



NIGERIA



GLOBAL
FINANCING
FACILITY



African Population and
Health Research Center



Countdown to 2030
Women's Children's & Adolescent's Health

Federal Ministry of Health

Analysis of reproductive, maternal, newborn, child and adolescent health indicators

2019-2023

chartbook with main results and interpretations



TABLE OF CONTENTS



- 1** Facility data quality assessment: numerators
- 2** Health facility data denominator assessment and selection
- 3** National coverage and equity: ANC, MNH, immunization, family planning
- 4** Equity
- 5** Maternal mortality and stillbirth rate in health facilities
- 6** Health services utilization: OPD and admissions under-5
- 7** Subnational coverage by health system inputs

General Introduction

This Chartbook summarizes the results for key indicators of reproductive, maternal, newborn, child and adolescent health (RMNCAH) that were produced by the country team at a Countdown analysis workshop in Kigali, April 22-26, 2024.

The analysis is based on routine district health facility data for 2019-2023, recent national surveys, health system data and global estimates, much attention is paid to data quality.

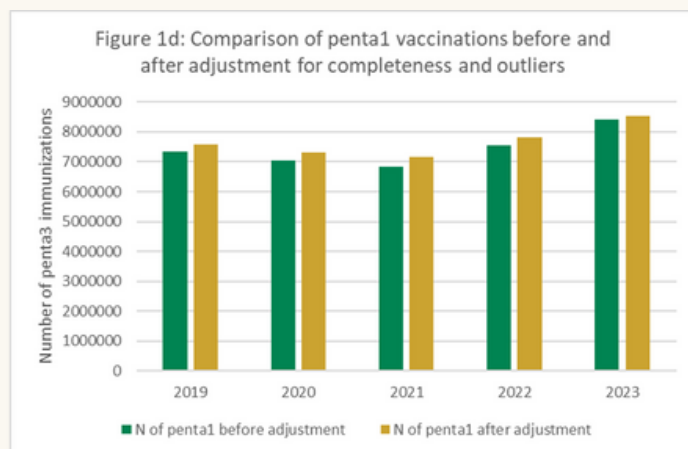
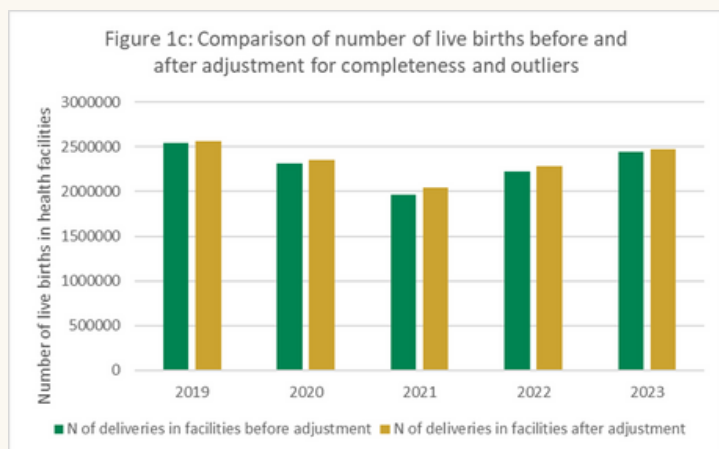
This Chartbook describes and interprets the results, which should be a critical input for the monitoring of country RMNCAH and health sector plans.

For each of the sections there are selected graphs and tables on key indicators with interpretations made by the country team during the workshop.



Background

Completeness of reporting affects analysis, especially if it is low or varies between years. Extreme outliers can have a large impact, especially on subnational numbers. Several steps are necessary to obtain a clean data set for annual analysis, including adjusting for incomplete reporting and correcting for extreme outliers. These graphs show the impact on the numbers.



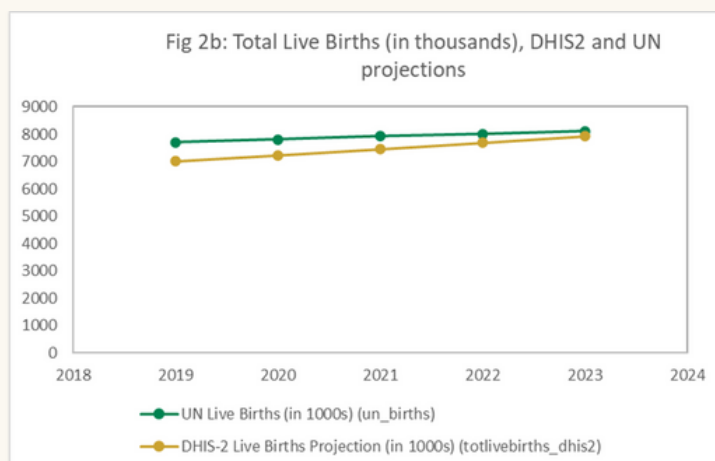
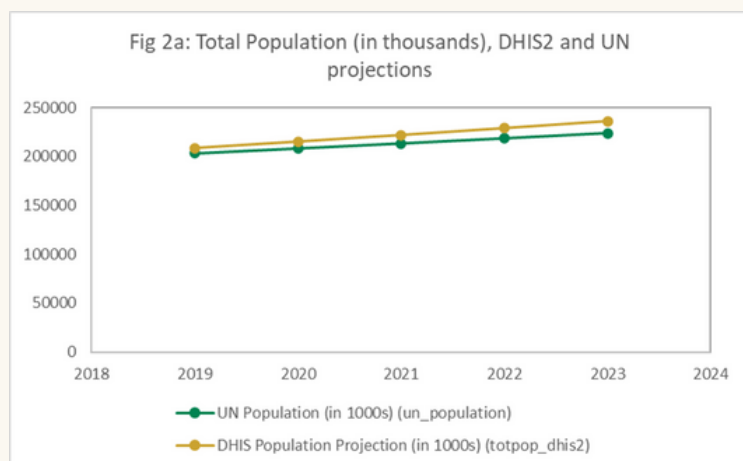
Numbers on top of bars represent percentage increases of adjusted numbers compared to unadjusted.

- There are year-on-year variations in the percentage increase resulting from adjustments, with the year 2021 showing the highest percentage increase of 3.8%, corresponding to an additional 74,295 live births. For 2021, the adjustment had a significant impact, suggesting that the initial data might have had substantial underreporting or inconsistencies that were corrected to provide a more accurate count of live births. The year 2023 shows a smaller percentage increase of 1.4% due to adjustment, corresponding to an additional 34,080 live births. This could be interpreted as a sign of improving data quality and completeness in reporting with less need for adjustments, or it may reflect a lower rate of outliers in the reported data.
- Similarly, there was variability in the percentage increase from year to year. In 2023, the adjustment leads to a 1.5% increase in the number of penta1 vaccinations reported, or an additional 125,313 vaccinations, which is the smallest adjustment over the five-year span. This suggests either an improvement in the initial reporting of vaccinations or fewer outliers present in the data. The most significant adjustment occurs in 2021, with a 4.7% increase. This substantial revision suggests that the data for that year was notably incomplete. The upward trend in the adjustments from 2019 through 2021 and the subsequent decrease in 2022 and 2023 could indicate either a temporary lapse in data quality or an improving trend in data reporting accuracy.

Health facility data denominator assessment

Background

Service coverage is defined as the population who received the service divided by the population who need the services: the denominator. The quality of the population projections in DHIS2 is assessed through consistency over time and comparison with the UN projections.



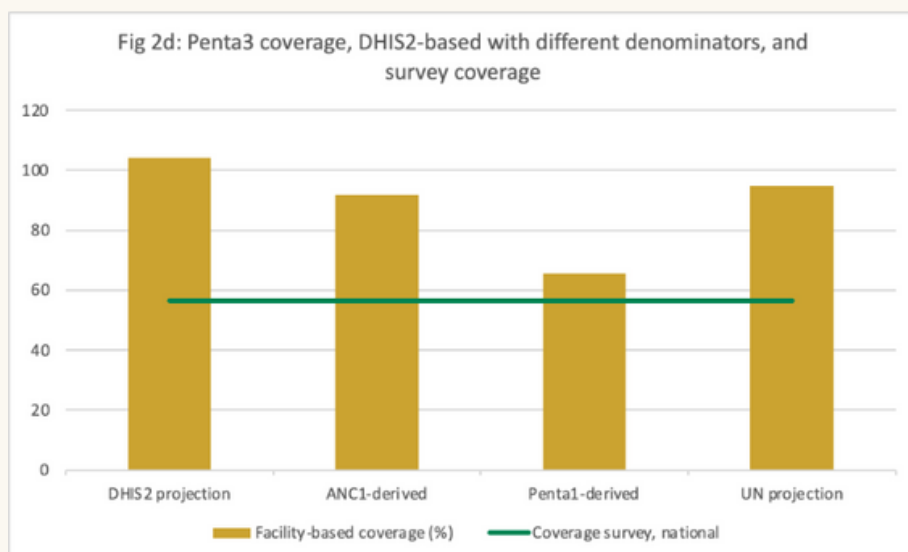
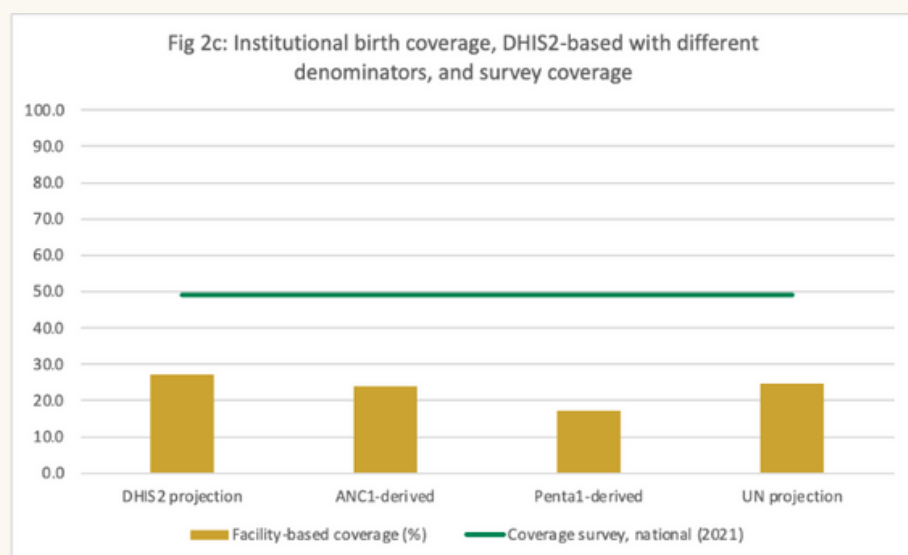
- The DHIS2 and UN total population estimates in Figure 2a closely aligned over the years 2019 to 2023, with a slightly increasing but consistently small percentage difference between them ranging from 3% (5.3M) in 2019 to 5% (12.1M) in 2023. DHIS2 and UN total live birth estimates (Figure 2a) are increasingly aligned over time, ranging from a 9% (0.7M) difference in 2019 to a 2% (0.2M) difference by 2023. The close correspondence suggests that the DHIS2 projections are robust, reflecting population growth that consistently aligns with UN estimates. The DHIS2 total population projection exhibits consistency over time and aligns closely with the UN estimates, indicating regular population growth. Also, the DHIS2 live birth projection is consistent over the examined period and shows a regular trend that closely follows the UN projection, despite a slight divergence in the later years.
- Overall, these graphs indicate that the DHIS2 system is providing projections that align closely with those of the UN, suggesting that estimates of population size and population growth data from DHIS2 are of good quality and can be considered robust for the purpose of planning and analysis for some RMNCH indicators.

2

Health facility data denominator selection

Background

The best performing denominator for coverage analysis with facility data is selected by comparing how close the different denominator methods are to survey coverage for a nearby year. This is done at the national and subnational levels (using the median difference with the survey).

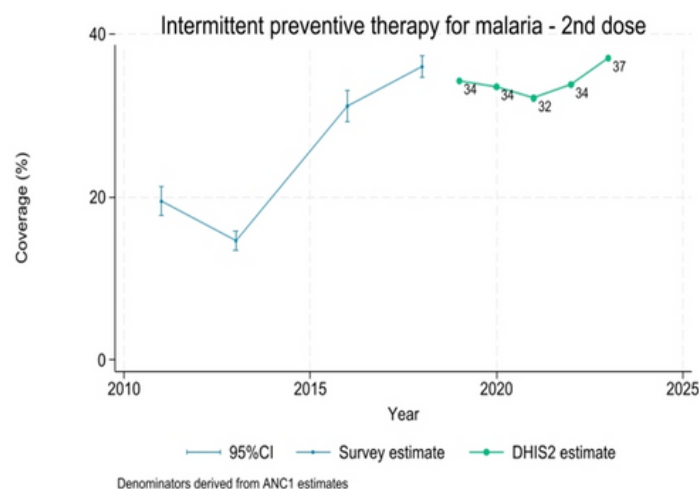
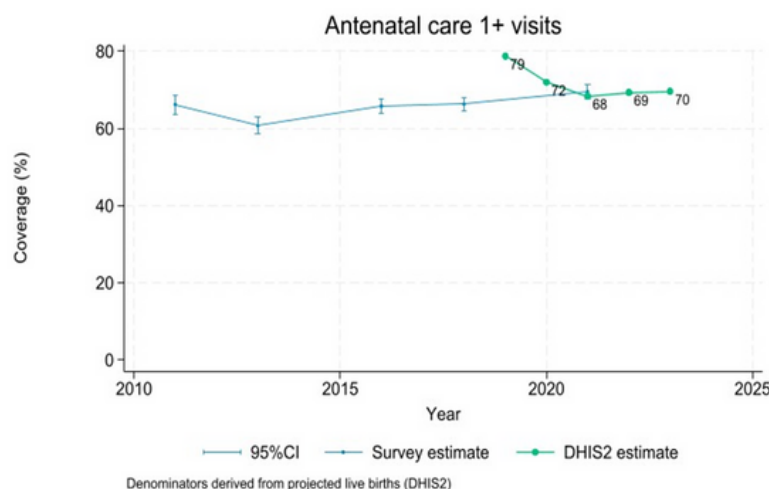


- For institutional births, the DHIS2-based denominator is closer to the survey estimate than the other denominators, but it is still much lower than the survey, suggesting underreporting of facility births.
- We used ANC1 as the denominator for subnational delivery care estimates and Penta1 for Penta3 subnational coverage estimates.
- However, factors such as local health policies, programme implementation strength, and demographic variations can affect service coverage differently in various parts of the country, and these would need to be taken into account for a more accurate assessment.

We used the DHIS2 projected live births as the denominator for ANC1 coverage estimates, we used ANC1 for IPTp and institutional live births, and we used Penta1 as the denominator for vaccination coverage estimates.

BACKGROUND:

Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

**Interpretations**

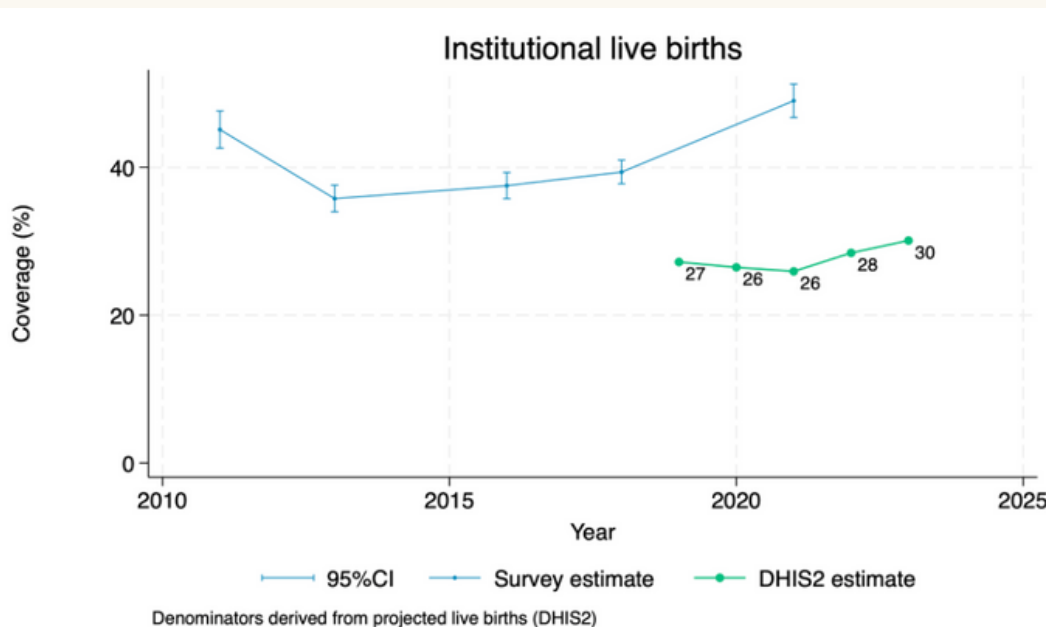
The level and trajectory of the DHIS2 estimates seem to align with the preceding trend of the survey estimates. The levels and trends observed in the graphs for antenatal care 1+ visits and the second dose of intermittent preventive therapy for malaria (IPT2) appear plausible based on general expectations and known factors affecting maternal and child health care in Nigeria.

The trend in the coverage of the second dose of IPT2 in the graph is positive and reflects progress in malaria prevention efforts in the population. The recovery after the dip suggests effective responses to address any potential shortfalls in IPT2 delivery that might have occurred around 2015.

Possible explanations for the observed IPT trends include: increased public health campaigns, education, and outreach could have contributed to higher uptake. Better supply chain management and accessibility of the medication could also explain the increased coverage. The discrepancy between the survey estimates and the DHIS2 data might indicate differences in data collection methods or possible underreporting in routine health data systems.

BACKGROUND

Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.



Interpretations

The survey estimate indicates a positive trend, with an increase in institutional live birth coverage, particularly noticeable from around 2015 onward.

There is a consistent upward trajectory, suggesting improvements in the health system's capacity to support institutional births or changes in population behavior favoring facility-based deliveries. The DHIS2 estimates are consistently lower than the survey estimates, but they also reflect an upward trend starting from around 2020..

The observed rise in institutional birth coverage could potentially be attributed to a combination of factors, encompassing improved healthcare facility accessibility, initiatives spearheaded by governmental bodies and non-governmental organisations to encourage facility-based deliveries, enhancements in the standard of maternal care provided in health facilities, and heightened public awareness regarding the advantages of childbirth in a healthcare environment.

The discrepancy between the coverage levels reported by DHIS2 and the survey data can be attributed to the observation that a significant proportion of women who registered for ANC frequently deliver their infants outside the health facility. Also, this phenomenon can be attributed to issues related to data collection and underreporting within the DHIS2 system.

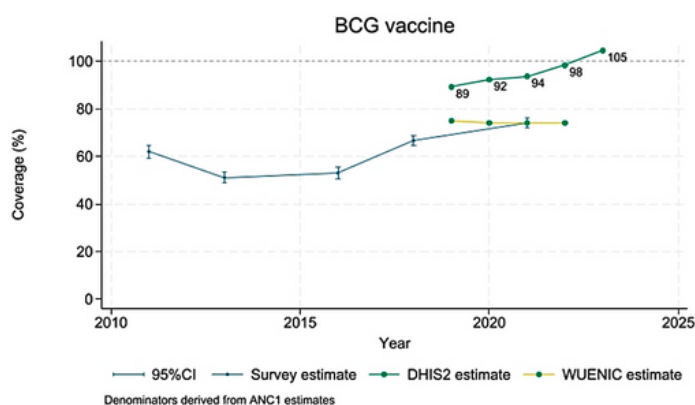
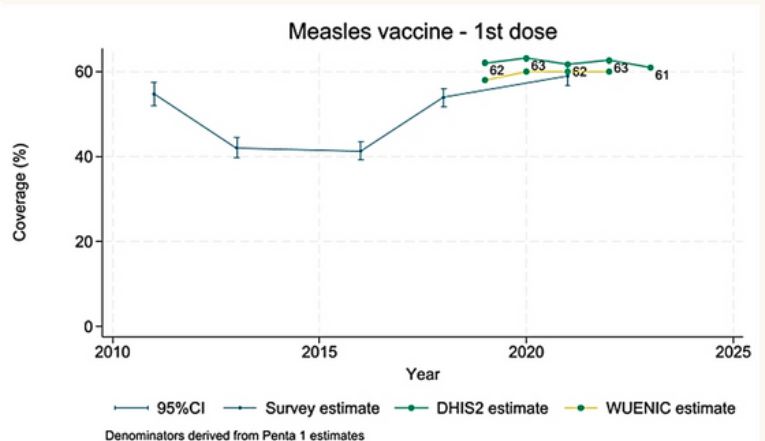
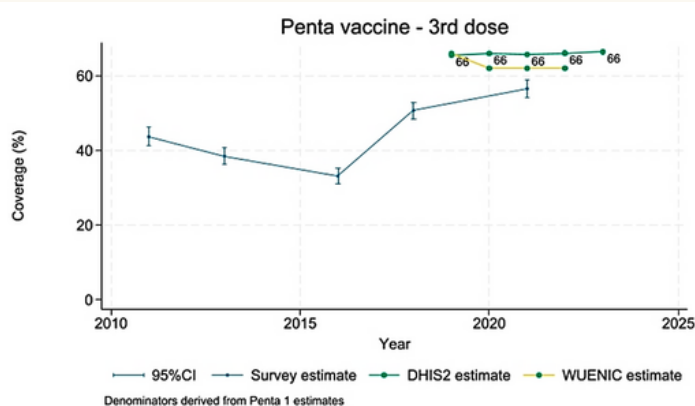
No facility C-section data available for 2022 or 2023

PNC facility data are missing for 2023

[SBA data are missing from National Coverage Estimates dataset]

3

National coverage trends: immunization indicators

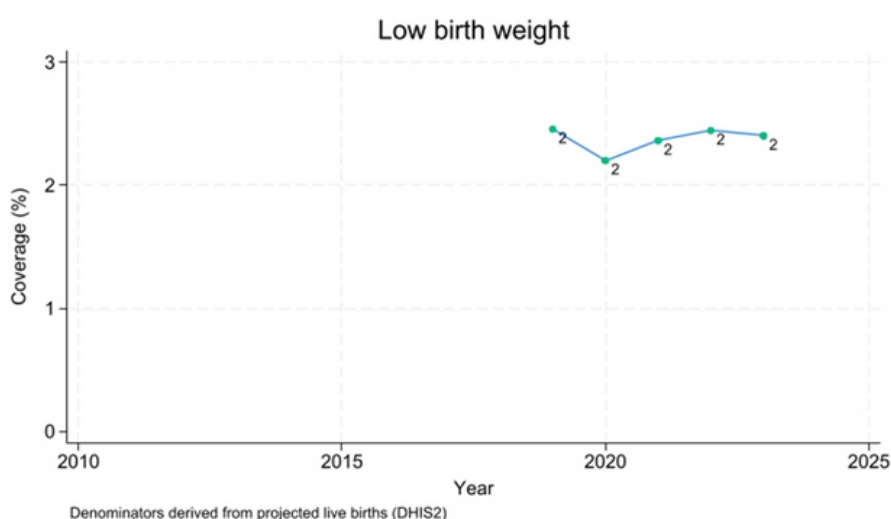


Interpretations

- First address data quality: Are the levels and trends plausible? Is there good consistency between the facility and survey data? How do the results compare to the UN estimates (WUENIC)?
- There is an upward trend in coverage of penta3 over time, which is plausible, reflecting some improvement in maternal and child health services. The survey data shows stability in measles vaccination coverage, with a slight variation over the years but generally remaining around the 60% mark.
- The coverage of the BCG vaccine shows a rising trend, which is plausible given the global health focus on tuberculosis prevention and it indicates high prioritization of BCG vaccination.
- Both the DHIS2 and WUENIC data are closely aligned with the survey estimates, showing good consistency.

BACKGROUND

Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.



Another aspect that reinforces this assumption is the median low birthweight prevalence in LMICs, which is around 8% - estimates derived from population-based nationally representative surveys.

- According to the World Health Assembly nutrition, the target is to reduce low birthweight prevalence by 30% between 2012 and 2030. However, DHIS2 estimates show stability of prevalence estimates - which are not compatible or in line with a reduction trend.
- Explanations for the stable trend might be related to stable and high adolescent fertility rates in Nigeria, which went from 102 to 101 between 2019 and 2021 - placing Nigeria as one of the countries with the largest adolescent fertility rates. Also, poor maternal malnutrition is also a possible explanation, but we don't have data to support this hypothesis.

Interpretations

- The low birthweight prevalence appears to have remained flat - there maybe issues with under reporting at all levels of care, since data published in DHS 2008 and 2018 reports showed prevalence of 7.6% and 7.0%, respectively.

Low birth weight estimates are not available in survey datasets. Postnatal care estimates are incomplete in DHIS2 for Nigeria; estimates not shown

BACKGROUND

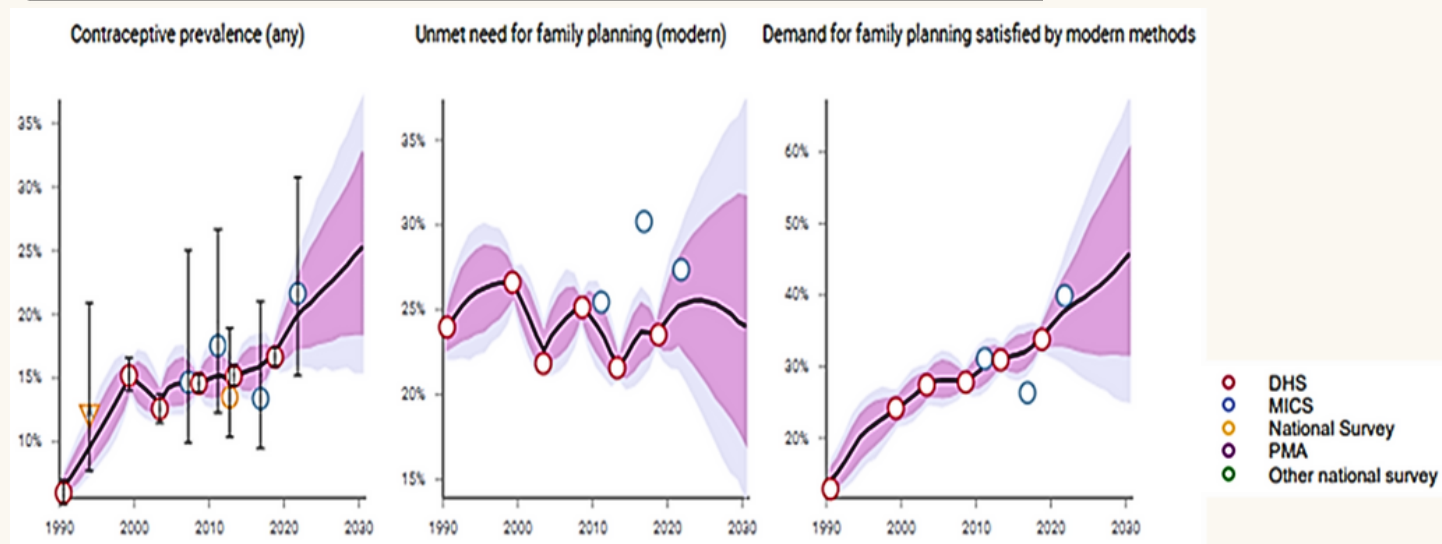
Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

Family planning – national (from Track20 analysis workshop)

	2015	2016	2017	2018	2019	2020	2021	2022
Contraceptive prevalence								
FPET estimate	14.2	14.1	14.3	14.7	15.4	16.3	17.0	17.6
Surveys		13.5		18.1			21.7	
Facility data								
Unmet need for family planning								
FPET estimate	17.6	18.0	18.2	18.4	18.5	18.5	18.5	18.6
Surveys		27.6		15.2			27.7	
Facility data								
Demand for modern methods satisfied								
FPET estimate	36.9	36.6	36.9	37.5	39.5	41.1	42.2	43.4
Surveys		32.7		48.3			39.9	
Facility data								

Surveys - NDHS 2018 and MICS - 2016 and 2021

Figures 3i and 3j: Trends in modern contraceptive use and in the FP coverage (demand satisfied for modern methods of family planning)



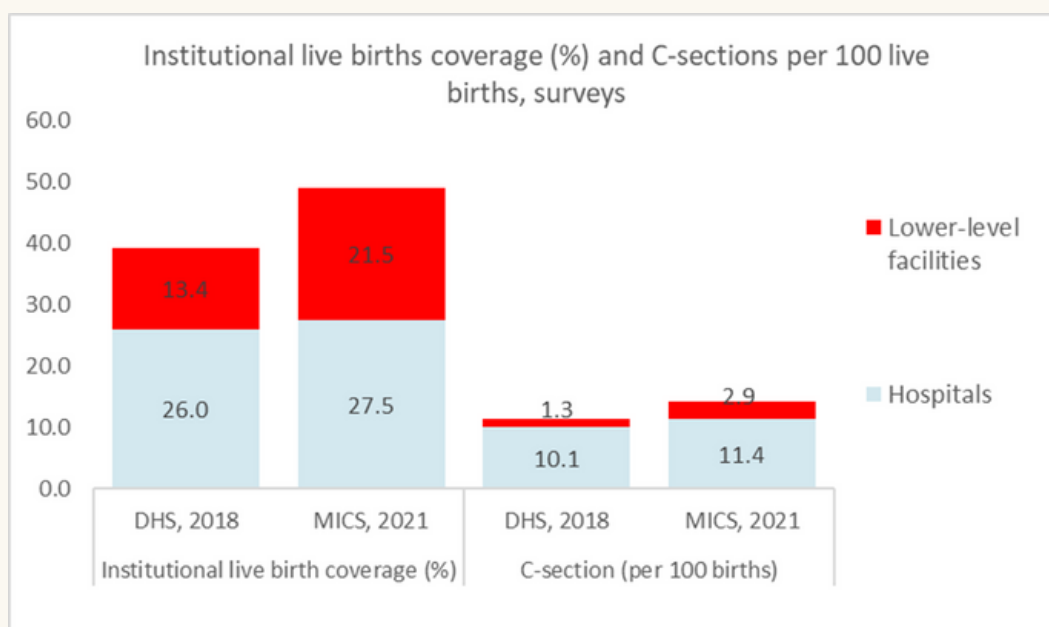
INTERPRETATION

- The FPET estimate for contraceptive prevalence shows a gradual increase from 14.2% in 2015 to 17.6% in 2022 while survey data indicates fluctuations, with a lower figure of 13.5% in 2015 and a higher figure of 21.7% in 2019 compared to the FPET estimates for those years. This suggests some inconsistency between the FPET and survey data. However, the levels and trends are plausible. There are no facility data on family planning.
- All the FP indicators are remarkably low compared with the targeted levels of 43%, 12% and 60% for prevalence, unmet need and demand for modern methods.
- There have been slight improvement in the prevalence of contraceptive use and the demand for modern methods satisfied but the unmet need has shown increase instead of expected reduction.

3 National coverage trends: delivery care by place and volume

BACKGROUND

Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used. Data on whether deliveries increased more at hospitals or lower-level facilities and in the public or private sector can be used to inform MNH service delivery strategies in the context of the SDG 2030 targets for maternal mortality, stillbirth and neonatal mortality.



Percent distribution of place of live births and median number of live births (2022) by type of facility					
	Hospitals	Lower-level facilities	Total	Public	Private
Institutional deliveries among all live births (population - DHS/MICS)					
DHS, 2018	26.0	13.4	39.4	26.4	13.0
MICS, 2021	27.5	21.5	49.0	32.7	16.3
C-sections among live births (population - DHS/MICS)					
DHS, 2018	10.1	1.3	2.9	4.6	12.0
MICS, 2021	11.4	2.9	3.8	6.3	10.4
Volume of (live) births by type of health facility (DHIS2, 2022)					
Median number of (live) births (2022)	211.0	30.0	33.0	35.0	19.0
% of facilities with 1-100 (live) births per year	38.7	78.1	75.3	74.2	87.8
% of facilities with any C-sections	77.8	6.2	11.2	7.8	49.8
% of facilities with 1-49 C-section per year	44.9	84.1	65.1	50.1	91.8

Interpretations

- Institutional live birth coverage dropped from 63.8% to 61.6% in DHS and MICS surveys. This slight decline over three years may reflect health service delivery or reporting differences. Except for major health system reforms or policy changes, the data has been consistent.
- C-sections per 100 live births rose from 13.0 to 14.9 between survey rounds. C-sections in lower-level clinics have increased from 0.7 to 2.5, suggesting surgical capacity or birth practices have improved. C-section rates are rising worldwide, thus this consistency suggests a trend.
- The overall trend shows an increase in institutional births in both hospitals and lower-level facilities, indicating progress in the utilization of health facilities for childbirth. Lower-level and public facilities had more institutional births than hospitals and private facilities. This may be owing to easier access to lower-level facilities, higher healthcare system confidence, or programs that encourage institutional deliveries. The bigger relative increase in lower-level facilities may also indicate that community outreach, and health promotion are convincing women to select them over home deliveries. Public facilities are cheaper or free, therefore their proportional increase may be attributed to public health programs or economic causes.
- The increase in health facility deliveries appears to have happened mostly at lower-level facilities with smaller delivery volumes and limited C-section capacity. Hospital median live births were 221.0, compared to 30.0 for lower-level facilities. Hospitals may be the best places for childbirth due to their better facilities, staffing, and ability to handle difficult cases. 77.8% of hospitals performed C-sections, compared to 6.2% at lower-level facilities. Given hospitals' C-section capacity, this discrepancy is expected. 11.2% of all institutions performed C-sections, similar to lower-level facilities, implying that most facilities countrywide may be lower-level with limited C-section capabilities. A high 91.8% of private institutions offered C-sections (1-49 per year), suggesting they offer fewer than public facilities (50.1%). Since Nigeria's C-section rate aim is less than 10%, the proportion of facilities doing C-sections looks reasonable. However, C-section availability may need to be addressed to ensure access in all regions. Health policies that emphasize institutional deliveries, investments in maternal health care at lower-level facilities, or community-based health strategies that encourage facility-based births may explain the patterns.

BACKGROUND

Household surveys provide critical information on inequalities. The focus is on two major dimensions of inequality: household wealth quintile and education of the mother. Equiplots are used to assess whether the country has made progress since 2010 in reducing the poor rich gap or the gap between women with no education or low education and women with higher education.

Fig 4g: Equiplot of the Composite Coverage Index (CCI) by wealth, recent surveys

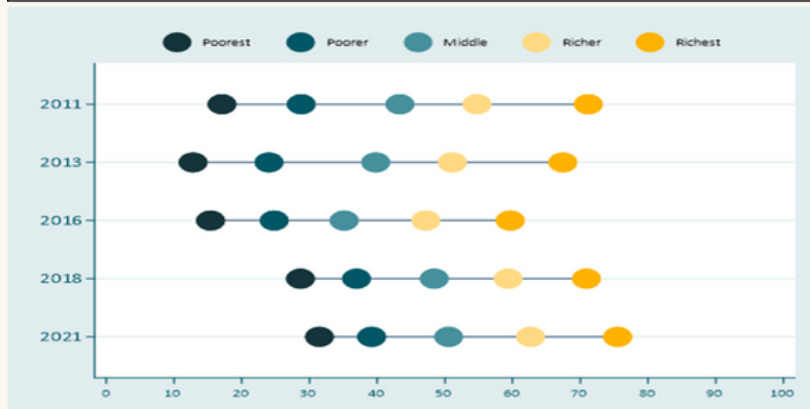
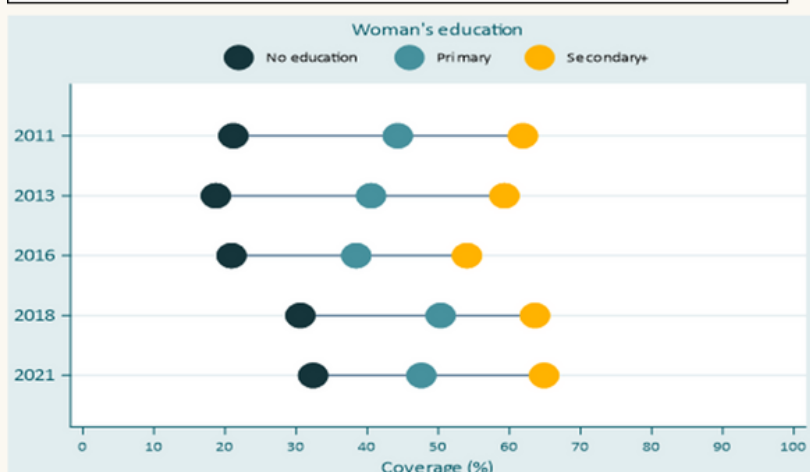


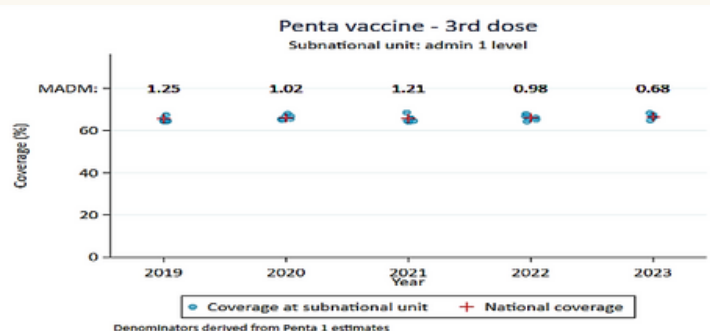
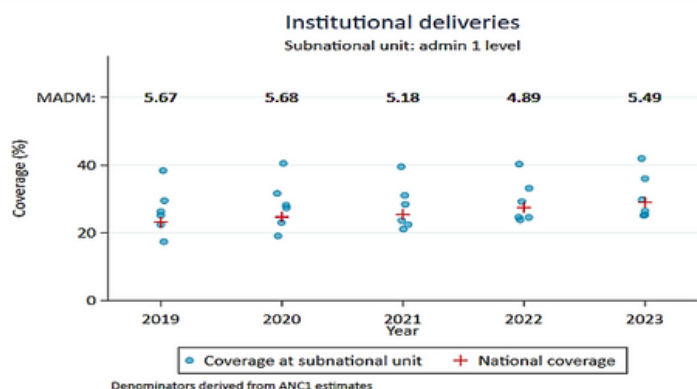
Fig4h: Equiplot of the CCI by level of education of the mother, recent surveys



- The CCI prevalence gap between the richest and the poorest slightly reduced from 2011 to 2021, however in the latest MICS survey the gap was still large between both groups - almost 50 percentage points. Though the gap between the poor narrowed slightly in 2018 and 2021, the linear inequality pattern that was perceived in 2011 remained very similar in 2021, with no evidence of a change on the patterns of inequality - due to a systematic increase on the CCI prevalence in all wealth quintiles.
- A similar behavior was perceived when focusing on maternal education. The CCI prevalence was consistently lower among women with no education and, higher in women with secondary or more. The linear pattern of inequality perceived in 2011 remained until 2021, even with a slight reduction on the gap between the extreme groups of maternal education. In 2021, the gap between women with no education and secondary+ was approximately 20 percentage points, compared to approximately 30 pp in 2011.

BACKGROUND

Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.



Interpretations

The **levels of institutional deliveries are not consistent with survey data**, since DHIS2 estimates range between 20-30% and survey estimates around 50%. In turn, **trends were consistent** between different data sources, with very small increases throughout the years. Regarding **penta 3rd dose, both levels and trends were consistent** between DHIS2 and survey estimates.

Subnational inequalities regarding institutional deliveries in Nigerian regions was high and stable, with a MADM equals to 5.67 in 2019 and 5.49 in 2023. Reasoning behind this could be the different structure on performing deliveries in different regions of the country and also due to under reporting, given the large difference between DHIS2 and survey estimates.

In contrast, **penta 3 coverage and inequalities were stable** from 2019 and 2023. **Very small MADM values were computed for all years**, ranging from 1.25 in 2019 to 0.68 in 2023. This shows that access and coverage of immunization of penta 3 vaccine seems to be effective in all Nigerian regions.

4

Equity- subnational coverage trends: delivery care and penta3 coverage by district (States), 2019-2023

BACKGROUND

Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

Fig 4b: coverage of Institutional deliveries by district

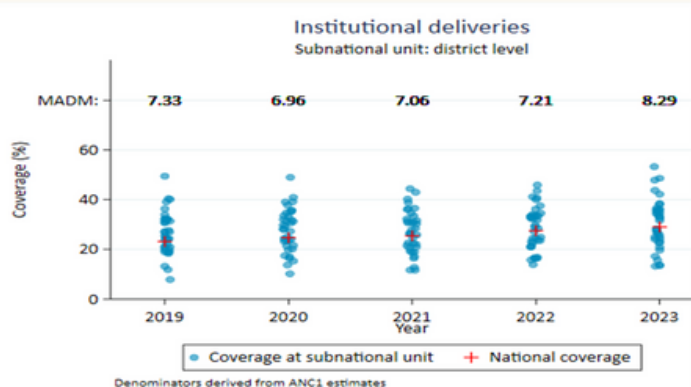
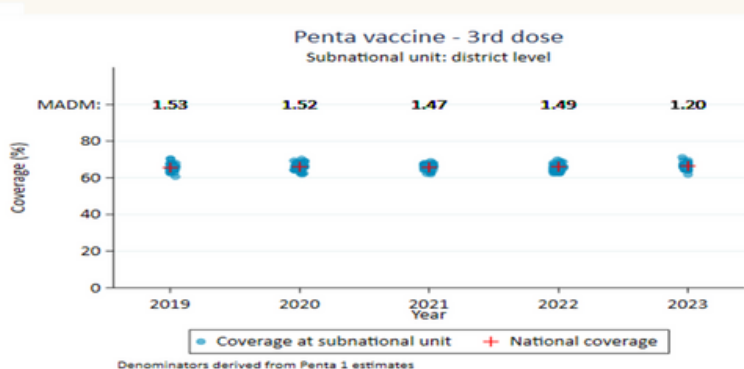


Fig4c: Penta3 coverage by district

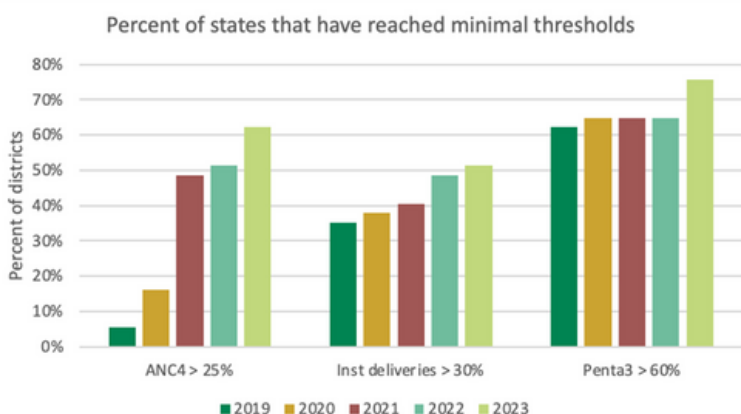


Interpretations

- State level analyses show consistent results compared to regional inequality analyses. State level institutional delivery coverages were always lower than 50%, not consistent to survey results. However, trends were similar and stable. For penta 3 vaccine, all Nigerian states had levels and trends similar to survey results.
- Regarding inequalities, a large between-state variability was found for institutional deliveries - with MADM reaching 8.29 in 2023. For penta 3, inequalities were very low and similar to regional results. When analyzing districts, MADM ranged between 1.53 in 2019 to 1.20 in 2023.

4

Equity- Wealth quintiles and female education from survey data



No state has met the international target for any indicator

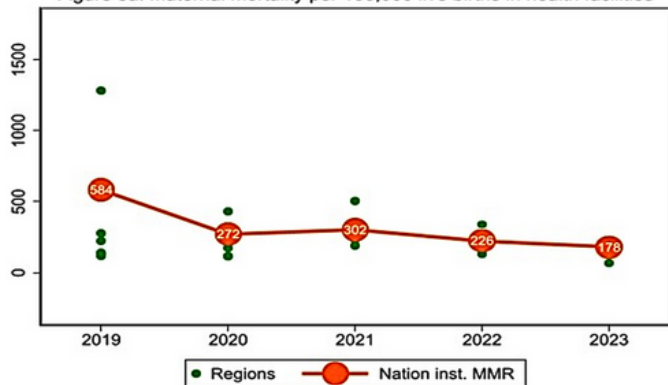
Interpretations

No state met the international target for any of the three indicators (ANC4>80%, institutional deliveries > 90%, penta 3 coverage >90%).

To still be able to assess trends, we have plotted the percentage of states that met a lower threshold for each indicator.

Estimated coverage has increased over time for all 3 indicators, but remains low. The steep increase for ANC4 is likely due to improved reporting rather than increased coverage, given that the average annual rate of increase in the DHIS2 far exceeds that observed rate of increase between survey rounds. The steep increase in the proportion of states reporting at least 60% Penta3 coverage in 2023 may reflect the vaccination campaigns that were carried out in some states in 2023.

Figure 5a: Maternal mortality per 100,000 live births in health facilities



BACKGROUND: The main challenge with mortality data from health facilities is underreporting of deaths. Deaths may not be recorded in the maternity register, or not reported. Also, maternal deaths in other hospital wards are more likely to be missed, e.g., deaths associated with abortion or sepsis. The main aim is to estimate the level of underreporting in DHIS2 or MPDSR.

INTERPRETATION

No regions had MMR < 25. The lowest estimate was 67/100,000, in 2023 for the Southeast region. However, underreporting of maternal deaths is suspected, since the UN MMR for 2020 was estimated at 1047/100,000, almost 4x higher compared to the 2020 DHIS2 estimate.

Still, both UN and DHIS2 MMR estimates are reducing over time. But while UN MMR showed an annual reduction compatible to 1 maternal death per 100,000 live births, DHIS2 estimates show an annual reduction of 86 maternal deaths per 100,000 live births.

The ratio was close to the expected range in 2019, and within it in 2020. As no data on stillbirths were reported for 2021-23, the ratios were calculated as 0. Although close to the expected range, as the MMR estimates are far from the UN estimate, we believe that both number of stillbirths and maternal deaths are underreported in 2019-2020.

Figure 5b: Ratio number of stillbirths to maternal deaths in health facilities

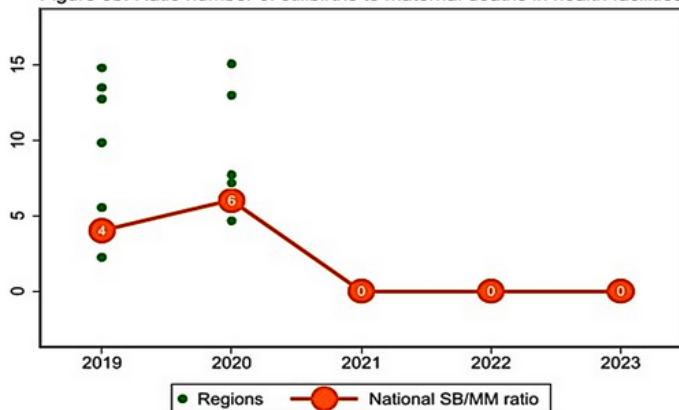
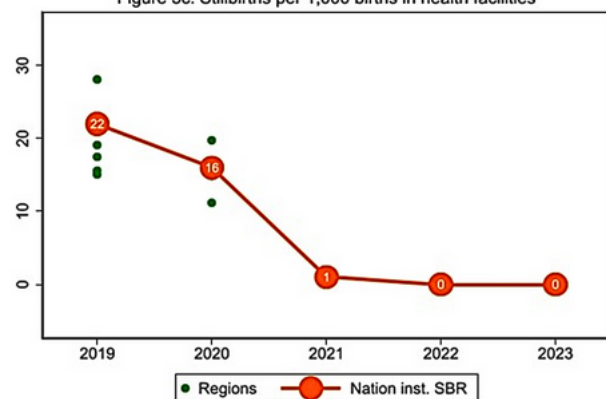


Figure 5c: Stillbirths per 1,000 births in health facilities



BACKGROUND: The main challenge with health facility data on stillbirths and neonatal deaths is underreporting. We can estimate the level of underreporting of stillbirths based on different assumptions. For neonatal deaths, DHIS2 reporting systems based on labour and delivery ward are limited to neonatal deaths before discharge in the reporting system. Therefore, they are only an indicator of mortality during the first 24-48 hours.

- The stillbirth rate per 1,000 newborns in health facilities dropped dramatically from 2019 to 2022. No stillbirths were reported by 2023. Regions with low stillbirth rates are possible given health care quality, access, and reporting accuracy. In recent years, the national trend has suggested eliminating stillbirths, which is unlikely and raises doubts about data quality..

For 2019-20, no regions had SBR < 6, while from 2021-23 SBR estimates were always zero, showing a clear lack of reporting. According to UN SBR estimates for 2020, SBR was equal to 22/1,000 births, in line with what was shown in 2019 and 2020. Regional variation was not that high, ranging from 11 to 28/1,000 births in 2019.

- The graph shows 3-4 per 1,000 national rates, much lower than the 33.0 per 1,000 live birth estimate of newborn death. The substantial difference between reported health facility rates and the national estimate calls into doubt the completeness and validity of the reporting rates.
- Health facility records might not have recorded all newborn fatalities, especially those following discharge or outside the facility.

Figure 5d: Neonatal deaths before discharge per 1,000 live births in health facilities

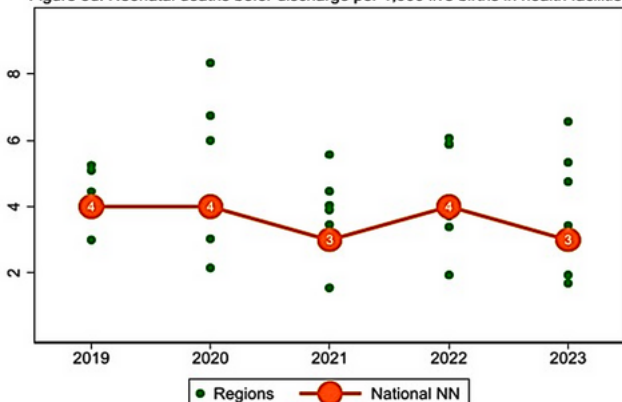


Fig 5e: Completeness of facility maternal death reporting (%), based on UN MMR estimates and community to institutional ratio

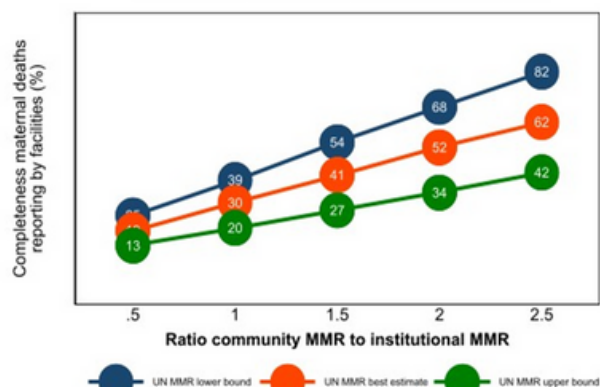
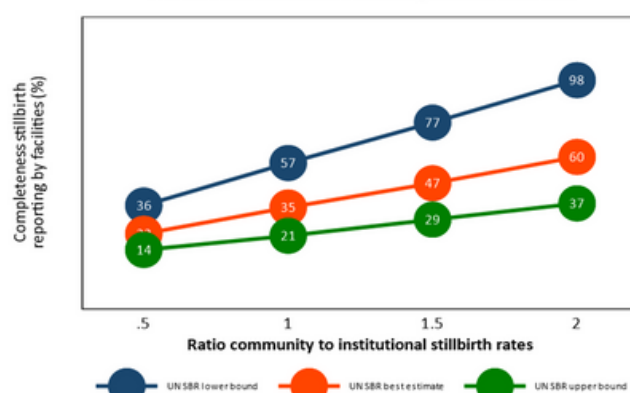


Fig 5f: Completeness of facility stillbirth reporting (%), based on UN stillbirth estimates and community to institutional ratio



BACKGROUND: The main challenge with health facility data on stillbirths and neonatal deaths is underreporting. We can estimate the level of underreporting of stillbirths based on different assumptions: 1) using population mortality estimates from the UN: lower bound, best estimate and upper bound 2) community to institutional mortality ratio: assumptions ranging from half as low to at least 2 times higher community mortality.

- Facilities seemed to have recorded fewer stillbirths than UN estimates. UN estimate scenarios, with lower, best, and upper bound completion percentages below 100%, support this. The levels of completeness across UN estimate scenarios show geographical diversity in stillbirth reporting. The data points at the bottom of the graph may have lower stillbirth rates than those near the top. If maternal health programs, prenatal care, and obstetric services are good, regions with low stillbirth rates are possible. Underreporting or errors in data gathering could also contribute to low reporting rates.
- Stillbirth reporting appears to be less than optimal in terms of completeness. No scenario (lower, median, or upper UN estimate bounds) is 100% complete. Reporting seems to be more complete when the ratio of community to institutional stillbirth rates is higher. This suggests that assumptions about the level of SBR in the population and the ratio of community to institutional deaths have a big impact on how complete reporting is seen to be. Given the statistics, the UN's median SBR population estimate is usually the most likely. However, this estimate's accuracy depends on local factors, including healthcare access and quality.

Fig 6a: OPD service use by children and all ages, Nigeria, 2019-2023

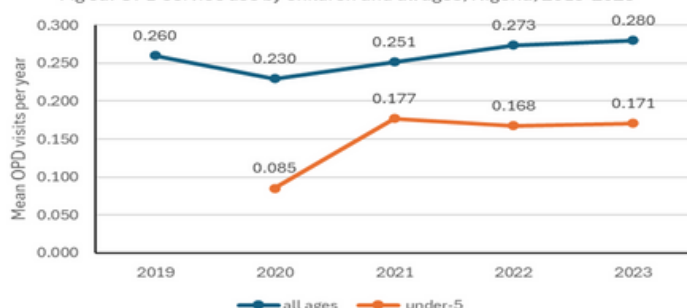
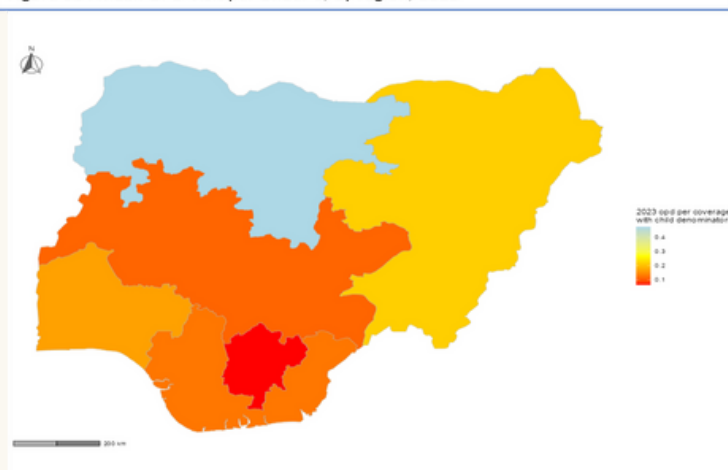


Figure 6b : Mean OPD Visit per Under 5, by region, 2023



BACKGROUND

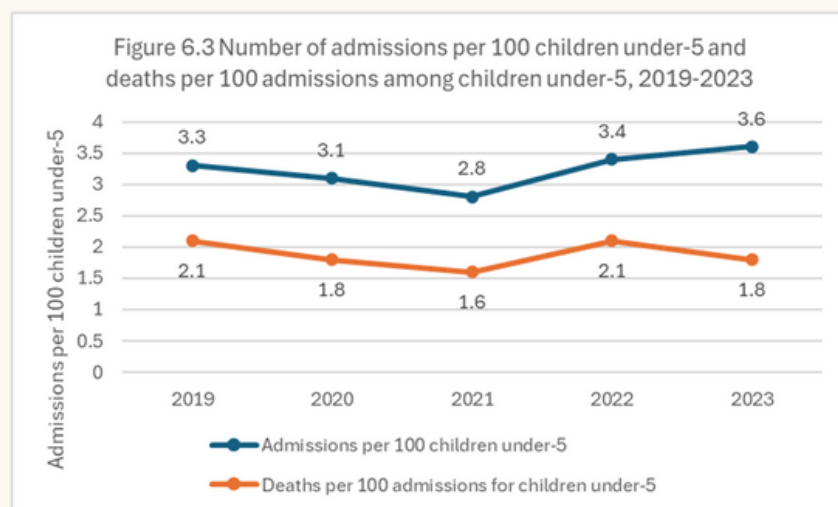
There is a major data gap on curative service utilization by children. Health facility data on outpatient (OPD) visits among under-fives are an indicator of access to curative services.

INTERPRETATION

- The numbers of OPD visits reported are fairly consistent between years. (No data are available on under-5 visits in 2019.) The proportion of all OPD visits that were under-5 was below the expected range of 15-40% in 2020 (9%) but was at the bottom of the expected range for 2021 (16%), 2022 (15%) and 2023 (15%), suggesting that under-5 OPD visits,
- The mean number of OPD visits per child per year is much lower than 1 visit per year in each year, indicating that children under-5 in Nigeria have low access to curative services. There was some improvement after 2020, but OPD utilization has remained very low throughout.
- In 2023, as in previous years, the mean number of OPD visits per child per year was well below 1 in all regions, indicating low OPD utilization among children under-5 across the country. This persistently low coverage may reflect families' seeking treatment outside of facilities, especially home treatment with over-the-counter medications.

6 Curative health services: admission and case fatality rates among children under-5

Figure 6c: Admissions per 100 children and case fatality rates per 100 admissions under-5, national, 2019-2023



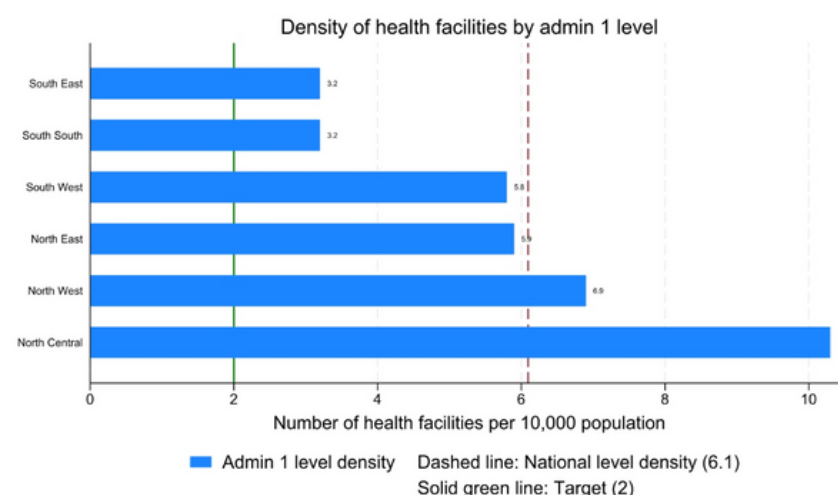
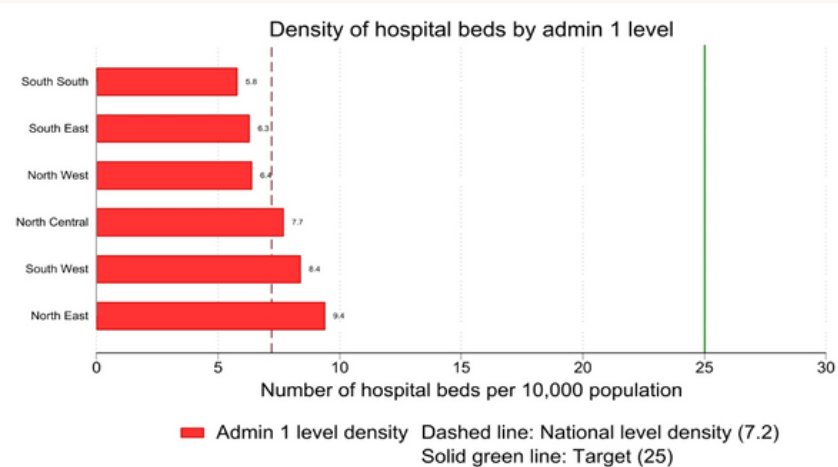
BACKGROUND

Data on inpatient admissions among under-fives are indicators of access to curative services. In-patient mortality (case fatality rates) is an indicator of quality of care.

MAIN FINDINGS

- What can be said about the data quality? Is there consistency of reported numbers of admissions / admission rates over time? Is the percent of admissions that are children under-5 plausible (within an expected range 15-40%)
- What is the number of admission per 100 children under 5 per year during 2019-2023? Trend? Is it low or high?
- What is the case fatality rate among admissions under-5, what is the trend? What does this say about the quality of care?
- What can be said about admissions per 100 children under-5 per year by region/province in 2023?

7 Health system performance assessment: indicators



BACKGROUND

Subnational analyses of health system inputs and service outputs are critical: districts and regions are key units of the health systems and their service delivery. This includes assessment of system inputs (health workforce, infrastructure) and outputs (use, coverage).

MAIN FINDINGS

- No region meets the global target of 25 beds/10,000 population, while all regions meet the target of 2 health facilities/10,000 population.
- The observed patterns in hospital bed and health facility densities across different regions potentially signifies discrepancies in the access to health services. North Central has a large land mass, which partly accounts for its relatively high number of health facilities, while also having a relatively low population density - resulting in a much higher health facility density than in other regions.
- Several factors could contribute to the observed regional patterns. These may include disparities in healthcare infrastructure investment across regions, population distribution — densely populated regions may have lower apparent facility density even with a substantial number of health facilities, data collection methods — inconsistencies in how data is gathered, reported, and updated can create anomalies.



Federal Ministry of Health



African Population and
Health Research Center



Countdown to 2030

Women's Children's & Adolescent's Health

Analysis of reproductive, maternal, newborn, child and adolescent health indicators

2019-2023



About Countdown 2030 in Nigeria

The Countdown to 2030 country collaboration in Nigeria includes the University of Ibadan and the Centre for Global Child Health at the Hospital for Sick Children. It aims to strengthen the analysis and synthesis of health data to inform national and local reviews of progress and performance in the context of Nigeria's national health plans and the Global Financing Facility (GFF) investment case for reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH+N).