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HEALTH

Substandard and Falsified Medicines in Nigeria

A Crisis of Distribution Governance

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Athena Centre for Policy and Leadership operates as an independent, non-partisan think tank in compliance with Nigerian laws and regulations, committed to promoting good governance, transparency, and accountability.

Our mission is to conduct rigorous research and provide evidence-based recommendations that contribute to the development of a prosperous and forward-looking society in Nigeria.

Cover Image: Transaction at an open-air market where over-the-counter medicines are being sold.

Executive Summary

Nigeria continues to face significant public-health risks from the circulation of substandard and falsified medicines, despite the existence of established regulatory institutions and comprehensive legal frameworks. The prevailing narrative attributes this crisis to weak enforcement. This policy brief advances a more precise diagnosis: Nigeria's medicine-quality crisis is primarily a failure of distribution governance rather than a deficit of laws or regulatory bodies.

Drawing on the World Health Organization's typology, the brief distinguishes between falsified medicines (criminal fraud), substandard medicines (manufacturing failure), degraded medicines (storage and transport failure), and unregistered or unlicensed products (regulatory non-compliance). Evidence from regulatory seizures, sentinel sampling studies, inspection reports, and border interceptions indicates that Nigeria's most persistent vulnerabilities lie in informal wholesale markets, weak cold-chain enforcement, fragmented distribution tiers, and porous import channels—not manufacturing defects alone.

Comparative experience from the European Union, Southeast Asia, and selected countries shows that durable progress depends on coordinated enforcement, licensed wholesale distribution, risk-based surveillance, and judicial follow-through, rather than episodic crackdowns.

This brief proposes a sequenced reform agenda centred on time-bound closure of open drug markets through phased relocation to Coordinated Wholesale Centres (CWCs); deterrent penalties and swift prosecution; risk-based surveillance and track-and-trace for priority medicines; tighter import controls alongside support for quality-assured local manufacturing; and sustained investment in regulatory capacity and public awareness.

Implemented coherently, these measures could realistically reduce the prevalence of substandard and falsified medicines to 5 per cent, restoring public confidence and safeguarding health outcomes.

Defining the Problem: Governance Failures in Medicine Quality

Effective regulation begins with conceptual clarity. Nigeria's medicine-quality crisis is frequently treated as a single phenomenon, yet it comprises distinct failure modes, each demanding a different policy response. Using the WHO framework, this brief aligns categories of poor-quality medicines with their primary regulatory levers as follows:

Falsified medicines: Deliberate misrepresentation of identity, composition, or source.

Primary failure: organised criminal activity. Policy levers: intelligence-led enforcement, supply-chain traceability, border controls, and criminal prosecution.

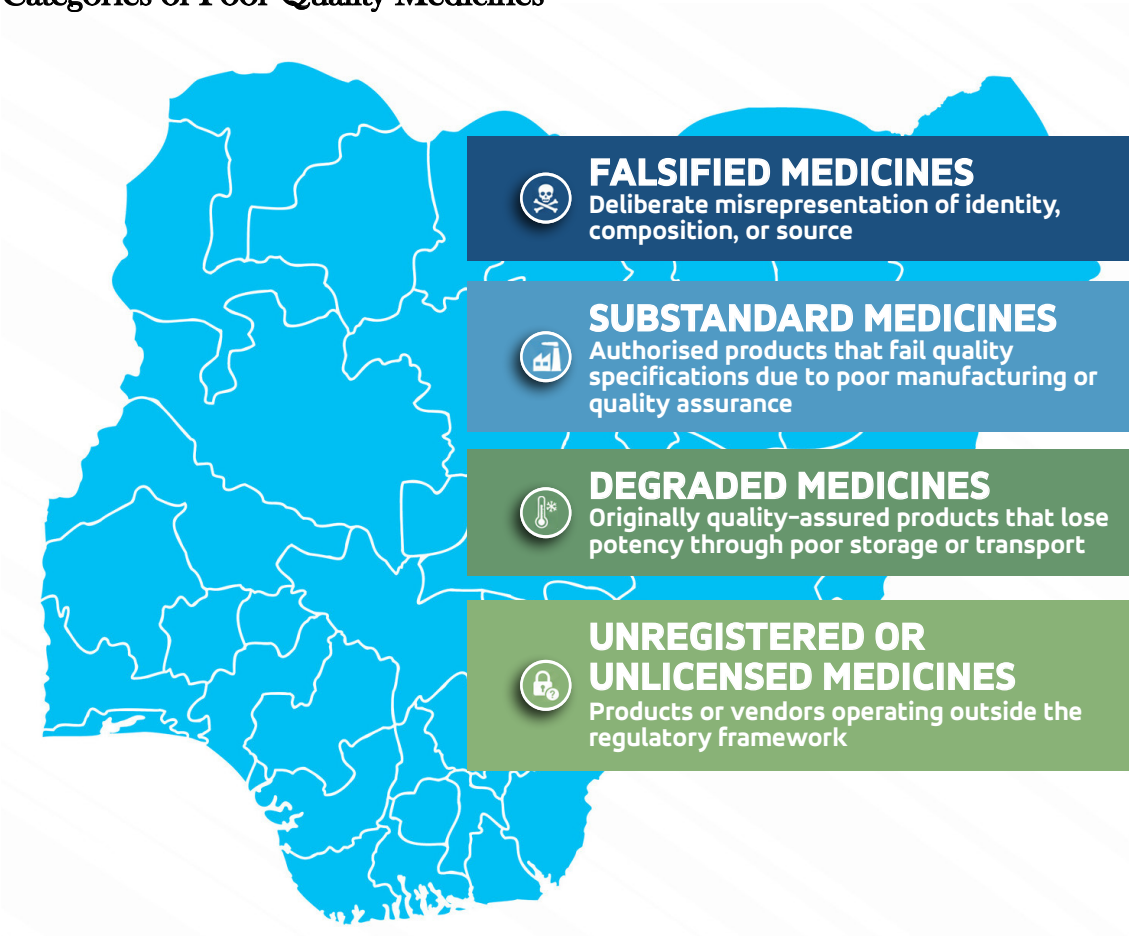
Substandard medicines: Authorised products that fail quality specifications due to poor manufacturing or quality assurance. Primary failure: weak Good Manufacturing Practice (GMP) compliance. Policy levers: factory audits, sanctions, and manufacturer upgrading.

Degraded medicines: Originally quality-assured products that lose potency through poor storage or transport. Primary failure: weak Good Distribution Practice (GDP) and cold-chain enforcement. Policy levers: licensed wholesale tiers, temperature-controlled logistics, and storage inspections.

Unregistered or unlicensed medicines: Products or vendors operating outside the regulatory framework. Primary failure: market-entry and compliance failure. Policy levers: registration enforcement, licensing sanctions, and market surveillance.

Nigeria's most persistent failures are concentrated in distribution and storage, not solely in falsification or manufacturing.

Categories of Poor Quality Medicines



Distribution and Storage: The Central Vulnerability

Falsified and substandard drugs have persisted as one of Nigeria's most alarming public health challenges, undermining healthcare delivery and eroding trust in the pharmaceutical system.

The problem dates back to the late 1970s and 1980s when weak regulation, porous borders, and import dependence allowed counterfeit medicines to flood the Nigerian market. By the early 2000s, reports indicated that over 40 per cent of drugs circulating in Nigeria were fake or substandard, with up to 70 per cent being unregistered.

Although the establishment of the National Agency for Food and Drug Administration and Control (NAFDAC) in 1993 marked a significant policy response, the persistence of open drug markets remains Nigeria's central regulatory challenge. Unlicensed vendors and unregulated environments in Lagos, Onitsha, Kano, and other hubs continue to facilitate the circulation of poor-quality medicines.

Implementation of the National Drug Distribution Guidelines (NDDG), particularly the relocation of open markets into CWCs, has stalled due to trader resistance, fragmented authority, and weak political backing.

Furthermore, Nigeria's overdependence on imported pharmaceuticals from Asia, particularly India and China, complicates the regulatory process since many products arrive without proper registration or verification of source authenticity.

Storage and distribution issues further exacerbate the problem. Even when medicines are genuine, poor handling and temperature fluctuations often compromise their quality. For example, a NAFDAC study found that up to 74 per cent of oxytocin samples fail stability tests due to improper storage and distribution practices.

Weak implementation of national policies such as the National Drug Policy (NDP) and NDDG also limits progress. While these policies provide frameworks for manufacturing standards and drug distribution, enforcement has been inconsistent, largely due to poor funding, inadequate staffing, and corruption within regulatory agencies.

Evidence on Substandard and Falsified Medicines in Nigeria

Claims about the prevalence of SF medicines in Nigeria require careful contextualisation. While estimates from the late 1990s and early 2000s suggested extremely high prevalence, current risks are uneven across drug classes and supply chains.

To improve analytical credibility, this brief organises evidence into a Nigeria-specific hierarchy of reliability:

1. **Regulatory seizure, recall, and destruction data (high confidence):** NAFDAC alerts and port seizures consistently identify recurrent pressure points and products.
2. **Sentinel sampling studies (moderate–high confidence):** Drug-specific studies—particularly on antimalarials, oxytocin, and antibiotics—show persistent failure rates linked largely to storage and distribution.
3. **Facility inspection outcomes (moderate confidence):** GMP and GDP inspections reveal uneven compliance, especially among import-dependent distributors and informal wholesale hubs.
4. **Border interception data (moderate confidence):** Joint Customs–NAFDAC operations highlight vulnerabilities at ports and land borders, though public datasets remain incomplete.
5. **Market surveys and consumer studies (lower confidence):** Useful for understanding risk perception but insufficient for prevalence estimation.

While overall prevalence may have declined since its historic peak, structural vulnerabilities, especially in informal wholesale distribution, remain acute.

Political-Economic Drivers of Open Drug Markets

Open drug markets endure not because of regulatory ignorance, but because they are embedded political–economic systems. These markets provide livelihoods for thousands, generate rents for intermediaries, and often operate under informal protection from local power structures.

Reform efforts have faltered due to trader resistance driven by fear of income loss, fragmented state–federal authority, weak compensation or relocation frameworks, and inconsistent political backing.

Effective reform must therefore combine coercive regulation with negotiated transition, including phased relocation to coordinated wholesale centres, temporary licensing pathways, financial or logistical support for compliant traders, and public accountability for persistent non-compliance.

Public Health and Socioeconomic Impacts

Substandard and falsified medicines impose significant socio-economic and public health costs in Nigeria. Patients frequently suffer prolonged illness, treatment failure, or, in severe cases, death. Counterfeit antimalarials and antibiotics exacerbate antimicrobial resistance, amplifying long-term health risks and undermining disease control efforts.

The economic toll is substantial. Ineffective treatments necessitate repeated care, resulting in annual losses amounting to billions of naira.

Beyond financial costs, public trust in the healthcare system and in regulatory institutions—most notably NAFDAC and the Pharmacy Council of Nigeria (PCN)—has been undermined.

Psychologically, uncertainty over medicine authenticity generates anxiety among patients and health professionals alike, reducing adherence to prescribed treatment protocols and further compromising health outcomes.

The cumulative effect is a vicious cycle: diminished confidence fuels informal purchasing channels, which in turn perpetuate the circulation of poor-quality medicines.

Regulatory Landscape and Institutional Gaps

Nigeria's drug regulatory ecosystem is fragmented across multiple institutions with overlapping mandates:

NAFDAC: Product registration, GMP inspection, post-market surveillance, recalls, and border collaboration.

Pharmacy Council of Nigeria (PCN): Licensing and regulation of pharmacies and patent medicine vendors.

Nigeria Customs Service: Import control at ports and borders.

Standards Organisation of Nigeria: Product standards and conformity assessment.

Law enforcement agencies (e.g., NDLEA): Criminal investigation where medicines intersect with organised crime.

State Task Forces: Market-level enforcement with variable capacity.

Although legal tools exist under the NAFDAC Act, PCN Act, and National Drug Distribution Guidelines, accountability weakens at institutional hand-offs, particularly between import clearance and wholesale distribution.

Hence, key gaps persist at ports and bonded warehouses, informal wholesale markets, secondary distribution chains, patent medicine vendor oversight, and online and cross-border trade.

International Experience: Lessons for Nigeria

International experience underscores that no single intervention is sufficient. Looking at other countries helps to see what works, what does not, and what might be adapted.

European Union: The Falsified Medicines Directive mandates safety features on medicinal packaging (e.g., unique identifiers, tamper-evidence), strict wholesale licensing, inspections, and end-to-end traceability. This has raised the bar on anti-counterfeit regulation across EU member states.

Southeast Asia: Countries such as Cambodia, Thailand and Vietnam combine outlet licensing, inspections, and public awareness, though weak sanctions and judicial follow-through persist.

Tanzania: Tanzania's post-market surveillance, sentinel sampling, and community education around drug purchase sources show promise but face resource constraints, corruption, and supply chain issues.

India: Some states in India have strengthened regulation of active pharmaceutical ingredients (APIs), mandated GMP, and improved sampling and enforcement through stricter import control, though counterfeit medicines are still a problem. Global reviews note that weak regulatory oversight, corruption, and supply chain complexity are common risk factors.

The common lesson is clear: durable progress requires coordinated legal, technological, and institutional reforms.

Policy Options: Strengthening Distribution Governance and Enforcement

The policy options outlined below are designed to close the regulatory, market, and institutional gaps identified earlier. Rather than introducing new laws or agencies, they focus on strengthening, sequencing, and enforcing existing frameworks. The emphasis is on feasibility, institutional incentives, and political economy. Each option is paired with an indicative implementation horizon to signal urgency and prioritisation.

Option 1: Deterrence and Accountability Reform (0–12 months)

Objective: Raise the cost of non-compliance to a level that credibly deters the manufacture, importation, and distribution of substandard and falsified medicines.

Near-term actions (0–6 months):

- Review and operationalise penalty provisions under existing statutes (NAFDAC Act, PCN Act, National Drug Policy) to ensure that violations attract sanctions proportionate to public-health risk, including substantial fines, licence suspension or revocation, asset forfeiture, and criminal prosecution.
- Issue prosecutorial guidelines clarifying admissible regulatory evidence, including sampling protocols, laboratory results, and seizure documentation.
- Establish dedicated drug-offense desks or fast-track procedures within relevant courts to reduce delays and case attrition.

Medium-term actions (6–12 months)

- Implement targeted capacity-building programmes for judges and magistrates on medicine regulation, supply-chain risk, and public-health harm.
- Institutionalise parliamentary oversight through annual hearings and mandatory public reporting by NAFDAC and the Pharmacy Council of Nigeria (PCN).
- Introduce transparency and anti-corruption safeguards in inspections and border control, including audit trails, officer rotation, and whistleblower protections.

Expected outcome: Faster case resolution, reduced regulatory capture, and credible deterrence against non-compliance.

Option 2: Structured Market Transition and Distribution Governance (6–24 months)

Objective: Eliminate high-risk open drug markets and establish a regulated, traceable, and accountable pharmaceutical distribution system.

Transition phase (6–12 months):

- Enforce the National Drug Distribution Guidelines through phased relocation of open drug markets into Coordinated Wholesale Centres (CWCs).
- Begin compulsory licensing and registration of all wholesalers, pharmacies, and patent medicine vendors, supported by publicly accessible registers.
- Publish and enforce minimum Good Distribution Practice (GDP) and Good Storage Practice standards.

Consolidation phase (12–24 months):

- Complete the closure of non-compliant open markets following clearly defined transition deadlines.
- Conduct routine audits of CWCs, wholesalers, and retail outlets.
- Introduce tiered distribution controls that restrict wholesale activities to licensed entities only.

Expected outcome: Reduced circulation of degraded and falsified medicines, improved storage conditions, and clearer accountability across the supply chain.

Option 3: Risk-Based Surveillance and Technology Deployment (6–18 months)

Objective: Improve early detection, monitoring, and rapid response to poor-quality medicines through targeted surveillance and data integration.

Initial actions (6–12 months):

- Expand Mobile Authentication Service (MAS) coverage for high-risk and high-volume medicines.
- Deploy portable screening technologies (such as Raman spectroscopy devices) at ports, markets, and inspection points.
- Strengthen post-market surveillance through routine and sentinel sampling focused on priority drug classes.

System-building actions (12–18 months):

- Establish an integrated national medicines database linking product registration, inspections, recalls, seizures, and border rejections.
- Connect national alert systems with WHO global surveillance platforms.
- Pilot serialisation and track-and-trace systems for selected essential medicines.

Expected outcome: Earlier detection of risks, faster recalls, and more data-driven regulatory action.

Option 4: Quality-Assured Supply Stabilisation (12–36 months)

Objective: Reduce dependence on high-risk imports while strengthening domestic pharmaceutical production and quality.

Supply-side support (12–24 months):

- Provide targeted incentives—including tax reliefs, concessional financing, and grants—for local manufacturers producing essential medicines.
- Support GMP upgrading through technical assistance and regulatory mentoring.
- Tighten import requirements through Drug Master Files, verified foreign manufacturer inspections, and pre-shipment clearance

Import discipline (24–36 months):

- Restrict pharmaceutical imports to designated, well-equipped ports.
- Institutionalise joint Customs–NAFDAC quality testing of imported consignments.
- Enforce mandatory destruction of non-compliant imports.

Expected outcome: Improved availability of quality-assured medicines and reduced exposure to substandard imports.

Option 5: Demand-Side Protection and Institutional Capacity Building (ongoing)

Objective: Reduce consumer exposure to unsafe medicines while strengthening regulatory and professional capacity.

Immediate actions (0–6 months):

- Launch sustained public awareness campaigns on identifying genuine medicines and avoiding unlicensed vendors.
- Engage market associations, pharmacists, and patent medicine vendors through structured dialogue to support compliance.

Capacity-building actions (6–18 months):

- Expand continuous professional development for regulators, pharmacists, and inspectors.
- Increase and stabilise budgetary allocations to NAFDAC and PCN for laboratories, staffing, logistics, and power supply.
- Institutionalise civil-society monitoring and feedback mechanisms.

Expected outcome: Better-informed consumers, improved compliance, and more resilient regulatory institutions.

Recommendations: Prioritised Actions for Reform

1. Enforce a time-bound closure of open drug markets through phased transition

Timeline: 6–24 months
Lead institutions: NAFDAC, PCN, and state governments.

Government should implement a non-negotiable, phased closure of open drug markets under the National Drug Distribution Guidelines, coupled with relocation to CWCs. A uniform national timetable, backed by conditional licensing and sanctions, is essential to prevent regulatory arbitrage. Non-compliant actors should face licence withdrawal, seizure of stock, and prosecution.

Why it works: Targets the single largest structural driver of degraded and falsified medicines—unregulated distribution.

2. Raise the cost of non-compliance through swift prosecution and deterrent penalties

Timeline: 0–12 months
Lead institutions: Ministry of Justice, Judiciary, NAFDAC, National Assembly

Existing laws must be operationalised to impose meaningful penalties, supported by specialised court tracks and trained judges. Parliamentary oversight should require annual enforcement and prosecution reporting.

Why it works: Targets the single largest structural driver of degraded and falsified medicines—unregulated distribution.

3. Institutionalise risk-based surveillance and track-and-trace for priority medicines

Timeline: 6–18 months
Lead institutions: NAFDAC, Ministry of Health, Nigeria Customs Service

Surveillance should prioritise high-risk medicines, such as antimalarials, antibiotics, oxytocin, vaccines, using sentinel sampling, authentication tools, and screening at ports and markets.

Why it works: Enables early intervention before harm reaches patients.

4. Strengthen import controls while accelerating quality-assured local manufacturing

Timeline: 12–36 months
Lead institutions: Ministry of Trade, NAFDAC, Customs, Ministry of Finance

Tighter import discipline must proceed in parallel with incentives and GMP support for domestic manufacturers.

Why it works:
Reduces systemic exposure to substandard imports while stabilising supply.

5. Protect consumers and invest in regulatory capacity

Timeline: Ongoing
Lead institutions: Federal and State Governments, NAFDAC, PCN

Sustained public education and predictable regulatory financing are essential to long-term compliance and trust.

Why it works: It shrinks demand for unsafe medicines while strengthening enforcement from within.

Conclusion: Towards a Safer Pharmaceutical System

Nigeria's struggle with substandard and falsified medicines is fundamentally a distribution governance failure, not a lack of laws or regulatory institutions. While frameworks such as the National Drug Policy and the National Drug Distribution Guidelines exist, weak enforcement at ports, wholesale markets, and storage points continues to allow poor-quality medicines to reach patients. Evidence shows that distribution-related degradation and regulatory evasion now pose greater risks than large-scale counterfeiting alone.

Comparative experience demonstrates that sustainable improvement requires more than enforcement campaigns. Nigeria must combine deterrent penalties with licensed wholesale tiers, cold-chain enforcement, risk-based surveillance, and judicial follow-through.

If implemented in a sequenced and coordinated manner, the reforms outlined in this brief can materially reduce poor-quality medicines, restore confidence in regulation and protect public health.

Author

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Dr Anyanwu holds advanced degrees in Political Science and Diplomacy, Political Theory and Philosophy, Public Policy Analysis and Education. He is a member of the Nigerian Political Science Association, the Centre for African American Research and other professional bodies.

Federal Government to Spend N3trn on Roads in 2026

The Federal Government plans to allocate N3.23 trillion to federal road construction and rehabilitation in the 2026 budget, representing a staggering 489 per cent increase from the N548.56 billion set aside in 2024. The surge underscores a renewed emphasis on transport infrastructure, aimed at completing long-delayed highways and repairing critical corridors nationwide.

In 2025, the Ministry of Works received N1.013 trillion for 468 roads, and the 2026 allocation more than tripled that amount, signalling the government's commitment to fast-tracking both inherited and flagship projects.

Of the proposed budget, N1.39 trillion is earmarked for new road construction, N285.62 billion for rehabilitation, and N1.56 trillion for related infrastructure, bringing the ministry's total capital envelope to N3.24 trillion. Key allocations include major sections of the Abuja–Lokoja Road, Kano–Maiduguri Road, and Mubi–Maiduguri Road.

https://punchng.com/federal-roads-spending-soars--489-to-n3-23tn/

Kebbi Govt Reopens Maga School After Abduction

The Kebbi State Government on January 13 announced the reopening of Government Girls' Comprehensive Secondary School, Maga, following the rescue of 24 schoolgirls who were abducted from the school in November 2025. The Commissioner for Basic and Secondary Education, Dr. Halima Bande, said the decision was taken after counseling support and the full deployment of security personnel restored confidence among parents, students, and teachers.

She assured that the government has put strong security measures in place to protect students and staff, including security awareness programmes for school leaders. Similar meetings have been held across the state to strengthen safety in schools. Bande stressed that principals, staff, students, and host communities all have roles to play in maintaining security. Security agencies also advised schools to improve fencing, lighting, vigilance, and communication to ensure a safe and peaceful learning environment across Kebbi State.

https://punchng.com/govt--reopens-kebbi-school-three--months-after-students-abduction/

ASUU Signs Historic Agreement With Federal Government

The Federal Government and the Academic Staff Union of Universities (ASUU) reached a landmark agreement on January 14 aimed at ending the ongoing strikes in Nigeria's public universities. The deal, which replaces the 2009 FG--ASUU agreement, provides for a 40 per cent salary increase for university teaching staff, with a particular focus on a new professorial cadre for full--time professors and readers.

Under the agreement, senior academics will receive an additional N140,000 monthly top-up. Minister of Education, Tunji Alausa, stressed that these allowances are strictly for full-time professors and readers, in recognition of the extensive workload and responsibilities of these senior faculty members.

The agreement represents a significant step towards improving the welfare of Nigerian university lecturers and addressing the persistent strikes that have disrupted the sector in recent years.

https://www.channelstv.com/2026/01/14/fg-signs-unveils-agreement-with-asuu/

Hospital Negligence Leads to Woman's Death

The Kano State Hospitals Management Board has confirmed that medical negligence led to the death of Aishatu Umar, a mother of five, at the Abubakar Imam Urology Centre in Kano. A preliminary investigation found that surgical scissors had been left inside her body following surgery, resulting in severe complications.

The case attracted public attention after reports emerged that Umar died following months of complications linked to a surgical procedure at the centre.

A family member, Abubakar Mohammed, said the deceased underwent surgery at the facility in September and subsequently suffered persistent abdominal pain. He alleged that repeated visits to the hospital resulted only in the prescription of pain medication, without comprehensive diagnostic assessments.

According to him, medical scans carried out shortly before her death revealed that surgical scissors remained inside her body, prompting plans for another operation that was never carried out.

https://pmnewsnigeria.com/2026/01/16/surgical-scissors-left-inside-patient-kano--health-board-confirms/

Chadian Army Clashes with Armed Group

In an official statement issued on January 14 the Chadian army said its defence and security forces were engaged in violent confrontations in Korbol, located in Moyen--Chari Province, against what it described as "groups of armed bandits".

The military said the armed elements had been active in the area for some time, carrying out acts of violence, intimidation and abuse against civilians. Forces were deployed to restore order and protect residents, leading to clashes on January 13, 2026, in the Kono village area.

According to the General Staff of the Armed Forces, loyalist troops succeeded in routing the armed group, inflicting heavy losses and wounding several fighters. However, the army also suffered casualties, with three personnel killed and ten others injured.

https://apanews.net/chadian--army-confirms-clash-with-rebel-group

Separatists Kill 14 in Attack on Cameroonian Village

Fourteen people, mostly women and children, were killed on January 17, 2026, in an attack on Gidado village in Ndu Subdivision, Donga Mantung Division of Cameroon's North-West Region, in the latest violence linked to the country's Anglophone conflict.

Victims of the attack included seven children aged between two and 11, six women and one adult. The assailants struck in the early hours of the morning, setting several houses ablaze, burning a vehicle and three motorcycles, and killing or stealing cattle. At least 14 injured residents were rushed to hospital for treatment.

Local reports indicate that the assault was carried out by suspected separatist fighters, allegedly in retaliation for the deaths of their colleagues during recent operations by the Cameroonian military. The attackers reportedly accused some Mbororo community leaders of collaborating with government forces.

The Gidado killings add to a long list of attacks marked by killings, looting, abductions and sexual violence that have characterised nearly a decade of conflict in Cameroon's Anglophone regions.

https://thepostnpcameroon.com/gidado-bleeds-as-suspected-separatist-unleash-terror--killing-14-injuring-others/

Niger Adopts Record CFA2.9 Trillion Budget for 2026

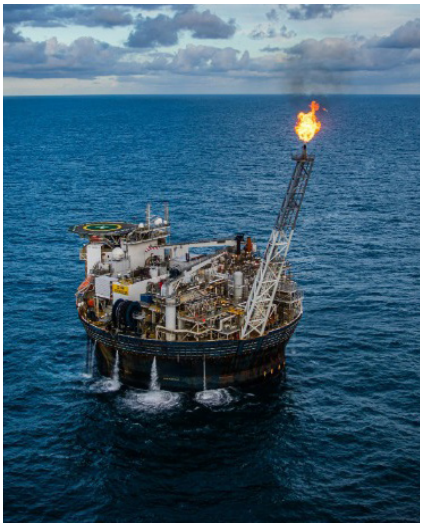
Niger has approved a record national budget of more than CFA2.9 trillion for the 2026 fiscal year, underscoring the authorities' determination to strengthen economic sovereignty and reduce dependence on external financing.

The budget prioritises domestic revenue mobilisation, a move aimed at boosting state income and enhancing fiscal autonomy amid persistent regional and global economic pressures.

More than CFA1.119 trillion has been allocated to capital expenditure, with funds directed towards infrastructure and other large-scale, strategically important projects. Officials say the investment drive is intended to modernise the economy and lay the groundwork for sustained long-term growth.

https://westafricaweekly.com/niger-adopts-record--2026-budget-in-push-for-economic-sovereignty/

Benin Moves to Revive Dormant Seme Oil Field



Benin is intensifying efforts to restart production at its long-dormant Seme oil field, with operations expected to resume by the end of January.

The field, which was shut down in 1998, is projected to produce about 15,000 barrels of oil per day once operational. The government estimates the project could generate up to 100 million US dollars annually through its 15 per cent equity stake, royalties and petroleum taxes.

Although oil made no contribution to Benin's gross domestic product in 2025, authorities expect the revival of the Seme field to provide incremental support to economic growth from 2026 onwards.

https://www.africanleadershipmagazine.co.uk/the-revival-of-benins-seme-field-economic-impact-and-strategy/

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