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Financing Mental Health in Nigeria (2021–2025): Budgetary Trends, Comparative Evidence, and Reform Pathways

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ABSTRACT

Background: Mental health accounts for an estimated 14% of the global disease burden yet receives less than 2% of health budgets in most countries, with even lower investment in low- and middle-income settings. This study examines federal mental health financing trends from 2021-2025 to assess whether legislative reform translated into fiscal prioritization.

Methods: A mixed-methods policy analysis was conducted, combining quantitative analysis of federal budget appropriation documents (2021-2025) with qualitative documentary review and comparative case studies. Mental health allocations were assessed by recurrent and capital expenditure, institutional distribution, and proportional share of total federal health spending. WHO reports, national policy documents from Ghana and Kenya, and peer-reviewed literature informed comparative analysis.

Results: Federal mental health allocations increased from ₦23.33 billion in 2021 to ₦88.24 billion in 2025, a 278% nominal rise. However, the sector's share of the total health budget declined from 3.67% to 3.12%, indicating relative marginalization. Over 90% of funding supported recurrent expenditures in ten federal neuropsychiatric hospitals, with minimal investment in community-based services or primary care integration. In contrast, Ghana and Kenya more effectively leveraged legislation, fiscal decentralization, and insurance mechanisms to expand access.

Conclusion: Despite legislative reform, Nigeria's mental health financing remains centralized, hospital-focused, and misaligned with population needs. Institutional inertia, weak coordination, and delayed implementation of the Act have constrained equitable scale-up. Activating the Mental Health Fund and integrating mental health into national financing mechanisms are urgently required to prevent deepening inequities.

Keywords: mental health financing, Nigeria, health policy, legislative reform, UHC, Sub-Saharan Africa.

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INTRODUCTION

Mental health accounts for approximately 14% of the global disease burden, yet receives less than 2% of health budgets in most countries, with even lower allocations in low- and middle-income countries (LMICs). [1] Nigeria, Africa's most populous nation, reflects these challenges acutely. An estimated 20-30% of Nigerians will experience a mental health condition in their lifetime, yet access remains severely limited due to structural barriers in financing, legislation, and service provision. [2]

Mental health services are concentrated in fewer than ten federal psychiatric hospitals with minimal primary healthcare integration. Nigeria's Universal Health Coverage (UHC) platforms - the National Health Insurance Authority (NHIA) and Basic Health Care Provision Fund (BHCPF) - do not explicitly incorporate mental health, resulting in poor financial protection and limited access. This funding gap has reinforced stigma, widened treatment inequities, and placed unsustainable burdens on families.

While Nigeria's experience mirrors broader trends across Sub-Saharan Africa, some countries have adopted more progressive models. Kenya and Ghana have implemented legislative frameworks, established mental health directorates, and created specific budget lines. In 2021, Nigeria enacted the National Mental Health Act, replacing the outdated Lunacy Act of 1958. This legislation provides a modern legal foundation and mandates integration into primary care with a dedicated Mental Health Fund. However, whether this has resulted in meaningful fiscal shifts remains unclear.

This study offers the first comprehensive, multi-year analysis of federal budget allocations for mental health in Nigeria (2021-2025), drawing on official appropriation records and comparative data from Kenya and Ghana. It assesses whether legal and policy commitments have translated into financial action, considering institutional path dependency, fragmented donor support, and political inertia.

Conceptual Framework: This study integrates principles from public health financing theory, institutionalism, and systems thinking, drawing on the WHO Health System Building Blocks model and the fiscal space approach. Among the six building blocks - service delivery, workforce, information systems, medicines, financing, and governance - this analysis centers on health financing and governance as structural determinants of outcomes and access.

The fiscal space framework examines how economic capacity, policy decisions, and institutional arrangements affect mental health prioritization within health budgets. [3] Key drivers include economic growth, budget reprioritization, earmarked taxation, efficiency gains, and external funding. Institutional theory, particularly path dependency, suggests historical policy decisions create entrenched arrangements that resist transformation even after legal reform. [4]

The passage of Nigeria's National Mental Health Act (2021, enacted 2023) represents a critical inflection point. However, translating this into tangible fiscal shifts requires overcoming institutional resistance through targeted budgetary instruments. This framework positions public budgeting as both an outcome of governance processes and a mechanism for operationalizing reform, assuming legislative change is insufficient without fiscal allocations, coordination, and accountability mechanisms.

Aim and Objectives

Aim: To assess the extent, structure, and implications of public financing for mental health in Nigeria between 2021 and 2025, with focus on budgetary trends, legislative developments, and comparative insights from Kenya and Ghana.

Objectives:

1. To analyse trends in federal budget allocations for mental health from 2021 to 2025
2. To examine alignment between mental health financing and the 2021 National Mental Health Act
3. To compare Nigeria's financing structure with Kenya and Ghana
4. To identify key institutional and systemic factors influencing budgetary decisions
5. To propose actionable financing strategies for enhancing sustainability and impact

METHODS

Study Design: This study adopts a mixed-methods policy analysis design, integrating quantitative budgetary analysis with qualitative documentary review and comparative case study methodology.

Data Sources and Collection: Primary data consisted of federal budget appropriation documents published by Nigeria's Budget Office (2021-2025), including detailed line-item allocations to the Federal Ministry of Health and psychiatric hospitals. Secondary data were drawn from WHO and World Bank reports, country-specific mental health investment cases from Kenya and Ghana,

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peer-reviewed literature on mental health systems and governance, and the full text of the 2021 National Mental Health Act.

***Analytical Framework and Procedure*:** Budget data were extracted and analysed to track annual allocations, recurrent versus capital expenditure distribution, proportional allocation relative to total health spending, and year-on-year trends over the 2021-2025 period. Descriptive statistics and time-series trends were used to illustrate spending patterns, focusing on both nominal figures and relative proportions. Legislative documents, including the National Mental Health Act and health financing policy instruments, were reviewed to assess alignment between legal mandates and fiscal behaviour. The mapping focused on provisions related to funding mechanisms, institutional responsibilities, and service integration.

Comparative analysis examined Kenya and Ghana's financing mechanisms, institutional arrangements for mental health governance, legal and regulatory frameworks, and implementation challenges. This allowed the study to draw lessons on how similar LMICs in Sub-Saharan Africa have addressed mental health funding within resource-constrained environments.

***Validity and Limitations*:** Budget data were sourced directly from official government publications, ensuring credibility. However, limitations exist due to absence of disaggregated mental health expenditure at the sub-national level and potential inconsistencies in budget coding over time. Actual expenditure data (versus allocations) were not consistently available and are not included in this analysis. Comparative data for Kenya and Ghana are drawn from publicly available sources and peer-reviewed literature.

Reporting Guidelines: This policy analysis adheres to principles of transparency and systematic reporting for documentary and comparative research. All data sources are transparently documented, analytical procedures are clearly specified, the conceptual framework is explicitly articulated, and a systematic approach to comparative case study selection has been followed. The study design, data collection methods, and analytical procedures have been described in sufficient detail to enable replication by other researchers.

Ethical Considerations: This study utilized only publicly available secondary data sources, including federal budget documents, policy reports, and published literature. No primary data collection involving human or animal subjects was conducted. As such, ethical approval was not required. All sources have been appropriately cited, and research integrity protocols were observed throughout the study.

RESULTS

Growth in Federal Allocations: Absolute Figures

Over the 2021-2025 period, federal health allocations grew from ₦635.55 billion to ₦2.83 trillion - a fourfold increase driven by fiscal expansion, inflation adjustments, and ongoing health system reforms. Mental health allocations rose from ₦23.33 billion (2021) to ₦88.24 billion (2025) - a 278% increase. The largest annual jump occurred in 2025 when mental health funding more than doubled compared to the previous year.

While these figures confirm that mental health has benefited from wider fiscal expansion in health spending, the growth appears to be part of general uplift across the sector rather than the result of targeted prioritization. In other words, mental health allocations have increased because the overall health budget envelope has grown substantially, not necessarily because of a deliberate strategic shift in funding emphasis

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Table 1: Nigeria's Federal Mental Health Budget Allocations (2021–2025)

Year	Total Health Budget (₦ Billion)	Mental Health Allocation (₦ Billion)	MH % of Health Budget	Psychiatric Institutions (₦ Billion)	Other MDAs (₦ Billion)
2021	635.55	23.33	3.67	21.17	2.16
2022	826.40	26.89	3.25	24.85	2.04
2023	1,373.79	38.85	2.83	35.62	3.23
2024	1,501.33	41.91	2.79	38.21	3.70
2025	2,828.00	88.24	3.12	69.18	19.06
Change 2021-2025	**+345%**	**+278%**	**-15%**	**+227%**	**+782%**

Legend: MH = Mental Health; MDAs = Ministries, Departments, and Agencies.
Note: *Figures are nominal allocations as stated in federal appropriation acts. The 2025 spike in "Other MDAs" reflects humanitarian and psychosocial programming in conflict-affected regions. Mental health allocation includes both recurrent and capital expenditure for psychiatric hospitals and mental health-related programs across government agencies.*

Budget Share: Mental Health within the Health Sector

Although mental health allocations rose sharply in nominal terms between 2021 and 2025, their relative share of the total federal health budget paints a less encouraging picture. In 2021, mental health accounted for 3.67% of total health sector spending, but this proportion steadily declined to 2.79% by 2024, before making only a marginal recovery to 3.12% in 2025. This downward trend in proportional allocation is occurring despite significant overall growth in the health budget - from ₦635.55 billion in 2021 to ₦2.83 trillion in 2025 - driven by inflationary pressures, health system reforms, and broader fiscal expansion. The persistence of such a low proportional share, consistently below the 5% international benchmark for LMICs, particularly in fragile and conflict-affected settings, highlights a critical misalignment between Nigeria's budgetary practice and the aspirations of the 2021 Mental Health Act.

In policy terms, this stagnation in relative prioritization suggests that mental health is still treated as a specialist service rather than an essential public health function. Without deliberate fiscal policy measures, such as earmarking a fixed percentage of the health budget for mental health or embedding mental health within UHC financing frameworks, Nigeria risks underfunding the systemic reforms needed to give life to the commitments enshrined in the Mental Health Act.

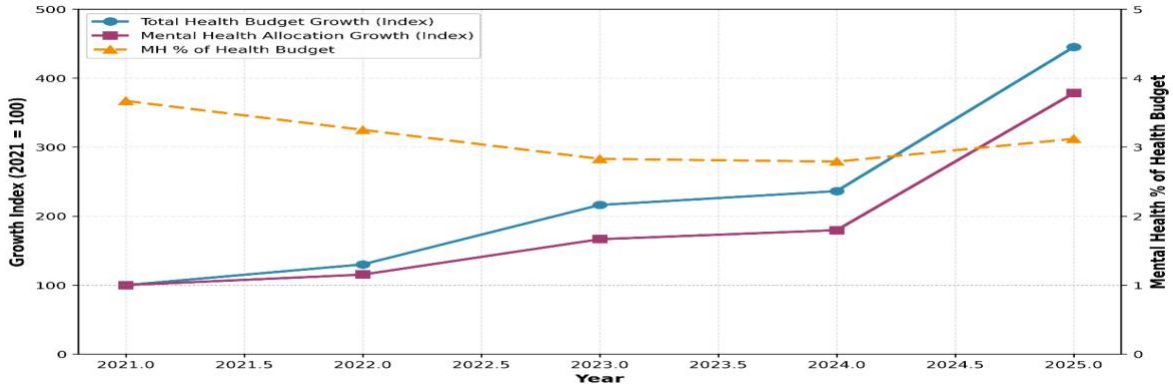

Figure 1: Nigeria's Mental Health Financing Trends (2021-2025) - Growth vs. Proportional Allocation
Line graph showing two y-axes: Left axis shows growth indices (2021=100) for total health budget and mental health allocations; Right axis shows mental health percentage of health budget. The graph demonstrates that while both budgets grew substantially, the proportional share of mental health declined

Figure Legend: This line graph illustrates the divergence between nominal growth and relative prioritization in Nigeria's mental health financing from 2021 to 2025. The left y-axis shows growth indices (2021 = 100) for both total federal health budget (blue line) and mental health allocations (purple line), demonstrating that both increased substantially over the period. The right y-axis displays mental health's share of the total health budget (orange dashed line), which declined from 3.67% in 2021 to 2.79% in 2024 before recovering slightly to 3.12% in 2025. The graph reveals that while mental health

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allocations grew in absolute terms, they failed to keep pace with overall health sector expansion, indicating persistent under-prioritization despite legislative reforms. MH = Mental Health.

Thematic Priorities: Infrastructure vs. Community-Based Care

The budgetary pattern over the 2021-2025 period underscores a persistent concentration of federal mental health spending within institutional care - primarily recurrent costs such as salaries, utilities, and maintenance at Federal Neuropsychiatric Hospitals. While these facilities are critical for specialist services, the heavy fiscal weighting towards them comes at the expense of expanding community-level access and integrating mental health into primary healthcare, as envisioned by the 2021 Mental Health Act. Notably, there is no discernible funding trajectory for preventive interventions, school-based mental health programs, substance use harm reduction, or the training of non-specialist providers who could extend service reach into underserved areas. These gaps are significant because they represent the very levers needed to shift Nigeria's mental health response from a reactive, hospital-centric model to a proactive, population-based system.

Although the percentage of the health budget allocated to psychiatric institutions declined from 3.33% in 2021 to 2.45% in 2025, this change reflects a dilution in relative share rather than a reallocation towards community-based services. Psychiatric facilities still accounted for between 78% and 92% of total mental health financing each year, maintaining their dominance in expenditure priorities. Other Ministries, Departments, and Agencies (MDAs) consistently received less than 1% of the total health budget for mental health-related functions, with the notable exception of 2025, when allocations surged to ₦19.06 billion. This spike was driven largely by psychosocial support within IDP camps and conflict-affected communities, embedded in broader humanitarian and social welfare programming. While these initiatives address urgent needs, their episodic and crisis-driven nature means they are rarely integrated into the national health financing framework. This fragmented, siloed approach undermines the Act's mandate to build a unified, rights-based, and community-oriented mental health system. Without deliberate structural reforms to ring-fence funding for prevention, early intervention, and integration into general health services, Nigeria risks perpetuating an urban, institution-heavy model that leaves the majority of its population without accessible, affordable mental healthcare.

Figure 2: Federal Mental Health Budget Distribution by Institution Type (2021-2025)

Figure Legend: This stacked bar chart shows the annual distribution of Nigeria's federal mental health allocations between psychiatric institutions (green) and other Ministries, Departments, and Agencies/MDAs (red) from 2021 to 2025.

Stacked bar chart showing annual distribution between psychiatric institutions (green) and other MDAs (red), with values and percentages labelled on each segment. Each bar displays both the nominal allocation in naira billions and the percentage share. Psychiatric institutions consistently received 78-92% of total mental health funding, with the lowest share occurring in 2025 when other MDAs received an unprecedented ₦19.06 billion (21.6% of total mental health budget), primarily driven by humanitarian psychosocial programming in conflict-affected regions. The chart demonstrates

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the persistent concentration of resources in tertiary psychiatric care and minimal investment in community-based or integrated primary care services. MDAs = Ministries, Departments, and Agencies; B = Billions. Values on bars represent allocation amounts in Nigerian Naira billions and percentage shares. Total allocations are shown above each bar.

DISCUSSION

Summary of Key Findings

This study examined Nigeria's federal mental health financing trends from 2021 to 2025, revealing a pattern of nominal growth accompanied by persistent structural shortcomings. Mental health allocations rose from ₦23.33 billion in 2021 to ₦88.24 billion in 2025 - a 278% increase. Yet this quantitative rise occurred alongside broader fiscal expansion in the health sector and did not translate into a sustained shift in funding priorities. Mental health's share of the total federal health budget fell from 3.67% to 3.12% over the period, indicating that mental health has not gained relative priority despite larger budget envelopes. Funding remained heavily skewed toward institutional care: on average, more than three-quarters of annual mental health spending was directed to federal neuropsychiatric hospitals. Importantly, the number of these federal psychiatric institutions increased from eight to ten during the study period. The establishment of two additional facilities reinforces the country's disposition toward institution-based funding by creating new sites that absorb recurrent costs (staffing, utilities, maintenance) and anchor future budgetary commitments to tertiary-level care.

This institutional expansion has happened with little parallel investment in community-anchored services. There is scant federal provision for community-based programs, school-based mental health, substance use harm reduction, or the training of non-specialist providers - all central to the 2021 Mental Health Act's emphasis on decentralized, rights-based care. The few increases in allocations outside the Ministry of Health, most notably in 2025 within Ministries such as Humanitarian Affairs and Women Affairs, appear episodic and tied to humanitarian responses, rather than signalling systematic integration of mental health into mainstream health financing.

Overall, the findings point to quantitative expansion but qualitative stagnation: new money and new facilities have been added, yet fiscal priorities remain anchored in an outdated, hospital-centric model. Without deliberate reallocation toward prevention, primary care integration, and sustained cross-sector financing, the increased institutional footprint risks perpetuating service gaps rather than advancing the reforms envisaged by the 2021 Mental Health Act.

Institutional Path Dependency and Colonial Legacies

Nigeria's mental health financing structure reflects colonial-era models prioritizing confinement and institutionalization over community healing. [5] The Lunacy Ordinance of 1916 entrenched a punitive, medicalized approach that persisted post-independence. Over 75% of 2021-2025 federal mental health expenditure was concentrated in federal neuropsychiatric hospitals for recurrent overheads, with marginal allocations to innovation or technology. This reflects institutional path dependency: early policy choices create self-reinforcing dynamics that resist reform. [4] Despite the 2013 National Mental Health Policy and 2021 Act, federal budget structures remain unchanged. There is no statutory earmarking for community programs, no state-level incentives, and no funding frameworks aligned with rights-based care. [1] The disconnect between policy aspiration and fiscal practice remains stark.

This centralization contributes to pronounced urban bias, making access nearly impossible for rural populations and internally displaced persons (IDPs) - particularly problematic given mental health burdens from conflict, gender-based violence, and youth trauma. Workforce distribution reinforces institutional dominance, with most psychiatrists, psychologists, and nurses employed in tertiary hospitals. Without task-shifting, community workforce training, or digital integration, the gravitational pull toward tertiary centres will persist.

Fragmented Governance and Donor-Driven Programming

Nigeria's mental health financing suffers from high institutional and fiscal fragmentation. Between 2021-2025, allocations were disbursed through multiple MDAs without unified governance or strategic coordination. Poor inter-ministerial collaboration and siloed policymaking undermine effectiveness. [7] Despite the 2021 Act's mandate for coordinated systems, no operational mechanism exists for cross-sectoral budgeting, planning, or evaluation. Each ministry independently prepares budgetary submissions, and the

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Budget Office lacks a dedicated unit to harmonize mental health financing. Consequently, budget lines emerge reactively, shaped by humanitarian crises and donor interest rather than domestic system-building.[8] The 2025 psychosocial allocation increase coincides with donor-supported trauma programs, typically implemented through project-based grants lacking sustainability or institutional embedding.

Nigeria's failure to develop a Mental Health Fiscal Strategy remains a critical gap. The BHCPF does not earmark funds for mental health, representing a missed UHC integration opportunity.[9] In the federal structure where states implement primary care, there are no fiscal incentives or accountability mechanisms encouraging subnational governments to prioritize mental health.

In contrast, Ghana and Kenya have integrated mental health into UHC strategies. Nigeria's NHIA excludes mental health from its minimum benefit package, leaving patients without outpatient care, psychotherapy, or medication coverage. [1] Fragmented governance and donor-led funding create structural bottlenecks. Without unified strategic planning, pooled financing, and results-based accountability, public mental health remains vulnerable to institutional neglect and unsustainable programming.

Comparative Lessons from Ghana and Kenya

Ghana: Legislative Anchoring and Insurance Integration

Ghana stands out for its strong legislative foundation. The passage of the Mental Health Act (Act 846) in 2012 marked a turning point, replacing outdated asylum-based laws with a rights-driven framework that prioritises community care and decentralisation. Unlike Nigeria's Mental Health Act (2021), which remains largely symbolic without clear funding or institutional mechanisms, Ghana's Act explicitly created the Mental Health Authority (MHA). This autonomous agency is legally empowered to coordinate planning, regulate service standards, engage development partners, and work with regional health directorates to support subnational implementation.[10]

Another key differentiator is Ghana's integration of mental health into the National Health Insurance Scheme (NHIS). Although still evolving in terms of benefit scope, the NHIS covers some outpatient and inpatient mental health services, a major advance toward financial risk protection and equity. By contrast, Nigeria's National Health Insurance Authority (NHIA) continues to exclude mental health from its minimum benefit package, limiting access to affordable care, particularly for low-income and rural populations.

Ghana's model also demonstrates how donor alignment can be achieved without fragmentation. The MHA serves as a focal point for coordinating donor and multilateral investments, ensuring that projects align with national strategy and regulatory oversight. For instance, World Bank and WHO-supported mental health interventions are implemented under the policy umbrella of the MHA, allowing for coherence, standardisation, and institutional learning. In Nigeria, by contrast, donor-funded initiatives often operate in silos or through non-health MDAs, with no harmonised framework for policy coherence or sustainability.

Despite these advances, Ghana still faces challenges, such as uneven implementation across regions, a shortage of specialised personnel, and limited NHIS benefit depth. However, the system's design clarity and policy coherence offer important templates for Nigeria.

Kenya: Fiscal Devolution, Community-Based Incentives, and Political Ownership

Kenya's mental health financing has been shaped by constitutional decentralization. Following the 2010 constitutional reform, health services were devolved to 47 county governments, each with its own budget authority, planning responsibility, and capacity to prioritize mental health. This structure has enabled counties to adapt mental health programming to local needs, develop innovative delivery models, and attract local political ownership of psychosocial issues. [11]

A key element of Kenya's success lies in the conditional fiscal grants and technical assistance provided by the national government and development partners. These grants, linked to measurable indicators such as trained personnel, facility functionality, or service coverage, have generated positive competition among counties while fostering local innovation. Counties that demonstrate progress in establishing mental health services, training primary care workers, or achieving coverage targets receive additional support and recognition. In contrast, Nigeria's federal system lacks any form of conditional transfer for mental health. Budget allocations are rigid, centrally controlled, and not linked to performance benchmarks, leaving states with little fiscal autonomy or incentive to prioritize mental health.

Kenya has also ensured that essential psychotropic medicines are included in its national essential medicines

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list, with subsidised distribution through primary care platforms. This integration has been coupled with public awareness campaigns that have helped reduce stigma and increase early care-seeking, especially in underserved counties. Moreover, mental health has been incorporated into Kenya's broader Universal Health Coverage pilot programs, enabling holistic service integration and expanding population-level access.

Another important lesson from Kenya is the value of intergovernmental coordination. Through joint planning platforms, national and county-level actors meet periodically to harmonise priorities, report progress, and identify gaps. This prevents duplicative efforts and facilitates data sharing. Nigeria, by contrast, suffers from bureaucratic fragmentation, with weak vertical coordination between the Federal Ministry of Health, the Budget Office, and state-level institutions.

Kenya's devolved model is not without challenges. Disparities exist across counties, with wealthier or more politically engaged regions achieving better outcomes than marginalised areas. Human resource shortages, particularly psychiatrists and clinical psychologists, remain a critical constraint. However, the system's design has created enabling conditions for local experimentation, accountability, and incremental progress, lessons that Nigeria could adapt to its own federal structure.

Lessons for Nigeria

Ghana and Kenya offer actionable principles:

i. Legislative authority with operational power through functional, resourced agencies
ii. Insurance inclusion for financial equity via benefit package amendments
iii. Fiscal devolution with conditional performance-linked transfers
iv. Donor alignment with national strategy through coordination platforms
v. PHC integration with trained personnel, medicines, and referral systems
vi. Community participation and public accountability through engagement and feedback mechanisms

These countries demonstrate that meaningful progress is possible through strategic combinations of legislation, fiscal design, decentralization, and coordinated donor engagement. Nigeria's tertiary-centred, fragmented structure cannot meet population needs. Learning from regional peers provides opportunities to build more inclusive, accountable, and sustainable systems.

Socioeconomic Consequences and Reform Imperatives

Nigeria allocated 2.5-3.7% of federal health budgets to mental health (2021-2025) - exceeding WHO's <1% estimate for many developing nations but remaining inadequate relative to disease burden. [1] Over 90% directed to tertiary psychiatric institutions with minimal community or primary-level investment creates far-reaching socioeconomic consequences. Treatment gaps exceed 80%, especially among rural dwellers, IDPs, and marginalized groups. [6] Vulnerable populations face systemic barriers, with many misdiagnosed, untreated, or subjected to abusive traditional practices. Without culturally competent, rights-based community services, these groups remain disenfranchised and at increased harm risk.

Absent subsidized or insured services compels families toward out-of-pocket payments for private consultations or distant tertiary centres, leading to catastrophic expenditure. No budgetary provision existed for primary-level mental health services (2021-2025), leaving vulnerable families without support. Mental illness curtails national productivity through reduced labour participation, increased absenteeism, and early retirement. Every $1 invested in mental health treatment generates $4 in improved health and economic output - returns Nigeria is forfeiting. [12]

Nigeria's large youth population amplifies risks. Without targeted school, correctional facility, and post-conflict interventions, intergenerational cycles of trauma, exclusion, and unemployment are entrenched. Mental health's cross-cutting developmental role intersects with education, gender equality, social protection, and economic growth. Despite formal strategic frameworks adoption, no corresponding financial architecture exists to operationalize them. Budgeting remains dominated by tertiary hospital allocations, with no statutory BHCPF earmarking for mental health and no NHIA minimum benefit package inclusion.

Nigeria risks missing key SDGs - including SDG 3 (Health and Wellbeing), SDG 5 (Gender Equality), and SDG 8 (Decent Work). Peer countries embraced results-based financing, decentralized budgeting, and insurance-backed delivery, creating more inclusive cost-effective systems despite similar constraints.

Legislative and Policy Reform Pathways

Nigeria's 2021 Mental Health Act marked pivotal progress, repealing the 1958 Lunacy Act and

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institutionalizing rights-based frameworks. It mandated healthcare integration and established a Department of Mental Health Services and Mental Health Fund. Despite legislative progress, implementation remains limited, underfunded, and weakly monitored.

Operationalizing the Mental Health Fund

Section 10 provides for a Mental Health Fund financed through federal allocations, donor contributions, and private support. However, no disbursement guidelines, operational frameworks, or timelines exist as of 2025. Mental health remains financed through fragmented line-item allocations concentrated in tertiary institutions, depriving the broader system of fiscal capacity for community and primary-level care. Without immediate steps to capitalize, structure, and operationalize the Fund, core Act ambitions are unlikely to materialize.

Institutional Coordination

Another challenge lies in mandate fragmentation and absent coordination frameworks. While the Act provides for a Department of Mental Health Services, its visibility, autonomy, and inter-agency authority remain limited. Mental health intersects with education, women's affairs, humanitarian services, corrections, and NHIA, yet no formal inter-ministerial body exists to harmonize planning or budgeting. Ghana's MHA and Kenya's National Mental Health Technical Working Group provide coordination across government levels and sectors. Nigeria's setup remains overly centralized and administratively ambiguous. Reform must include clear organograms, budget codes, and governance structures enabling oversight, coordination, and performance tracking.

Primary Care and Insurance Integration

Section 8(1)(e) calls for PHC integration, yet this remains largely unimplemented. The BHCPF has no mental health-specific allocations or conditional disbursement lines. PHC providers are neither routinely trained nor incentivized to deliver mental health services. The NHIA presents another gap: despite the Act's recognition of insurance scheme integration needs, NHIA excludes outpatient psychiatric care, counselling, and medication from core benefit packages.

Reform measures must prioritize regulatory mandates or fiscal policy adjustments ensuring standard mental health services, including diagnosis, outpatient care, medication, and psychosocial support, are guaranteed under insurance and primary care systems, aligning Nigeria's financing architecture with WHO UHC and mental health integration recommendations. [1]

State-Level Domestication

Given Nigeria's federal structure, national reforms require state-level domestication. Only a handful of states (Lagos, Ekiti) have begun aligning policies and budgets with the 2021 Act. Without legal backing sub-nationally, PHC facilities remain without mandates or funding. The Act provides for State Mental Health Councils, yet few states have implemented this. Progress requires coordinated national efforts including legislative toolkits, technical support to state assemblies, and conditional intergovernmental transfers incentivizing compliance. Kenya's model provides county support through technical assistance and fiscal transfers for decentralized mental health plans. Nigeria could adopt similar strategies through the National Council on Health with civil society and professional bodies to promote state-level ownership and harmonization.

Strengths and limitations of the review

This study makes a novel contribution as the first multi-year analysis of federal mental health budget allocations in Nigeria covering the period immediately following enactment of the 2021 National Mental Health Act. By drawing directly on official federal appropriation documents published by Nigeria's Budget Office from 2021 to 2025, it ensures a high degree of data credibility and transparency. The integration of quantitative budgetary analysis with qualitative legislative review and comparative case study methodology strengthens analytical depth, enabling the study to move beyond descriptive trend analysis toward institutional and governance explanation. The comparative framework, drawing on Kenya and Ghana, provides contextually relevant benchmarks from similar lower- and middle-income settings in Sub-Saharan Africa, enhancing the applicability of the findings to regional policy debates.

Nonetheless, several limitations should be acknowledged. First, the analysis is confined to federal-level budget allocations; sub-national mental health expenditure data were not consistently available, which means the study may understate the full picture of public financing for mental health across Nigeria's federal structure. Second, the study relies on budget appropriations rather than actual expenditure releases, meaning that allocations may not reflect funds ultimately disbursed or utilized. Discrepancies between appropriated and released funds are known to occur

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within Nigeria's public financial management system and could affect the accuracy of conclusions drawn from nominal figures alone. Third, as a desk review of publicly available documents, the study is subject to the limitations of documentary research, including potential inconsistencies in budget coding across years and gaps in the granularity of line-item disaggregation. Finally, comparative data for Ghana and Kenya were drawn from published literature and publicly available policy documents, which vary in recency and methodological consistency, and direct comparisons must therefore be interpreted with appropriate caution.

CONCLUSION

Despite a 278% nominal increase in federal mental health allocations between 2021 and 2025, Nigeria's mental health financing remains structurally deficient. The proportional share of the health budget declined from 3.67% to 3.12%, funding remained concentrated in federal neuropsychiatric hospitals, and community-based care, primary care integration, and insurance coverage remained unrealized. The 2021 Mental Health Act provides a transformative legal foundation, but implementation has been slow and underfunded. Activating the Mental Health Fund, integrating mental health into the BHCPF and NHIA benefit packages, and operationalizing intergovernmental accountability structures are urgently required. Closing Nigeria's mental health treatment gap is not merely a fiscal challenge; it is a political and moral imperative for achieving equitable, people-centred universal health coverage.

Declarations

Ai Usage: The authors confirm that this manuscript represents their own original intellectual work. The manuscript was conceived, researched, and written by the authors. During the editing and revision process, AI-assisted language tools were used to improve sentence clarity and grammatical expression in some sections - a practice increasingly common among non-native English-speaking researchers working in a second language. The analytical framework, all interpretations, the policy analysis, the comparative case study assessments, and the reform recommendations are entirely the authors' own.

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