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When Health Facilities Become Soft Targets:
**Sub-National Protection Gaps for Primary
Health Centres in North-West Nigeria**



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COVER IMAGE: The entrance of Noma Children Hospital in Sokoto, Nigeria. Photo by: Claire Jeantet / Fabrice Catérini / Chloe Fournier / Inediz

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Nigeria is no longer confronting isolated attacks on health facilities in its northwest region. It is confronting the steady normalisation of Primary Health Centres (PHCs) as undefended public assets, visible, predictable, and increasingly abandoned. What is unfolding across Zamfara, Katsina, Kaduna, and Sokoto states is not merely an insecurity problem bleeding into healthcare delivery. It reflects a failure of sub-national governance to treat PHC protection as a defined institutional responsibility rather than an incidental by-product of broader security conditions.

This shift has accelerated since 2019, as decentralised primary healthcare reform has collided with a sustained deterioration in rural security conditions. Armed banditry has evolved from episodic rural violence into persistent territorial pressure on public infrastructure. Schools, markets, local government offices, and health facilities have all been targeted. Yet PHCs occupy a distinct position within this pattern. Unlike mobile populations or private assets, PHCs are fixed, publicly identifiable facilities with predictable operating hours, limited physical protection, and staff drawn largely from surrounding communities. Their exposure is therefore structural, not accidental.

At the same time, Nigeria has pursued a deliberate policy shift to strengthen sub-national ownership of primary healthcare delivery. Under the Primary Health Care Under One Roof (PHCUOR) framework, states are expected to coordinate planning and financing, while local government authorities (LGAs) retain [responsibility](#) for facility-level operations and community interface. This decentralisation has expanded sub-national authority over PHCs without a corresponding expansion of sub-national protection capacity. The result is a widening governance gap between responsibility and risk.

Public discourse frequently frames attacks on PHCs as evidence of federal security failure or insufficient military deployment. While federal security constraints are significant, this framing is analytically incomplete. PHCs are not federal facilities. They are planned, staffed, supervised, and maintained by state and local institutions. Their day-to-day safety depends less on battlefield outcomes than on whether sub-national authorities have built the institutional mechanisms required to anticipate threats, coordinate responses, and sustain service delivery under conditions of chronic insecurity.

The national stakes are considerable. PHCs form the backbone of Nigeria's disease surveillance system, immunisation architecture, maternal health delivery, and rural health access. When they close, surveillance weakens, preventable diseases resurge, health expenditures shift onto households, and public confidence in state presence erodes. What begins as a security incident becomes a governance failure with system-wide consequences.

Nigeria cannot build resilient primary healthcare while treating PHC protection as an externality. The sustained exposure of PHCs in northwest Nigeria signals a deeper institutional breakdown: sub-national governments have assumed responsibility for healthcare delivery without developing the governance capacity required to protect the infrastructure on which that delivery depends.

1 The Governance Failure Driving PHC Exposure

The vulnerability of PHCs in northwest Nigeria is often described in operational terms: lack of guards, absence of fencing, and delayed response to attacks. These descriptions obscure the underlying institutional failure. The core problem is not that PHCs are attacked. It is that no sub-national governance layer has clearly internalised PHC protection as a defined, enforceable responsibility.

Three interlocking governance breakdowns explain why PHCs remain persistently exposed.

First, state-level coordination between health and security institutions remains underdeveloped. State ministries of health are responsible for PHC policy and oversight, yet they are rarely embedded within state security coordination platforms. Threat assessments, deployment decisions, and security prioritisation exercises typically exclude health facilities as a distinct category of civic infrastructure. As a result, PHCs fall outside routine security planning, even in LGAs experiencing sustained violence.

Second, local governments lack both the authority and the instruments required for risk governance. LGAs are legally responsible for PHC operations, staffing, and maintenance. However, while LGAs manage facilities, they possess no statutory authority over armed policing or security deployment. They also exercise limited influence over policing priorities and operate under highly

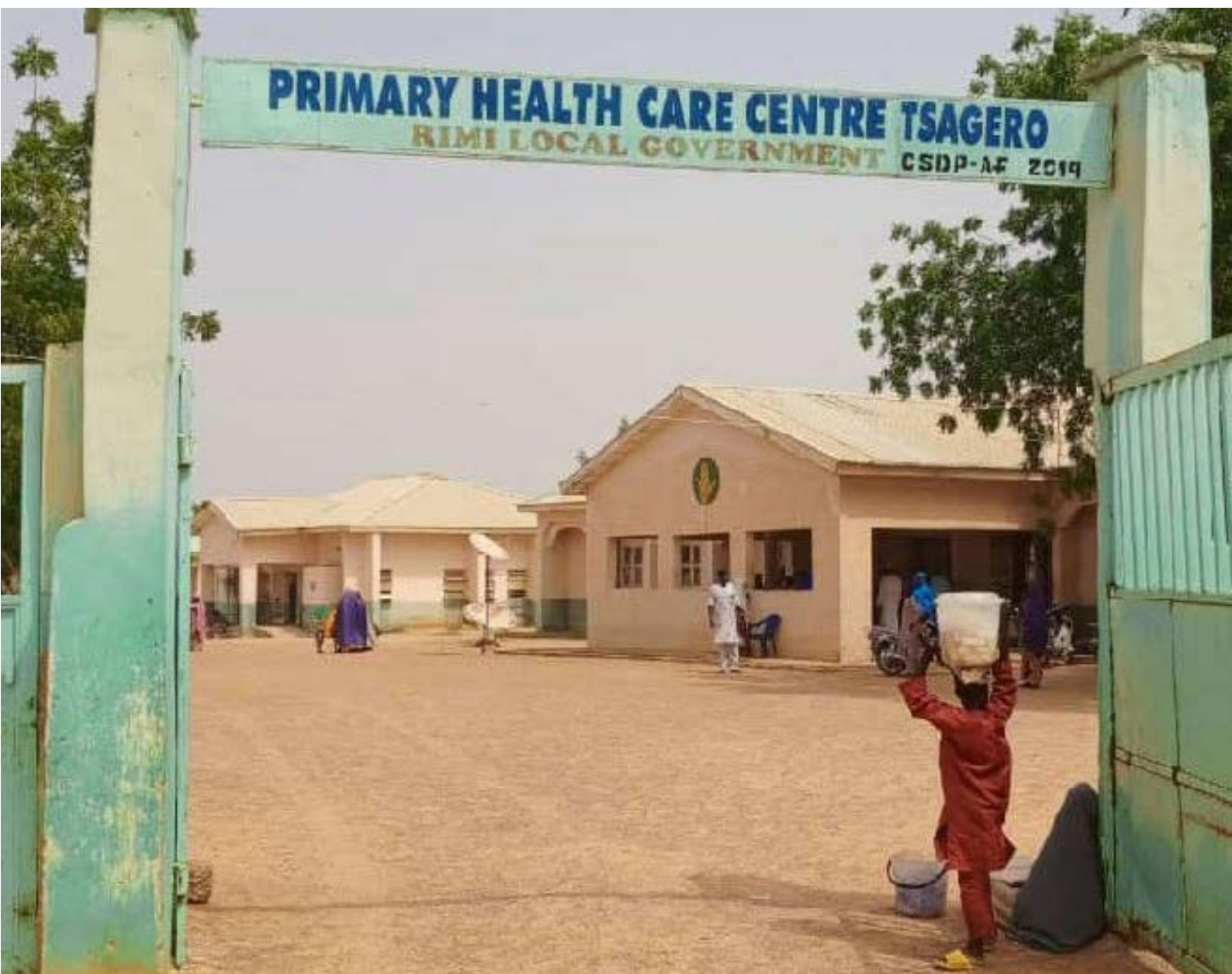
constrained and unpredictable fiscal transfers. In practice, this means local governments can close facilities following attacks but lack the legal and operational capacity to reopen them safely. Facility closure becomes the default risk-management response, not because it is optimal, but because it is administratively defensible.

Third, community leadership structures are systematically under-institutionalised. Traditional rulers, religious leaders, ward heads, and community development associations possess granular knowledge of local security dynamics. They often know when threats are escalating, which routes are unsafe, and how armed groups interact with local populations. Yet these actors are rarely formalised as partners in PHC protection governance. Their role remains informal, discretionary, and dependent on personal relationships rather than institutional design.

This governance gap is not accidental. It reflects a broader pattern in Nigeria's decentralisation process: responsibilities are devolved faster than protection, coordination, and enforcement mechanisms are built. PHC exposure is therefore not simply a symptom of insecurity. It is an indicator of institutional incompleteness at the sub-national level.

Policy intent and operational reality have diverged sharply. PHCUOR and related reforms assume functional state-local coordination, [predictable financing](#), and effective community engagement. In high-risk northwest settings, these assumptions no longer hold. Yet policy frameworks have not been recalibrated to account for insecurity as a structural condition rather than a temporary disruption.

Until PHC protection is explicitly defined as a governance function, planned, resourced, coordinated, and monitored, sub-national authorities will continue to manage insecurity through retreat rather than institutional adaptation.



Primary Health Care Center in Katsina

2 What the Evidence Reveals

The empirical record from northwest Nigeria indicates that PHC exposure is producing measurable system damage rather than marginal disruption.

Documentation by Human Rights Watch shows repeated attacks on health facilities across Zamfara, Katsina, and parts of Kaduna and Sokoto States, including looting, arson, and abduction of [health workers](#). These incidents form part of a sustained pattern of pressure on public infrastructure rather than isolated events.

While comprehensive administrative data are unavailable, triangulated estimates from state reports, humanitarian assessments, and PHC operational records suggest that in several high-risk LGAs, between [25 and 35 per cent](#) of PHCs have experienced prolonged service disruption or closure since 2020. Closure periods often extend for months or years, not because facilities are irreparably damaged, but because sub-national authorities lack the institutional confidence and coordination required to reopen them safely.

The service consequences are immediate. Routine immunisation coverage in some affected LGAs has fallen below [30 per cent](#), less than half the national average. Antenatal care attendance and skilled birth delivery have declined, while disease surveillance reporting has weakened. These outcomes do not reflect declining demand for services. They follow directly from the physical absence of functioning facilities.

The fiscal implications are equally significant. When PHCs close, households seek care from private providers, informal drug vendors, or distant secondary facilities. Evidence from USAID links insecurity-related service disruption to increased out-of-pocket expenditure and rising [catastrophic health](#) spending among rural households. In effect, the cost of insecurity is transferred from the state to households least able to absorb it.

Health workforce data reveal a parallel trend. The International Committee of the Red Cross documents elevated levels of stress, burnout, and [redployment requests](#) among health workers operating in insecure environments. In northwest Nigeria, repeated exposure to threats without credible protection assurances has accelerated attrition from rural postings. Recruitment incentives lose effectiveness when basic safety cannot be assured.

Notably, these outcomes persist even when federal security deployments increase temporarily. This underscores a critical point: PHC exposure is not resolved by episodic security surges. It is sustained by the absence of sub-national governance mechanisms capable of maintaining service continuity under chronic threat.

The evidence does not indicate a failure of effort. It points to a failure of institutional design.

3 Why the System Perpetuates Failure

PHC exposure persists not because solutions are unknown, but because prevailing incentive structures reward avoidance rather than adaptation.

For state governments, PHC protection competes poorly with more visible political priorities. Security coordination tends to focus on urban centres, major transport corridors, and symbolic state assets. Rural PHCs generate limited political visibility yet carry significant reputational risk if staff are harmed. The rational bureaucratic response is caution: limit operations in high-risk areas rather than invest in complex protection arrangements.

For local governments, the incentive structure is more acute. LGAs bear operational responsibility for PHCs but lack authority over armed response and receive unpredictable fiscal transfers. Reopening a PHC after an attack exposes local officials to personal and political risk without providing commensurate institutional backing. Closure, by contrast, carries little sanction and minimal scrutiny.

Health workers face their own calculus. In the absence of credible protection commitments, continued service in insecure locations becomes a personal risk assessment rather than a professional obligation. Transfer requests and exit from public service are rational responses to institutional silence on safety.

Community leaders operate in an ambiguous space. They are often expected to provide intelligence

or mediation informally, yet lack formal mandates, legal protection, or accountability frameworks. This ambiguity discourages sustained engagement and exposes leaders to retaliation risks.

At a system level, no institution is explicitly penalised for prolonged PHC closure, while multiple actors incur downside risk for keeping facilities open. In such an environment, retreat becomes the equilibrium outcome.

Regulatory weakness reinforces this dynamic. Few states have enacted legal instruments explicitly criminalising attacks on health facilities or defining PHCs as protected civic infrastructure. Without legal clarity, enforcement remains discretionary and deterrence weak.

The system, therefore, sustains failure by distributing responsibility without authority, risk without protection, and expectations without incentives.

Key Impacts of Insecurity on Primary Healthcare Facilities

1



At least **69** health centres shut down across Batsari, Jibia and other LGAs (Katsina), while **23** out of **41** health care centres abandoned in Anka LGA (Zamfara).

2



Health workers are frequent targets for abduction, kidnapping for ransom, or sexual assault, leading to a severe shortage of skilled staff in rural areas.

3



Bandits have burned down health centres, damaged facilities and looted equipment, including converting solar-powered refrigerators for their own use.

4



Many facilities in the North-West now operate on reduced hours, opening only in the morning and closing well before dark, preventing night-time emergency services.

Insecurity is closing health centres, putting health workers at risk, destroying essential infrastructure and denying communities the healthcare they urgently need.

4 Comparative Lessons on Sub-National Health Security Governance

International experience suggests that protecting healthcare in insecure settings depends less on militarisation than on institutional clarity at the sub-national level.

Afghanistan: Community Compacts and Neutrality Agreements

In Afghanistan, provincial health authorities negotiated explicit community compacts involving elders, local councils, and service providers. These agreements defined clinics as [neutral community](#) assets and established local accountability for protection. Evaluations by the World Health Organization indicate that facilities operating under such arrangements experienced fewer attacks despite minimal armed presence.

South Sudan: Adaptive Service Delivery Under Insecurity

In South Sudan, county health departments integrated insecurity mapping into routine service planning. Rather than maintaining static facilities at all costs, authorities adjusted service modalities through mobile outreach, temporary relocation, and flexible staffing. UNICEF reports indicate that this approach [preserved service](#) continuity in high-risk counties without escalating violence.

Colombia: Legal Deterrence and Municipal Enforcement

In Colombia, municipal governments [adopted ordinances](#) criminalising attacks on health facilities and formalised community reporting mechanisms. These measures, reinforced by national law but implemented locally, increased the legal and social cost of targeting health infrastructure.

These experiences offer adaptive lessons rather than directly transferable models. Their relevance lies not in context replication, but in the consistent use of institutional levers to align authority, incentives, and accountability.

Nigeria's North-West differs in context but not in principle. Sub-national governments cannot eliminate insecurity, but they can govern within it.

5

Policy Pathways for Strengthening Sub-National PHC Protection

Restoring PHC protection in North-West Nigeria does not require a new national programme. It requires recalibrating existing institutions to treat PHC protection as a core governance function. Four interlocking pathways are decisive.

A. Re-establish PHCs as Protected Civic Infrastructure

States should formally designate PHCs as critical sub-national infrastructure within state security coordination frameworks. This designation should be incorporated into existing state security coordination structures within 12–18 months, led by state ministries of health in collaboration with state security councils. The observable output is the routine inclusion of PHCs in threat assessments and security briefings.

B. Align Local Government Authority with Risk Governance Functions

LGA health departments, under state oversight, should complete facility-level risk assessments and continuity plans within 18 months. Outputs include documented risk profiles and adaptive service plans for all PHCs in high-risk LGAs. While LGAs lack coercive authority, formal risk planning improves coordination and reduces reliance on ad hoc closures.

C. Formalise Community-Based Early Warning and Protection Systems

Ward development committees should formally integrate traditional and religious leaders into PHC protection arrangements within

12 months, with defined reporting channels and oversight mechanisms. The observable output is a functioning ward-level early-warning interface linked to LGA health departments.

D. Strengthen Legal and Regulatory Deterrence Against Attacks on Health Facilities

State legislatures should enact regulations criminalising attacks on health facilities and protecting health workers within 3–5 years. Outputs include enacted statutes and formal enforcement guidance to security agencies. While enforcement capacity varies, legal clarity strengthens deterrence and accountability.

Together, these pathways shift PHC protection from an ad hoc response to a governed subnational function.

Implementation Monitoring and Performance Indicators

To assess progress, state governments should track a limited set of observable indicators:

- PHC operational days per quarter
- Percentage of PHCs with completed risk assessments
- Health worker retention rates in high-risk LGAs
- Continuity of routine immunisation sessions

State ministries of health should consolidate these indicators annually. Persistent PHC closure without documented risk mitigation should trigger administrative review rather than quiet withdrawal.

7

Conclusion: The Governance Stakes of PHC Protection

The exposure of PHCs in the North-West geopolitical region of Nigeria is not an incidental by-product of insecurity. Evidently, sub-national governance has not adapted to a reality in which insecurity is persistent rather than exceptional.

PHCs sit at the intersection of health delivery, state presence, and community trust. When they close, Nigeria loses surveillance capacity, workforce confidence, fiscal efficiency, and institutional credibility.

Nigeria cannot decentralise healthcare delivery while implicitly outsourcing protection responsibility. Nor can it expect communities and health workers to absorb risk indefinitely in the absence of governance adaptation.

The decisive question is not whether PHCs can be protected perfectly. It is whether subnational governments are prepared to govern deliberately under conditions of threat. Until that shift occurs, decentralised primary healthcare will remain institutionally fragile.

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