Federal Republic of Nigeria

National Health Product Supply Chain Strategy 2026-2030

Version 2.0 of the Maturity Advancement Program (MAP) of the National Health Supply System (NHSS)

Federal Ministry of Health and Social Welfare

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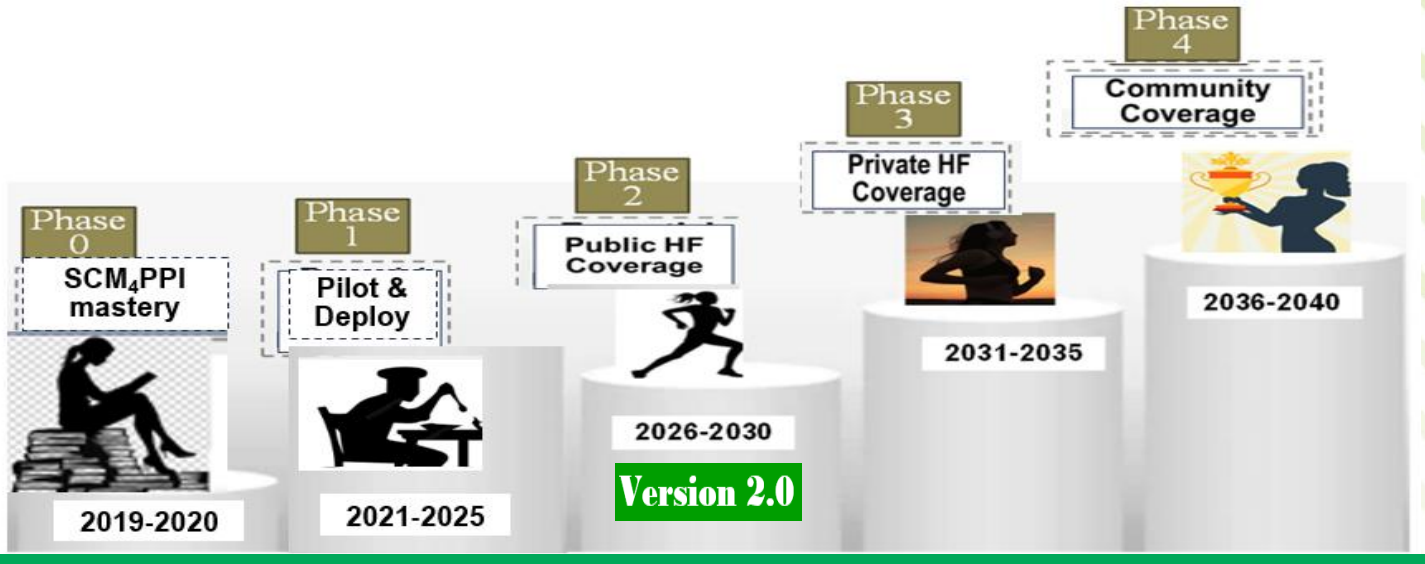


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Acronyms and Abbreviations

Acronym/Abbreviation	Full Meaning
CFoR	Common Frame of Reference
DPRS	Department of Planning, Research and Statistics
DMA	Drug Management Agency
DQA	Data Quality Assessment
eLMIS	Electronic Logistics Management Information System
ERP	Enterprise Resource Planning
DFDS	Department of Food and Drug Services
FDMA	Federal Drug Management Agency
FHI	Federal Health Institution
FMOH	Federal Ministry of Health
FMOH&SW	Federal Ministry of Health and Social Welfare
GDP	Good Distribution Practice
GPO	Group Purchasing Organization
KPIs	Key Performance Indicators
LGA	Local Government Area
LGAHSS	LGA Health Supply System
LMCU	Logistics Management Coordinating Unit
LMIS	Logistics Management Information System
LPR	Legacy Parallel Regime
M&E	Monitoring and Evaluation
MIOS	Maturity – Integration – Optimization – Sustainability
MIOS Gates	Checkpoints/Rules that decide when and how they happen
MNRTI	Maturing Not Ready To Integrate
MRTI	Maturing Ready To Integrate
NACA	National Agency for the Control of HIV/AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NASCP	National AIDS, Viral Hepatitis, and STIs Control Programme
NHIA	National Health Insurance Authority
NHLMIS	Nigeria Health Logistics Management Information System
NHPSC	National Health Product Supply Chain
NHSS	National Health Supply System
NMEP	National Malaria Elimination Programme
NOP	National Operating System
NPSCMP	National Product Supply Chain Management Programme
NSCIP	Nigerian Supply Chain Integration Project
NTBLCP	National Tuberculosis & Leprosy Control programme
NVOP	National Viable Operating System
OSRS	Operating System Reform Stream
OTIF	On-Time In-Full
PHC	Primary Health Care
PPF	Pooled Purchasing Framework
PPP	Public–Private Partnership
PVAC	Presidential Initiative for unlocking the healthcare value chain
QA	Quality Assurance

Acronym/Abbreviation	Full Meaning
RUTF	Ready-to-Use Therapeutic Food
SCM4PPI	Supply Chain Management for public policy implementation
SDGs	Sustainable Development Goals
SDMA	State Drug Management Agency
SHF	Secondary Health Facility
SHSS	State Health Supply System
SLA	Service Level Agreement
SMoH	State Ministry of Health
SOP	Standard Operating Procedure
SPA	Strategic Priority Area
SWAp	Sector-Wide Approach
THF	Tertiary Health Facility
ToA	Theory of Action
ToC	Theory of Change
TQM	Total Quality Management
UHC	Universal Health Coverage
UIS	Unification and Investment Stream

Foreword

Nigeria cannot achieve Universal Health Coverage unless essential medicines and health products are reliably available where they are needed, when they are needed, and at a cost the country can sustain. Supply continuity is not a technical luxury; it is patient safety, service credibility, and national resilience.

Likewise, every Nigerian deserves a health supply system that does not collapse when leadership changes. This Strategy is our pledge to build a stable, government-managed supply chain that outlives politics—one that keeps medicines available, protects quality, prevents losses, and continues to improve year after year. We call this **intergenerational survivability**: the permanent stewardship ability to hold the system together across administrations, funding shocks, and emergencies, so that access to essential health products becomes a dependable national guarantee for Nigerians now and those yet unborn.

The first National Health Supply Chain Strategy (2021–2025) proved a decisive point: a **government-led, financially self-sustaining, and well-governed** supply system that delivers reliable service to public health facilities is possible. It validated the operating logic and demonstrated that disciplined standards, accountability, and execution capacity can translate into real improvements at facility level.

Two gaps, however, remained. First, the **state DMA model** must be scaled to cover all states and the FCT—so every public facility is served by a functional, performance-managed delivery engine. Second, Nigeria must complete **federal-level integration**—reducing fragmented lanes and unmanaged parallel systems—so the whole system can move as one.

The 2026–2030 Strategy is therefore a deliberate course correction to close these gaps. It is strengthened by three practical levers now shaping the environment: the Sector-Wide Approach (SWAp) to align government and partners behind one set of priorities; the national GPO/Medipool to drive pooled purchasing, affordability, and sustainability; and the shifts in donor funding that make deeper integration, stronger governance, and domestic financial reliability not optional but urgent. Together, these levers support a reform pathway driven more firmly from the federal level, implemented through the states, and extended to the LGA level—so the entire system moves as one.

I therefore urge all stakeholders—Federal and State institutions, public health programme, partners, and service providers—to align faithfully with the provisions of this Strategy and its Blueprint.



Professor Muhammad Ali Pate, CON

Coordinating Minister of Health & Social Welfare,

Federal Ministry of Health & Social Welfare, Nigeria 2026

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We commend the Director, Food and Drug Services along with the Management and Staff of National Product Supply Chain Management Programme for their professionalism and sustained commitment to strengthening governance, operational discipline, and system performance across the national health supply chain. Additionally, we extend our gratitude to the National Health Programme (NASCP, NTBLCP, NMEP, FP, NTD,), NACA, NCDC, NAFDAC, PCN, NPHCDA, NHIA, PVAC, MEDIPOOL, and the State DPS, Heads of DMAs and State LMCUs for their technical support and commitment, which greatly enhanced the robustness of this document.

The Ministry is equally grateful to our Implementing Partners and Donors for their strategic, financial, and technical support, which has enhanced system design, operational innovation, and long-term sustainability. Special acknowledgement is extended to the two Technical Assistance for their analytical input and technical drafting support in translating policy direction into a structured and implementable national framework.

Recognition is also accorded to the Management and Staff of the National Tuberculosis, Leprosy and Buruli Ulcer Control Programme (NTBLCP), UNICEF, and other development partners whose sectoral expertise and collaborative engagement enriched the Strategy's technical depth and accountability mechanisms.

This Strategy represents a coordinated national effort grounded in partnership, shared responsibility, and institutional accountability. Its successful implementation will depend on sustained collaboration as Nigeria advances towards a resilient, transparent, and performance-driven health supply chain system that guarantees equitable access to safe, effective, and quality-assured health commodities nationwide.



Daju, Kachollom S. mni

Permanent Secretary

Federal Ministry of Health and Social Welfare

The National Health Product Supply Chain Strategy 2026-2030,

---One National System. Reliable Supply. Better Health—Stewarded to Last --



...improving the "intergenerational survivability" of the National Operating system and its disciple operations and reliable services.

If donors pause tomorrow, if the government fails or delays in releasing recurrent funds, would the system be able to still use rules and capacity to deliver routine, quality-assured, affordable essential products to all public facilities to ensure consistent availability in line with Universal Health Coverage?

The answer is rooted in **Sustainable stewardship** - the government's cross generational capacity to govern, run, assure, integrate, and finance the supply chain as a coherent national operating system—so it performs reliably regardless of personalities, administrative changes, donor swings, or shocks. This strategy is a critical part of the sustainable stewardship journey that aims to achieve by 2030, 100% coverage of all the public health facilities sustained by financially self-reliant, effectively governed, vulnerability controlled and government-led management systems.

Pilot implementations in several Nigerian states during the 2021-2025 strategy periods demonstrate that sustainable stewardship is feasible; with the new political and financial leverage from the Sector Wide Approach (SWAp) agenda and the Group Purchasing Organizations (e.g. Medipool). The Department of Food and Drug Services (D/FDS) through the National Product Supply Chain Management Programme (NPSCMP) can now confront and address the parallelism at the federal level decisively and scale the model operating system nationwide.

- The Use in part or full of this document within the supply chain space shall be with recourse to NPSCMP of the Department of Food and Drug Services of Federal ministry of Health & social welfare (FMoH&SW).

Glossary

i. **Actionable plan**: the operational translation of a strategy or blueprint into clearly defined actions with owners, timelines, inputs, process, expected outputs, and review points, so that implementation can begin immediately and progress can be tracked.

ii. **Blueprint**: a structured way of expressing a pillar or system as a purposeful public institution: its Aim, the Engine (Routines + Capabilities + Role Holders + Relationships + Enablers) that produces results, the Steering arrangements that keep it on course, and the Sustaining arrangements that keep it viable across time, shocks, and generations.

iii. **Federated delivery system**: Nigeria's public health supply chain is best understood as a federated delivery system: each delivery system (state DMA) is operationally autonomous but use standards provided by NPSCMP. Balances unity and autonomy.

iv. **Functional Health facility coverage**: the degree (in %) to which the functional health facilities within a defined geography or service network are onboarded into the distribution framework of a DMA for consistent supply of quality-assured health products in the volumes and varieties needed.

v. **Highway**: UHC-aligned outcomes for the supply chain can only be achieved if the diverse operations are conducted in a particular way. The Highway is the metaphorical description of the nationally approved operating space, ruleset, and coordination pathway through which all legitimate supply chain actors, delivery channels, and functions can be made to move as the one coherent system that can generate those types (UHC-aligned) of outcomes.

vi. **Monolithic Integration**: a type of integration where multiple programmes are merged into one single operating structure with one management chain, one set of routines/SOPs, one delivery calendar, one data truth, and one governance/decision system—so the supply chain runs as one system, not as several coordinated pipelines.

vii. **Onboarding**: Onboarding is the guided introduction and early installation process through which a new actor is assessed for eligibility and supported (if needs be) to fit into a system's purpose, rules, roles, standards, routines, and expectations so that they can participate correctly and effectively.

viii. **National Health Supply System**: the "living" national union of all the supply chain delivery pillars, institutions, rules, lanes, interfaces, and operating arrangements that together make health product delivery function as one coherent public system in support of UHC-aligned outcomes. The sub-systems include the Federal Health Supply System (FHSS); State Health Supply System (SHSS); LGA Health Supply System (LGAHSS); the health facilities & the community structures.

ix. **Public Health Supply Chain (PHSC):** the public-purpose application of supply chain concepts, methods, and practical operating disciplines to implement health policy on access to medicines and other health products. It ensures that needed products are selected, procured, moved, stored, made continuously available, protected in quality, and supported for appropriate use so they can contribute to the intended health and social outcomes. Unlike the commercial supply chain, it is optimized for equitable reach, continuity, affordability, and population benefit rather than profit, built for intergenerational survivability, and aligned to Universal Health Coverage.

x. **Strategic Delivery Framework**: the implementation architecture that shows how a strategy will be translated into coordinated action, who carries which responsibilities, what mechanisms will drive execution, how progress will be monitored, how problems will be corrected, and how the intended results will be secured over time.

xi. **Supply Chain Leadership**: In a public health supply chain, supply chain leadership is the public stewardship role that guides the system toward reliable access outcomes by providing vision, coordination, standards, accountability, and problem-solving, while keeping the system government-led, strongly governed, and sustainable over time.

xii. **Sustainable stewardship** - the government's cross generational capacity to govern, run, assure, integrate, and finance the supply chain as a coherent national operating system—so it performs reliably regardless of personalities, administrative changes, donor swings, or shocks

xiii. **UHC-aligned outcomes**: SDG 3.8 target specifies the Supply Chain service framework for citizens; the outcome characteristics that align with that framework requires that the supply system deliver the right health products, in the right condition, in the right quantities and varieties, at the right places, at the right time, at the lowest reasonable cost, and with fair reach to all populations, especially the poor, vulnerable, and hard-to-reach.

xiv. **Vision Blueprint (the destination)**: the structured design of the desired future supply system. It shows what the finished system should look like, how its major parts fit together, what roles each part must play, what outcome characteristics it must produce, and the core operating logic that makes the whole arrangement work as one coherent system.

xv. **Vulnerability (Dependency type)**: the tendency of a system, institution, process or practice to lose discipline, derail or malfunction when the sustaining, enforcing, or overseeing influence is reduced or removed. Some public systems appear to work well only while: a strong leader is present; a donor is closely watching; a consultant is driving; a central authority is policing, or unusual attention is being paid.

The List of Strategic Priorities (The "Must-Win Bets") for 2026-2030

A. Strategic Core Priorities

Strategic **Priority 1**: **DMA Maturity Acceleration:** Support the 21 states and the 10 states plus FCT that are yet to adopt the model to at least "Maturing Ready-to-integrate" level.

Strategic **Priority 2**: **Federal Public Health Program Logistics Integration**: Integrate the 6 public programmes "monolithically" into one structure, one governance & planning routine, execution backbone, data & visibility platform into the NPSCMP Org structure.

Strategic **Priority 3**: **Program Integration in Maturing-Ready-to-Integrate States**: With focus on warehousing, information management and LMD, integrate the public health programme systems into the essential management framework of eligible states.

Strategic **Priority 4**: **Local Manufacturing Expansion**: deliberately support the expansion base through procurement arrangements that ensure repeatable demand; make inroads into ownership of the manufacturing processes (tech know-how, raw materials & equipment.

Strategic **Priority 5**: **Standardize the weak public program logistics systems** with focus on the Nutrition Supply Chain: Others include the NTDs, NCDCs, etc.

Strategic **Priority 6**: **Establish a Federal DMA:** Use the cost-recovery mechanism to operationalize a federal DMA for procuring and supplying the federal health institutions – while leveraging lessons from the maturing State DMAs

Strategic **Priority 7: Strengthen the federal GPOs (e.g. Medipool):**

Strengthening the Federal GPOs (e.g. Medipool) for improved visibility and accountability of their deliveries to the PHCs including community involvement while establishing a clear handoff pathway so that once a State DMA attains the Maturing-Ready-to-Integrate status, the federal GPO like Medipool can integrate into it.

B. Cross-Cutting Strategic Priorities (2)

Cross-Cutting **Priority 8**: **Capacitate NPSCMP** as the National Architect and Principal steward of the National Health Supply System (NHSS).

Cross-Cutting **Priority 9: Workforce Professionalization and Knowledge Codification:** Institutionalize a certified, standards-based supply chain workforce and national knowledge system with defined roles, training, SOPs, and supervision.

Cross-Cutting **Priority 10: Supply Chain Function Optimization**: Standardize and optimize Nigeria's supply chain with national operating standards including performance improvement techniques, safety (Track and Trace), risk management and resilience building systems.

C. Preparatory projects for next phase – (2031-2036)

Pilot Project **Priority 11: Business model for onboarding private health facilities:** - targeting the elimination of falsified and substandard products, etc.:

Pilot Project **Priority 12: Business model for onboarding community units:** -into systems that connect the hub public and private health facilities with ambient family units of health seekers for health and commodity fulfillment, etc.:

Reader Guide — How to Read and Use This Strategy

This 2026–2030 Strategy is a second-generation Strategy because it is not mainly the normal collection of operational fixes (reporting, stock-outs, and HR gaps). It is a system transformation agenda that sets enforceable operating rules and institutional capability—so operational performance improves as a consequence of a stronger system. It builds on the 2021–2025 reform direction and upgrades it into *institutionalized, enforceable, and scalable* national practice—standards, accountability, integration discipline, and performance visibility. It is grounded in *Nigeria's established public health supply chain practice* (what is already used, tested, and scalable), and it is *transformational* in intent. For these reasons, the document combines formal policy language with brief, plain-language explanations to support a common understanding across political leadership, system stewards, implementers, and partners.

This Strategy is also organized in such a way that different readers can find what they need—without confusing national direction with project-level implementation detail. It follows one internal logic chain:

Domain Map → Pillars → Situation analysis -Objectives → Strategic Priorities → Delivery Framework → National Outcomes & Headline KPIs

1) The Strategy's internal logic (how the pieces connect)

- **Domain Map:** the system map that assembles all the major parts of the supply chain, so nothing is missed and every topic has a home.
- **Pillars:** cross-cutting "levers" to move the system (e.g., standards/control, capability, integration discipline, performance visibility, sustainability).
- **Situation analysis:**
- **Objectives:** the national commitments for 2026–2030—specific end-results Nigeria must achieve.
- **Strategic Priorities:** the "must-win" focus areas—where national attention, policy force, and resources concentrate first.
- **Delivery Framework:** how delivery is governed across multiple executors and lanes—sequencing, readiness gates, roles, verification, escalation, and consequences.
- **Outcomes & Headline KPIs:** how success is defined and proven: These are measures that make performance visible, comparable, and enforceable.

2) Who should read what (quick navigation by audience)

A. Minister/Governors/Commissioners/Legislators - the *policy story*
Where to read: Executive Summary; Vision + National Outcomes; Headline KPIs; Strategic Priorities; Delivery Framework (high-level).
Take-away: national direction, non-negotiables, and how success will be judged.

B. System stewards (NPSCMP, FMoH leadership, SHSS structures, Federal/State DMA leadership) – can focus on the *governance story*
Read: Pillars + Objectives; Delivery Framework (roles, gates, verification, escalation, consequences); Outcomes & Headline KPIs.
Take-away: what must be standardized/enforced and how performance management will run.

C. Implementers (Federal DMA, State/FCT DMAs, LMCUs, logistics/warehouse/distribution teams, facility managers) - *the execution story*
Read: Objectives + Strategic Priorities; Delivery Framework (sequencing, readiness, routines, evidence); Standards/definitions + annexes.
Take-away: what must change in practice, what readiness looks like, and what evidence is required.

D. Partners/programme/GPO/TA/private sector - *alignment story*
Read: Pillars + Objectives; Strategic Priorities; Delivery Framework (alignment rules, allowed vs. not allowed, integration/transition discipline); Outcomes & KPIs.
Take-away: how your lane aligns to the national operating system and how integration will be governed.

3) What this Strategy is meant to do

- Set national direction for UHC-aligned availability, quality, affordability, and service reliability.
- Define priorities and non-negotiables—what must be built, enforced, and protected.
- Define success via national outcomes and headline KPIs (measurable and comparable).
- Organize delivery across multiple executors and lanes using one Delivery Framework (sequencing, gates, roles, verification, and consequences).
- Create accountability—who is responsible for what and how compliance will be verified.

4) What this Strategy is not meant to do

This Strategy is not a project implementation manual, a substitute for state/programme/partner workplans, or a replacement for technical SOPs. It sets *national standards and alignment rules* that SOPs and plans must follow. Detailed "how-to" delivery sits under the Strategy in the *Blueprint and implementation instruments* (sequencing plans, readiness tools, transition templates, scorecard guidance, and operational guides).

5) How to use this Strategy in practice

- **Policy/funding:** use Strategic Priorities + Outcomes/KPIs to protect and enforce what matters most.
- **Oversight:** use Delivery Framework + KPIs to run reviews, verify compliance, and apply consequences.
- **Implementation:** use Objectives + Delivery Framework + Standards/Definitions to build capability, pass gates, and prove performance.
- **Partner support:** use Pillars + Delivery Framework to align investments and prevent parallel systems.

1. Executive Summary

- UHC focus: Nigeria cannot achieve Universal Health Coverage unless health facilities reliably receive the health products they need in the right quantity, at the right quality, at an affordable cost, and on time. Experience from several states has already shown that this can be done. The task now is to scale it nationwide in a disciplined and measurable way. This Strategy (2026–2030) sets out Nigeria's national plan for doing that.
- National Transformational Agenda: Nigeria is on a 21-year journey (2019–2040) toward UHC-aligned supply outcomes. The period 2026–2030 is the 3rd and national scale phase. Its purpose is to achieve full public health facility onboarding and make disciplined supply performance the normal way of operating across the country. The numerical target is 100% public health facility coverage. Kaduna state already achieved this feat by October 2024 and the whole country stood at 31% & 33% for secondary/tertiary and PHC levels respectively at the end of the 2021-2025 pilot phase.
- Sustainable Stewardship of institutional gains: Across the 21-year transformation agenda, the gains of each phase will be carried forward through **sustainable stewardship of institutional gains**. This means that each phase is expected to leave behind lasting improvements that the next phase can inherit, strengthen, and expand. These gains include stronger institutions, better systems, clearer standards, improved workforce capacity, stronger financing and oversight, better data use, and more reliable quality and performance management. This ensures that progress is not temporary but is preserved and deepened from one phase to the next on the path to UHC-aligned outcomes.
- Current phase: Nigeria enters this phase at an important moment. First, the reforms and implementation experience from 2021–2025 have already shown that government-led, more sustainable supply chain practice is possible. Second, the Sector-Wide Approach (SWAp) provides stronger political and financing leverage for federal integration and national alignment. Third, external financing conditions are becoming tighter, which means that ownership, sustainability, and integration are no longer optional.
- Phase target: By 2030, Nigeria aims to reach a clear and testable end-state. All public health facilities should be onboarded into a nationally disciplined operating model. Every onboard facility should consistently receive quality-assured and affordable essential health products in the right volumes and mix. Facilities should experience one more coherent service offer across essential medicines, programme commodities, and procurement or distribution arrangements, instead of many fragmented parallel deliveries. The system should also become more durable, resilient, governable, and financially sustainable, with less dependence on donors and irregular funding releases.
- The federated delivery system: The Strategy is built on one central idea: one national operating system, many executors. Nigeria will continue to have federal and state institutions, programmes, partners, facilities, and private suppliers. This Strategy does not assume that one actor will do everything. Instead, it aims to make many actors work within one national operating system through shared standards, clear interfaces, performance visibility, verification, and consequences.
- Maturing DMA as Catalyst: The strongest lesson from 2021–2025 is that stronger State DMAs create wider system improvement. For that reason, this Strategy treats DMA maturity as a major driver of reliability and sustainability. Every State and the FCT is

expected to operate a functional DMA that supplies all public health facilities. Integration will be controlled, not assumed. Federal programme commodities and other lanes will move into eligible state systems only when readiness has been proven.

- The strategy pillars: The Strategy is built on five reinforcing pillars: talent and knowledge codification; UHC-aligned system design, product assurance, and federal integration; system maturity and financial strength through the federated DMA network; national facility coverage expansion; and integration, optimization, performance, and resilience.
- The Blueprint: To avoid paper policy, the Strategy will be implemented through a Blueprint. The Blueprint will translate priorities into action through sequencing, readiness gates, clear roles, accountability arrangements, partner alignment, and practical tools that make compliance visible and transitions safer.
- Monitoring & Evaluation: Success will be judged in two linked ways. First, by what facilities experience: facility onboarding, routine availability, replenishment reliability, product quality, and reduced parallel deliveries. Second, by what the system can prove: financial sustainability, governance strength, vulnerability control, and the ability to continue performing over time. In simple terms, 2026–2030 is Nigeria's national scale phase. Its purpose is to achieve full public health facility coverage with complete, integrated, quality-assured, affordable, and reliable supply, backed by enforceable standards, maturing DMAs, stronger federal integration, and a Blueprint that turns policy into result

2. Introduction - Nigeria's National Health Supply Chain Strategy 2026–2030

This Strategy is Nigeria's national plan for making access to essential health products a **routine, verifiable service**—so that health facilities consistently have the medicines and commodities they need, in the required volumes and varieties, with assured quality and affordable cost. It is written to deliver one testable result: **UHC-aligned supply performance proven at the point of care**.

Nigeria's 21-year transformation journey (2019–2040)

Nigeria is implementing a deliberate, phased transformation toward UHC-aligned supply outcomes over **2019–2040**:

- Phase 1 (2019–2020): Establish how supply chain performance drives access to health products as a public policy lever for UHC.
- Phase 2 (2021–2025): Pilot a **sustainable, government-led** supply chain model and test the governance and operating reforms needed for disciplined delivery.
- Phase 3 (2026–2030) **— this Strategy:** Achieve **100% onboarding/coverage of all public health facilities**, with measurable service reliability at facility level.
- Phase 4 (2031–2035): Extend disciplined coverage to **private-sector health facilities**.
- Phase 5 (2036–2040): Extend disciplined coverage to **community units**, to achieve equitable reach as a routine reality.

Phase 3 is therefore the **scale phase**—moving from pilots and early reform traction to national normalization across all public facilities.

The central promise of 2026–2030

This phase is focused on one practical ambition: ensure every onboard public health facility receives **complete service** from the full set of supply channels—rather than fragmented, parallel delivery. This includes (as applicable):

- Essential medicines and routine commodities
- Public health program commodities
- Specialized lines such as Neglected Tropical Diseases
- GPO arrangements e.g. pooled procurement/distribution lanes

The intent is a disciplined, predictable facility experience where services are integrated into a coherent offer and performance is provable.

What must be true for this phase to succeed

Three requirements are non-negotiable:

1. **Upstream control aligned to UHC outcomes:** enforceable standards must protect quality, affordability, and reliability—so "standards" are not paperwork but a control mechanism that shapes real practice.
2. **Durable, sustainable institutions:** routine availability cannot depend on ad hoc projects; institutions must be governable, stable, and **financially self-reliant or reliably resourced**.

3. **DMA maturity as the catalytic pathway:** the key lesson from 2021–2025 is that **maturing State DMAs** produces wide catalytic effects. This phase will face major setbacks if most states do not progress beyond early maturity—especially if a critical mass does not reach at least the **"Emerging"** level required to sustain routine delivery and safely integrate additional flows.

What changes in this phase?

Phase 3 does two things at once:

- **Scales what worked in 2021–2025:** especially DMA maturity and the operating discipline needed for routine facility service reliability.
- **Closes what remained outstanding at federal level:** integration challenges that were difficult to resolve through technical coordination alone are advanced in this phase—enabled by the **SWAp reforms**—while also initiating preparation work required for **Phase 4 (private facilities)**.

How this Strategy avoids "paper policy"

This Strategy adopts a deliberate **Policy-to-Results approach**. It is paired with a robust implementation **Blueprint** that translates policy into sequenced deliverables, routines, verification, and performance management—so the Strategy does not remain a document on paper.

What the reader should expect in this document

The Strategy sets out:

- the national objectives and outcomes for 2026–2030,
- the chosen pillars and strategic priorities that drive those outcomes,
- the implementation Blueprint (sequencing, gates, deliverables), and
- the governance, measurement, and accountability mechanisms used to prove results at facility level.

Who is this Strategy for

- **Federal leadership and coordinating institutions** responsible for standards, control, and alignment
- **State/FCT leadership and DMAs** responsible for routine execution and facility reliability
- **Programs, partners, and GPOs /distribution lanes** whose services must align into a coherent facility experience
- **Manufacturers and suppliers** who require predictable rules and credible demand/contracting to support affordability, quality, and supply security

Bottom line

Nigeria's 2026–2030 phase is where reforms become **national routine practice** across public facilities. Success will be judged by whether every onboarded facility can reliably provide

complete, quality-assured, low cost, product availability, proven through enforceable standards, performance visibility, and durable institutions—at national scale.

3. Vision, Mission, Scope, and 2030 End-State

Introduction to this section

The hard decision: On **5 April 2019**, national and sub-national supply chain stakeholders took a hard but necessary decision to align public health supply chain practice with **Universal Health Coverage (UHC)**. The decision was overdue and could have been made earlier, when Nigeria adopted UHC as a national policy guide in **March 2014**. It was difficult because **NPSCMP** was not yet fully equipped with the knowledge and skills needed to adapt conventional supply chain management approaches to the public policy goal of improving access to medicines in line with UHC. Faced with this gap, NPSCMP responded by becoming a self-made innovation engine for the design, development, management, operation, and governance of the public health supply chain.

Key concepts: Strategy is often described as the path from **Point A**, where we are now, to **Point Z**, where we want to arrive, under conditions of uncertainty. For this reason, the first duty of a strategy is to make the destination clear. It must define not only the goal, but also the measurable and provable signs that show the goal is being reached. These signs, which may be called the **vision objectives** or the **North Star**, give all stakeholders a **common frame of reference** for decision-making, even as the journey passes through changing governments, shifting conditions, and other uncertainties.

In this Strategy, the North Star is not something that can be reached by isolated activities. It can only be produced by a functioning **operating system**. That operating system is made up of parts that must work together in harmony, including its architecture, rules, relationships, and ways of operating, all directed toward **UHC-aligned outcomes**. Because this is a man-made system, it must be deliberately designed, reviewed as conditions change, brought to life in real-world operations, and then continuously policed and maintained. This is a central role of **NPSCMP**.

NPSCMP therefore has a dual responsibility. First, it must design and steward the national operating system for health product delivery. Second, it must ensure that all operators work within the system's approved rules and structure. This is why the **National Health Supply System (NHSS)** can be pictured as a **highway** with many marked lanes for different product delivery service providers. Each lane has its place, but all must work within the same highway rules so that, together, they expand and sustain **UHC-aligned outcomes**.

The Vision Blueprint: In 2019, Nigeria began to define a new framework for its public health supply chain service, rooted in the principles of **Universal Health Coverage (UHC)**. While UHC depends on the contribution of many sectors, this Strategy focuses on the part to be delivered by the supply chain. For this reason, it defines a clear vision objective, or **North Star**, which we refer to as **UHC-aligned outcomes**.

This Theory of Change is based on a simple assumption: if the public health supply chain can consistently deliver **quality-assured health products**, in the **right volumes and varieties**, to the people who need them, at the **lowest possible cost or at subsidized rates**, across the country, with special attention to the **hard-to-reach, indigent, and most vulnerable groups**, and support their **appropriate use**, then the supply chain would have fulfilled its service contribution to UHC.

Vision

A Nigeria where every public health facility is reliably supplied through one disciplined, government-stewarded national health product supply system.

Mission

To build, govern, scale, and protect a nationally aligned health product supply system that delivers complete, quality-assured, affordable, and reliable service to public health facilities.

Scope

This Strategy focuses on the public health system during 2026–2030. It covers federal and state public supply arrangements, programme logistics integration, DMA maturity progression, pooled procurement alignment, workforce strengthening, system governance, product assurance, data discipline, financial sustainability, and resilience. It does not yet seek full private-sector expansion as a central outcome of this phase, although it prepares the ground for that later phase.

The 2030 End-State

By 2030, all public health facilities should be onboarded into a disciplined national supply framework and should receive a reliable, quality-assured, and affordable supply service through a more harmonized delivery model. Parallel arrangements should be significantly reduced. State and federal execution arrangements should operate within one national accountability logic. NPSCMP should function as an effective national steward and system architect. The supply system should be stronger, more governable, more resilient, and better able to continue performing across shocks and leadership change.

Strategy principles

The implementation of this Strategy shall be guided by the following principles:

One National Architecture — Unified governance with federated execution
Nigeria will operate one nationally coordinated supply chain architecture governed by a single framework of policies, standards, and accountability rules. Execution shall be federated across Federal, State/FCT, and facility levels, allowing operational adaptation only within nationally defined rules, interfaces, and compliance requirements.

ii. Facility-Centric Service Guarantee — Every functional public health facility should be supplied and auditable
The supply chain shall be designed and governed to ensure that every public health facility reliably receives complete, quality-assured, and low cost essential health products in the required quantities, at the required time, and under the required conditions. Facility service performance shall be auditable through defined minimum service standards, routine verification, and evidence-based performance reporting.

iii. Performance and Compliance Discipline — Scorecards, KPIs, escalation protocols, and enforceable accountability
National and sub-national performance shall be managed through standardized KPIs, scorecards, and verification protocols that enable objective assessment of results.

Underperformance and non-compliance shall trigger predefined escalation and corrective action pathways, including support measures and enforceable consequences tied to clearly assigned responsibilities.

iv. Equity and Geographic Inclusiveness — No state or public health facility left structurally behind

Equitable coverage shall be treated as a core design requirement, not an optional output. Planning, resourcing, and performance management shall prioritize underserved populations and geographies, using needs-based allocation rules and continuous monitoring to identify and correct structural disparities in service coverage and commodity availability.

v. Sustainability and Cost Transparency — Clear financing logic across cost-recovery and non-cost recovery lanes

Financing arrangements shall be explicitly defined across cost-recovery and subsidized/non-cost-recovery supply channels, with clear rules for pricing, revenue management, and financial controls. Cost transparency and routine financial reporting shall be mandatory to protect affordability, ensure value for money, and sustain reliable delivery service without hidden liabilities.

vi. Digital Integration and Data Integrity — Interoperable systems with standardized identifiers and minimum datasets

Digital systems and data practices shall be governed as national infrastructure, requiring interoperability, standardized identifiers, and minimum datasets across all lanes. Data integrity rules shall be enforced to ensure that planning, monitoring, verification, and decision-making are based on timely, accurate, and consistent information.

vii. Product Integrity and Patient Safety — End-to-end assurance and traceability

Product quality and patient safety shall be protected through end-to-end assurance controls covering procurement, storage, distribution, dispensing, and use. Traceability and security measures shall be implemented to detect and prevent diversion, counterfeiting, theft, and expiry risks, and to ensure that only quality-assured products reach patients.

viii. Market Shaping and Domestic Capacity Strengthening — Predictable demand to stimulate local industry

The supply chain shall generate predictable demand signals through improved forecasting, pooled procurement where applicable, and transparent contracting, to strengthen domestic pharmaceutical manufacturing and reduce import dependence. Policy incentives and market-shaping instruments shall be applied to align private sector capacity with public health objectives, without compromising quality, affordability, or equity.

ix. Risk-Informed Planning and Resilience — Institutionalized risk management mechanisms

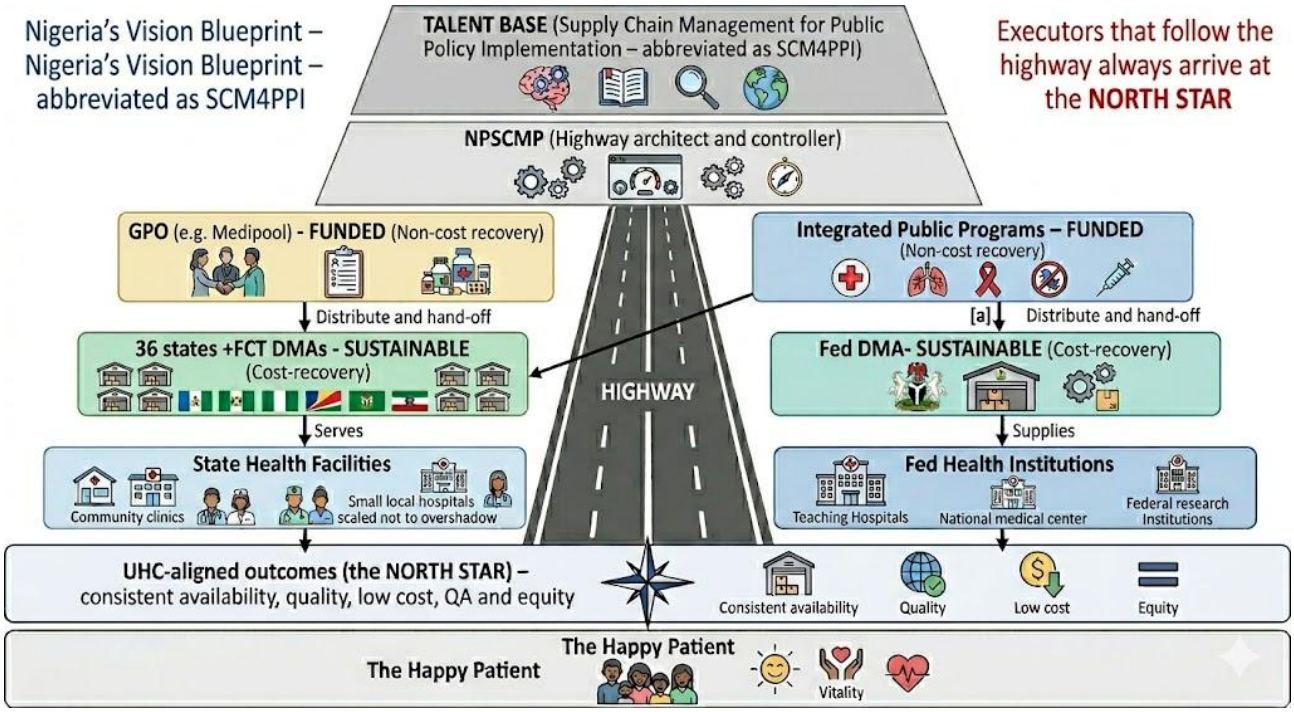
Risk management shall be institutionalized through routine vulnerability assessments, scenario planning, and mitigation measures embedded in national and state supply chain operations. Continuity arrangements shall be established to maintain service during fiscal shocks, disease outbreaks, security disruptions, and other emergencies.

x. Partnership and Coordinated Federalism — Clear roles across Federal, State, and Local Government levels

Partnerships shall operate within a coordinated federalism framework that defines roles,

decision rights, and responsibilities across tiers of government and implementing actors. Coordination mechanisms shall be enforced to prevent duplication, reduce fragmentation, align partner inputs to national priorities, and ensure coherent execution that strengthens—not substitutes—government-led systems.

The 2026-2030 architecture



The layers

- **The Foundation: Talent base**

➢ The apex layer focuses on **Supply Chain Management for Public Policy Implementation** (SCM4PPI). This ensures that the system is run by professionals capable of translating high-level policy into ground-level results.

- **NPSCMP (The Architect):**

➢ The National Product Supply Chain Management Programme acts as the Highway Architect and Controller, designing the routes and overseeing the flow of life-saving commodities.

- **The Parallel Delivery Channels**

➢ The blueprint recognizes two distinct financial and operational mechanisms:

1.1. *The Funded Channel (Non-Cost Recovery):* Comprised of GPO and Integrated Public Program. These manage commodities that are donor-funded or government-subsidized,

provided to the facilities without a requirement for cost recovery. They are expected to be integrated into the Federal DMA and eligible State DMAs. The GPO is already integrated; the public programs must be monolithically integrated into one operating structure.

1.2. *The Sustainable Channel (Cost Recovery):* Comprised of the Federal DMA and the 36 States + FCT DMAs. These function as sustainable, revolving-fund entities designed to ensure long-term availability through market-based replenishment. They are the only ones authorized to directly interface with and supply the health facilities – federal DMA for federal health institutions and state DMA for state health facilities

- **The federated service delivery model**

- Nigeria operates the "federated delivery model" meaning that every state exercises autonomy in managing own operation while using uniform standards issued by NPSCMP. Adherence to uniform standards issued from a central point (NPSCMP) ensures that the outcomes of the various supply chain operations align with the UHC outcomes for supply chain notably – consistent availability, quality health products, low-cost and equitable coverage. The system that delivers the service is government-led, financially self-reliant, strongly governed and vulnerability-controlled for intergenerational survivability.

- **The "HIGHWAY" Concept**

- The Highway concept simply means that all service delivery channels that comply with the National Standards will have the outcome of their operations align the identified UHC outcomes. Those nonnegotiable rules (standards) make up the highway and any service delivery establishment that bides by those rules are said to take up a "lane" in the highway. We are constrained to use the metaphorical terms "Highway", "lanes" and "roadworthiness" (Maturity eligibility) for want of an English word that captures their meaning. NPSCMP is the HIGHWAY architect (designer) and traffic controller that manages flow and conflicts.

  - **Health facilities**

  - One of the nonnegotiable rules of the highway is that a health facility can only receive one integrated/harmonized delivery per supply bout from the DMA that serves it. This means that all forms of integration must happen before the facility delivery. However, the information management system to be installed at the health facility will be robust enough to make those facilities act as "system sensors" for the upstream.

  - **Conclusion: The Happy Patient**

  - The final dividend of this architecture is the Happy Patient. The blueprint operates on a singular governing philosophy: "Executors that follow the highway always arrive at the NORTH STAR." By strictly adhering to these institutional roles and hand-off protocols, Nigeria will transform its health outcomes by 2030 and achieve 100% onboarding coverage.

4. 2030 Outcomes and National Headline KPIs - Strategy-Level Scorecard Snapshot

2030 transformation focus:

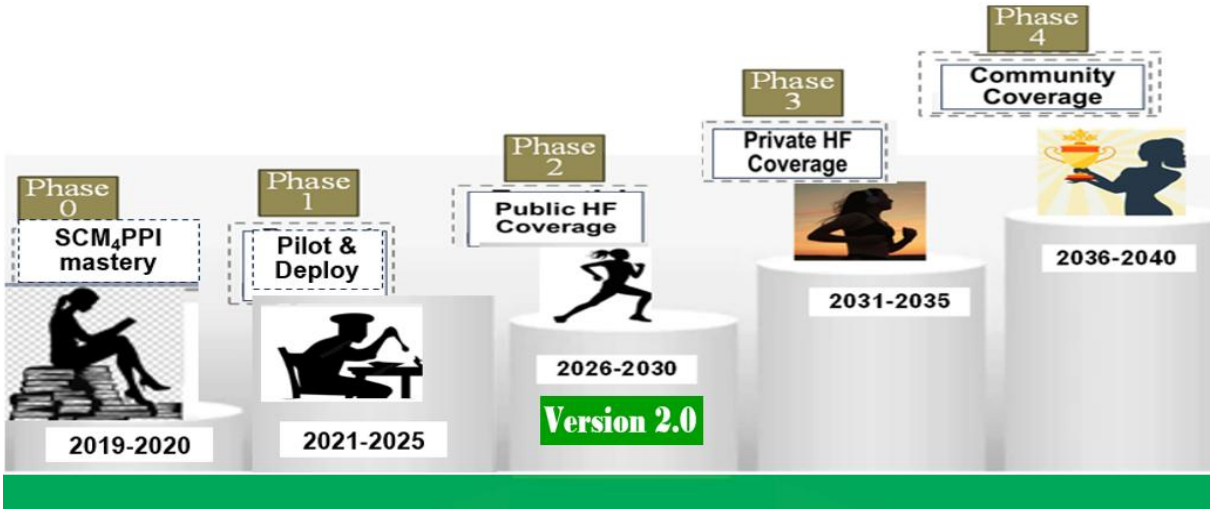
a. 100% onboarding of public health facilities.
b. Onboarded health facilities receive consistent supply of quality-assured, low-cost essential health products in needed volume and varieties.
c. functional State DMAs supplying all public facilities.
d. The institutional systems (DMAs and NPSCMP) to be government-led, financially self-sustaining with strong governance and vulnerability control.
e. DMA maturity enabling safe integration of non-cost recovery federal program channels (one harmonized delivery stream per supply bout);
f. Elimination of substandard and falsified medicines circulation in all public health facilities in the country
g. disciplined integration at both state and federal levels.
h. All distribution mechanisms should be harmonized and aligned with the national operating system;
i. a federal DMA operating on a cost recovery basis pooling demands from programmes
j. **Coverage & Equity: onboarding all functional** *Public health Facility in to Onboarding Coverage* **%** of public facilities onboarded into the nationally governed supply system (target: 100%).
k. **Functional Facility Coverage (National + Bottom Quartile)** % facilities meeting the service guarantee nationally and in the lowest-performing quartile of states/LGAs.
l. **Facility Tracer Availability Compliance %** facilities meeting national tracer basket availability standard.
m. **Availability & Service Reliability:** *Stockout Burden (Tracer Basket)* **-** Average stockout days per tracer product per facility per period (lower is better).
n. **OTIF Order Fulfillment - %** orders delivered On-Time, In-Full within the agreed replenishment cycle.
o. **Replenishment Cycle Adherence - %** facilities served on the scheduled supply cycle (lower ad-hoc/emergency runs).
p. **Quality & Patient Safety:** SF Elimination Performance — Confirmed substandard/falsified incidents in public channels and median time-to-detect-and-remove (lower is better).
q. **Quality Compliance (QA Pass Rate) —** % sampled lots/batches passing quality testing/verification.
r. **Cold-Chain Integrity —** Rate of significant temperature excursions (lower is better).
s. **Expiry & Wastage Rate —** Expired/wasted stock as % of stock handled (lower is better)
t. **Affordability & Financial Self-Sustaining Capacity:** average cost of tracer medicines at the public health facilities compared with offerings in the commercial sector (expressed as %).
u. **Procurement Price Efficiency (Pooled Procurement)** Variance of contract prices vs. benchmark/reference for priority products (lower is better, without compromising QA).

v. **System discipline outcomes (what the system must demonstrate):** *Institutional Capability (DMA maturity profiles):* **DMA Roadworthiness/Maturity Attainment:** % State/FCT DMAs (and Federal DMA) at/above nationally defined maturity thresholds required for reliable service and safe integration.

w. **Integration + Governance/Visibility:** *Verified Operating Discipline (Integration + Visibility)* % program flows (state + federal) operating under national standards and integrated interfaces, including aligned GPO/Medipool distribution, plus verified reporting discipline and corrective-action closure.

5. Strategic Context: Nigeria's Long Reform Journey

Nigeria's health supply chain reform is part of a longer 21-year national journey from 2019 to 2040.



- The first milestone (2019–2020) focused on building the basic knowledge and operational skills needed to run a modern public health supply chain.
- The second milestone (2021–2025) focused on piloting the government-led model and proving that disciplined stewardship, DMA-based service delivery, and structured onboarding of health facilities are possible.
- The third milestone (2026–2030), which this Strategy covers, is the scale phase. Its purpose is to achieve full public health facility onboarding and make disciplined national supply performance the normal way of working.
- The fourth milestone (2031–2035) will extend defined service frameworks to private health facilities.
- The fifth milestone (2036–2040) will connect onboarded facilities more fully to households and health seekers so that supply reliability translates more directly into sustained UHC impact.

This longer roadmap matters because it shows that the 2026–2030 Strategy is not an isolated document. It is the scale-up phase of a deliberate national transformation pathway. It also makes clear that this phase is expected to focus on full public facility coverage and disciplined national scale, not on every future reform ambition at once.

6. Background - Nigeria's Health Supply Chain "On the Ground"

Introductory Note

This section explains the real supply chain environment Nigeria is working with today. It shows the institutions that exist, how they relate to one another, and how products and information move in practice. The purpose is to keep the Strategy grounded in reality and make sure later recommendations are linked to what is actually happening on the ground.

Why Reform Was Needed

Nigeria's problem was not only the absence of policy. The deeper problem was the absence of one enforceable national operating system that could make the supply chain work reliably over time. In the 1980s, major shortages and widespread poor-quality and counterfeit medicines led to the National Essential Drugs Policy and Drug Revolving Fund schemes. These efforts improved essential medicines discipline, but they did not build enough operating skill, governance enforcement, and financial discipline to keep systems stable for the long term. Many DRF schemes later weakened or collapsed.

Later, support programmes improved planning, management capacity, and some parts of governance. But gains remained fragile because they were not fully institutionalized into one national operating model that could survive leadership changes, funding shifts, and operational shocks. From 1999 onward, large external funding for HIV, TB, malaria, vaccines, and family health expanded important public health programmes. However, it also deepened fragmentation. Different programmes often operated separate logistics systems, reporting systems, and delivery arrangements, while the routine essential medicine needs of the wider population remained disconnected.

To improve coordination, NPSCMP was established in 2012, and by 2013–2014 the country approved the creation of LMCUs across all states. These steps helped coordination, but coordination alone could not solve the deeper structural problem. Integration required clear standards, disciplined interfaces, and a governed method for bringing programme flows into one national system. Earlier attempts at monolithic integration faced resistance from programmes and partners. This produced an important lesson: Nigeria did not need forced merger of everything. It needed integration by standards, gates, and accountability.

The lesson from Nigeria's reform history is clear: reliable access to essential health products cannot be secured by policy alone, by projects alone, or by many parallel programme systems. It depends on a single national operating system with enforceable standards, disciplined execution, maturing DMA capacity, controlled integration, performance accountability, and assurance systems that protect continuity.

Brief on Nigeria's Disease Burden

This Strategy is mainly an institutional reform. It is not designed for only one disease area. Its purpose is to build a national supply chain system that can reliably support Nigeria's major health needs.

Nigeria's current disease burden shows the scale of that need:

- maternal, newborn, and child survival remains a major concern
- malaria remains one of the country's biggest health burdens
- TB and HIV remain major chronic infectious disease burdens
- malnutrition continues to worsen child illness and child death
- non-communicable diseases are rising alongside communicable diseases
- recurrent outbreaks create sudden surge demand

These burdens translate directly into the commodity groups the supply chain must not fail to support: RMNCH products, anti-malaria commodities, TB diagnostics and medicines, ARVs, RUTF, vaccines, and outbreak-response supplies.

Nigeria's Health Supply Chain in Transition

Nigeria's supply chain in 2026 should be seen as a system in transition, not as a fixed picture. Three currents are operating at the same time:

- **Legacy Fragmented Regime (LFR):** the older programme-based, fragmented order that still shapes many daily practices
- **Operating-System Reform Stream (OSRS):** the NPSCMP-led technical reform stream that designed the architecture, standards, business model, and DMA method from 2019 onward
- **Unification and Investment Stream (UIS):** the SWAp-linked political and financing leverage that is making integration more enforceable at federal level

That is why the system looks mixed in 2026. In some places, the reform model is already visible. In others, the older fragmented model still dominates. Sometimes both are visible in the same state. This is not confusion. It is the reality of transition. The purpose of the 2026–2030 Strategy is to complete that transition. It aims to make the reform streams the national routine and reduce the legacy fragmented regime to a temporary and shrinking exception.

Key Achievements of the 2021–2025 Strategy

The first strategy cycle produced several important achievements and lessons that now support the 2026–2030 scale phase. One of the biggest achievements was the introduction of the Blueprint. It became a bridge between long-term direction and changing reality by fixing the national goal, defining what success should look like, and building the enduring conditions for delivery: roles, standards, gates, maturity progression, verification, and accountability. The reform also adopted a clearer system-based design called the National Health Supply System. This organized the country's supply chain into linked federal, state, and LGA sub-systems operating under one standards framework.

The State DMA became one of the most important reform tools. It is not just a medicine warehouse. It is the bridge between national stewardship and state-level execution. It supports disciplined ordering, storage, distribution, data control, financial governance, stakeholder alignment, vulnerability control, and integration. The model was adopted by 26 states (70%) while deep implementation promoted 5 of them to the maturity level designated as "Maturing Read To Integrate".

National Health SUPPLY CHAIN STRATEGY implementation 2021-2025

STATE ADOPTION OF THE DMA Model of FMOH&SW & PROGRESSION IN MATURITY

	1 2 3 4 5 — 5 States	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 — 21 states	27 28 29 30 31 32 33 34 35 36 37 — 11 States
Maturity Profile	Maturing (14%)	Responsive @ Emerging stage (57%)	Non-responsive (29%)
The States	Kano, Kaduna, Yobe, Nasarawa & Bauchi	Niger, Plateau, Kogi, Benue, Adamawa, Borno, Gombe, Taraba, Sokoto, Katsina, Zamfara, Kebbi, Abia, Ebonyi, Enugu, Cross River, Edo, Ekiti, Ogun, Ondo, Osun	FCT, Kwara, Jigawa (PLC), Anambra, Imo, Akwaibom, Bayelsa, Delta, Rivers, Lagos Oyo
General Characteristics	Low Risk, Strong governance system, financial self-reliant, Structured service delivery system, Capable of integrating the Public Health Programs	High Risk, weak governance system, largely unstructured, financially unstable, uncapable of integrating the public health programs.	Very high risk; difficult to characterize

Another major achievement was the development of a practical method for gradually onboarding public health facilities into formal distribution systems. This gave Nigeria a measurable pathway for expanding functional health facility coverage – a core function of government supply chain.

At the same time, the period also showed the limits of progress. Integration did not advance as far or as fast as intended, and parallel arrangements remained common in many places. This is an important lesson for the current strategy.

Qtr1 2025 Coverage data for the S/THFs and PHCs respectively

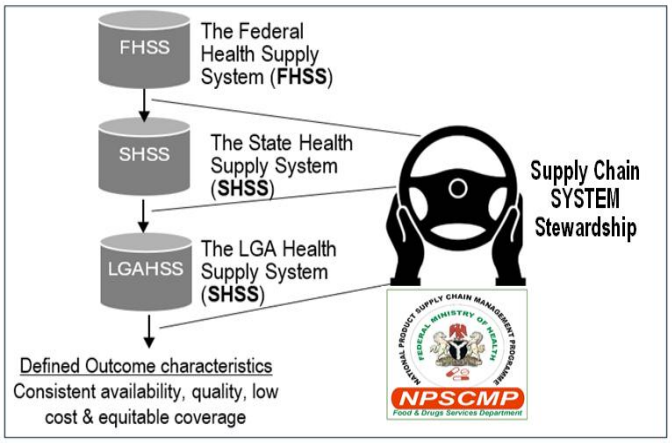
#sec&Ter HFs	Total onboarded	% onboarded	Remarks
1,264	395	31%	• Only the S/THFs served from legally backed distribution systems (DMAs) • Distribution system adopted the FMoH maturity model for standardized processes, service consistency and protection from vulnerabilities & other risks

# PHCs	Total onboarded	% onboarded	Remarks
27,137	8,931	33%	• Only the PHCs served from legally backed distribution systems (DMAs)

DMA States per zone		Zone	Sec&Tert HFs		PHCs		% Coverage	
			#Functional	#Onboarded	#Functional	#Onboarded	S&T	PHCs
5/7		North Central	296	59	6553	1018	20%	16%
6/6		North East	164	94	4388	2269	57%	52%
7/7		North West	208	154	7362	4478	74%	61%
3/5		South East	133	15	3104	87	11%	3%
1/6		South South	232		2400			
4/6		South West	231	73	3330	1079	32%	32%

NPSCMP Leadership in the Current Reform Period

NPSCMP is the national foundation and leadership engine of public health supply chain management in Nigeria. Its role is not to do all the operations of the supply chain itself. Her role is focused on making the health supply chain of Nigeria behave more like a *viable system* that can sustain itself in a changing environment by being self-regulating, adaptable, resilient, and sustainable. These attributes ensure the system can respond to threats, seize opportunities, and evolve while maintaining its identity as the National Health Supply SYSTEM (NHSS) and purpose of systematically delivering the UHC-aligned outcomes. Therefore, its role is to make the national system runnable, governable, enforceable, survivable across generations and tailored to the purpose.



NPSCMP's leadership is best understood as stewardship of one national health supply chain operating system. This means creating the rules, standards, and routines that allow many executors — State DMAs, Federal DMA arrangements, GPO/Medipool, facilities, and programme lanes — to function as one coherent system.

Its stewardship role includes designing and protecting the national operating system, validating business models before scale, translating the system into national normative tools (policies, strategies, guidelines, SOPs, tools, including lexicon), and running perimeter surveillance so the system can detect threats and adapt early.

However, its full transformation has not yet been completed. Some important capacities still depend too much on individual knowledge, partner support, and incomplete institutional structures. The current strategy therefore needs to strengthen NPSCMP's organizational design, codify its talent and methods, accelerate the transfer of specialized capacity from partners, and strengthen its authority in areas such as integrated logistics, standards, and financing-linked validation. To effectively execute the 2nd strategic priority of integrating, in a monolithic manner, the public health programme logistics systems, NPSCMP should now be expanded by incorporating the "Directorate of integrated logistics services" ably supported by a Programme Management Unit (PMU).

What This Strategy Assumes — and Does Not Assume

This Strategy assumes that multiple executors and lanes will remain in the system, that states will continue to differ in capability, and that safe integration depends on proven readiness rather than goodwill.

It does not assume that one giant operator will replace everybody, or that policy statements alone will create uniform practice across thousands of facilities and many parallel lanes.

The Strategy therefore focuses on national discipline: clear standards, clear interfaces, measurable performance, stronger DMA maturity, and alignment mechanisms that reduce fragmentation and prevent model drift.

7. Situation and Problem Diagnosis (Baseline Reality)

From General Problems to Phase-Based Gap Closure

Before the 2021–2025 strategy, system challenges were often treated as an open-ended list of things to improve. Almost anything could be called a challenge. This made planning broad, heavy, and unfocused.

Nigeria now has a clearer roadmap to UHC-aligned outcomes. Because of that, challenges are now defined in a more disciplined way. A challenge is no longer just a problem. It is a phase-specific gap: the distance between what exists today and what is required for the current phase to succeed and for the next phase to be entered safely. In practical terms, Nigeria is no longer collecting problems. It is running a structured phase-based gap assessment against clear standards, targets, and readiness requirements.

Problem Diagnosis for the 2026–2030 Phase

The main national target for 2026–2030 is 100% functional public health facility coverage. But coverage is meaningful only if each public health facility can reliably receive the full mix of products it needs to provide services.

For this reason, Nigeria must move beyond fragmented delivery and achieve structural harmonization of delivery lanes. This means facilities should receive one integrated facility-facing delivery line, not many separate programme deliveries.

Because the delivery lane that interfaces directly with facilities is the cost-recovery lane, State DMAs must become mature enough to serve as the host lane into which other programme lanes can safely integrate. This is why DMA maturity is so important in this phase.

Main Challenges to Be Addressed by the Strategy (2026–2030)

The main challenges are:

1. DMA maturity gap
2. Programme logistics integration gap
3. NPSCMP institutionalization gap
4. Talent and knowledge codification gap
5. Programme-to-DMA convergence gap
6. Performance control gap
7. Flow design and optimization gap
8. GPO lane gap
9. Federal DMA gap
10. Risk management and continuity gap
11. Quality assurance and track-and-trace gap
12. Financial sustainability gap
13. Local manufacturing support gap
14. Partner alignment and transition gap

Why These Challenges Persisted for So Long

Nigeria's most persistent supply chain problems were mainly integration problems. Fragmentation continued not because the technical answers were unknown, but because several forces kept reinforcing one another.

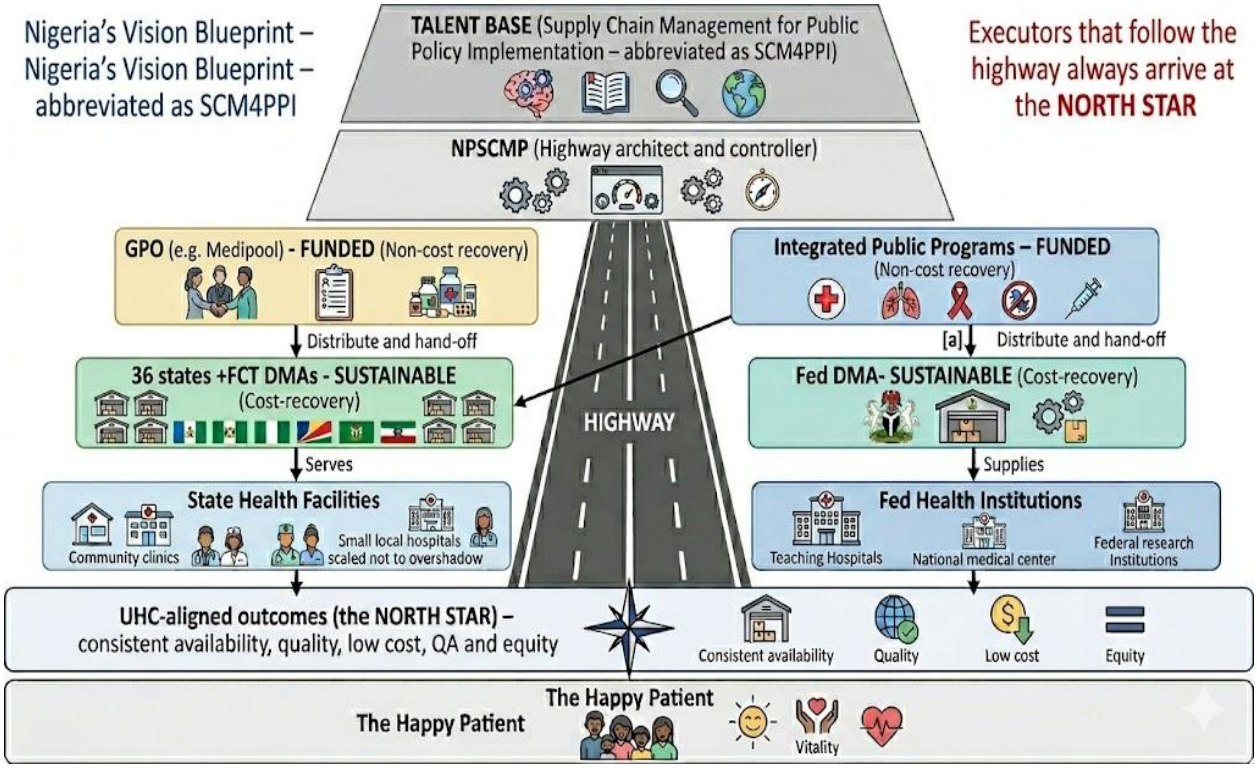
Programmes protected their vertical autonomy. Government did not always apply enough force to overcome resistance. For instance, the Nigeria Supply Chain Integration Project (NSCIP 2015-2018) was originally conceive to ensure a monolithic type of integration of the public programs logistics systems, due to widespread resistance, NPSCMP was constrained to capitulate into supporting integration at the level of standards. In the face of unsurmountable resistance, even Donor funding flowed along to prevent service disruption.

Behind many types of operational challenges that persisted were some disabling mindsets: subtle they are, they exerted powerful influences on the inability of the managers and leaders to see things differently. They are **decision-pattern failures** that kept the system stuck even when technical solutions were known. They shaped what leaders saw as "possible," what they prioritized, what risks they over-feared, and what underperformance they tolerated. Common examples are the "*elephant in the room*" syndrome; *attribution bias* (single-factor explanation that hide the real system fault); *fixed mindset* (problems seen as unchangeable constraints). Lastly, for many years, there was no widely visible, operational sample of a truly integrated system (like the state maturing DMA) to demonstrate the full value of integration beyond last-mile distribution (LMD).These forces kept one another alive, so integration remained a stated goal but not a governed reality.

Why These Challenges Can Be Solved Now

The conditions that kept these problems alive for years are now weakening. The current administration of the Ministry came in with a forceful vision of an integrated system that spans across all sectors - thereby filling the long yearned political will gap. SWAp has changed the center of gravity. Tightening Donor funding is increasing ownership pressure. State DMAs now provide a reference model of integration excellence. In preparing the brainstorming stakeholders for the development of this strategy, NPSCMP introduced the philosophical concept and application of "*reasoning by first principles*" (popularized by Mr. Elon Musk) to help identify and uproot deep seated and disabling psychological mindsets. The way challenges are framed now is stronger. And the Strategy has a clearer delivery framework and stronger implementation machinery.

Together, these factors reduce the space for mandate-based autonomy, strengthen government's ability to enforce one operating spine, align donor behavior more closely with shared systems, provide a visible proof model, and replace open-ended reform language with phase-based delivery discipline.



8. Theory of Change

Introduction

The opportunity window described above does more than create hope. It creates a practical basis for change. In earlier reform periods, Nigeria's integration agenda often stalled because strong forces kept the system fragmented. In the 2026–2030 phase, those forces are now being weakened. SWAp strengthens the integrating center and alignment discipline. Tighter external financing makes fragmentation harder to sustain. State DMA progress now provides visible proof that integrated systems can improve control, affordability, quality assurance, and facility coverage. The phase-gap method replaces open-ended problem lists with measurable requirements. The Strategy Delivery Framework and Blueprint provide the routines, gates, and enforcement tools needed to hold the reform together. For this reason, the Theory of Change is built on two linked ideas:

- **System Transformation Logic** — what must change in the system to achieve meaningful national coverage.
- **Opportunity-enabled Implementation Logic** — why those changes can now be carried out more successfully than in the past.

Dual-Lens Theory of Change for 2026–2030

The national target for this phase is 100% Functional Public Health Facility Coverage. For coverage to be meaningful, each public health facility must reliably receive the full mix of products it needs to function. To solve this, Nigeria must structurally harmonize delivery lanes so that each facility receives one integrated delivery line, not many separate programme deliveries.

Because the cost-recovery lane is the lane that interfaces directly with facilities, State DMAs must mature enough to become the facility-facing host lane. Other programme lanes must then integrate into that host lane through the MIOS method, using controlled transitions and readiness gates.

Theory of Change Lens 1: System Transformation — What Must Change

End-of-phase outcome: By 2030, Nigeria achieves 100% Functional Public Health Facility Coverage. This means all functional public health facilities are onboarded into the distribution framework of the hub cost-recovery lanes that serve them and are consistently served with quality-assured, affordable products in the right volume and mix through one integrated delivery line.

Core proposition: If Nigeria harmonizes delivery lanes around one facility-facing host lane, matures State DMAs, integrates programme lanes through MIOS, converts data visibility into operational control, strengthens quality assurance and performance management, and verifies coverage through scorecards and consequences; NPSCMP consolidates on the current design of the NHSS and effectively polices its highway, then the system will be able to deliver reliable full-basket supply at facility level and sustain national coverage.

Main pathways:

- define and verify coverage
- build the right architecture
- Strengthen the host lane
- integrate programme lanes safely
- assure quality and improve performance
- steward and enforce the system

Theory of Change Lens 2: Opportunity-enhanced Implementation — Why It Can Work Now

If the Strategy deliberately uses the current opportunity window — SWAp discipline, stronger pressure for country ownership, visible DMA progress, and requirements-based gap closure — then the barriers that kept fragmentation alive in the past can now be reduced. This creates the governance, incentive, and accountability conditions needed for the system transformation to succeed in practice. The main implementation levels are:

- SWAp as an added influence on integration drive of the FMoH&SW
- Increased drive for ownership adding more traction to the transition drive
- DMA progress as proof of the benefit of the transformation.
- Psychological Mindset correction also helps to drive positive change

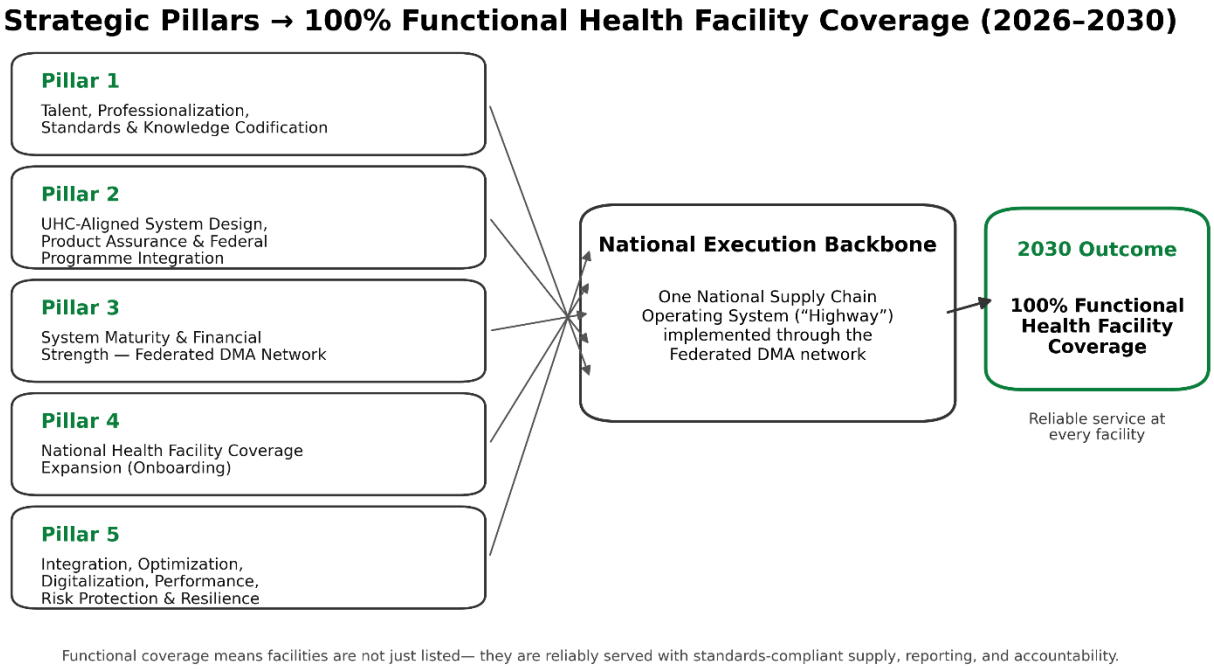
Simple Summary of the Theory of Change

If Nigeria strengthens State DMAs, harmonizes delivery lanes, integrates programme flows through controlled MIOS transitions, applies national standards, improves quality and performance, and enforces compliance through NPSCMP stewardship, then public health facilities will receive more complete and reliable service.

And if Nigeria uses the current opportunity window — stronger SWAp discipline, tighter ownership pressure, visible DMA proof, and requirements-based implementation — then the long-standing barriers that blocked integration in the past can now be overcome.

9. Strategy Pillars (System Capability Requirements)

The National Health Supply System (NHSS) has a clear end-state picture (the destination) pictorially representing the *vision blueprint*. The latter is a system that can deliver integrated, reliable, government-led supply service to all health facilities in the country. So far as the destination was made clear, the pillars had to reflect the major *system conditions* required to reach it. Thus, the Strategy is built on five pillars. These pillars describe the main system capabilities Nigeria must strengthen to achieve full public health facility coverage with reliable, integrated, quality-assured, and affordable supply.



Pillar 1: Talent, Professionalization, Standards, and Knowledge Codification

It means that the strategy will build the human capability and institutional discipline required to run Nigeria's public health supply chain as a serious, repeatable, national system rather than as a loose collection of individual efforts. It gets the right people, defines the right way of working, and preserves that knowledge so the system can keep performing beyond particular individuals. Supply chain performance remains uneven because capability is uneven. Standards are not always applied consistently, institutional memory is weak, and too much performance still depends on a few trained individuals or partner-supported teams.

Pillar 2: UHC-Aligned System Design, Product Assurance, and Federal Programme Integration

This is the design of the national public health supply chain so that it serves universal health coverage as one coherent system, while protecting product quality and bringing federal public programme logistics into one integrated national operating model.

Multiple vertical systems still create duplication, weak facility experience, high transaction costs, weak national visibility, and uneven quality control. This pillar will strengthen the national target operating model, federal integration rules, shared operating standards, and end-to-end product assurance.

Pillar 3: System Maturity and Financial Strength — The Federated DMA Network

Nigeria cannot achieve reliable national coverage if the institutions responsible for distribution are weak, unstable, or underfunded. It means the building of supply chain institutions that are not only formally established, but capable, disciplined, and financially strong enough to deliver reliable services at scale and sustain them over time This pillar will strengthen DMA maturity, backbone capacity, operational discipline, financial stability, and service predictability.

Pillar 4: National Health Facility Coverage Expansion (Onboarding)

This is a structured way of bringing more and more health facilities into the distribution frameworks of the state and federal DMAs until all eligible facilities are being served under them. This pillar will define functional facility coverage, standardize onboarding processes, clarify the obligations of facilities and service providers, and regulate coverage expansion through readiness checks, supervision, and performance verification.

Pillar 5: Integration, Optimization, Digitalization, Performance, Risk Protection, and Resilience

These make the national supply chain work as one connected, efficient, data-enabled, performance-controlled, risk-aware, and shock-resistant system. As the system expands, there is a risk that it will become larger but not stronger. This pillar will support maturity-gated integration, stronger use of facilities as system sensing points, better performance management, routine optimization, stronger digital and data use, and resilience measures for shocks.

Pillar Completeness and Fit Verification Through the Vision Blueprint

The strategy has used the **Vision Blueprint** to check that its pillars are complete, work well together, and leave no important area uncovered. It does this by comparing the pillars with the full national design and confirming that every major function needed to achieve the goal has a place within the pillar set. This matters because the pillars are the main functional parts of the strategy, and their combined work is what should produce the **EPICTONE** — the goal in measurable reality. The **Theory of Change** checks that the pillars can logically produce that result, while the **architectural steward** confirms that they fit properly within the approved design.

10. Objectives

Pillars tell us the big domains of work. Objectives state the specific change each pillar must produce. The objectives below describe the main results the Strategy will establish during 2026–2030. They translate the Strategy pillars into concrete national commitments.

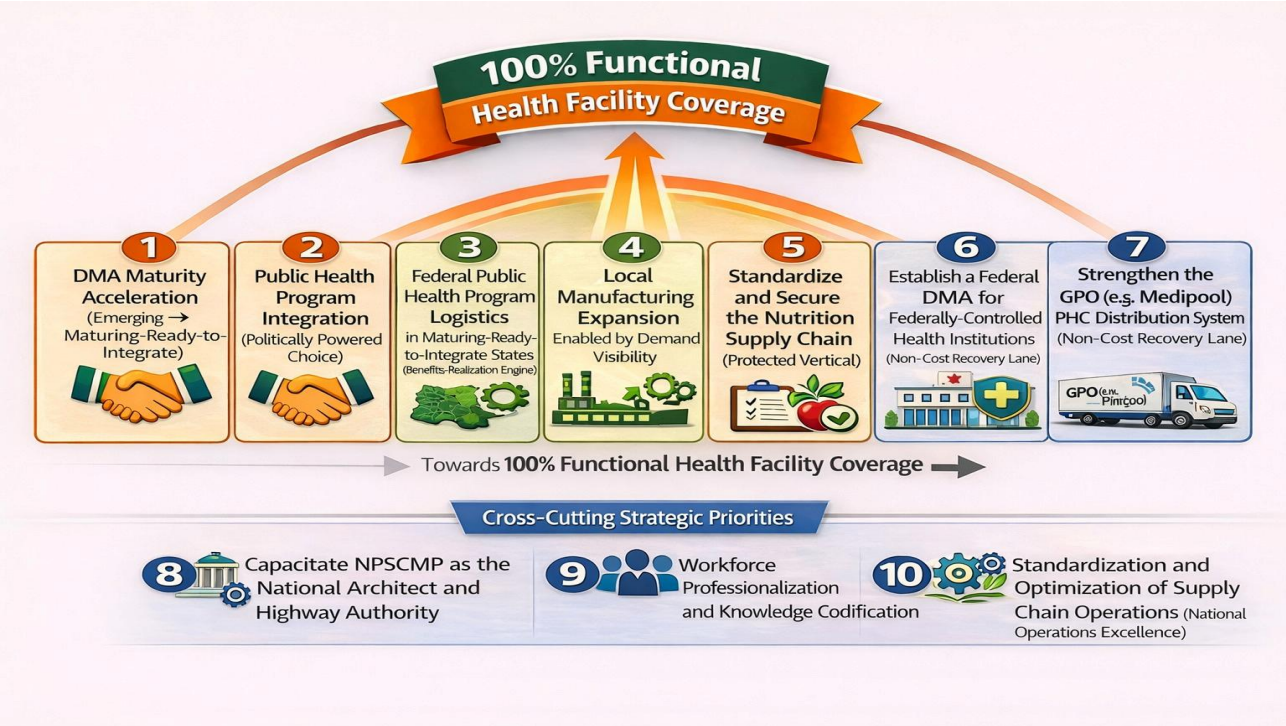
1. **Strengthen NPSCMP** — strengthen NPSCMP to function as Nigeria's National Supply Chain Architect and Highway Authority.
2. **Establish National Operating Standards and Compliance** — develop, adopt, publish, and enforce national operating standards and compliance requirements for the main supply chain lanes and service points.
3. **Establish a National Policy-to-Practice Method** (the delivery framework) — institutionalize a national method for turning approved standards, models, and reforms into routine practice and measurable performance.
4. **Operate a National Performance Scorecard and Compliance Regime** — establish and run a national performance and compliance system that measures results, verifies compliance, supports corrective action, and applies consequences.
5. **Institutionalize Talent** — build a standardized, documented, and certified public health supply chain knowledge and workforce system.
6. **Optimize Core Supply Chain Functions** — mature, integrate, and improve the core supply chain functions.
7. **Strengthening Infrastructure and Asset Readiness** — develop and implement a national plan for warehousing, cold chain, fleet, power, and maintenance readiness.
8. **Institutionalize Performance Improvement Methods** — standardize and embed proven operational improvement methods.
9. **Accelerate State DMA Maturity** — expands and strengthens State and FCT DMAs so that all states move along the DMA maturity pathway.
10. **Expand Facility Onboarding and Functional Coverage** — implement a national facility onboarding and readiness programme.
11. **Establish a Federal DMA / Pooled Procurement Mechanism** — build and operationalize a government-led pooled procurement and distribution mechanism for federal health institutions.
12. **Strengthen and Standardize GPO / Medipool PHC Distribution** — strengthen PHC-bound pooled distribution arrangements while ensuring time-bound transition into DMA-led integrated lanes.
13. **Standardize the Nutrition Supply Chain** — bring nutrition logistics up to the required national operating standard and integrate it into the wider federal programme logistics system.
14. **Integrate Federal Public Health Programme Logistics** — integrate federal public health programme logistics into one governance arrangement, one planning logic, one data spine, and one execution backbone.
15. **Integrate Programme Logistics in Ready States** — integrate public health programme logistics into the essential medicines management systems of states that reach the required maturity level.

16. **Establish a National Data Spine and Interoperability Standards** — create a national supply chain data spine and interoperability rules.
17. **Strengthen Product Assurance and Track-and-Trace** — strengthen product assurance, traceability, and anti-diversion systems across the national supply chain.
18. **Strengthen Risk Management and Resilience** — institutionalize supply chain risk management and resilience.
19. **Support Local Manufacturing Expansion** — strengthen the conditions for competitive local pharmaceutical manufacturing through more predictable demand, stronger quality assurance, smarter procurement behavior, and improved national supply security.

Objective Completeness and Fit Verification

The strategy has used clear means to verify that its objectives are **complete, complementary, and orphan-free**. It has checked that all major requirements needed to achieve the goal are covered, that the objectives support one another properly, and that no important area has been left without an objective. This verification has been carried out through the **Theory of Change** and the **architectural steward**. The Theory of Change has been used to confirm that the objectives are logically sufficient to deliver the goal, while the architectural steward has been used to confirm that the objectives fit properly within the national design, with no major gap, harmful overlap, or orphaned area. This gives assurance that the strategy is well put together and strong enough to guide implementation.

11. Strategic Priorities (The Must-Win Bets)



The Strategic Priorities are the principal national bets for the 2026–2030 period. They identify the areas where government will concentrate policy attention, reform effort, institutional strengthening, and implementation discipline in order to achieve full public health facility coverage through one more coherent and nationally governed supply system.

A. Core Strategic Priorities Areas (SPAs)

Priority 1: Accelerate DMA Maturity

Nigeria will implement a national DMA acceleration programme with two linked tracks. The first will secure adoption of the **FMoH model of the State DMA** as the nationally recommended model in all states and the FCT. The second will move adopting states from **Emerging** status to **Maturing-Ready-to-Integrate (MRTI)** through verified standards, minimum operating routines, disciplined technical support, and the resources required for maturity progression.

This priority is foundational because national facility coverage cannot be built on weak, fragmented, or non-standard execution foundations. Progress to nationwide MRTI status depends first on adoption of the correct model and then on disciplined progression along the maturity pathway. The adoption track addresses three barriers: the spread of alternative DMA models, continued reliance on the older DRF approach, and incomplete compliance in some states with the technical guidance required to build the FMoH model correctly. The maturity track then focuses on what is required to advance an adopted DMA from Emerging status to MRTI through the necessary governance, systems, processes, financing, and operating discipline.

Success by 2030

- All 36 states and the FCT adopt the nationally recommended FMoH model of the State DMA.
- All 36 states and the FCT attain at least the MRTI level.
- All 36 states and the FCT establish sustainable governance systems that prevent relapses and sustain performance.

Priority 2: Integrate Federal Public Health Programme Logistics

Nigeria will adopt a **monolithic federal integration model** that brings public health programme logistics under one management structure, one governance and planning system, one execution backbone, and one data and visibility system within NPSCMP. This will be institutionalized through a **Directorate of Integrated Logistics Services**, supported by an upgraded **SCOU** (Supply chain coordinating unit) functioning as a **Programme Management Unit (PMU)**. This priority is necessary because fragmentation at federal level continues to create duplication, conflicting calendars, reporting burden, and weak national coherence.

Success by 2030

- Federal public health programme logistics operate under one management umbrella within NPSCMP.
- Integrated programme flows are handed off in a disciplined manner to eligible **MRTI states** for continued service to state health facilities and to the **Federal DMA** for delivery to federal health institutions.

Priority 3: Integrate Programme Logistics in MRTI eligible States

Nigeria will rapidly integrate programme logistics into State DMA lanes in all states that attain **Maturing-Ready-to-Integrate (MRTI)** status, beginning with the current cohort and expanding as more states qualify.

This priority is important because it transfers greater ownership, responsibility, and accountability for programme commodities to state systems. It also creates the prospect of reducing cost-to-serve overtime while maintaining, and where possible improving, the quality standards already established under donor-supported arrangements.

Success by 2030

- Integrated DMA lanes become the dominant operating model in all MRTI-ready states.
- Service standards at the point of integration are maintained or improved.
- Facilities in integrated states show measurable gains in reliability, including fewer stock-outs, faster lead times, higher fill rates, and lower cost-to-serve.

Priority 4: Support Local Manufacturing Through Better Demand Visibility

Nigeria will support the responsible expansion of quality-assured local manufacturing by strengthening DMA performance, improving demand visibility, creating more predictable off-take signals, and using more credible contracting frameworks, including PPP and MoU mechanisms where appropriate.

This priority matters for three reasons. First, Nigeria is acting on the strategic assumption that expanding the local manufacturing base will help reduce exposure to falsified and substandard products, given that many recorded incidents have been associated with importation. Second, more organized demand is now being generated through PPP MoUs, more consistent tendering processes, and pooled procurement framework contracts. Third, a stronger domestic manufacturing base will improve resilience, supply security, and responsiveness during external shocks.

The second aspect of local manufacturing is the promotion of local ownership of the components of technical how-how, equipment and raw materials through substitution with home-grown alternatives. PVAC is already working on this aspect.

Success by 2030

- Domestic manufacturing contributes more strongly in priority product areas.
- Local supply becomes more reliable, quality-assured, and more supportive of national resilience.
- Dependence on imported product categories associated with higher integrity risk reduces overtime.
- Recorded successes in the substitution of imported technical know-how, equipment and raw materials with locally made alternatives.

Priority 5: Standardize and Secure the Nutrition Supply Chain

Nigeria will standardize and secure the nutrition supply chain, especially for high-risk commodities such as RUTF, through a tighter operating model, stronger integrity controls, and end-to-end accountability across planning, storage, distribution, and service delivery points.

This priority is necessary because nutrition commodities combine high public health importance with high diversion risk. Weak control reduces availability where need is greatest and increases leakage, misuse, and black-market exposure.

Success by 2030

- Nutrition supply chain processes are standardized and aligned with the national integrated logistics system.
- Diversion, leakage, and other integrity failures reduce significantly

Priority 6: Establish a Federal DMA for Federal Health Institutions

Nigeria will establish a Federal DMA that serves as the pooled procurement and distribution lane for federally controlled health institutions, operating on cost-recovery principles and aligned with national operating rules. It will also provide a federal integration platform through which non-cost-recovery public health programmes can increasingly plug in for integrated delivery to federal institutions.

This priority is important because federally controlled institutions require one disciplined lane for pooled procurement, quality assurance, pricing reduction and uniformity, and predictable service performance.

Success by 2030

- Federal health institutions are served through one reliable Federal DMA Lane with more predictable ordering cycles and stronger service performance.
- Pooled procurement improves price consistency, supplier performance, quality compliance, and reduces emergency purchases.
- Public health programmes increasingly use one federal delivery lane rather than parallel federal distribution arrangements.

Priority 7: Strengthen GPO (Medipool) PHC Distribution and Enable Handoff to State DMAs

Nigeria will strengthen the GPO (Medipool) PHC distribution mechanism funded through the 1% allocation from the Federal Consolidated Revenue Fund, while establishing a clear handoff pathway so that once a State DMA reaches Maturing-Ready-to-Integrate status, GPO (Medipool) allocations and delivery responsibilities in that state move into DMA-led integrated delivery.

This priority matters because PHCs in emerging states still require a protected and reliable non-cost-recovery channel, but that channel should not become a permanent parallel arrangement.

Success by 2030

- GPO (Medipool)-funded PHC deliveries are more transparent, measurable, and trusted.
- States that attain readiness absorb GPO (Medipool) flows into DMA-led integrated delivery without service disruption.
- Parallel PHC delivery arrangements reduce progressively as more states qualify.

B. Cross-Cutting Strategic Priorities

Priority 8: Strengthen NPSCMP as the National Architect and Highway Authority

Nigeria will strengthen NPSCMP's capacity to design, review, protect, govern, and enforce the National Supply Chain Highway across all lanes and actors.

This priority is fundamental because without a credible viable national operating system, the NHSS will disintegrate even as the supply chain space drifts back into parallelism, weak compliance, and non-standard execution.

Success by 2030

- The newly reviewed NHSS architecture is and rules operationalized
- The National Supply Chain Highway operates under credible national authority with enforceable standards, predictable governance routines, and transparent performance accountability.
- NPSCMP hosts the "directorate of integrated logistics" working routinely with the support of the upgraded SCOU as the PMU.

Priority 9: Workforce Professionalization and Knowledge Codification

Nigeria will institutionalize a professional, standards-driven supply chain workforce and a stronger national knowledge system so that reliable facility coverage becomes reproducible across states and resilient to turnover.

This priority is essential because a system that depends heavily on a few individuals cannot scale safely or remain stable over time, especially when staff can be transferred without adequate notice. Professionalization and knowledge codification are therefore necessary to protect continuity, strengthen capability, and make performance more consistent across the country.

Success by 2030

- Competence is more standardized and transferable.
- Staff turnover no longer causes major service disruption.
- Performance becomes more repeatable across states.

Priority 10: Standardize and Optimize Supply Chain Operations

Nigeria will standardize and continuously improve end-to-end supply chain operations through national operating standards, advanced optimization layers, stronger contract and SLA management, and routine performance improvement methods.

This priority matters because Nigeria requires not only broader coverage, but also more disciplined, efficient, and resilient operations. It will therefore be pursued through three linked tracks: the standardization of core supply chain functions; the institutionalization of tested performance-enhancing methods; and the embedding of risk management, quality assurance, and safety measures to protect continuity during shocks and disruptions.

Success by 2030

- National operating standards are applied more consistently across programmes and lanes.
- Advanced optimization methods improve reliability and reduce cost-to-serve.
- Contracts and SLAs are actively managed with evidence-based enforcement.
- Continuous improvement becomes routine rather than crisis-driven.

Preparatory projects for next phase – (2031-2035)

Note:

The NHSS is a conceptual model - an abstract representation that explains how the health supply chain delivery pillars are organized, often simplifying the complexity of the real-world of uncountable supply chain systems in the country into understandable ideas. It helps stakeholders visualize, reason about, and communicate processes, structures, or relationships involved with and in the system. Strictly speaking, the major delivery systems in the country should be treated as sub-models of the NHSS. The state DMA model that is being scale in the 2026-2030 period was piloted during the last phase. The scale up model for the next phase will have to be piloted during this phase. Again, due to the nature of supply chain, stakeholders might want to enter the community before the due phase period. Hence NPSCMP has to prepare

for both through pilots that may be conducted in this phase as the motivation for engaging in them increases.

Pilot Project **Priority 11: Business model for onboarding private health facilities:** -targeting the elimination of falsified and substandard products, etc.:

Pilot Project **Priority 12: Business model for onboarding community units:** -into systems that connect the hub public and private health facilities with ambient family units of health seekers for health and commodity fulfillment, etc.:

Concluding Note on the Strategic Priorities

Taken together, these priorities expand the number of roadworthy execution lanes, reduce fragmentation across federal and state delivery arrangements, and strengthen the national stewardship, workforce, and operational discipline required to sustain service over time. They are therefore the Strategy's principal reform bets for 2026–2030 and the main areas against which implementation seriousness, alignment, and investment value should be judged.

12. Strategy Delivery Framework

Five Building Blocks and Cross-Cutting Enablers

One of the ways NPSCMP has strengthened national supply chain reform is by improving how policy is connected to implementation and results. During the 2021–2025 strategy period, it introduced the Blueprint as a practical tool for moving from policy intention to real delivery. This was later deepened through Conceptual Model Design, which helped to define the State DMA model more clearly as an operational system design. In the present strategy, NPSCMP is deepening this same tradition again through the Delivery Framework, which has been introduced to ensure that implementation workplans are more clearly tied to the results the strategy seeks to achieve. The Strategy Delivery Framework shows how the Strategy will move from policy to results. It organizes implementation into five main building blocks, supported by a small set of cross-cutting enablers.

Building Block 1: National Stewardship, Verification, and Enforcement

This is the system's control center. It ensures that Nigeria's health supply chain works as one nationally governed operating system, not as many voluntary projects. It covers NPSCMP stewardship, continuous refinement of the national operating system, certification of lanes and service channels, routine compliance checks, coverage verification, scorecards, corrective action, consequence management, perimeter surveillance, and learning loops.

Building Block 2: National Highway Architecture and Service Design Standards

This building block defines the national design of the system. It ensures that integration is not left to negotiation, but is built into the architecture. Its central rule is simple: each facility should receive one integrated delivery line, not many parallel deliveries.

Building Block 3: Host-Lane Execution Engine (State DMA) and Function Optimization

This is the main service delivery engine. It turns the State DMA into a reliable facility-facing host lane that can deliver routine service and absorb integration safely.

Building Block 4: Integration and Transition Discipline (MIOS)

This provides the method for safe and repeatable integration. It ensures that programme lanes do not remain parallel forever, but also that integration does not create service collapse.

Building Block 5: Reliability, Quality, Control, and Sustainability

This ensures that coverage is credible and durable. It focuses on making service reliable, quality-assured, measurable, and sustainable over time.

Cross-Cutting Enablers

- **Talent and Institutionalization** — competency frameworks, training, certification, supervision, standard work tools, and succession planning.

- **Data and Digital Enablement** — interoperability, data governance, data quality routines, analytics, and audit trails.
- **Change Management and Mindset Neutralization** — requirements-based gap closure, communication, leadership alignment, gates, and learning loops.
- **Partner Alignment and Governance Discipline** — SWAp routines, partner alignment instruments, shared accountability, and compliance conditions tied to transition and integration rules.
- **Resourcing and Incentives for Sustainability** — cost-to-serve transparency, settlement discipline, predictable financing rules, transition safeguards, and incentives linked to verified performance.

13. Governance and Accountability

Purpose

This section explains how the Strategy will be governed, how performance and compliance will be reviewed, and how corrective action, escalation, and consequences will be applied.

Governance Logic

The Strategy is built on the idea that Nigeria's public health supply chain will continue to involve many actors, but those actors must operate within one nationally governed system. Governance under this Strategy has four linked functions:

- direction-setting
- execution oversight
- corrective control
- system protection

Core Accountability Roles

- **Federal Government / National Leadership** provides the national direction and protects the one-system approach.
- **NPSCMP** is the national standards holder and system steward.
- **State and FCT DMAs** are the main routine service executors.
- **Federal DMA / Pooled Procurement Arrangements** provide purchasing and backbone services where adopted.
- **Public Health Programmes** must operate within national rules and avoid unmanaged parallel systems.
- **Facilities** are accountable for service-point stewardship.
- **Partners and Technical Assistance Providers** must align their support with national direction and standards.

Review and Accountability Cycle

The Strategy will use a regular review cycle:

1. performance and compliance evidence is collected
2. results are reviewed against standards and targets
3. gaps and non-compliance are identified clearly
4. corrective actions are assigned and tracked
5. unresolved issues are escalated

Compliance and Verification

This Strategy does not rely on self-reporting alone. Compliance must be checked through routine scorecard review, supervision, spot checks, triangulation, selective audits, review of exception use, and validation of readiness before onboarding, integration, or scale-up decisions.

Corrective Action, Escalation, and Consequence Management

Corrective action is part of disciplined system improvement. The Strategy adopts a support-first but discipline-backed approach. Repeated failure or refusal to comply should not be ignored. Escalation is used when corrective action is not taken, non-compliance is repeated, transition conditions are ignored, unmanaged exceptions continue, or system risks become serious. Consequence management may include support and coaching, intensified supervision, conditional approval, delayed scale-up, withholding integration privileges, formal flagging of repeated non-compliance, and stronger sanctions where required.

Exception Control and Perimeter Surveillance

Exceptions must be formally recognized, time-bound, reviewed, and prevented from becoming permanent through silence or delay.

Perimeter surveillance should identify service risks, funding and sustainability risks, data or reporting breakdowns, quality and market integrity threats, transition risks, and signs of model drift or re-parallelization.

14. Results Framework — Line of Sight

This Strategy is designed to do two things at the same time: deliver more reliable supply to health facilities now, and build a government system that can survive shocks, remain stable across administrations, and continue to improve over time.

For this reason, results are defined in two layers:

- service results — what citizens and facilities experience; and
- institutional results — what makes those service results stable and sustainable.

Purpose

A durable, government-led, and financially sustainable national health supply chain operating system that delivers UHC-aligned supply outcomes to all public health facilities, resists drift into parallel systems, remains stable through leadership changes and shocks, and keeps improving over time.

Outcomes: What Success Looks Like

Service outcomes:

- reliable availability of health products at public facilities
- better service reliability and replenishment performance
- stronger quality assurance and protection from substandard or counterfeit products
- better affordability, efficiency, and value-for-money
- more equitable reach, including hard-to-reach and insecure settings
- more integration and coherence, with fewer parallel systems and a more harmonized delivery experience

Institutional outcomes:

- sustainable stewardship
- perimeter surveillance and response
- executor maturity
- financial sustainability and resilience
- data discipline and visibility
- transition resilience
- continuous improvement capability

Headline KPIs (National Scorecard)

The Strategy uses one national scorecard to track progress and enforce discipline.

It measures both service performance KPIs and institutional health KPIs. To make sustainable stewardship measurable, the scorecard will include indicators such as verification coverage, corrective action closure, rate and duration of exceptions or waivers, governance cadence compliance, time to detect major risks, and time to respond to major risks.

How Strategy Moves Results

The pillars define the major capability areas. The objectives turn those pillars into specific system changes. The priorities show where government will place the strongest attention. The delivery framework ensures disciplined execution. The crosswalk then shows how each priority is supported by the required building blocks and how it is expected to improve specific headline KPIs.

15. Risks, Assumptions, and Strategic Mitigation

Purpose

This section highlights the main risks that could derail the Strategy, the assumptions the Strategy depends on, and the high-level mitigation measures that will help keep implementation on track.

Main Risk Pattern

The relative probability of derailment is highest in the following order:

State DMAs → Public Programmes → Federal DMA → NPSCMP

Service-Specific Risks and Mitigation

State DMAs: The biggest risk is that many State DMAs may not progress from Emerging to Maturing capability. This would weaken facility onboarding, routine supply reliability, harmonized delivery, cost-recovery discipline, and safe integration. The main mitigation is NPSCMP-aligned DMA maturity support and verified adherence to the maturity pathway.

Public Health Programmes: Many programmes still depend heavily on donor-funded consultants. As funding reduces, reporting may decline, forecast instability may rise, and resistance to integration may grow. The main mitigation is to treat TA as temporary support with mandatory skills transfer, enforce MIOS integration gates, and use a Partner Alignment Framework.

Federal DMA / Pooled Procurement Mechanism: A Federal DMA-like mechanism may face resistance from powerful federal institutions. The main mitigation is to position it as a backbone service, use transparent governance, and phase rollout with visible proof of performance improvement.

NPSCMP: Without stronger legal, financial, and institutional support, NPSCMP may struggle to maintain standards, verification, and continuity. The main mitigation is to strengthen the basis for NPSCMP's national functions and institutionalize playbooks, methods, and knowledge systems.

Cross-Cutting Risk

A major cross-cutting risk is donor funding reduction leading to TA shrinkage. The main mitigation is to build stronger local technical Assistance capacity through structured training, certification, and NPSCMP-aligned quality control.

Core Assumptions

The Strategy depends on a few things remaining true:

- political support for integration and enforcement continues
- roadworthiness and MIOS gating remain accepted as the basis for onboarding, integration, and scale
- states commit to real DMA maturity, not just legal establishment
- programmes and partners align with national rules
- cost-recovery remains protected for routine essential health products

- NPSCMP's continuity constraints are addressed enough for it to perform its role
- a Federal pooled procurement mechanism can operate transparently and attract enough participation

16. Stakeholder Commitments and Partner Alignment

What Alignment Means in This Strategy

Alignment means that all actors in Nigeria's public health supply chain follow one national direction and behave in ways that protect it.

In practical terms, alignment means four things:

- actors work within the National Supply Chain Highway and follow national standards, interfaces, and performance expectations
- actors do not create or maintain unmanaged exceptions
- scale-up, onboarding, and integration follow readiness-based gates and controlled transition rules
- All actors accept routine performance accountability through the national scorecard, verification, corrective action, and learning processes

Commitments of the Government of Nigeria

The Federal Government is expected to lead and protect a nationally governed supply chain system that can survive leadership change and continue to improve over time.

Its main commitments are to provide sustained political and technical leadership, maintain a clear national direction, define and maintain national operating standards, institutionalize the national performance regime, sustain routine oversight and verification, promote government-led financial sustainability, strengthen local technical capacity, and ensure that national stewardship functions are institutionally supported.

Commitments of States and the FCT

States and the FCT are the main executors of reliable facility service through functional DMAs. They are expected to establish and sustain functional DMAs, build the capacities required for maturity, adopt and apply national operating standards, use the national scorecard, respect readiness gates, protect cost-recovery discipline and financial transparency, reduce leakage and diversion, and progressively reduce unmanaged parallel delivery arrangements.

Expectations for Partners and Public Programmes

Partners and Programmes are expected to align their design, funding conditions, technical assistance, procurement practices, data systems, and delivery approaches with national direction and standards; avoid unmanaged exceptions; support readiness-based integration and managed transitions; and support skills transfer and local workforce development.

Expectations for NPSCMP

NPSCMP is expected to set and maintain national operating standards and interfaces, support routine use of the national KPIs and performance system, enable verification and corrective action follow-through, run perimeter surveillance and early warning, provide readiness principles and transition guidance, and support alignment across states and partners without weakening national standards.

Special Area: State-Level Mandate Harmonization

The state level is where mandate interaction is most frequent and where fragmentation can most easily damage service continuity. For this reason, NPSCMP is expected to provide practical national guidance that clarifies role boundaries, operational interfaces, performance accountability linkages, and dispute-resolution pathways across key state actors.

17. Conclusion and Call to Action

Nigeria's National Health Supply Chain Strategy (2026–2030) is a national promise: that every public health facility will be reliably supplied with quality-assured and affordable health products, in the right volumes and mix, through one coherent and nationally governed operating system.

This Strategy is not a collection of projects. It is the deliberate building and protection of one National Supply Chain Highway so that reliable service becomes routine, measurable, and durable across administrations.

It is also a direct response to one of Nigeria's biggest current pressures: the need for greater financial self-reliance. As donor support becomes less predictable, Nigeria must reduce dependence on external funding and technical assistance for routine essential health products. The country must build stronger institutions, better cost-recovery discipline where appropriate, more efficient pooled purchasing, and stronger accountability for performance and sustainability.

What Must Be Protected

The first priority is to protect service continuity and patient safety.

Stock-outs should no longer be treated as ordinary operational problems that can be solved only by emergency action. They are signs of deeper system weakness. The answer is not endless firefighting, but stronger system maturity so reliable supply becomes routine.

The same is true for product quality. Weak quality assurance exposes patients to substandard or falsified products, weakens trust, and harms health outcomes. As reforms move forward, transitions must not be allowed to destabilize service delivery. Integration must be paced by readiness, and continuity safeguards must remain non-negotiable.

What Must Change

Three shifts are essential.

First, discipline must replace drift. Nigeria cannot achieve UHC-aligned outcomes if standards are optional and compliance is inconsistent.

Second, integration must replace unmanaged exceptions. Parallel procurement, data systems, distribution arrangements, and supervision structures weaken accountability, increase cost, and reduce sustainability.

Third, institutional capability must replace transactional activity. Establishing a DMA is only the beginning. The real gains come when State and FCT DMAs move into the maturing zone, where stronger routines, controls, data use, and financial discipline make reliable service possible and sustainable.

What Success Should Look Like by 2030

By 2030, success should be visible in both service performance and system strength:

- all public health facilities are onboarded and served more reliably
- quality assurance standards are applied more consistently
- procurement and distribution become more efficient

- parallel systems reduce substantially
- financial sustainability improves
- the system shows that it can hold together and improve over time

Call to Action

To move from strategy to results, leadership must act early and clearly in four areas:

1. **Adopt and protect the national direction.** Leadership at all levels should make it clear that Nigeria will operate one nationally governed supply chain system.
2. **Strengthen national stewardship and enforcement.** The standards-holder function must be supported so that standards, verification, and perimeter surveillance can operate routinely and fairly.
3. **Accelerate DMA maturity as the main engine of reliability and sustainability.** States should commit to measurable maturity progression and scale the lessons from states that are already showing stronger performance.
4. **Align resources to one scoreboard.** Government and partners should align funding, technical assistance, and transition support to the national KPIs and readiness gates.

This Strategy is an opportunity to lock in a durable national operating system for health products — one that protects patients, improves equity, reduces cost, and strengthens sustainability.

The time for fragmented approaches is ending. With disciplined stewardship, maturity-based execution, and aligned support, Nigeria can make reliable, affordable, and quality-assured health product supply a routine national reality by 2030

Annex A: List of Contributors

Contributors in the technical workshops for the co-creation, validation, and finalization of the National Health Products Supply Chain Strategy 2.0 (2026–2030), held at Goshen Guest House, Nasarawa State, between November 2025 and March 2026.

S/N	Name	Designation	Organisation
FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE AND FEDERAL AGENCIES			
1	Olufowobi-Yusuf Adeola, mni	DIRECTOR, FOOD AND DRUG SERVICES (DFDS)	FMOH&SW
2	Olubunmi Aribeana	FORMER DIRECTOR, FOOD AND DRUG SERVICES	FMOH&SW
3	Elom Emeka	DIRECTOR	FMOH&SW
4	Abatta Emmanuel	DIRECTOR NUTRITION DEPARTMENT	FMOH&SW
5	Yusuf Alhassan	DIRECTOR	NHIA
6	Nicholas Olobio	DIRECTOR	FMOH&SW
7	Paul Okhakhu	DIRECTOR	FMOH&SW
8	Uzor Loveline C	DIRECTOR	FMOH&SW
9	Nnamani Daniel	DIRECTOR, PUBLIC HEALTH	FMOH&SW
10	Henrietta Bakura Onyeneke	D/NDAD	FMOH&SW
11	Kassim Y Talatu	DIRECTOR, PHARMACEUTICAL SERVICES	FMOH&SW
12	Yakubu James Sumi	DEPUTY DIRECTOR	FMOH&SW
13	Bulama Yakubu	DEPUTY DIRECTOR, DND	FMOH&SW
14	Vivian Okafor	DEPUTY DIRECTOR, DHS	FMOH&SW
15	Nwokedi N. Nwodo	DEPUTY DIRECTOR / HEAD (POLICY)	DHPRS
16	Thomas Onazi	DEPUTY DIRECTOR, MLSCD	FMOH&SW
17	Chuka Juliet	ASSISTANT DIRECTOR	FMOH&SW
18	Audu Friday	ASSISTANT DIRECTOR	NAFDAC
19	Folasade Osho	ASSISTANT DIRECTOR	NAFDAC
20	Okorie Chidi	ASSISTANT DIRECTOR	PVAC
21	Bilkisu Usman	CHIEF PHARMACIST	FMOH&SW
22	Zubairu Umar	HEAD NUT. LOGISTICS	FMOH&SW
23	Ife Ale Tanko	FHD	FMOH&SW
24	Obioha Elizabeth	FHD	FMOH&SW
25	Nwokedi Dozie	SMOI	DHPRS
26	Fortune Udott	SCM	FMOH&SW
27	Ogunsanya Olutayo	SCM PROGRAMME OFFICER	FMOH&SW
28	Ezebuiro Eberechi	SSO	FMOH&SW

S/N	Name	Designation	Organisation
29	Dangana Charles	PSH OFFICE	FMOH&SW
30	Olohitare J. Uduokhai	PUBLIC HEALTH	FMOH&SW
31	Oladeji Yetunde Tolulope	SENIOR ADMIN. OFFICER	DHR/FMOH&SW
32	Taiye Bayode	FMF	MINISTRY OF FINANCE
33	Alex Ugochukwu	DEPUTY DIRECTOR	FMOH&SW
34	Aliyu A Bandado	CCS/MH	MH
35	Pat Naison Anthony	SENIOR ANALYST	PVAC
36	Kingfahd Umar	SMO1	NPHCDA
37	Anagwu Victor Chimezie	CONSULTANT PHARMACIST	PCN
38	Ugwu M. Vincent	PHARMACIST	PCN
39	Caroline Utoro	NCS	CUSTOMS
40	Salamatu Orakwelu	PCN	FCT
41	Ibrahim Tajudeen	EXECUTIVE SECRETARY	CCM-NIGERIA
NATIONAL PROGRAMMES			
42	Oluwatoyin Karimu	NATIONAL COORDINATOR	NPSCMP
43	Celine Onunkwo	FORMER NATIONAL COORDINATOR	NPSCMP
44	Uzoma Atu	DEPUTY DIRECTOR	NPSCMP
45	Amina Hamza Hammawa	ASSISTANT DIRECTOR	NPSCMP
46	Martin Ukwuaba	ASSISTANT DIRECTOR	NPSCMP
47	Daniel Onwuh	TEAM LEAD	NPSCMP
48	Emmanuel Abu	DMS	NPSCMP
49	Gideon Orkeghen	M&E	NPSCMP
50	Onwukwe Kenechi	LMIS	NPSCMP
51	Frances Okosi	PMI	NPSCMP
52	Folayemi Okunriboye	PMI	NPSCMP
53	Chioma Onyenegecha	PMI	NPSCMP
54	Nonju Ahmed	SCSQA	NPSCMP
55	Francis Ugochukwu	SCSQA	NPSCMP
56	Okwudili Augusta	SCSQA	NPSCMP
57	Ferdinand Nuhu	SCSQA	NPSCMP
58	Okogbue Onyekachi	ICT	NPSCMP
59	Andra Nwachukwu	RND	NPSCMP
60	Chidinma A Kalu	FO	NPSCMP
61	Rachael T Ogugbesan	COMMS	NPSCMP
62	Grace Chibudo	F/A	NPSCMP
63	Abdulmalik Yahaya	ADMIN	NPSCMP
64	Folorunsho Oluwaseun	ADMIN	NPSCMP

S/N	Name	Designation	Organisation
65	Nwazu Chucks	ADMIN	NPSCMP
66	Nnamdi Eneude	ADMIN	NPSCMP
67	Yadu Samuel	CONSULTANT/WAREHOUSING	NPSCMP
68	Bashir Yusuf	DRF CONSULTANT	NPSCMP
69	Mohamed Ibrahim Patiko	DEPUTY DIRECTOR	NASCP
70	Aisha Babale	PSM	NASCP
71	Akinola Abolaji	DEPUTY DIRECTOR, PSM	NTBLCP
72	Idris Momoh	HEAD, PSM	NTBLCP
73	Samson Oshogboju	PSM/NTBLCP	NTBLCP
74	Raji Mobolaji	PSM	NTBLCP
75	Olusegun Simeon-Olu	HPM SPEC	NMEP
76	Adelakun Olubukola	FORMER HEAD, PSM	NMEP
77	Rhoda Atteh	PROJECT DIRECTOR, GF	NACA-PMU
78	Ishaya Dawha	HEAD, PSM	NACA
79	Livinus Akwashiiki	ASSISTANT DIRECTOR	NACA
80	Fatima A Bukar	PSM	NCDC
81	Okeh Chekwuemeka	SP	NCDC
82	Damian Agbo	HEAD, PSM	NTD SCM
83	Rukayya Aliyu	NTD	FMOH&SW
84	Adewale Ayodeji	NTDS	FMOH&SW
STATE AND LOCAL GOVERNMENT REPRESENTATIVES			
85	Victoria N. Emuchay	DIRECTOR, PHARMACEUTICAL SERVICES	ABIA SMOH
86	Etim Ubam	DIRECTOR, PHARMACEUTICAL SERVICES	AKWA IBOM SMOH
87	Regina M. Chichi Agir	DIRECTOR, PHARMACEUTICAL SERVICES	BENUE SMOH
88	Moses Okoro	DIRECTOR, PHARMACEUTICAL SERVICES	EBONYI SMOH
89	Osa-Afe Tivere	DIRECTOR, PHARMACEUTICAL SERVICES	EDO SMOH
90	Bunmi Peter Ejimokan	DIRECTOR, PHARMACEUTICAL SERVICES	EKITI SMOH
91	Eloka Christopher	DIRECTOR, PHARMACEUTICAL SERVICES	ENUGU SMOH
92	Kamilu Mudi Salisu	DIRECTOR, PHARMACEUTICAL SERVICES	KANO SMOH
93	Ishaleku Christopher	DIRECTOR, PHARMACEUTICAL SERVICES	NASARAWA SMOH

S/N	Name	Designation	Organisation
94	Olanrewanju Samuel Adewale	DIRECTOR, PHARMACEUTICAL SERVICES	ONDO SMOH
95	Adewole Moses	DIRECTOR, PHARMACEUTICAL SERVICES	OYO SMOH
96	Habibu Mohammed	DIRECTOR, PHARMACEUTICAL SERVICES	SOKOTO SMOH
97	Abdulkadir Ahmed	MANAGING DIRECTOR	DMMA-BAUCHI
98	Abubakar M. Hassan	EXECUTIVE SECRETARY	GOMBE DMA
99	Aisha Tukur	EXECUTIVE SECRETARY	KADHSMA
100	Lasekon Gbenga	HEAD DMA	ONDO DMA
101	Abdulaziz G. Mohammed	EXECUTIVE SECRETARY	YODMA
102	Nnaemeka Kanu-Oji	EXECUTIVE SECRETARY	ABIA SMOH
103	Sani Bello	EXECUTIVE SECRETARY	ZAMFARA DMA
104	Kim Jerry Bot	DIRECTOR GENERAL (HEAD OF DMA)	ES/DMCMA
105	Okafor Venatus U	AD-P	ALGON
106	Haruna Wakili	DIRECTOR GENERAL	NASARAWA SMOH
107	Isa Labaran Uba	LMCU COORDINATOR	KANO SMOH
DONORS			
108	Omotayo Hamzat	PSM LEAD-WHO NIGERIA	WHO
109	Marcia F Attaran	PS MANAGER	UNICEF
110	Layna Beason	HEALTH	UNICEF
111	Onwumere Kingsley C	NUT. DATA & LOGISTICS	UNICEF
112	Adoki Prince	PROJECT OFFICER	UNICEF
113	Jamila Isa Tahir	HEALTH OFFICER-SUPPLY AND LOGISTICS	UNICEF
114	Issa Usman	PSM	UNICEF
115	Fred Atsenokhai	FP/SCM	UNFPA
116	Florence Aizobu	FP PSM ASSISTANT	UNFPA
117	Cassandra Elagbaje	SPMS-SC/DOS	DOS
118	Obinna Nnadozie	LSS	USG-CDC
119	Abubakar Suleiman	SPS-SC	USG-DOD
120	Obianeri Victor	PMS	USG
PARTNERS			
121	Imans Id	COUNTRY DIRECTOR	GHSC-PSM
122	Olutomi Oloniyo	MD	GHSC-PSM
123	Dinda James	TECHNICAL DIRECTOR	GHSC-PSM
124	Mary Ameh	DIRECTOR WDC	GHSC-PSM
125	Anthonia Ibeme	DIRECTOR PLAN & SOURCE	GHSC-PSM

S/N	Name	Designation	Organisation
126	Olumide Oyebanji	DIRECTOR	GHSC-PSM (PLS1)
127	Segun Obatoyinbo	CONSULTANT	CHAI
128	Jolaosho Olayinka	HOSCM	CRS
129	Dedan David	LMIS SPECIALIST	CRS
130	Dangana Christopher	PD	SFH
131	Bravo Otahabru	DIRECTOR PSM	MSH
132	Kolo Yakubu	CHIEF EXECUTIVE OFFICER	C4SD
133	Uko Ituen	LMCU SPECIALIST	MSH
134	Anya Chidinma	HPM	IHVN
135	Sunday Adeola	DCD	MEBS GLOBAL
136	Amaka Agusiobo	SCS	MEBS GLOBAL
137	Yewan Yusuf Ishaya	MANAGER SUPPLY CHAIN OPERATIONS	MEBS GLOBAL
138	Adesina Adeposu	SENIOR CONSULTANT	KAIZEN INSTITUTE
139	Jackson Uwaifo	SENIOR CONSULTANT	KAIZEN INSTITUTE
140	Judith Effiong	SENIOR PROJECT MANAGER	ARC_ESM
141	Omokhapre Irobodu Joseph	COUNTRY MANAGER	CIPS
142	Kanyinsola Oluyide	PSM LEAD	SWAp
143	Amina Atta	SPO	NUTRITION INTERNATIONAL
144	Samari Godwin Bawa	SND-NUTRITION	FMOHSW
145			
146	Dauda Hamzat	CHIEF OPERATING OFFICER	MEDIPOOL
147	Oluwaseun Ajayi	SUPPLY CHAIN	MEDIPOOL
148	Adeyinka Aderounmu	SCS	MEDIPOOL
149	Usman Babale	LEAD	TRANSPORT & LOGISTICS
150	Ezeh Ambrose S	NATIONAL CHAIRMAN	ACPN
151	Akelikwunu Gabriel	NATIONAL SECRETARY	AHAPN
152	Hafsat Ismaila	NATIONAL LIAISON OFFICER	AHAPN
153	Frank Mounemeh	EXECUTIVE SECRETARY	PMGMAN
154	Nelson A Ochekpe	PROFESSOR (ACADEMIA)	UNIVERSITY OF JOS
155	Ndidi Ngwuluka	ACADEMIA	UNIVERSITY OF JOS
156	Sam Orubu	PROFESSOR (ACADEMIA)	BAYELSA MEDICAL UNIVERSITY (BMU)
157	Martins Onyia	CONSULTANT	INDEPENDENT CONSULTANT
158	Linus Odonmene	CONSULTANT	INDEPENDENT CONSULTANT