ATHENA CENTRE FOR POLICY AND LEADERSHIP

PERSPECTIVES

VOL. 3, ISSUE 1 • 6-12 JANUARY, 2026

Welfare First: *Retaining Nigeria's Health Workforce in an Era of Global Competition*

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Executive Summary

Nigeria is losing its health workforce at a pace that increasingly threatens system viability. Between 2021 and early 2024, more than 42,000 nurses emigrated, while thousands of Nigerian-trained doctors registered to practise abroad, particularly in the United Kingdom. Survey evidence suggests that outflows are likely to persist: nearly three-quarters of current medical and nursing students report an intention to work overseas, and one-third indicate no plans to return.

Available evidence indicates that emigration is driven primarily by domestic welfare and governance failures rather than by professional ambition alone. Key push factors include low and irregular remuneration, unsafe and overstretched working environments, limited access to funded specialist training, and weak social protection. These conditions intersect with sustained international demand and increasingly structured recruitment practices in destination countries.

In response, Nigeria adopted a National Policy on Health Workforce Migration in 2023, aimed at promoting ethical recruitment and improving retention. Early implementation reviews, however, suggest that the policy has had a limited effect on outward flows. Weak financing, uneven state-level execution, and poor translation of policy commitments into tangible welfare improvements at the facility level have constrained impact. Migration, in this context, reflects a rational response to institutional uncertainty and uneven service conditions.

This policy brief argues that meaningful retention is achievable, but only if welfare reform is treated as a core economic and governance priority rather than as a subsidiary component of migration management. It proposes a Welfare-First Retention Package (WFRP) centred on guaranteed and predictable remuneration, improved workplace safety, funded career progression pathways, fair and enforceable bonding arrangements, strengthened social protection, and disciplined use of bilateral and ethical recruitment instruments.

The proposed reforms are designed for implementation by the Federal and State Ministries of Health, professional regulators (including the NMCN and MDCN), teaching hospitals, and development partners such as the WHO and World Bank. The effectiveness of the reforms, however, depends on being embedded within a politically feasible, fiscally credible, and legally enforceable framework that explicitly accounts for vested interests, state-level fiscal disparities, and constitutional constraints under Nigeria's federal system.

If adequately funded and effectively governed, the package could reduce short-term attrition by approximately one-third within two years. It would also substantially improve medium-term retention over a five-year horizon, while better protecting Nigeria's public investment in health worker training.

Health Workforce Migration in Nigeria: Welfare Failures, Policy Gaps, and Systemic Risk

Historically, Nigeria has experienced recurrent waves of health-worker emigration, shaped by long-standing structural underinvestment in the health sector, periodic mass hiring freezes, and strong pull factors from high-income countries. By early 2024, regulators and media reports indicated substantial cumulative losses, including an estimated 42,000 nurses who exited the country over a three-year period.

These developments are consistent with earlier empirical findings that document high mobility among health graduates and steadily increasing registrations of Nigerian clinicians in destination countries.

The current phase is distinguished not only by the scale of departures but also by the stark clarity of their underlying drivers. Health workers repeatedly cite poor and irregular remuneration, unsafe and overstretched workplaces, limited access to funded postgraduate training, and weak social protection as decisive push factors.

Articulated consistently by professional associations and unions, these concerns reflect a sustained deterioration of employment conditions rather than transient dissatisfaction.

In response, the Federal Government introduced the National Policy on Health Workforce Migration (2023/2024), intended to manage outward mobility while offering incentives to retain critical personnel. The policy offers safeguards, including timely and predictable remuneration, funded speciality training pathways, hazard and retention allowances, improved workplace safety, and credible social protection.

However, early implementation reviews and administrative assessments point to material shortcomings. Financing provisions remain inadequate, monitoring arrangements are weak, and policy commitments have not translated into predictable welfare improvements at state and facility levels, where service delivery pressures are most acute.

The consequences of continued outflows are multidimensional and mutually reinforcing.

- Socio-culturally and academically, the loss of experienced clinicians has eroded mentorship and specialist training capacity within teaching hospitals, narrowing pathways for skills transfer and professional development.
- Politically and institutionally, recurrent strikes and public protests signal a deterioration of labour–government trust and expose persistent weaknesses in health-sector governance.
- Economically, the state forfeits returns on public investment in training while incurring rising costs to sustain service coverage with a shrinking workforce.
- Clinically, staff shortages constrain access to care and compromise quality across both rural and urban public facilities.
- Psychologically, remaining personnel report burnout and declining morale, conditions that further reinforce migration intent.

Responsibility for both the problem and its resolution spans multiple actors. The Federal Ministry of Health and Social Welfare provides overall policy direction; regulatory bodies, including the Nursing and Midwifery Council of Nigeria (NMCN) and the Medical and Dental Council of Nigeria (MDCN), oversee professional standards; state ministries and teaching hospitals act as principal employers and implementers; health unions represent workforce interests; and international partners, including the World Health Organization and donor agencies, shape financing and normative frameworks. Effective reform therefore requires coordinated and sustained action across these institutions.

The case for this policy brief is clear: despite the existence of a formal national migration policy, welfare-centred interventions have not been operationalised at scale. Empirical indicators continue to show high migration intent alongside realised exits, placing health-system resilience and public investment in training at significant risk. Targeted research into welfare-focused, implementable strategies is therefore required to inform urgent policy reforms and guide coherent stakeholder action.

Brain Drain: Migration of Nigerian Healthcare Professionals

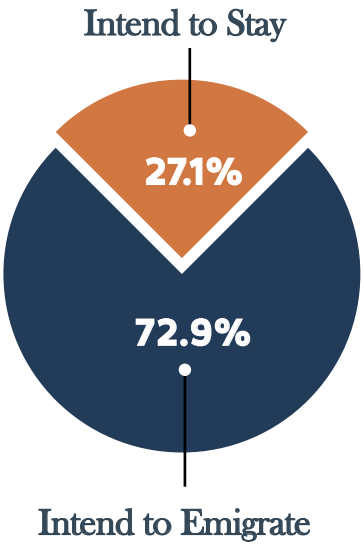
Nurses Leaving Nigeria

42,000

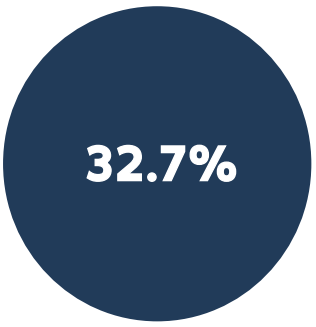
Total over the last 3 years

15,000 in 2023 alone

Nursing/Medical Students



Permanent Loss



Have no Intention to Return to Nigeria

Nigerian-Trained Doctors in UK

12,198

Total UK Registrants (Dec 2023)

1,197 newly registered (May-Dec 2023)

Sources: Vanguard News, Healthwise, Punch Nigeria, BioMed Central

Effects of Health Workforce Attrition on the Public Health System

Economic, Fiscal, Psychological and Institutional Consequences of Sustained Health Worker Outflows

Economic Losses

Loss of Public returns on education Investment

- Training cost unrecovered
- Rising costs to maintain service coverage

Fiscal Pressures

Rising Unit Cost of Service Delivery

- Economic overtime for limited staff
- Costly and unsustainable locum use
- Disrupted health-sector planning

Workforce Strain

Burnout and Declining Morale

- Emotional Exhaustion and Stress
- Increased Intent to Emigrate

Institutional Weakening

Erosion of State Capacity

- Frequent strikes and crisis bargaining
- Diminished trust in public employment

Together, these efforts form a self-reinforcing cycle that undermines health system stability, fiscal discipline and workforce sustainability

Comparative Perspective: Governing Health Workforce Migration

International migration of health personnel intensified markedly across the 2010s and early 2020s, reflecting structural shortages in destination health systems and widening global wage and welfare differentials. By 2023, OECD countries alone reported more than 600,000 foreign-trained doctors and approximately 732,000 foreign-trained nurses on their professional registers, underscoring sustained and systemic demand. The World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel (2010) remains the principal normative framework guiding ethical recruitment and seeking to mitigate adverse effects on source-country health systems.

Comparative evidence is unequivocal on one point: no country has eliminated health-worker migration. Effective systems instead define acceptable thresholds of mobility, prioritise retention of critical cadres, and permit managed movement for others. Migration is thus treated as a labour-market outcome to be governed through policy instruments, not a moral failure to be suppressed through administrative fiat.

Export-Oriented and State-Managed Models

Philippines: Labour Export With Regulatory Oversight

The Philippines has long incorporated skilled migration into national labour and development policy. The state actively supports health worker education, licensing, and overseas deployment through dedicated agencies and licensed recruitment firms, negotiates bilateral labour agreements, and provides pre-departure orientation and contract monitoring.

Policy emphasis has centred on worker protection, regulation of recruiters, and facilitation of remittance flows rather than restriction of mobility.

This approach has generated substantial remittance income and employment opportunities for graduates.
However, it has also produced domestic shortages in key specialities and significant fiscal losses on publicly trained cadres.

The Philippine experience demonstrates that supply-side expansion—training more nurses—without commensurate domestic welfare and retention incentives is insufficient to safeguard service coverage.

For Nigeria, the implication is clear: export-oriented arrangements, without strong internal retention measures, cannot stabilise workforce supply.

Cuba: State Training and Contractual Internationalism

Cuba operates a state-led model of medical internationalism, characterised by large-scale public training, government-to-government medical missions, and contractual overseas deployment with return obligations. Strong state oversight and guaranteed domestic employment for returning professionals have allowed the government to shape migration patterns while generating foreign exchange and diplomatic capital.

Although Cuba's political economy is not transferable, the model illustrates the leverage created by explicit state planning, bilateral contracting, and credible domestic employment alternatives. For Nigeria, the lesson lies not in replication but in selectively adopting government-negotiated agreements and contractual modalities as complements to, rather than substitutes for, welfare-based retention strategies.

Destination-Country Governance and Ethical Recruitment

United Kingdom: Ethical Recruitment Frameworks

High-income destination systems have increasingly adopted ethical recruitment codes aligned with the WHO Global Code. The United Kingdom's Code of Practice and NHS guidance employ red and amber country lists to discourage active recruitment from health systems facing critical shortages and require transparency from employers and recruitment agencies.

These instruments have improved disclosure and created limited leverage for source countries. However, strong labour demand and uneven enforcement have constrained their overall impact on migration flows. For Nigeria, the opportunity lies in strategically engaging destination-country frameworks through bilateral agreements and systematic use of registry verification data to inform diplomacy and workforce planning.

Retention Incentives and Administrative Controls in Source Countries

Ghana: Incentive-based Rural Retention

Ghana has experimented with mixed incentive packages to improve retention, particularly in underserved areas. These have included rural allowance top-ups, housing support, accelerated promotion pathways, continuous professional development opportunities, and selected non-financial incentives. Task-shifting and strengthened supervision have also been employed to ease workload pressures. Importantly, discrete choice experiments and pilot trials informed the design of these interventions.

Evidence suggests that financial incentives can improve short-term retention, but durable effects depend on reliable payment, credible career progression, and safe working environments. Ghana's experience underscores that incentive design alone is insufficient; guaranteed financing and administrative capacity at state and facility levels are decisive. For Nigeria, the central lesson is that well-crafted packages fail without execution discipline.

Kenya: Compulsory Service And Bonding Mechanisms

Kenya has relied on mandatory internship and compulsory service requirements for newly qualified medical and dental graduates, alongside bonding arrangements for government-sponsored trainees. While these measures temporarily bolstered staffing in public facilities, their effectiveness has been undermined by delayed deployment, weak monitoring, and uneven supervision.

Where deployment systems functioned efficiently, compulsory service contributed to service continuity. Where they did not, the result was frustration, administrative backlog, and accelerated exit.

Nigeria's takeaway is that bonding and compulsory service are viable only when supported by transparent deployment systems, predictable timelines, and enforceable—yet proportionate—sanctions and incentives.

Cross-cutting Lessons for Nigeria

1. Welfare measures must be reliable and funded: Countries that offered allowances or pay increases achieved only transient gains where payments were irregular. Nigeria must establish guaranteed financing lines at the federal and state levels and ensure timely disbursement to maintain credibility and staff morale.

2. Political feasibility matters as much as technical design: Successful reforms in other contexts paired welfare measures with enforceable institutional mechanisms and clear lines of authority. Nigeria must explicitly identify veto players—state governments, payroll administrators, hospital boards, and unions with divergent interests—and sequence reforms to minimise resistance and reform fatigue.

3. Supply expansion without retention is insufficient: The Philippines demonstrated that training more clinicians alone did not secure domestic coverage. Nigeria must combine workforce expansion with retention incentives, including competitive pay, career progression, and safe working environments.

4. Bonding and compulsory service require robust administration: Kenya showed that deployment delays and weak oversight undermine compulsory-service objectives. Nigeria should strengthen deployment systems, ensure transparent enforcement, and couple bonding with fair and predictable incentives.

5. Bilateral and contractual arrangements can be leveraged ethically: Strategic government-to-government contracts and bilateral agreements, with clauses on training, compensation, and return pathways, can protect Nigeria's public investment in health professionals. Cuba and Philippine precedents illustrate how structured, state-led agreements shape migration without restricting worker mobility unethically.

6. Uniform incentives risk deepening inequalities: Incentive packages must be differentiated by cadre, geographic location, and skill scarcity to avoid creating new retention pressures within the health system.

Policy Option: Welfare-First Retention Package (WFRP)

The Welfare-First Retention Package (WFRP) builds on Nigeria's existing migration policy but shifts the focus from regulation to welfare delivery. Its goal is to reduce net outflow and increase retention of clinical cadres (nurses, doctors, midwives) by addressing key welfare drivers—pay, timely payment, workplace safety, funded training, and social protection—while maintaining ethical bilateral arrangements and leveraging destination-country data for strategic workforce planning.

Phase 1: Competitive Remuneration and Guaranteed Timely Payment

Action	Timeline	KPI	Risk & Mitigation
Create a ring-fenced Health Worker Retention Fund (federal+ state+transitional donor support) to fund salary top-ups and hazard allowances	0–24 months (pilot in 6 states, 10 tertiary hospitals)	% of payroll paid on schedule (target 98% within 12 months); annual nurse outflow change (target - 30% at 24 months)	Fiscal shortfalls - multi-year budget line & donor support; leakages - digital payroll & public expenditure tracking
Automate payroll nationwide to eliminate arrears and discretion	0–24 months	Payroll automation operational in pilot sites; reduction in arrears	Technical delays - phased rollout & IT capacity building

Phase 2: Safe Staffing and Burnout Reduction

Action	Timeline	KPI	Risk & Mitigation
Establish minimum staffing ratios and locum pools; invest in protective equipment and facility security	0–24 months (pilot facilities)	Staffing ratio improvements; staff burnout indices	Procurement/logistics delays - PPP frameworks & emergency procurement windows
Launch national well-being hotline for health workers	0–24 months	Hotline usage and satisfaction metrics	Low adoption - awareness campaigns & facility-level promotion

Phase 3: Funded Specialist Training and Career Pathways

Action	Timeline	KPI	Risk & Mitigation
Competitively awarded funded fellowships for speciality training (local & accredited foreign placements) with return obligations	Year 1 pilots; years 2–5 scale-up	% of bonded specialists trained and retained; % completing return obligations	Non-return reciprocal bilateral agreements, financial surety, enforcement via licensing/registration
Expand in-country specialist training capacity through teaching hospital partnerships	Years 2–5	Training seats filled; retention post-training	Capacity constraints - phased expansion & donor/PPP support

Phase 4: Fair and Enforceable Bonding

Action	Timeline	KPI	Risk & Mitigation
Redesign bonding to be time-limited, compensated, and legally transparent; grievance redress and regulated buyout options	0–18 months (legal/regulatory revisions); 18–36 months (rollout)	Compliance rates; reduced complaints; net reduction in early departures	Evasion - improved deployment systems, alignment with licensing bodies

Phase 5: Bilateral Agreements & Ethical Recruitment Frameworks

Action	Timeline	KPI	Risk & Mitigation
Negotiate government-to-government agreements with major destination countries (training compensation, circular migration provisions, data sharing)	Start negotiations within 6 months; initial MoUs 12–24 months	Number of bilateral agreements signed; value of compensation/retraining funds; reduction in unregulated recruitment	Weak negotiating capacity - inter-ministerial negotiation team with WHO support
Operationalise WHO Code of Practice and use destination registry data for surveillance	6–24 months	Registry data utilised; compliance reports	Data gaps - capacity building and digital verification systems

Phase 6: Social Protection Reform

Action	Timeline	KPI	Risk & Mitigation
Harmonise pension portability, expand insurance coverage, and provide housing support	Policy design 0–12 months; phased implementation 12–36 months	% of health workers with active pension/insurance; staff satisfaction indices	Regulatory inertia - legislative fast-track & donor technical assistance

Phase 7: Data, Monitoring & Accountability (Governance)

Action	Timeline	KPI	Risk & Mitigation
Operationalise National Human Resources for Health Unit, publish workforce dashboards, and conduct annual independent audits	0–36 months	Functioning NHRH Unit; public workforce dashboard live; annual independent evaluation reports	Poor data quality - digital registry, capacity building, partner support (WHO/Africa CDC)
Use Discrete Choice Experiments (DCEs) to iteratively refine incentives	12–36 months	Incentive design refined; retention outcomes improved	Low participation - stakeholder engagement campaigns

Indicative Consolidated KPI Table and Evaluation Framework

KPI	Baseline	Short-term target (24 months)	Medium-term Target (5 years)	Measurement/Notes
Annual Nurse Outflow (Net Emigration)	14,000/year (42,000 over 3 yrs)	-30%	-60%	Tracked via NMCN/ MDCN registry data; net emigration calculated as exits minus new entries into workforce
Payroll Punctuality	Low (frequent delays reported)	98% on-time monthly	99%	Monitored via digital payroll audits; HWRF disbursement reports
Newly Trained Specialists Retained 2yrs	Unknown	70%	85%	Tracked via training registries and bonding contract audits; return obligations monitored via licensing bodies
Staff Wellbeing (Burnout Score)	High (strikes, survey data)	20% improvement	40% improvement	Measured using validated burnout indices and staff surveys; periodic cohort tracking for comparative analysis

Evaluation Mechanisms & Governance

NHRHP Unit (MOH)

- Publish quarterly progress dashboards
- Conduct annual independent evaluations in partnership with external academic institutions

Third-Party Audits

- Annual audits of the Health Worker Retention Fund (HWRF) and payroll systems, including procurement and public financial management processes

Incentive Testing and Iterative Refinement

- Use Discrete Choice Experiments (DCEs) and periodic cohort tracking to assess incentive effectiveness and recalibrate interventions as needed

Expected Impact

If the WFRP is fully funded and implemented with strong governance, projections indicate:

Short Term (0-24 months)

- 30% reduction in nurse attrition

Medium Term (3-5 years)

- Material improvement in retention and training returns

System-wide Benefits

- Strengthened governance and data systems to ethically manage health worker migration with Africa CDC economic modelling suggesting that investment retention is cost-effective relative to the long-run economic losses of continued outflow

Policy Recommendations

Nigeria's health workforce crisis cannot be resolved through regulation alone. What is required is a clear ordering of action—first to stabilise the system, then to secure it for the long term. The recommendations below follow that logic.

Immediate Priorities (0–24 months)

1. Restore Pay Reliability Through a Ring-fenced Retention Fund

Establish a Health Worker Retention Fund, jointly financed by the Federal Government and states, with limited transitional support from development partners. Link the fund to biometric and automated payroll systems to guarantee the timely payment of salaries, hazard allowances, and retention top-ups. Reliable pay is the fastest signal of institutional seriousness.

2. Stabilise Working Conditions and Reduce Burnout

Mandate and fund minimum staffing ratios in priority facilities, supported by locum pools to relieve pressure. Ensure immediate procurement of personal protective equipment and facility security, and roll out national wellbeing and mental-health support programmes to curb burnout and unsafe conditions.

3. Put Governance and Accountability in Place Early

Operationalise the National Human Resources for Health Programme with state coordinators, a public workforce dashboard, quarterly reporting, and annual independent evaluation. Subject payroll and retention funds to third-party audits, and use discrete choice experiments to refine incentives as evidence accumulates.

4. Engage Destination Countries While Leverage Remains

Initiate government-to-government negotiations with major destination countries to operationalise ethical recruitment, secure compensation for public training, enable circular migration, and establish routine data sharing on Nigerian registrants abroad.

Medium-Term Consolidation (3–5 years)

5. Anchor Retention in Funded Specialist Training and Career Progression

Scale competitively awarded fellowships for in-country and accredited overseas specialist training, anchored by fair return clauses and structured reintegration. Expand postgraduate training capacity within teaching hospitals to absorb skills domestically.

6. Reform Bonding to Make it Fair, Enforceable, and Credible

Redesign bonding arrangements to be time-limited, financially compensated, and legally transparent, with grievance redress and regulated buyout options. Align enforcement with professional licensing bodies to ensure compliance without coercion.

7. Secure Lifetime Welfare through Social Protection Reform

Harmonise pension portability, expand insurance coverage, and provide targeted housing support for posted staff through coordinated action by the Ministry of Finance and the National Pension Commission. Long-term retention depends on confidence in future security, not pay alone.

Conclusion

Nigeria's health-worker exodus is not an inevitability. It is a policy failure—driven less by global demand than by domestic welfare breakdowns: irregular and insufficient pay, unsafe and overstretched workplaces, limited funded specialist pathways, and weak social protection. These failures have produced sustained outflows, reflected in large cumulative nurse departures, rising foreign registrations of Nigerian clinicians, and persistently high emigration intent among trainees. Migration, in this context, is not the problem; unmanaged welfare neglect is.

This policy brief argues that retention must therefore be approached through a welfare-first, fiscally anchored strategy. The proposed Welfare-First Retention Package reframes workforce policy away from restriction and towards delivery—combining guaranteed, timely remuneration through a ring-fenced retention fund; safe staffing and wellbeing measures; funded and bonded specialist training; fair and enforceable bonding reforms; strengthened social protection; and strategic bilateral engagement grounded in the WHO Global Code. Crucially, these measures are designed to be governed through data, monitoring, and independent evaluation, rather than discretion and promise.

Implementation will hinge on institutional coordination and credibility. Success requires aligned leadership across the Federal Ministry of Health and Social Welfare, State Ministries of Health, professional regulators, fiscal authorities, and health unions, supported by development partners and destination-country regulators. Early piloting, transparent key performance indicators, and independent oversight are essential to demonstrate seriousness and rebuild trust.

At its core, retention policy represents a renegotiation of the public health employment contract. It must accept managed mobility, operate within realistic fiscal limits, and restore confidence through predictability rather than rhetoric. In the absence of such political and fiscal anchoring, even well-designed welfare reforms will repeat Nigeria's familiar cycle of ambition undermined by weak execution.

A welfare-first approach, disciplined by fiscal realism and institutional enforcement, offers a path out. By paying health workers on time, protecting them at work, investing in their careers, and engaging the global labour market with strategy rather than resignation, Nigeria can slow attrition, recover public investment in training, and rebuild health-system resilience. The cost of inaction is not merely continued migration but the quiet hollowing out of the health system itself.

Author
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Acronym	Full Form	Brief Description
AFR CDC	Africa Centres for Disease Control and Prevention	Regional public health institution supporting disease surveillance, workforce development, and health security in Africa
CPD	Continuous Professional Development	Structured training programmes for health professionals to maintain and enhance clinical skills
DOLE	Department of Labour and Employment (Philippines)	Government agency overseeing labour policy, employment, and workforce regulation
DCE	Discrete Choice Experiment	Research method assessing preferences and trade-offs among policy or incentive options
GMC	General Medical Council (UK)	UK regulatory body for doctors, responsible for registration, licensing, and professional standards
HWRF	Health Worker Retention Fund	Ring-fenced fund to guarantee timely remuneration, hazard allowances, and retention incentives for health staff in Nigeria
MDCN	Medical & Dental Council of Nigeria	Regulatory authority overseeing training, registration, and professional conduct of medical and dental practitioners
MOF	Ministry of Finance	Federal institution responsible for budgeting, fiscal policy, and financial oversight in Nigeria
MOH	Ministry of Health	Government body responsible for health policy, regulation, and administration at federal or state levels
NANNM	National Association of Nigerian Nurses and Midwives	Professional association representing nurses and midwives, advocating for welfare, rights, and standards
NHRHP / NHRH Unit	National Human Resources for Health Programme / Unit	Institutional mechanism overseeing health workforce planning, data, monitoring, and policy evaluation

Acronym	Full Form	Brief Description
NMCN	Nursing & Midwifery Council of Nigeria	Regulatory body responsible for licensing, professional standards, and training oversight for nurses and midwives
NMA	Nigerian Medical Association	Professional body representing doctors, advocating for welfare, standards, and labour rights
OECD	Organisation for Economic Co-operation and Development	International organisation promoting economic policy coordination and health workforce research
PPP	Public-Private Partnership	Collaborative framework between government and private sector for service delivery or project implementation
UK	United Kingdom	Destination country for Nigerian-trained health workers, often referenced in bilateral agreements and migration data
WHO	World Health Organization	UN agency providing technical guidance, normative frameworks, and support for global health workforce governance.bilateral agreements and migration data

Peter Obi Defects to ADC

The 2023 presidential candidate of the Labour Party (LP), Peter Obi, has officially defected to the African Democratic Congress (ADC).

Mr Obi announced the decision on December 31, 2025, during a political rally at the Nike Lake Resort Hotel in Enugu.

"We are ending this year with the hope that in 2026 we will begin a journey of rescue of our country," Mr Obi, a former governor of Anambra State, said.

"We are saying that those who are planning to rig elections in Nigeria come 2027, we will resist it by every means lawful and legitimate."

The former governor joined the ADC alongside his LP supporters and politicians from other parties. Obi argued that he was only formalising his membership of the ADC rather than defecting, stating that he had been part of the discussions that led to the formation of the opposition coalition, which adopted the ADC as its platform for the 2027 general election.

https://www.premiumtimesng.com/news/headlines/846742-peter-obi-finally-dumps-lp-joins-adc.html?tztc=1

Tinubu Reaffirms January 1 Commencement of New Tax Laws

President Bola Tinubu has confirmed that sweeping new tax reforms will take effect on January 1, 2026, despite opposition from various groups and associations.

The President described the overhaul as a "once-in-a-generation" reset aimed at boosting revenue and harmonising the tax system. A key feature of the new laws is the introduction of a ₦50 stamp duty on electronic transfers of ₦10,000 and above.

Government officials spent the final hours of 2025 assuring the public that no unauthorised debits would be made from personal bank accounts under the new regime.

https://dailytrust.com/amid-uproar-tinubu-declares-tax-laws-effective-jan-1/

Former Justice Minister Malami Remanded in Prison over Corruption Charges

Former Attorney General of the Federation and Minister of Justice Abubakar Malami was further remanded on January 2, 2026, at the Kuje Correctional Centre, Abuja, alongside his son, Abubakar Abdulaziz Malami, and his wife, Hajia Bashir Asabe.

Justice Emeka Nwite of the Federal High Court sitting in Maitama, Abuja, ordered that the trio remain in custody until January 7, 2026, pending a ruling on their respective bail applications.

The Economic and Financial Crimes Commission is prosecuting them over alleged money laundering offences involving ₦8,713,923,759.49.

The defendants are facing a 16-count charge bordering on conspiracy, procuring, disguising, concealing and laundering the proceeds of unlawful activities, contrary to the provisions of the Money Laundering (Prevention and Prohibition) Act, 2022.

https://dailypost.ng/2026/01/02/malami-son-to-remain-in-kuje-prison-till-january-7/

Resident Doctors to Resume Strike

The Nigerian Association of Resident Doctors (NARD) has announced plans to resume its previously suspended total, indefinite and comprehensive strike from January 12.

The decision follows the Federal Government's failure to fully implement agreed resolutions. It was taken at an emergency virtual meeting of the association's National Executive Council (E-NEC) held on January 2, 2026, and conveyed in a statement issued on NARD's official X handle, "@nard_nigeria".

According to the association, the resumption, tagged "TICS 2.0: No Implementation, No Going Back", will commence at 12.00 am on 12 January.

https://www.vanguardngr.com/2026/01/resident-doctors-to-resume-suspended-strike-january-12/

Benin Suspends Embassy Operations in Niamey

Diplomatic relations between Niger and Benin have entered a critical phase following the expulsion of a Beninese diplomat and the subsequent closure of Benin's embassy in Niamey amid mutual accusations of subversive activity.

The Embassy of Benin in Niamey announced on January 1 the suspension of its activities with effect from January 5, 2026.

Niger's Ministry of Foreign Affairs, Cooperation and Nigeriens Abroad declared Seidou Imourana, First Counsellor at the Embassy of Benin, persona non grata on Wednesday, 31 December. According to a statement signed by the ministry's secretary-general, the diplomat was ordered to leave Nigerien territory within 48 hours. The measure, justified based on "the principle of reciprocity", was taken without the Nigerien authorities specifying the precise reasons.

The decision follows the expulsion by Cotonou of the head of the local office of the DGDSE (Nigerien intelligence services) and a police commissioner posted at the Embassy of Niger in Benin, both suspected of subversive activities.

https://fr.apanews.net/diplomacy/niger-benin-les-tensions-atteignent-un-point-critique/

Niger Adopts 2026 Budget

The Nigerien government adopted the 2026 budget on December 31, 2025, prioritising agricultural, energy, and mining development.

Key areas include the continued export of crude oil, with daily production expected to rise sharply in 2026; increased uranium output, notably with the commencement of production by the DASA Mining Company (SOMIDA) in 2026; and an average increase of 5.2 per cent in gold production over the 2026–2028 period.

The draft Finance Law also provides for the development of special economic zones, particularly the agro-industrial zones of Niamey and Maradi, and introduces measures aimed at alleviating pressures on the population and supporting national production.

https://fr.apanews.net/news/niger-le-conseil-des-ministres--adopte-le-projet-de-loi-de-finances-2026/

Chad Holds Talks with Libya Following Abduction of Truck Drivers

Chad has initiated direct talks with the eastern Libyan government after Libyan drivers were abducted on Chadian soil. Libya described the incident as an isolated criminal act and demanded the immediate release of the victims.

Videos of the attack sparked outrage, prompting Chad to arrest four armed suspects and seize weapons, while truck movements along trans-Saharan routes were temporarily suspended for security reasons.

https://fr.apanews.net/security/contacts-entre-lest-libyen-et-le-tchad-sur-le-rapt--de-chauffeurs

Cameroon Unveils Special Road Rehabilitation Programme

President Paul Biya announced on December 31, 2025, a special programme to rehabilitate Cameroon's deteriorating roads and construct new routes, aimed at improving urban, intercity, and production-area access.

Key corridors, including Yaoundé–Douala and Edéa–Kribi, face severe degradation, slowing trade and increasing accident risks. In 2025, only 384 km were paved out of a 754 km target, with funding shortfalls likely prompting President Biya to seek international, particularly Chinese, investment.

https://www.businessincameroon.com/public-management/0201-15571-cameroon-announces-special-road-rehabilitation-programme-this-year

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