health care providers.^{19,21,22} By strengthening healthcare services at the grassroots level, these initiatives have the potential to address systemic challenges and drive lasting improvements in Nigeria's health sector.³⁶ In line with identified systemic challenges, we propose CBHI strategies encompassing needs assessment, community engagement, health insurance, local recruitment and training of health workers, and incentive mechanisms:

Promising CBHI Models for the Nigerian Context
Community Health Needs Assessment:

Community health needs assessment (CHNA) can play a pivotal role in complementing stakeholder efforts to address gaps created by limited awareness of available health services, inadequate policies, and inequities in the distribution of healthcare resources. CHNA involves systematic, evidence-based efforts to improve public health by collecting and analysing local data from each region, particularly in rural, hard-to-reach, and resource-limited settings.¹² The aim is to identify the unique health challenges, existing resources, and service gaps within each community. This enables the design of tailored strategies that address specific needs rather than applying a uniform approach across all regions.⁶ Data collected should emphasise locally available resources that can support sustainable

Evidence from Ghana demonstrates that community health management committees (CHMCs), community health volunteers (CHVs), and the CHPS policy have enhanced the availability of resources, optimized the utilisation of limited healthcare personnel, and improved service quality.^{23,27} Similarly, Ethiopia's Community Health Extension Program (HEP) achieved substantial gains in material and child health, com-

interventions, reducing reliance on imported solutions that may not be adaptable or maintainable. By aligning resources with actual community needs, CHNA promotes equity, reduces resource wastage, and prevents misaligned priorities, such as constructing a cancer centre in an area where malnutrition and maternal mortality rates are pressing concerns.³¹ Moreover, CHNA ensures that community health initiatives leverage the best available research evidence to transform healthcare delivery and improve population health outcomes.²¹

Participatory Governance and Community Engagement:

Community engagement and participation, a fundamental principle of primary healthcare, have often been neglected in Nigeria's health system. Yet meaningful community involvement is critical to the success and sustainability of any health intervention implemented for the benefit of the population.³⁷ It is imperative for government and other stakeholders to involve grassroots populations from the earliest stages of program conceptualization and decision-making, through to every step of implementation and evaluation.^{6,38} The goal of such engagement is to collaboratively plan and execute interventions that are both acceptable and accessible to the intended beneficiaries.³¹ For example, selecting sites for health infrastructure should incorporate input from local residents to foster a sense of ownership and ensure the long-term sustainability of facilities. Adopting a bottom-up approach, interventions are more likely to succeed when community members

and leaders are engaged through meaningful co-creation, rather than merely focusing on outcomes.²⁰

Community engagement strategies can be further reinforced through culturally appropriate awareness campaigns and sensitization initiatives that inform the public about available healthcare services and the importance of utilizing them.^{17,39,40} The recently launched National Health Fellows Program (NHFP) by the Federal Government of Nigeria exemplifies such an approach. By deploying young professionals to each Local supported monitoring of service delivery. Such participatory approaches have significant potential to enhance health outcomes and strengthen the public health system.

Local Recruitment and Training of Health Workers: A major challenge confronting Nigeria's public healthcare system is the shortage of skilled human resources.³⁰ This initiative targets the identification of promising students in communities, beginning in secondary school, and supports their education and professional training through tertiary institutions, with the aim of returning them to serve their immediate communities. The program can be used to develop a range of healthcare cadres, including community health workers, nurses, physicians, dietitians, social workers, and counselors.²¹ By training individuals from within the community, this approach helps mitigate the challenges healthcare personnel often face in rural settings, such as social separation from family and difficulties adapting to local conditions. Effective implementation of this strategy has the potential to reduce shortages and address inequities in the distribution of health personnel, particularly in rural and resource-limited areas.³⁰ This approach aligns with the mandate of the National Primary Health Care Development Agency (NPHCDA), which emphasizes community support through the training of village health workers.⁴¹

Community-Based Health Insurance

Government Area (LGA), the program aims to enhance service delivery, improve access to healthcare, and foster community participation.³⁶ Sustaining community-based engagement initiatives is essential to improving healthcare utilisation. Evidence from across Nigeria, particularly in northern regions, demonstrates that local accountability platforms, traditional leadership structures, and civil society organizations have successfully mobilised demand for services, strengthened community trust, and

To complement the National Health Insurance Scheme (NHIS), which currently covers only about 5% of Nigerians, and to reduce the high out-of-pocket expenditures borne by households, a well-structured community-based health insurance (CBHI) scheme could be adapted for use across local communities. Poverty and the high cost of healthcare remain major barriers to accessing quality services in Nigeria.^{6,14} A carefully designed CBHI has the potential to overcome these financial obstacles and expand healthcare utilisation.

Community-based health insurance schemes implemented in several low- and middle-income countries (LMICs) have demonstrated significant success in improving access to quality healthcare. For example, CBHI programs in Bangladesh, Burkina Faso, Ghana, Kenya, Mali, Rwanda, Tanzania, Senegal, and parts of Nigeria have been reported to substantially increase healthcare utilisation among citizens.²⁶ In Rwanda, multiple standalone CBHI schemes were consolidated into the "*Mutuelles de Santé*," achieving enrollment of over 90% of the population. This system notably improved access to both preventive and curative services.²⁵ The successes of these initiatives highlight the potential of CBHI to enhance healthcare utilisation in Nigeria, particularly for rural and resource-limited populations. By reducing financial barriers, CBHI can complement government efforts, improve equity in access to care, and strengthen the overall public health system.

Incentive Structure for Rural and Community-Based Health Workers:

Evidence suggests that healthcare personnel avoid working in rural settings for several reasons. Some of which include inadequate remuneration, lack of social amenities, and separation from family and relatives. This initiative can be achieved by providing rural allowances, on-the-job training, adequate remuneration, and regular promotion, among other measures.³⁰ If effectively implemented, this strategy will not only encourage the retention of community-based health workers but may also encourage those from other settings to work in rural areas.

The failure of top-down approaches to significantly reduce maternal and child mortality, disease burden, and service access barriers underscores the critical need for a paradigm shift. Community-Based Health Initiatives (CBHIs) represent this necessary shift, offering a decentralized model that directly tackles these systemic flaws. By empowering communities through needs assessments, local health worker recruitment, and community-based insurance, CBHIs foster local ownership, improve resource allocation, and build trust from the ground up. To translate this potential into reality, future research should prioritize evaluating the real-world effectiveness and scalability of diverse CBHI models across Nigeria's varied contexts. Ultimately, integrating these community-powered strategies into national health policy is not just complementary, it is essential for achieving the resilient, equitable, and sustainable health system required for Universal Health Coverage in Nigeria.

STRENGTHS AND LIMITATIONS OF THE STUDY

In this narrative review, we provided an integrated synthesis of Nigeria's public health indicators, systemic challenges, and community-based solutions over a 25-year period (2000-2025). By drawing on data from both peer-reviewed and grey literature, the review captures policy-relevant evidence that is often absent from academic

CONCLUSION

This review synthesizes evidence indicating that Nigeria's persistent health crisis is not only as a result of lack of interventions, but rather due to deep-seated systemic weaknesses in coordination, funding, equity and policy gaps. Despite numerous interventions by government and other stakeholders over the past three decades, key health indicators, including maternal, infant, neonatal, and under-five mortality, malnutrition, access to skilled antenatal and delivery care, immunization coverage, and contraceptive use, remain unacceptably poor

publications, thereby enhancing its applicability to health system planning and decision-making. A key strength is its focus on community-based approaches, which are contextually appropriate and feasible strategies for improving access, equity, and service utilisation. As a narrative review, we did not employ systematic review methods, such as formal quality appraisal or meta-analysis. Although this approach may have subjected the study to selection bias, this limitation was mitigated by a comprehensive search of the literature across multiple databases and screening of identified sources of evidence against predefined inclusion and exclusion criteria.

IMPLICATIONS FOR POLICY AND FUTURE RESEARCH

The findings of this study highlight the need for strengthened political and financial commitment to primary health care, with a focus on scaling community-based health models. Policy makers should prioritize sustainable health financing, including integration and expansion of community-based health insurance, alongside investment in the recruitment, training, and retention of community-based health workers, particularly in rural areas and resource-limited settings. In addition, institutionalizing community engagement and health education is essential to improve service utilization and system responsiveness. Future research should evaluate

the effectiveness, scalability, and cost-effectiveness of community-based interventions, while examining regional variations in health system performance and the integration of the approaches into broader health system reforms.

CONFLICT OF INTEREST

Authors declare no conflict of interest

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AUTHORS' CONTRIBUTIONS

Conceptualization: UY;

Literature review: UY, AY, SM, and HY;

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