

A System in Transition: **Nigeria Country Report**

December 2025

Executive Summary

As a result of the recent disruptions in U.S. government funding and declining support from other donors, Nigeria's surveillance, laboratory, and specimen transport systems have entered a period of heightened uncertainty and vulnerability. Anecdotal evidence has emerged that funding shifts have already disrupted Nigeria's surveillance, laboratory, and specimen transport functions, creating material risks to outbreak detection and response, routine disease monitoring, and timely diagnosis and care. This assessment aimed to systematically document how recent and anticipated financing disruptions are affecting Nigeria's surveillance, laboratory, and specimen transport systems, identify the most consequential system vulnerabilities and impacts, and synthesize practical opportunities to improve integration, efficiency, and sustainability. To achieve this objective, external consultants conducted semi-structured key informant interviews with over 40 stakeholders across government ministries, departments, and agencies, in addition to donors and implementing partners to document how recent financing shifts are affecting surveillance, laboratory services, digital data systems, and specimen transport operations. These interviews were complemented by a desk review of relevant materials, including program and donor reports, national strategies and guidelines, budgets, and system inventories.

Overall, the report found that while donor investments over the past two decades have substantially expanded diagnostic capacity, digital surveillance platforms, laboratory networks, and outbreak response functions, they have also reinforced vertical, disease-specific approaches that leave Nigeria's core systems fragmented and highly dependent on external financing. Across surveillance, multiple parallel digital tools and program-specific platforms have proliferated, contributing to duplication, weak interoperability, and high recurrent costs to operate and maintain systems. For diagnostic laboratories, a tiered network exists, but coordination and financing remain uneven and siloed across disease programs, with persistent dependencies on donor-funded commodities, maintenance contracts, and specialized technical staff. Specimen transport similarly operates through multiple co-existing, disease-specific models rather than a unified national network, and recent funding cuts have resulted in inconsistent coverage, delayed payments, service interruptions, and limited ability to reroute samples efficiently when disruptions occur.

Despite these challenges, the report identifies a practical set of opportunities to improve efficiency and resilience by reducing duplication, strengthening integration across ministries, departments, and agencies and disease programs, and leveraging the 2026 financing window. Key opportunities include updating and operationalizing an integrated specimen referral network; fully implementing the National Guideline for Integrated Laboratory Services and Systems (including pooled maintenance, harmonized quality systems, and more sustainable Laboratory Information Management System (LIMS) approaches); advancing data integration across diseases by leveraging existing multi-disease digital platforms such as the National Health Management Information System, the Surveillance, Outbreak Response Management and Analysis System, and LIMS; stabilizing the workforce through expertise-sharing and strategic alignment across institutions; and reinvigorating national and state Public Health Emergency Operations Centre readiness.

By aligning stakeholders around shared foundational investments, Nigeria can protect essential public health functions in the near term while building more sustainable, country-owned systems over time. Importantly, 2026 presents a time-bound financing window to implement priority activities by advocating for increased domestic resources, including the Basic Health Care Provision Fund, alongside major existing investments such as the World Bank's Health Security Program and HOPE-Primary Health Care programs, Global Fund Grant Cycle 8 Resilient and Sustainable Systems for Health resources, and additional sources of targeted bilateral and multilateral donor support.



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Methods

This analysis draws on a mixed-methods approach combining stakeholder interviews, document review, and real-time tracking of policy, operational, and financing developments between October and December 2025. Close to 40 semi-structured interviews were conducted, on background, with senior officials and technical experts across Nigeria’s public health ecosystem and its key development partners.

Interviewees included representatives from federal government institutions and agencies, including the Federal Ministry of Health and Social Welfare (FMOH&SW)—with participation from the National Tuberculosis, Leprosy and Buruli Ulcer Control Programme (NTBLCP), National Malaria Elimination Programme (NMEP), National AIDS and Sexually Transmitted Infections Control Programme (NASCP), Medical Laboratory Services Division (MLSD), Department of Public Health (Non-Communicable Diseases Division (NCD) and Neglected Tropical Diseases (NTD) Division), Department of Family Health (Maternal Health Division and Child Health Division), and the Departments of Planning, Research and Statistics (DPRS) — as well as the Nigeria Centre for Disease Control and Prevention (NCDC), the National Agency for the Control of AIDS (NACA), the National Primary Health Care Development Agency (NPHCDA), the Federal Ministry of Budget and Economic Planning, and the Ministry of Finance.

Domestic and regional implementing and technical partners interviewed included the African Field Epidemiology Network (AFENET), Institute of Human Virology Nigeria (IHVN), Jhpiego, , and Management Sciences for Health (MSH). Global and bilateral partners and donors engaged included the World Health Organization (WHO), United States Centers for Disease Control and Prevention (U.S. CDC), Global Fund to Fight AIDS, Tuberculosis and Malaria, World Bank, the Gates Foundation, Clinton Health Access Initiative (CHAI), Palladium, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Knowledge Network for Disease Control and Vigilance (KNCV), Georgetown University, UK Aid / Foreign, Commonwealth and Development Office (FCDO), and Resolve to Save Lives (RTSL).

Interviews focused on the operational impacts of recent funding shifts, financing flows, institutional responses, and emerging adaptations across surveillance, laboratory systems, specimen transport, digital platforms, and emergency preparedness functions. Qualitative findings were triangulated through review of relevant policies, strategies, budget and financing documents, and implementation plans to ensure consistency and validity.

Authorship and Contributions

This report synthesizes research conducted by Drs. Olukayode Fasominu, Gafar Alawode, and Kingsley Odiabara, who carried out the data collection, led the stakeholder interviews, and were responsible for the analysis and drafting of the findings. This report was developed with contributions from Catherine Cantelmo, Celestina Obiekea, Aaron Bochner, Elizabeth Ortiz, Rabi Usman, and Christopher Lee. The research process and analytical framework were overseen by Amanda McClelland, who provided strategic guidance and editorial direction throughout the study.

This report reflects a rapidly evolving landscape. Findings represent the best available synthesis at the time of writing and may change as decisions and reforms are finalized. Any errors or omissions are the responsibility of the authors and should not be attributed to consulted individuals or institutions.

1. Overview of Systems, Financing, and Donor Landscape

Nigeria’s surveillance, laboratory, and specimen transportation systems have been heavily shaped by donor investments over the past two decades, which have expanded diagnostic capacity, digital surveillance platforms, laboratory networks, and outbreak response functions, but have also left core systems heavily dependent on external financing and vulnerable to disruption. Across surveillance, laboratories, and specimen transport, funding has routinely flowed through vertical, disease-specific programs and implementing partners, resulting in fragmented mandates with disease programs operating in silos. This financing model has enabled rapid scale-up but has constrained efficiency and sustainability, as surveillance tools, laboratory services, and specimen transport systems were often built and financed separately for different programmes with limited integration at the point of data collection, testing, and use. The following sections present a brief overview of the MDAs involved in surveillance, laboratory services, and specimen transportation, as well as the digital data systems that are in use.

1.1. Surveillance System

Nigeria’s surveillance architecture includes indicator-based, case-based, and event-based data, as well as data collected through surveys and sentinel surveillance approaches. While some data systems, including the National Health Information Management System (NHMIS) and the Surveillance Outbreak Response Management and Analysis System (SORMAS) capture data for many diseases, there are also a large number of disease-specific systems, many arising from the U.S. government President's Emergency Plan for AIDS Relief (PEPFAR), The Global Fund to Fight AIDS, Tuberculosis and Malaria, and President's Malaria Initiative’s (PMI) siloed support for HIV, TB, and malaria. This has resulted in a multitude of fragmented digital systems with high costs to sustain system operations. Many of these digital systems were designed to track the administration of clinical services and client outcomes at the health facility level, including electronic medical records systems and tablet-based data collection tools. Table 1 below summarizes the MDAs involved in Nigeria’s public health surveillance, their key responsibilities, and the digital data systems they use or support.

Table 1. Overview of key ministries, departments, agencies, and institutions in Nigeria’s public health surveillance system

Institution	Key Surveillance Function	Digital System
Nigeria Centre for Disease Control and Prevention (NCDC)	Oversees case-based, weekly and monthly aggregated surveillance for IDSR priority diseases, event-based surveillance, AMR sentinel surveillance, SARI/ILI surveillance, and genomic surveillance	SORMAS, NHMIS, SitAware, Tataafo, EIOS, Connect Centre SugarCRM, Excel-based case-based surveillance.
National AIDS and STI Control Programme (NASCP), FMOH&SW	Oversees HIV surveillance, including case-based surveillance, HIV EMR deployments, viral load and HIV drug resistance monitoring, HIV mortality verbal autopsy surveillance, Population-Based HIV Impact Assessment (PHIA)	NHMIS, National Data Repository, SmartVA, 3 EMRs (LAMISPlus, Nigeria Medical Records System, and Viva) supported by three different PEPFAR implementing partners.
National Agency for the Control of AIDS (NACA)	Coordinates the national response to HIV/AIDS through strategic planning, policy formulation, advocacy, and program	Works in conjunction with NASCP but is not directly responsible for digital system implementation.



	implementation. As a coordination body, they are not directly involved in surveillance implementation.	
National Tuberculosis, Leprosy and Buruli Ulcer Control Programme (NTBLCP), FMOH&SW	Coordinates surveillance for TB, Buruli Ulcer (BU), and Leprosy, as they share the causative agent, Mycobacterium species. Activities include case-based and weekly surveillance, drug-resistance monitoring, and monitoring of TB treatment outcomes	NHMIS, e-TB Manager, Mobile Application for TB Screening (supported by MSH), CommCare (supported by KNCV)
National Malaria Elimination Programme (NMEP), FMOH&SW	Oversees malaria surveillance. Activities include case-based and weekly surveillance, entomology sentinel surveillance at 29 sites, and population-based Malaria Indicator Surveys	NHMIS, National Malaria Data Repository
National Primary Healthcare Development Agency (NPHCDA), FMOH&SW	Coordinates immunizations and vaccine safety surveillance. Its responsibilities include leading the Polio Outbreak Response Program through Acute Flaccid Paralysis (AFP) case-based surveillance and environmental sampling (in collaboration with WHO), monitoring Adverse Events Following Immunization (AEFI), and National Immunization Coverage Surveys (NICS).	NHMIS, VigiFlow (supported by National Agency for Food and Drug Administration and Control and Uppsala Monitoring Centre), eSURV (supported by WHO)
Maternal and Child Health Divisions, Department of Family Health, FMOH&SW	Oversees Maternal, Perinatal, and Child Death Surveillance Response (MPCDSR). This includes case-based surveillance and monthly aggregate surveillance.	NHMIS, Nigerian MPCDSR e-Platform
Neglected Tropical Diseases Division, Department of Public Health, FMOH&SW	Oversees surveillance for neglected tropical diseases via weekly and monthly aggregate surveillance.	NHMIS, CIMS-NTD (implemented by the Federal University of Technology, Owerri)



1.2. Laboratory and Specimen Transportation

Nigeria’s laboratory network is organized as a tiered but fragmented system spanning national reference laboratories, state, and zonal laboratories, as well as disease-specific networks, with coordination challenges that mirror those seen across surveillance. The two core national NCDC laboratories are 1) the National Reference Laboratory (NRL) in Abuja, which is responsible for advanced diagnostic testing, quality assurance, genomic surveillance, and national public health laboratory coordination and 2) the Central Public Health Laboratory (CPHL) in Lagos, which serves as a major regional hub supporting routine diagnostics, surveillance testing, and capacity building across southern Nigeria. In addition, other important national-level laboratories include the Nigerian Institute of Medical Research, TB reference laboratories (e.g., National Tuberculosis and Leprosy Training Centre), polio reference laboratories supported by WHO (UCH Ibadan and University of Maiduguri Teaching Hospital), and additional specialized or partner-run laboratories, which maintain molecular laboratories supporting HIV, TB, malaria, and emerging pathogens. At the subnational level, state public health laboratories form the backbone of routine diagnostics, though some program-specific laboratory mandates (e.g., TB GeneXpert sites, HIV PCR labs) remain fragmented with vertical disease programs operating in silos.

Specimen transport systems are also fragmented, with multiple co-existing models rather than a single institutionalized sample transportation network. NCDC runs a national specimen transport system for epidemic-prone diseases, but its subnational implementation has been constrained by funding gaps and delayed payments. In parallel, the National Integrated Specimen Referral Network (NiSRN), supports integrated referrals for HIV, TB, and related samples using a hub and spoke model, including a two-state pilot using NIPOST. However, NiSRN remains heavily donor-driven and heavily supported by uncertain U.S. government funds. In addition, WHO’s polio program has supported an ad hoc transport system for AFP stool samples.

Table 2. Overview of key ministries, departments, agencies, and institutions in Nigeria’s public health laboratory and specimen transport systems

Institution	Laboratory and specimen transport roles	Digital Systems
Medical Laboratory Services Division (MLSD)	Provides national policy leadership, coordination, and governance for all laboratory services; issues national standards and directives. Sets national integrated rules and guidelines for specimen collection, handling, transport, and interagency collaboration.	DHIS2
Nigeria Centre for Disease Control and Prevention (NCDC)	Authority for public health laboratories under the NCDC Act (2018); leads surveillance testing, outbreak diagnostics, biosafety, reference labs, and specimen referral networks for IDSR priority diseases.	NCDC LIMS, SORMAS, Epi-Info
National Primary Health Care Development Agency (NPHCDA)	Oversees PHC laboratory functions and community-level diagnostic systems. Responsible for PHC-level sample collection, cold-chain management, and VPD specimen flow.	DHIS2
National Tuberculosis, Leprosy and Buruli Ulcer Control Programme (NTBLCP)	Lead diagnostics, quality assurance, and support sample transportation for TB.	DHIS2



National AIDS, Viral Hepatitis, and STIs Control Programme (NASCP)	Lead diagnostics, quality assurance, and support sample transportation for HIV.	DHIS2, National Data Repository, National Data Reporting System, HIV Laboratory Information Management System (LIMS), GHSC-PSM
National Malaria Elimination Programme (NMEP)	Lead diagnostics, quality assurance and support sample transport for malaria, though standard malaria diagnostics are point of care.	DHIS2
World Health Organization (WHO)	Provides global standards, technical guidance, and capacity building; supports diagnostic system strengthening and specimen transport (primarily for AFP) via ad hoc systems.	
Management Sciences for Health (MSH)	Provides technical support on laboratory governance, quality improvement, supply chain, and workforce capacity. Supports specimen transport for AMR in human, animal and environment.	WHONET, INFAM

1.3. Domestic Financing

While Nigeria remains reliant on external financing support for surveillance, laboratories, and specimen transport, the government makes significant domestic contributions in terms of core workforce salaries, particularly staff within FMOH&SW, NCDC, State Ministries of Health, public health laboratories, and disease surveillance units. Specific cadres supported by the government include epidemiologists, surveillance officers, laboratory scientists/technicians, port health officers, and administrative personnel. The government also has domestic budgets to cover utilities for day-to-day functioning of laboratories, data offices, PHEOCs, and surveillance units. Lastly, the government partially funds procurement of some key laboratory supplies, including reagents, personal protective equipment, and other basic supplies.

Existing budget lines across several federal agencies support surveillance and laboratory activities, including the FMOH&SW, NCDC, NPHCDA, Federal Ministry of Agriculture and Rural Development, Federal Ministry of Environment, and Federal Ministry of Livestock Development. For NCDC, budgetary allocation to surveillance increased from ₦190.8 million in 2024 to ₦440.8 million in 2025, representing a meaningful prioritization of surveillance in the overall NCDC budget. The allocation to laboratories increased from ₦720 million in 2024 to ₦920 million in 2025, but the 2025 allocation was a proportionally smaller percentage of the overall NCDC budget in 2025 compared with 2024 and high inflation reduced purchasing power. Given the Medium-Term Expenditure Framework projected growth in national expenditure in 2026 to be only 0.43%, there may be limited fiscal space to significantly increase allocations to these two budget lines without prioritizing surveillance and laboratory investments over other areas within the NCDC budget. NCDC is also considering creating a new specimen transport budget line as the country transitions away from donor support for this function.

Table 3. Overview of Nigeria Domestic Health Financing Trends and Epidemic Surveillance Allocation (in million Naira), 2024-2027

Year	2024	2025	2026	2027
Total Government Revenue	₦ 20,980,070	₦ 40,889,739	₦ 34,334,860	₦ 37,067,729



Total Government Expenditure	₦ 34,494,250	₦ 54,990,165	₦ 54,458,969	₦ 59,617,902
NCDC Budget	4,357	7,409	N/A	N/A
NCDC Budget as % of Total Government Expenditure	0.01%	0.01%	N/A	N/A
NCDC Surveillance Budget	₦ 191	₦ 441	N/A	N/A
NCDC Laboratory Budget	₦ 720	₦ 970	N/A	N/A

1.4. Donor Landscape

Nigeria’s surveillance, laboratory, and specimen-transport systems continue to rely heavily on external financing, with donors funding most of the operational costs, digital systems, equipment maintenance, consumables, and technical assistance. Most of this funding is channeled through implementing partners rather than directly to the government. Key donors for surveillance, laboratories, and specimen transport in recent years include USAID (now transferred to the US Department of State), US CDC, the Global Fund, GIZ, the Gates Foundation, and Fleming Fund. Overall funding from these sources in 2025 is similar to 2024 levels, despite disruptions in U.S. government programs (Table 4). Surveillance funding increased from \$25.6 million in 2024 to \$31.8 million in 2025, driven by significant increases in funding from the Gates Foundation and the Global Fund. Specimen transport funding also increased, from \$5.5 million in 2024 to \$6.6 million in 2025. Laboratory funding, however, decreased from \$16.4 million in 2024 to \$14 million in 2025.

Although many USAID awards were terminated in 2025, funding levels have remained relatively stable due to pre-approved commitments that continued to flow through implementing partners even as USAID wound down operations. Much of USAID’s support, particularly for surveillance, HIV/TB diagnostics, malaria activities, and specimen transport, was delivered through multi-year partner-managed awards rather than direct government transfers. As a result, after the abrupt stop-work orders, most implementation gradually restarted and funding already obligated before the agency’s closure continued to be disbursed into early and mid-2025, creating the appearance of stability despite the broader institutional shutdown.

While Nigeria is facing funding cuts in 2026 from the US and UK governments, Fleming Fund, and the Global Fund with the end of the C19RM grant, there are new funding opportunities for surveillance and laboratory systems through two new World Bank-funded projects: the Health Security Program (HeSP) and the health security component of the Primary Healthcare Provision Strengthening Program (HOPE-PHC). Further, the government is currently negotiating with the US for new bilateral financial assistance starting in April 2026, which may lead to temporary rather than permanent disruptions in U.S. government funding for staff, supplies, training, and other key activities for surveillance and laboratory systems. Still, the evolving and highly uncertain financing landscape poses significant risks to Nigeria’s surveillance and laboratory systems, particularly for AMR surveillance as Fleming Fund contributions end in March 2026.

Table 4. Overview of Donor Landscape: Estimated Contributions (in USD)*

Partner or Funder	Type of Support / Systems Funded	MDAs Supported	2024	2025	2026 (Anticipated)
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USAID/ Department of State	Support for malaria (31% of 2025 funding), polio (27%), HIV (16%), and crosscutting (26%) disease surveillance systems and surveys.	Funding channeled through implementing partners (Ips)	\$13,025,000	\$14,650,000	Decreasing. 53% of 2025 funding is terminated for malaria, polio and cross-cutting disease surveillance; new funding possible amid MOU negotiations)
	Includes procurement of laboratory supplies and other support for HIV, TB, malaria, polio and cross-cutting disease areas.		\$7,799,237	\$6,372,169	Decreasing. Funding in 2025 has decreased for HIV, TB and cross-cutting lab support
	Support for TB and polio specimen transport		\$1,010,809	\$1,001,774	Decreasing
US CDC	Funding estimates for HIV surveillance only. Figures not available for cross-cutting support.	NCDC, IPs	\$5,012,000	\$ 4,212,000	Stable. Funding after 2026 is highly uncertain
	Funding estimates for HIV laboratory systems only.	NCDC, NASCP, IPs	\$6,176,000	\$ 5,046,000	Stable
	Funding estimates for HIV specimen transport only.	IPs	\$1,644,000	\$1,374,000	Stable
The Global Fund	Most financial support is for malaria and HIV surveillance (44% and 40%, respectively) as well as TB.	NACA, NASCP, NTBLCP, NMEP, IPs	\$6,094,823	\$8,532,753	Decreasing. The COVID-19 Response Mechanism (C19RM) ends in Dec 2025



	Laboratory systems		\$1,537,718	\$2,050,291	Decreasing. C19RM ends in Dec 2025
	Specimen transport		\$2,784,638	\$4,176,957	Decreasing. C19RM ends in Dec 2025
GIZ	Support for digital surveillance systems, particularly SORMAS	NCDC	\$280,600	\$137,600	\$1,000,000
Gates	Digital and wastewater surveillance; covers multiple pathogens + maternal mortality	NCDC, IPs	\$1,000,000	\$3,966,666	\$4,466,666
	Lab management information systems	IPs	N/A	\$466,666	\$466,666
Fleming Fund	AMR	IPs	\$228,117	\$310,225	Decreasing. Ends in March 2026
	AMR laboratory systems		\$891,351	\$484,252	Decreasing. Ends in March 2026
	AMR specimen transport		\$66,048	\$29,563	Decreasing. Ends in March 2026

* The analysis is limited by lack of financial data for JICA and WHO contributions.

2. Real-world Consequences of System Disruption

Funding disruptions are already creating noticeable strain across Nigeria’s surveillance, laboratory, and specimen transport systems and have been reflected in population-level measures (Box 1). Several routine activities that help monitor disease trends have slowed or paused, including population-based surveys, some mortality surveillance efforts, and selected sentinel and laboratory-based monitoring. Constraints on operational funding have also led to reduced training, fewer supervisory visits, and delays in data reporting and specimen movement. Many programs are working with smaller teams after donor-supported positions were lost, which affects the consistency and timeliness of surveillance activities at national and subnational levels. Laboratory networks are seeing longer turnaround times in some areas due to equipment maintenance delays, shortages of certain consumables, and delayed specimen transport.

Box 1. Snapshot: Quantified System Impacts

- TB case detection declined by 88 percent following the stop-work order, reflecting a severe national surveillance failure.
- Reported TB notifications fell from more than 500 cases in Q4 2024 to approximately 60 cases in Q1 2025, representing an eight-fold quarterly decline.
- HIV mortality surveillance halted across all 33 states after Q3 2024, eliminating national visibility into HIV-related deaths and quarterly reporting.
- Malaria stockouts were reported in approximately 5,000 PMI-supported facilities, directly undermining diagnostic and treatment capacity.

These pressures extend to digital data systems that depend on steady technical and financial support. This is especially true for systems designed to support surveillance or clinical services for a single disease such as HIV, TB, and malaria, which face uncertainty as partner support decreases. Some of these systems were not currently functional (Annex 1). Subnational capacity has also been affected because states have relied on donor-funded logistics and personnel to support surveillance and laboratory functions, including key capacity-building activities such as supervisory visits, mentorship, and training. While the system continues to function, the cumulative impact of these disruptions has made it harder to maintain the previous level of responsiveness and consistency.

Rather than providing an exhaustive catalogue of every consequence of recent funding shifts, the section below presents a representative series of seven impact stories that illustrate the wide-ranging effects across Nigeria's surveillance, laboratory, and sample transportation systems. These examples highlight not only the disruptions to core surveillance and laboratory functions, but also downstream implications for clinical service delivery and patient care, demonstrating how funding changes reverberated across the entire health system.

- **Equipment Downtime and Lapsed Maintenance Reduce Diagnostic Capacity**—Donor funding reductions disrupted routine preventive maintenance, calibration, and servicing of critical laboratory and surveillance equipment across Nigeria's public health system. Many essential diagnostic platforms, including GeneXpert machines, PCR instruments, genomic sequencers, and biosafety cabinets have historically been reliant on donor-funded maintenance contracts, vendor servicing agreements, and donor-supported biomedical engineers. As these contracts have lapsed or been scaled down, laboratories have faced calibration delays, prolonged equipment breakdowns, and limited access to technical support. The National Equipment Maintenance and Calibration Hub, which is responsible for the maintenance of essential equipment such as PCR machines and biosafety cabinets, has also been unable to fully implement scheduled preventive maintenance due to reduced operational funding.

These maintenance gaps have had direct and measurable impacts on diagnostic services, surveillance, and patient care. In the TB program, multiple GeneXpert machines in Ogun, Osun, Oyo, and Lagos states were operational for less than 60% of expected runtime because of overdue calibration and limited cartridge supply, forcing facilities to revert to less sensitive smear microscopy and delaying treatment initiation. In one South-Eastern LGA, a four-module GeneXpert machine remained non-functional for four months due to the absence of an active maintenance contract, increasing result turnaround time from approximately 48 hours to over 10 days. At the national level, delayed calibration of PCR machines and biosafety cabinets at the NCDC's reference laboratories resulted in prolonged downtime, slowed routine diagnostics, and increased biosafety risks. Collectively, these disruptions have reduced diagnostic throughput, created biosafety risks, delayed outbreak detection and response, and left expensive laboratory assets idle.



- **Fragmented Specimen Transport Delays Diagnosis and Weakens Surveillance**— Nigeria’s specimen transport structures stem from a fragmented and donor-dependent system that has evolved along vertical program lines rather than as a unified national service. Programs such as HIV, TB, and polio have relied on parallel, disease-specific transport arrangements heavily financed and managed by external partners. For example, donors funded the daily movement of GeneXpert and culture samples from healthcare facilities to zonal TB laboratories. Withdrawals and reductions in donor funding in 2025 severely disrupted these siloed specimen transportation systems — regular courier movements reduced or stopped, payments to third-party logistics providers lapsed, vehicles could not be repaired, and pickup schedules became irregular. Subnational sample transportation, such as between health facilities and LGA, zonal, or state hubs, was especially impacted. In the absence of a coordinated national specimen transport system, there was no established mechanism to reroute samples. Responsibilities shifted to frontline health workers and facilities, forcing reliance on ad-hoc solutions such as facility drivers, commercial buses, or healthcare workers leaving their posts to personally carry samples to laboratory hubs.

Impacts of specimen transportation delays were felt across disease programs and geographies. NCDC had to deploy its own staff and vehicles to transport samples, a stop-gap approach that is inefficient, costly, and unsustainable. Despite these efforts, reduced courier frequency left measles, cholera, Lassa fever, and diphtheria samples stranded longer at primary healthcare facilities and delayed laboratory confirmation. TB programs reported multi-day delays moving sputum samples from healthcare facilities to GeneXpert sites, with some LGAs in Benue and Ebonyi resorting to non-standard transport methods such as commercial buses that compromised sample integrity and delayed TB treatment initiation. In Bauchi State, the inability to access funding to repair a courier motorcycle caused a 10-day interruption in specimen movement, resulting in a backlog of more than 300 sputum samples awaiting transport. For polio, ad-hoc transport arrangements led to samples arriving outside recommended temperature ranges and longer periods before suspected cases could be confirmed. HIV programs reported extended transit and processing times for viral load and EID samples that weakened real-time surveillance and delayed clinical decision-making. Collectively, these examples illustrate how funding cuts and siloed systems delayed timely diagnosis, treatment initiation, and reduced the overall effectiveness of the health system’s surveillance and response capabilities.

- **Erosion of Laboratory Accreditation and Workforce Investments Threatens Long-Term Performance**—Recent funding reductions have directly undermined investments critical to sustaining laboratory quality, including accreditation, staff training/mentorship, and workforce retention. Cuts to PEPFAR and other donor support halted funding for laboratory accreditation preparation, routine Quality Management Systems (QMS), and structured QMS training programs such as Strengthening Laboratory Management Toward Accreditation (SLMTA), leaving facilities without financial support to maintain standards and certifications. For example, at the Institute of Human Virology Nigeria’s Plateau State Virology Research Centre (PLASVIREC), reductions in PEPFAR funding have jeopardized continued support for maintaining ISO 15189 accreditation, the globally recognized standard for medical laboratories. Across the NCDC laboratory network, donor-funded training, mentorship, and professional development programs were suspended, while the withdrawal of donor-supported molecular technologists, QA officers, and laboratory mentors nationwide created immediate gaps in staffing, quality oversight, and laboratory governance.

Over the longer term, these disruptions risk substantial declines in laboratory performance, reliability, and preparedness. The loss of accreditation support and QMS training threatens the sustainability of previously achieved standards, increasing the likelihood that laboratories will lose national or international accreditation and compromising diagnostic integrity. At NCDC, funding cuts have paused the training and certification of newly employed biomedical engineers, prevented the retraining and recertification of already certified engineers, and led to the attrition of two fully certified engineers, resulting in immediate and increasing dire long-term impacts on equipment servicing and maintenance. Without continuous training and mentorship, laboratory staff will lose competencies,

increasing diagnostic errors, turnaround times, and biosafety risks. Collectively, these trends weaken surveillance, delay detection and confirmation of outbreaks, and heighten future public health risks, demonstrating how unresolved funding gaps in accreditation and workforce development may translate into long-term declines in laboratory performance and national health security.

- **Commodity Stock-Outs Undermine Laboratory Testing and Disease Surveillance—** Pauses and reductions of donor funding led to sudden declines in available financing for laboratory commodities. Laboratories lost access to routinely financed inputs such as diagnostic reagents, test kits, packaging, cold-chain materials, and basic laboratory consumables such as gloves and pipette tips. The immediate result was widespread stock-outs across national reference laboratories, LGA, zonal, and state laboratories, and high-burden sentinel sites.

These shortages have resulted in system-wide impacts on program implementation and service delivery. NCDC laboratories reported that widespread stock-outs of diagnostic reagents and consumables delayed genomic sequencing and interrupted Lassa fever and diphtheria testing, with prolonged turnaround times for outbreak confirmation. HIV viral load testing kits were out of stock for weeks in Lagos and Oyo States, while EID samples in Kaduna and Bauchi States experienced long turnaround times, delaying patient monitoring and treatment decisions. In the TB program, facilities in Lagos, Gombe, and Rivers States ran out of triple-packaging materials and sputum cups, forcing temporary halts in sample collection and testing. Collectively, these illustrative examples highlight how disruptions reduced testing volumes, increased rejection rates, prolonged turnaround times, delayed treatment initiation, and weakened Nigeria's ability to generate timely laboratory data for clinical services, surveillance, outbreak response, and program decision-making.

- **Funding Disruptions Undermine TB Case Detection, Clinical Services, and Surveillance—** Recent donor budget cuts and funding pauses severely disrupted Nigeria's TB program. In recent years, domestic financing has covered only 6–8% of TB program needs, leaving the program highly dependent on donors. Following the USG stop-work orders and funding reprioritization in early 2025, TB case finding activities declined sharply. Between Q4 2024 and Q1 2025, reported TB cases fell from over 500 to approximately 60, an approximately 88% reduction, with the steepest declines observed in states most reliant on donor-supported partners. Active TB screening in outpatient departments was halted in at least 18 high-priority states, GeneXpert sites experienced downtime due to cartridge stock-outs and delayed calibration, and specimen transport disruptions led to delays of days to weeks in diagnostic confirmation. In some locations, facilities were forced to suspend sample collection entirely due to commodity shortages, while others resorted to ad-hoc transport methods that compromised sample integrity and increased turnaround times.

These immediate disruptions are translating into longer-term risks for TB control and patient outcomes. Delays in diagnosis and treatment initiation—particularly for drug-resistant TB (DR-TB)—have weakened surveillance and increased the likelihood of ongoing transmission in communities. In several states, presumptive DR-TB samples took up to three weeks to reach reference laboratories. If sustained, these funding gaps threaten to reverse recent gains in TB case detection, reduce treatment coverage, increase transmission (including of drug-resistant strains), and compromise the quality of Nigeria's TB surveillance and clinical care systems.

- **Cancelled Survey and Sentinel Surveillance Erodes Public Health Intelligence—**The recent reductions in donor funding have directly resulted in the cancellation, suspension, or partial implementation of multiple population-based surveys and sentinel surveillance systems. For the TB program, ongoing drug-resistant TB surveys have been suspended, disrupting surveillance of resistance patterns that inform treatment guidelines and procurement decisions. For the malaria program, the 2025 Malaria Indicator Survey was a planned donor-funded activity (60% PMI, 40% Global Fund) but had to be cancelled due to funding uncertainties, leaving the National Malaria Elimination Programme forced to explore alternatives. In addition, funding for entomological surveillance, which had been entirely supported by PMI, is now uncertain, threatening sentinel

monitoring at 29 entomology sites that track vector density, insecticide resistance, and therapeutic efficacy.

The HIV program faced an abrupt halt to HIV mortality surveillance using verbal autopsy, leaving a gap in understanding causes of death among people living with HIV. Similarly, planned subnational Population-based HIV Impact Assessments (PHIAs) in Lagos and Rivers States, which were receiving 80% of their funding from the U.S. government, have been disrupted. Although Government of Nigeria funds have been prioritized to conclude the ongoing PHIA in Lagos State, the ability to conduct future PHIAs remains uncertain. Taken together, the cancellation and postponement of surveys and sentinel surveillance erode Nigeria's ability to detect emerging threats and measure program impact, increasing reliance on routine data systems that are themselves experiencing strain due to funding cuts.

- **Workforce Reductions Undermine Surveillance and Program Operations**—Recent reductions in donor funding have led to significant losses across the public health workforce responsible for surveillance, monitoring and evaluation (M&E), data management, ICT infrastructure, and frontline clinical staff who are often responsible for data entry. Stop-work orders and funding pauses resulted in the suspension of contracts for surveillance officers, M&E staff, community health workers, and technical advisors who support routine disease surveillance and program oversight. HIV, TB, and malaria programs were especially affected, with active case finding, supervisory visits, and data quality assurance activities halted or scaled back. Community-based surveillance was impacted as community informants lost support for transport and communication, leading to fewer alerts for suspected cases of measles, cholera, diphtheria, TB, malaria, and other priority conditions. At the primary health care level, remaining clinical staff absorbed additional responsibilities following workforce reductions, increasing workloads and reducing the time available for case investigation, reporting, and follow-up.

These workforce losses have had cascading effects on surveillance system performance and clinical care. Reductions in surveillance, M&E, and ICT staffing have weakened data entry, validation, and analysis within national digital health platforms. Vertical programs have experienced direct impacts; for example, the National TB Programme's IT team has limited technical capacity and has historically relied on implementing-partner funding to engage external developers for system maintenance. With budget cuts and the loss of external support, eTB Manager, which is used for TB case-based surveillance, has ceased to function, curtailing data collection. The siloed implementation of many digital data systems has further amplified the effects of these human resource reductions. Interruptions to routine supervision and mentorship threaten to further erode adherence to surveillance reporting protocols at subnational levels. In several programs, declines in field staff capacity have coincided with drops in case detection and slower initiation of investigation and response actions, increasing the risk of undetected transmission. Collectively, these impacts demonstrate how reductions in the surveillance and data workforce have directly weakened infectious disease surveillance systems.

3. Opportunities

Nigeria's programmatic and financial outlook for 2026 is shaped by deep uncertainty, continued reductions in donor support, and growing pressure on surveillance, laboratory, and specimen transport systems. Vertical programs including HIV, TB, and malaria, which until recently had received substantial and consistent USG funding, have been especially impacted. Many essential functions rely on external financing for reagents, commodities, equipment maintenance, digital platforms, specimen movement, and key workforce roles. With some donors reducing or pausing investments and uncertain commitments for 2026, core activities face significant operational threats and impacts have already been felt, as described in the previous section (Table 4).

Despite these challenges, 2026 also presents opportunities to improve efficiency by reducing duplication across programs while developing more efficient and sustainable implementation of surveillance, laboratory, and specimen transport systems. The remainder of this section highlights some of the financing available in 2026 that could be leveraged to transform surveillance, laboratory and sample transportation systems into more cost-effective and sustainable structures, followed by a section that describes specific projects that could be implemented to improve implementation efficiency by reducing existing silos.

Table 5. Cross-Cutting Opportunities and Threats

Dimension	Opportunities	Threats
Surveillance	Strengthen strategic planning and policy alignment across MDAs; streamline and integrate digital data collection; leverage existing digital learning platforms; integrate surveys across multiple diseases	Digital surveillance system sustainability from decreased financing and human resources; loss of technical expertise; decreasing subnational capacity; loss of intelligence from surveillance surveys and sentinel surveillance; ongoing fiscal uncertainty impeding strategic planning
Laboratory	Lab integration across diseases; implement new cost sharing models to distribute financial burden; improve donor alignment; strengthen governance structures; Implement LIMS for all diseases	Loss of technical staff supported by implementing partners; staff attrition; reagent shortages; need for equipment maintenance; ongoing laboratory accreditation and QA; siloed laboratories; reliance on siloed donor funding
Specimen Transport	Update and implement an integrated specimen transport system (NiSRN); Possible use of NIPOST for sample transportation; digital tracking; optimized specimen routes; improved cross-agency coordination	Delayed sample referral and transportation; Cold chain failures; reliance on siloed donor funding
Financing	Improved donor activity alignment; pooled procurement; leverage and increase the BHCPF; state-level financing mechanisms	Continued declines in donor funding; donor uncertainty; lack of continuity; limited fiscal space ; decreased implementation capacities; continued siloed funding

3.1. Financing Opportunities

Although there is significant macro-fiscal uncertainty and an overall tightening financial landscape predicted in 2026, Nigeria still has several major donors with substantial active funding commitments and domestic financing potential. This creates a critical opportunity to advance priority surveillance, laboratory, specimen transport, and digitalization activities. By using these resources to focus on interventions that reduce duplication, strengthen domestic ownership, and improve coordination and collaboration across MDAs, Nigeria can leverage 2026 financing to stabilize critical operations while laying the groundwork for greater efficiency and long-term resilience. The upcoming year represents a critical window to make these strategic shifts, and the section below highlights key domestic and external financing opportunities.

The Basic Healthcare Provision Fund (BHCPF) earmarks 1 percent of the Consolidated Revenue Fund (CRF) for four health “gateways”, including one for NCDC. The legislature is currently reviewing a

proposal to increase revenue to the BHCPF from 1 to 2 percent of the CRF, and to increase the allocation of the BHCPF going to NCDC from 1.25 percent to 10 percent. If this is approved, NCDC and states will receive significantly more domestic funding for health security activities, including laboratories and surveillance systems.

World Bank-funded projects allow for large-scale investments in integrated systems. HeSP can be leveraged to address surveillance, laboratories, specimen transport, and digital architecture, while HOPE-PHC offers a platform for strengthening primary healthcare diagnostics and reporting. Under HeSP, Nigeria is expected to receive US\$107.24 million in International Development Association (IDA) funding for detection of health emergencies, which includes funding for collaborative surveillance (\$37.18 million) and laboratory quality and strengthening (\$51.75 million). Under the HOPE-PHC program, \$75 million is allocated for strengthening health system resilience. Under Disbursement Linked Indicator (DLI) 9, the government would receive a yearly payment of \$2.5 million if state-level epidemic preparedness and response planning indicators are achieved. These plans would include surveillance and laboratory strengthening activities. The payment would be shared across BHCPF MOC, NPHCDA, NHIS, NEMSAS, and NCDC (20% each).

The **Global Fund** remains a critical financial supporter of HIV, TB, and malaria systems, and GC8 offers an opportunity to invest more deeply in cross-cutting health system structures through Resilient and Sustainable Systems for Health (RSSH). However, overall funding from the Global Fund to Nigeria is anticipated to decrease in the GC8 three-year grant cycle that starts in 2027 compared to current GC7 funding levels, which again highlights the need to invest in building financial efficiency through integration.

Multilateral development banks and bilateral donors can complement World Bank and Global Fund investments. While there is a huge amount of uncertainty around future U.S. government funding levels, other partners have played important role providing targeted technical assistance, capacity building, and support for specific functions. While specific donors often have focal areas in which they provide financial and technical support, there is now an opportunity to better align bilateral support toward integrated, cross-cutting investments that strengthen foundational systems, such as shared digital infrastructure, workforce retention and accreditation, coordinated surveillance platforms, and sustainable maintenance and quality assurance, rather than reinforcing disease- or project-specific siloes.

3.2. Opportunities for Integration and Efficiency

This section outlines opportunities identified through the assessment to improve efficiency by reducing existing silos that have emerged from programmatic funding and by promoting more integrated, efficient, and sustainable implementation of surveillance, laboratory, and specimen transport systems. While these activities would require targeted short-term investments, they are expected to yield long-term cost efficiencies and improved outcomes across surveillance, laboratory, and clinical services. The section proposes five priority activities that, if implemented, could help Nigeria maximize the impact of available resources and stabilize critical public health functions.

Update and operationalize the Nigeria Integrated Specimen Transport Network (NiSRN)

Investment in a fully integrated specimen referral network is among Nigeria's most pressing cross-cutting systems needs. Separate logistics vendors funded by specific programs and recent donor withdrawals have fragmented courier systems, increased sample batching, delayed viral load/EID testing and TB diagnosis, and slowed outbreak confirmation, resulting in reduced reliability of diagnostic service. Historically, NiSRN has been a PEPFAR-led initiative, but there is now an opportunity to strengthen NiSRN by updating it to harmonize sample transportation for all disease programs and MDAs. A revised NiSRN could optimize the national specimen transport model that integrates lab capacity, surveillance priorities, courier networks, and digital tracking tools.

Recommended components:

- NiSRN implementation overseen by the Medical Laboratory Services Division, FMOH&SW
- National redesign and consolidation of courier networks for all diseases
- Unified service-level agreements with pooled multi-disease delivery contract
- A centralized digital tracking and data system, such as barcode-based real-time specimen tracking integrated with LIMS and SORMAS
- Standardized cold-chain, packaging, and transport protocols
- Utilization of a hub-and-spoke model to reduce costs and improve efficiency
- State-level logistics coordination units with clearly defined responsibilities and reporting requirements to national level

Implement the National Guideline for Integration of Laboratory Services and Systems

Nigeria's laboratory ecosystem remains highly segmented across programmes and MDAs, which has resulted in the inefficient use of limited financial and human resources. Narrowly focused, project-based LIMS implementations, often reliant on short-term donor funding, have resulted in long-term sustainability challenges once project funds dry up, leading to a fragmented and unstable laboratory information system landscape. If not addressed, inadequate training and lapsed maintenance contracts introduce biosafety risks. There are opportunities to improve laboratory services by utilizing existing laboratory physical infrastructure for multiple diseases. Implementing the National Guideline for Integrated Laboratory Services and Systems would take a phased approach to address the fragmentation of laboratory services, resulting in reduced duplication, boosted efficiency, maximized investments, and ultimately improved outbreak surveillance and response.

Recommended components:

- Integration of disease-specific physical laboratories
- Cross-program use and standardization of PCR, GeneXpert, sequencing and culture platforms
- Integration of commodity procurement and supply chain management
- Pooled preventive maintenance and calibration contracts
- Unified national laboratory Quality Management System (QMS) and accreditation pathways
- Strengthen workforce capacity through integrated laboratory training curricula, targeted training, retention incentives, and strategic skill development programs
- LIMS consolidation into a platform that is integrated with the broader health system to inform clinical and public health decision-making
- Improve country capacity and cross-program alignment to generate EQA/PT panels for TB, HIV, Malaria, COVID-19, and other diseases.

Digital Integration for Surveillance, Laboratories & Specimen Transportation Networks



Nigeria's surveillance and laboratory digital landscape includes multi-disease systems such as the NHMIS, SORMAS, and LIMS, as well as a many disease-specific digital tools implemented for HIV, TB, and malaria (see Annex 1). Rather than creating new digital platforms, investment should prioritize interoperability and integration of data at the point of data collection, data warehousing, and data use while leveraging the Nigeria Digital in Health Initiative (NDHI). This can result in a streamlined data entry experience for clinicians, more efficient utilization of available financial and human resources, and improved access and enhanced data use for decision-making.

Recommended components:

- Review the data collected in NHMIS, SORMAS and LIMS to identify integration opportunities, eliminate duplicate data collection, and develop a unified national data architecture
- Review disease-specific tools and identify opportunities for integration into NHMIS, SORMAS or LIMS to reduce the number of digital platforms
- A centralized digital specimen tracking system integrated with LIMS and SORMAS
- Unified standards and national minimum dataset for surveillance within FMOH&SW across MDAs
- A shared digital and human resource infrastructure utilized across digital data systems at all levels
- Donor alignment to support equipment and IT infrastructure maintenance for prioritized digital systems
- A healthcare facility infrastructure plan to identify existing physical assets with recurrent costs and prioritize gaps in existing infrastructure to inform financial investment
- A workforce development plan to address gaps from withdrawal of donor-funded technical expertise to ensure the GoN has the technical capacity to implement these digital initiatives
- When applicable, leverage existing multi-stakeholder alignment platforms including the ATM Technical Working Group, the Nigeria Governors Forum health security scorecard, and the NHSRII sector-wide approach

Workforce Stabilization and Technical Cadre Development

Donor-funded staff including programmatic technical experts, surveillance officers, molecular technologists, bioinformaticians, QMS officers, and specimen transport coordinators have been lost due to recent funding reductions. Remaining staff have been facing increased workload and there is an ongoing risk of staff burnout among remaining personnel. Stabilizing, expanding, and upskilling this workforce is essential to protect system performance. This can be accomplished by aligning MDAs around shared priorities, leveraging available technical staff across platforms and diseases, and optimizing resources through alignment of training, mentorship, and other capacity-building activities.

Recommended components:

- Identification of critical specialized technical gaps that resulted from the funding/staff withdrawals.
- Development of joint training modules for common competencies (e.g., infection control, data management) across disease programs

- Alignment of mentorship programs across diseases and MDAs to improve efficiency
- Training laboratory personnel to perform tests and operate equipment for multiple programs to increase workforce flexibility and reduces dependency on program-specific staff
- Establishment of a national health workforce registry to monitor skills, deployments, and training needs, supporting strategic placements, while promoting staff rotations between facilities to balance workloads and distribute expertise
- Using existing digital learning platforms to promote remote capacity building and training such as the ECHO platform and e-learning platform
- Strengthened HRH planning across MDAs for laboratory and surveillance to promote donor alignment and efficient utilization of available financial resources
- Build on existing support for the National Workforce Retention Strategy: RTSL has engaged a consultant to develop a National Workforce Retention Strategy focused on strengthening institutional systems across the workforce lifecycle—from recruitment to exit—through evidence-based analysis and policy engagement.

National & State PHEOC Strengthening

Public Health Emergency Operations Centres (PHEOCs) are critical for multisectoral outbreak response. This is true at both the national and state level, as most outbreaks are initially managed subnationally. However, after major recent financial investments to strengthen national and state PHEOCs, performance has declined due to reduced supervision and operational financing. A structured reinvestment with improved strategic and operational planning can restore readiness.

Recommended components:

- A national PHEOC surge financing mechanism.
- Integrated PHEOC dashboards linking LIMS, SORMAS, NHMIS and any other data systems useful for informed decision-making
- Simulation exercises, SOP modernization, and governance reforms
- Institutionalized training and workforce development for PHEOC staff at all levels
- Minimum infrastructure package for all state PHEOCs

Annex 1: Surveillance and Laboratory Systems Inventory

The tables below include a list of the different digital data systems implemented for Surveillance or Laboratory in Nigeria. The level of government ownership of these systems varied, with some fully government led and others heavily reliant on implementing partners to develop, sustain and implement the system. The tables briefly describe each system, the lead MDA, pathogens, system objectives and scale, key information products, and major donors and the funding trend.

System Name	Lead MDA	Pathogens / Diseases	Objective	Scale	Key Information Products	Major Donor(s)	Funding Trend (2024-2026)
National Health Management Information System (DHIS2)	FMOH&SW	22 notifiable diseases (including HIV, TB, malaria), mortality, adverse drug reactions	Collect weekly and monthly aggregate surveillance data from health facilities.	Nationwide. Paper-based at health facility level, entered into DHIS2 at LGA level. Public and private facilities.	Dashboards within DHIS2, quarterly and annual bulletins	30% GoN, GF, USAID	Unknown
National Malaria Data Repository (DHIS2)	National Malaria Elimination Programme, FMOH&SW	Malaria	Serve as a central repository for all validated malaria data (aggregate case counts pushed via API from NHMIS, therapeutic efficacy studies, malaria vector surveillance) with email alerts for changes in incidence.	Nationwide, aggregated at health facility level. Users are primarily at national level	Five malaria dashboards (morbidity/mortality, surveillance, prevention, case management, and health systems) and malaria bulletins	PMI, GF	Decreasing

SmartVA (KoboToolbox)	National AIDS and STDs Control Programme, FMOH&SW	Verbal autopsy (currently used for HIV mortality surveillance)	Collect cause of death data for HIV mortality surveillance	Over 2000 workers across 33 states are implementing for HIV mortality surveillance	Quarterly SitReps, dashboard within the National Data Repository (NDR)	US CDC	Decreasing
National Data Repository (NDR)	National AIDS and STDs Control Programme, FMOH&SW – but implementation is managed by PEPFAR partners	HIV	Data repository for case-based HIV data collected via at least 3 different EMRs and updated weekly	Consolidates data from 2,000 PEPFAR-supported health facilities where at least 3 different USG-funded EMR systems are used	NDR internal dashboards, HIV mortality monthly reports. Donor reports	US CDC	Decreasing
EMRs: LAMISPlus, (Open source), Nigeria Medical Records System (OpenMRS-based), and Viva	National AIDS and STDs Control Programme, FMOH&SW – but implementation is managed by PEPFAR partners	HIV	Facility-based electronic health record for HIV care	Available across ~2000 comprehensive PEPFAR-supported ART facilities. Each EMR was developed by different implementing partners, and are deployed in different states.	HIV national programmatic reports, patient-level ART and VL monitoring, real-time HIV dashboard and sync with NDR	PEPFAR	Uncertain, likely to decrease
SORMAS	NCDC	24 IDSR case-based priority diseases inclusive of maternal and perinatal deaths; 11	Collect case-based and weekly data to detect and manage disease outbreaks	Implemented nationwide. In <10% of healthcare facilities,	SORMAS internal dashboards, Weekly Epidemiology	GIZ, GF	Uncertain



		weekly aggregate reported with no overlap		otherwise data entry at LGA level.	Bulletin, Disease-specific SitReps		
Tataafo	NCDC	41 notifiable diseases	Support event-based surveillance by mining the internet (e.g. X) for keywords to detect signals	NCDC ICC and 38 states	Weekly consolidated EBS reports. Verified events are shared with relevant NCDC staff for risk assessment and public health action	GF, US CDC	Uncertain
EIOS	NCDC	41 notifiable diseases	Support event-based surveillance by searching digital media to detect signals	NCDC ICC	Weekly consolidated EBS reports. Verified events are shared with relevant NCDC staff for risk assessment and public health action	WHO	Decreasing
ConnectCentre SugarCRM	NCDC	41 notifiable diseases	Support event-based surveillance by using a toll-free hotline, SMS, live chat and WhatsApp platforms to receive signals, as well as the traveler health	NCDC Connect Centre	Weekly consolidated EBS reports. Verified events are shared with relevant NCDC staff for risk assessment and public health action	GoN	Uncertain



			declaration form, which are all logged into SugarCRM for signal management				
SitAware	NCDC	Notifiable diseases and non-infectious events such as chemical hazards	Manage signals and events reported by States to NCDC and archive key event data and 7-1-7 timeliness metrics	35/36 states and FCT PHEOCs and NCDC ICC	Internal dashboard	UKHSA, Gates Foundation	Decreasing
VigiFlow	National Agency for Food and Drug Administration and Control (software developed and maintained by The Uppsala Monitoring Centre)	Adverse events following immunization (AEFI)	Support case-based AEFI surveillance to monitor vaccine safety. Users can push data to global WHO Vigibase system	Nationwide, system is paper-based until data entry into VigiFlow by NAFDAC at national level	No routine information products in Nigeria, but data contributes to Vigibase which includes a publicly available dashboard	Uppsala Monitoring Centre	Unknown
Nigerian MPCDSR e-Platform (formerly NOQA)	Maternal Health Division, FMOH&SW	Maternal, Child and Perinatal Deaths	Support case-based surveillance of Maternal, Child and Perinatal Deaths to improve future maternal and child health outcomes	Selected secondary and tertiary health facilities	No sitreps or bulletins currently generated	Rotary International	Unknown



e-TB Manager	National Tuberculosis and Leprosy Control Programme, FMOH&SW	TB, leprosy, Buruli Ulcer	Collect case-based TB surveillance, laboratory and treatment data, and push aggregate TB data into the NHMIS,	Nationwide: data entry is at 300 high-burden TB facilities or at LGA level. Last update was system was not operational	Publicly available e-TB dashboard, monthly TB newsletters, DHIS2 dashboards	USG, GF	Decreasing
Mobile Application for TB Screening	National Tuberculosis and Leprosy Control Programme, FMOH&SW, maintained by PEPFAR implementing partner (MSH)	TB	Collect case-based TB surveillance data from private facilities	Private healthcare facilities in 22 states	monthly TB newsletters, DHIS2 dashboards	USG	Uncertain, likely to decrease
CommCare	National Tuberculosis and Leprosy Control Programme, FMOH&SW, maintained by PEPFAR implementing partner (KNCV)	TB	Collect case-based TB surveillance, care and treatment data	Public healthcare facilities in 14 states	Donor reporting	USG	Uncertain, likely to decrease
CIMS-NTDs	Department of Public Health, Federal University of Technology, Owerri (FUTO)	Onchocerciasis, Lymphatic filariasis, Trachoma, Buruli Ulcer, Guinea worm infection,	Enable community members to self-report NTD cases, capture symptoms	Piloted in three states	Incidence reports, study reports	Gates Foundation Grand Challenge on NTDs	Funding ended in 2024



		Leprosy, and Ascariasis.	using smartphones and submit images via text to a central database for expert analysis and identification.				
eSURV	WHO	AFP	Supports active case searches and integrated supportive supervision	Not routine, used by WHO when an AFP case is confirmed	eSURV Annual Report Bulletin	WHO	Unknown

* Excel data collection mentioned for case-based surveillance (parallel to SORMAS) and AMR sentinel surveillance data. Epi-Info for SARI/ILI surveillance.

Annex 2: Laboratory Surveillance Systems

System Name	Lead MDA	Pathogens / Diseases	Objective	Scale	Key Information Products	Major Donor(s)	Funding Trend (2024-2026)
Wastewater surveillance	Health - NCDC	<i>Salmonella Typhi</i> <i>SARS-CoV-2</i> <i>Measles</i> <i>Monkeypox virus</i> <i>Lassa fever virus</i> Other vaccine-preventable diseases Antimicrobial-resistant (AMR) bacteria <i>Entero bacteria (Escherichia coli, Pseudomonas species Klbesiella species etc)</i> <i>Cryptosporidium</i>	Early Warning Systems	Pilot in 4 states (FCT, Kwara, Kano & Maiduguri)	Sample collection data Pathogen detection results Environmental parameters Laboratory analysis data Geospatial and epidemiological data. Data management metrics: using tools such as Kobo Collect, RedCap, Power BI, and SORMAS for real-time tracking and analysis	Gates Foundation	Steady funding - ending in 2026
Genomic Surveillance	Health - NCDC	All pathogens	Pathogen tracking and characterization to support	National	Genetic sequences of priority pathogens such as SARS-CoV-	Africa CDC, WAHO, USCDC, CEPI	Decreased for Global Fund & UKHSA; Uncertain for



			public health response		2, cholera, and diphtheria Data on variant identification and lineage tracking for circulating and emerging strains. Antimicrobial resistance (AMR) markers Quality control and sequencing performance data, such as run coverage and analysis metrics Records of data sharing with global repositories	UKHSA, WHO, Global Fund	other funders
Serosurveillance	Health - NCDC	Measles Rubella Diphtheria COVID-19 Lassa fever Cholera (in select pilot studies)	Disease prevalence and vaccine efficacy monitoring	National (NAIIS) + Pilot for other diseases	Population-level seroprevalence rates Vaccination history Trends in immunity gaps for vaccine-	USCDC	Stopped in 2025, Uncertain for 2026 and beyond



					preventable diseases Data on emerging infections for exposure estimation and preparedness planning		
NCDC Biomedical engineering hub	Health - NCDC	All pathogens	Strengthen national capacity for equipment calibration and maintenance	NCDC NRL	Maintenance & calibration reports, preventive maintenance, schedules, equipment performance dashboards	WHO, UKHSA, Global Fund, NALEC, USCDC (through IHVN), JICA	Decreased in 2025, largely uncertain in 2026
VHF network	Health - NCDC	Lassa Fever, Ebola, Marburg, Rift valley fever, Crimean Congo HF	Strengthen early detection of VHFs in Nigeria	NCDC NRL + 7 other labs in the NCDC network of labs	Lab test results, weekly reports	USCDC, WHO	Decreased in 2025, largely uncertain in 2026
YFMR network	Health - NCDC	Yellow Fever, Measles, Rubella	Detect and confirm cases of YF, Measles & Rubella to support response and	NRL, CPHL, other labs in NCDC network	Lab test results, weekly reports	WHO, USCDC	Funding steady up to 2025, but largely



			immunization activities				uncertain in 2026
Bacterial pathogens network	Health - NCDC	Cholera, CSM, Diphtheria	Laboratory based surveillance to detect outbreaks of bacterial pathogens	NRL, CPHL, other labs in NCDC network	Lab test results, Lab data dashboards	WHO, USCDC	Decreased in 2025, largely uncertain in 2026
Influenza/SARS COV2 network	Health - NCDC	Influenza viruses, SARS-CoV-2	Monitor and detect respiratory viruses	NRL as the testing site + 8 sentinel sites across the country	Lab reports (including test results)	WHO, Global Fund	WHO's funding remains active (but reduced) in 2026 while GF is also reduced
LIMS	Health - NCDC	All pathogens	To standardise real-time laboratory data capture and reporting	NCDC labs (NRL & CPHL)	Lab test results, Lab data dashboards	GGHN, RTSL	Uncertain in 2026
AFI	Health - NCDC	Lassa Fever, Dengue Fever, Salmonella typhi, Influenza, Ebola, Yellow Fever, Zika, Chikungunya, Rift	To detect and diagnose undifferentiated febrile illnesses of unknown etiology in order	NCDC - NRL	Weekly & monthly AFI bulletins, policy briefs and	USCDC (through IHVN)	Stopped in 2025, Uncertain for 2026 and beyond



		valley fever, COVID-19, Malaria, and other undifferentiated febrile illnesses of unknown etiology	to prevent large-scale outbreaks		technical updates		
AMR	Health - NCDC	E. coli, Staph aureus, Klebsiella, Salmonella spp., Pseudomonas, Neisseria	Strengthen lab & surveillance capacity for detection of resistant strains	AMR National Reference Labs (x2) 11 sentinel surveillance sites	Test results, trend analyses, national AMR surveillance reports	Fleming Fund, Gates Foundation, Global Fund	Decreased in 2025, largely uncertain in 2026
MPOX network	Health - NCDC	Zoonotic orthopoxvirus	To monitor and detect Mpox cases and prevent spread of the disease	NCDC NRL + selected sentinel sites	Test results, weekly epidemiology bulletins, trend analyses,	WHO, USCDC, Gavi	Only Gavi funding remains active in 2026; others are uncertain
NCDC Sample transport system	Health - NCDC	All diseases of public health importance	Safe and efficient referral and transport of samples for diseases of public health importance	Nationwide (from state hubs to indicated testing labs)	Chain of custody forms, sample movement logs, samples pickup and delivery details	REDISSE (major funding mechanism; now closed out) CoPREP, WHO (for transport of some samples under the EPI	Currently, no mechanism exists to fund this system since REDISSE & CoPREP closed out



						program), USCDC (modest financing through ongoing surveillance programs	
Integrated National AMR Framework for Animal Health AMR Surveillance (INFAM)	Animal	Bacterial pathogens affecting livestock	Collect and manage AMR data from animal health labs	NVRI + sentinel sites	Resistance pattern results, surveillance summaries for livestock & aquaculture	Flemming Fund	Active through 2025, Uncertain in 2026
WHO EPI program	Human- WHO/NPHCDA	Polio	Poliomyelitis detection to support eradication programme	Nationwide	Test result, patient demographics	USCDC, UNICEF, Global Fund, Gates Foundation, GAVI	Reduced in 2025, largely uncertain in 2026
NTBLCP ad hoc sample transport system	NTBLCP/IHVN	TB	Efficient, timely and secure transport of TB samples to testing labs	2 reference labs (Kaduna & Lagos) 6 zonal labs (Kano, Abia,	Test results, sample logs	Global fund (through IHVN)	Reduced funding through 2025 and 2026



				Calabar, Oyo, Jos, Adamawa)			
National Integrated Specimen Referral Network (NiSRN)	Health	HIV	Timely, efficient and secure transport of HIV (and other samples)	National	Specimen details, transport and tracking info, facility & location data, test results, result communication	USG/PEPFAR, Global Fund, WHO, CHAI	Decreasing funding from 2025 through to 2026
National Data Repository (NDR)	Health	HIV	To manage patient-level HIV and laboratory data from all facilities	All NASCP-supported HIV facilities	Patient-level dashboards,	USCDC, WHO	Reduced funding from 2025 into 2026
National Data Reporting System (NDRS)	Health	HIV	To consolidate & summarise data from the NDR and provide national-level HIV program indicators	All NASCP-supported HIV facilities (approx. 30,000 facilities nationwide)	Summary reports, national dashboards, KPIs, trend analyses etc.	Global Fund, USCDC	Reduced funding from 2025 into 2026
HIV LIMS	Health	HIV	To capture, manage and track laboratory sample-level data across	All PCR labs linked to NASCP facilities	Test results, lab dashboards	Global Fund, PEPFAR, CHAI	Reduced funding from 2025 into 2026



			NASCP- supported laboratories for HIV testing	mapped regionally			
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