Federal Ministry of Health & Social Welfare

JAR

JOINT ANNUAL REVIEW



Nigeria Health Sector Statistical Book

JAR BOOK 2026

A Third-Year Review of HSSB Implementation- 2026

Department of Health Planning, Research & Statistics (DHPRS)

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Foreword

It gives me great pleasure to present the 2026 Nigeria Health Sector Statistical Book, developed as part of the Joint Annual Review (JAR) of the Health Sector. This publication reflects the Federal Ministry of Health and Social Welfare's commitment to strengthening health information systems, promoting evidence-based decision-making, and improving accountability across the health sector.

Reliable and timely health statistics are essential to advancing Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (SDGs). They enable us to track progress, identify gaps and inequalities, inform policies and plans, allocate resources effectively, and improve health outcomes.

The publication is an important reference and policy tool for government, development partners, programme managers, researchers and other stakeholders. It provides evidence to support the JAR process, identify priority challenges and guide actions and investments under the Nigeria Health Sector Renewal Initiative (NHSRII).

As we advance the implementation of the Nigeria Health Sector Renewal Initiative (NHSRII) and pursue the broader goal of Universal Health Coverage, we must continue to strengthen health information systems, improve data quality and timeliness, promote data use at all levels, and ensure that decisions are increasingly guided by credible evidence.

I commend the Department of Health Planning, Research and Statistics (DHPRS) and all Federal and State institutions, agencies, development partners, professional bodies and other stakeholders whose collective efforts contributed to the generation, compilation, review and validation of the data presented in this publication.

The value of statistics lies not in their publication, but in their use to drive action. I therefore urge all stakeholders to use the evidence presented in this publication to strengthen policies, target investments, improve services and track results.

Let us continue to make data a driver of action, accountability and better health outcomes for every Nigerian.



Muhammad Ali Pate, CON

Honourable Coordinating Minister of Health and Social Welfare
Federal Republic of Nigeria
November 2026

Preface

The 2026 Nigeria Health Sector Statistical Book is a key output of the Joint Annual Review (JAR) of the Health Sector. It brings together essential health-sector statistics to provide a clear picture of health status, service delivery and overall sector performance, and to support planning, monitoring, policy development and decision-making.

The publication consolidates key indicators on areas including population health, health services, human resources, health financing and health infrastructure. It provides stakeholders with an evidence base to assess progress, identify gaps and set priorities for improving health outcomes. The development of the Statistical Book involved the compilation, review, validation and harmonisation of data from relevant sources. This was made possible through the collaboration of Federal and State Ministries of Health, departments and agencies, health institutions, development partners and other stakeholders.

While efforts have been made to ensure the quality and accuracy of the data, differences in sources, definitions, reporting periods and data availability may affect comparability across indicators. Users are therefore encouraged to refer to the definitions, notes and methodological information provided when interpreting the data. The Statistical Book is intended for policymakers, health managers, programme officers, researchers, development partners and other stakeholders. More importantly, it should serve as a tool for action using evidence to guide policies, target resources, strengthen programmes, improve service delivery and track progress.

I commend and appreciate all institutions, departments, agencies, States, development partners and individuals who contributed to the generation, validation and compilation of the data presented in this publication. Their continued collaboration is essential to strengthening Nigeria's health information system and building a more responsive, accountable and evidence-driven health sector.



Dr. Iziaq Adekunle Salako

Honourable Minister of State for Health and Social Welfare
Federal Republic of Nigeria
November 2026

Acknowledgement

The successful production of the 2026 Joint Annual Review (JAR) Report, otherwise known as the Nigeria Health Sector Statistical Book, would not have been possible without the visionary leadership, strategic direction, and unwavering support of the leadership of the Federal Ministry of Health and Social Welfare. I therefore express my profound appreciation to the Coordinating Minister of Health and Social Welfare and the Honourable Minister of State for Health and Social Welfare for their exemplary leadership, policy guidance, and steadfast commitment to the successful completion of this important publication.

The rich evidence base, analytical depth, and comprehensive insights presented in this report are a testament to the dedication and professionalism of the Department of Health Planning, Research and Statistics (DHPRS) of the Federal Ministry of Health and Social Welfare (FMoHSW), which provided overall leadership and coordination throughout the development process. I particularly commend the leadership and staff of the Monitoring and Evaluation Division, as well as the numerous technical officers and personnel across the Ministry, for their diligence, technical expertise, and unwavering commitment.

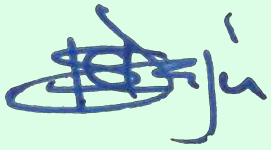
Special recognition is extended to the JAR Efficiency Team and the Data Sub-Committee Team, whose meticulous analytical work, rigorous quality assurance processes, and effective coordination efforts were instrumental in shaping the report. I also acknowledge the Sector-Wide Approach (SWAp) Coordination Office for its pivotal role in fostering sectoral alignment, promoting stakeholder engagement, and facilitating collaboration across the health sector.

The technical robustness of this publication was significantly strengthened by the invaluable contributions and professional expertise of our tertiary health institutions. I sincerely appreciate the clinical specialists and representatives from the National Hospital, Abuja, and the University of Abuja Teaching Hospital (UATH), Gwagwalada, for their insightful inputs, technical reviews, and collaborative support throughout the process.

Our special appreciation goes to all donor agencies, development partners, for their technical and financial contributions, and all stakeholders across the health sector for their enduring partnership and collective commitment to strengthening Nigeria's health system and advancing evidence-based decision-making.

Finally, I extend my heartfelt gratitude, programme managers, technical officers, and members of staff of the Federal Ministry of Health and Social Welfare who contributed, directly or indirectly, to the successful development of this statistical report. It is our firm hope that the evidence, analyses, and insights contained in this publication will continue to inform policy formulation, strategic planning, resource allocation, performance monitoring, and accountability mechanisms across Nigeria's health sector, thereby contributing to improved health outcomes for all Nigerians.





Daju, Kachollom S, mni

Permanent Secretary
Federal Ministry of Health and Social Welfare

About the Report

Purpose of the 2026 Joint Annual Review (JAR)

01	**Review progress on the National and State Performance on the Health Sector Renewal UHC Compact**
02	Review and track progress on the NHSRII priorities and commitments, and the resolutions from the 2025 Sector-wide JAR.
03	Evaluate the sector's performance under the SWAp framework in alignment with HSSB 2023–2027 and the priorities of NHSRII.
04	Spotlight best practices and opportunities and facilitate multi-sectoral cross-learning and collaboration across core initiatives.
05	Jointly identify performance optimisation opportunities and align on the way forward to accelerate progress in 2027

Structure of the Nigeria Health Sector Statistical Book 2026

The Nigeria Health Sector Statistical Book 2026 is the statistical instrument of the Joint Annual Review (JAR) process, providing a consolidated assessment of health sector performance against the Nigeria Health Sector Renewal Investment Initiative (NHSRII) and the Health Sector Strategic Blueprint (HSSB). It supports the One Report principle of the Sector-Wide Approach (SWAp) by bringing together data and evidence from the Federal Ministry of Health and Social Welfare, the 36 States, the Federal Capital Territory, and development partners into a unified sector performance report.

The 2026 edition represents the second annual statistical book developed by the health sector, as precursor for the state of health of the nations report. This edition provides a three-year perspective on progress, achievements, implementation gaps, and emerging priorities in Nigeria's health sector transformation agenda.

The report is organised into seven parts, comprising 23 chapters that examine the national context, health system performance, strategic pillars, enabling systems, priority interventions, and future directions. Part I presents Nigeria's demographic and health system profile, including governance structures, financing arrangements, implementation progress, data sources, methodology, and progress towards Universal Health Coverage (UHC) and SDG 3 commitments.

Parts II to V assess performance across the four HSSB pillars: Leadership and Governance; Efficient and Quality Health Service Delivery; Unlocking the Health Value Chain; and Health Security. These sections review governance and accountability mechanisms, health service availability and quality, RMNCAH+N outcomes, communicable and non-communicable disease programmes, pharmaceutical and supply chain systems, research and innovation, disease surveillance, emergency preparedness, antimicrobial resistance, and climate resilience.

Part VI examines the three critical enablers that support health system performance: Data and Digitisation, Health Financing, and Culture and Talent Management. It assesses progress in strengthening health information systems, improving data quality and digital

transformation, expanding financial protection, enhancing resource mobilisation, and building institutional capacity and workforce performance.

Part VII highlights selected strategic interventions, including MAMII, Primary Health Care revitalisation through BHCPF and PHC Under One Roof, gender and equity initiatives, HOPE PHC, and priority indicators under spotlight, providing deeper insights into implementation progress, lessons learned, and areas requiring further attention.

Supporting material is provided in the annexes.

The 2026 Nigeria Health Sector Statistical Book serves as both an accountability mechanism and a decision-support tool, enabling stakeholders to track progress, identify bottlenecks, strengthen evidence-based planning, and accelerate actions towards improved health outcomes and Universal Health Coverage in Nigeria.

Acronyms

Abbreviation	Meaning
A&E	Accident and Emergency
AAR	After Action Review
ACRN	Africa Clinical Research Network
AFDB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ALGON	Association of Local Governments of Nigeria
AMR	Antimicrobial Resistance
ANC	Antenatal Care
AOP	Annual Operational Plan
API	Active Pharmaceutical Ingredient
ART	Antiretroviral Therapy
BCG	Bacillus Calmette–Guérin (Vaccine)
BEMONC	Basic Emergency Obstetric and Newborn Care
BHCPF	Basic Health Care Provision Fund
CBS	Community-Based Surveillance
CEMONC	Comprehensive Emergency Obstetric and Newborn Care
CEPI	Coalition for Epidemic Preparedness Innovations
CFR	Case Fatality Ratio
CHAI	Clinton Health Access Initiative
CHE	Current Health Expenditure
CHEW	Community Health Extension Worker
COVID-19	Coronavirus Disease 2019
CPAP	Continuous Positive Airway Pressure
CRVS	Civil Registration and Vital Statistics
CSM	Cerebrospinal Meningitis
CSO	Civil Society Organisation
CT	Computed Tomography
DAPS	Departments, Agencies and Parastatals
DHIS2	District Health Information Software 2
DHPRS	Department of Health Planning, Research and Statistics
DHS	Demographic and Health Survey

Abbreviation	Meaning
DLI	Disbursement-Linked Indicator
DQA	Data Quality Assessment
DR-TB	Drug-Resistant Tuberculosis
DRF	Drug Revolving Fund
DTP3	Diphtheria, Tetanus and Pertussis (Third Dose)
EBF	Exclusive Breastfeeding
EBS	Event-Based Surveillance
ECM	Enterprise Content Management
EIB	European Investment Bank
EMR	Electronic Medical Record
EO	Executive Order
EOC	Emergency Operations Centre
EVD	Ebola Virus Disease
EWARS	Early Warning, Alert and Response System
FASTR	Frequent Assessments and System Tools for Resilience
FCT	Federal Capital Territory
FHIR	Fast Healthcare Interoperability Resources
FMC	Federal Medical Centre
FMoHSW	Federal Ministry of Health and Social Welfare
FP	Family Planning
FTH	Federal Teaching Hospital
GDP	Gross Domestic Product
GGHE	Government General Health Expenditure
GLASS	Global Antimicrobial Resistance and Use Surveillance System
HBV	Hepatitis B Virus
HESP	Health Security Programme
HIE	Health Information Exchange
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMO	Health Maintenance Organisation
HNAP	Health National Adaptation Plan
HOPE-PHC	Health Opportunities for People Everywhere – Primary Health Care
HREC	Health Research Ethics Committee

Abbreviation	Meaning
HRH	Human Resources for Health
HSSB	Health Sector Strategic Blueprint
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDSR	Integrated Disease Surveillance and Response
IFA	Iron and Folic Acid
IHR	International Health Regulations
IOM	International Organization for Migration
IPC	Infection Prevention and Control
IPTP	Intermittent Preventive Treatment of Malaria in Pregnancy
IVF	In Vitro Fertilisation
JAP	Joint Application Package
JAR	Joint Annual Review
JEE	Joint External Evaluation
JMP	Joint Monitoring Programme
LBW	Low Birth Weight
LGA	Local Government Area
LIMS	Laboratory Information Management System
LLIN	Long-Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MAMII	Maternal Mortality Reduction Innovation Initiative
MDAS	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria
MEARL	Monitoring, Evaluation, Accountability, Research and Learning
MHRA	Multi-Hazard Risk Assessment
MLSCN	Medical Laboratory Science Council of Nigeria
MMR	Maternal Mortality Ratio
MMS	Multiple Micronutrient Supplement
MNCH	Maternal, Newborn and Child Health
MOC	Ministerial Oversight Committee
MOU	Memorandum of Understanding
MPCDSR	Maternal, Perinatal and Child Death Surveillance and Response
MRI	Magnetic Resonance Imaging

Abbreviation	Meaning
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NAIIS	Nigeria HIV/AIDS Indicator and Impact Survey
NAPHS	National Action Plan for Health Security
NBS	National Bureau of Statistics
NBSA	National Blood Service Agency
NCD	Non-Communicable Disease
NCDC	Nigeria Centre for Disease Control and Prevention
NCH	National Council on Health
NCRC	Nigeria Clinical Research Consortium
NDHS	Nigeria Demographic and Health Survey
NEMA	National Emergency Management Agency
NEMSAS	National Emergency Medical Services and Ambulance System
NFELTP	Nigeria Field Epidemiology and Laboratory Training Programme
NHFR	Nigeria Health Facility Registry
NHIA	National Health Insurance Authority
NHLMIS	National Health Logistics Management Information System
NHMIS	National Health Management Information System
NHRC	National Health Research Committee
NHREC	National Health Research Ethics Committee
NHSRII	Nigeria Health Sector Renewal Investment Initiative
NHTDAO	National Health Technology and Data Analytics Office
NICRAT	National Institute for Cancer Research and Treatment
NIMR	Nigerian Institute of Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NISS	National Influenza Sentinel Surveillance
NMDHS	Nigeria Mini Demographic and Health Survey
NMEP	National Malaria Elimination Programme
NNRA	Nigerian Nuclear Regulatory Authority
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NTBLCP	National Tuberculosis, Leprosy and Buruli Ulcer Control Programme
NTD	Neglected Tropical Disease

Abbreviation	Meaning
NTHISC	National Tertiary Health Institutions Standards Committee
OOP	Out-of-Pocket (Expenditure)
PCN	Pharmacy Council of Nigeria
PCR	Polymerase Chain Reaction
PFR	Program-for-Results
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PHEOC	Public Health Emergency Operations Centre
PLHIV	People Living with HIV
PMS	Performance Management System
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PPP	Public–Private Partnership
PVAC	Presidential Initiative for Unlocking the Healthcare Value Chain
R&D	Research and Development
RCCE	Risk Communication and Community Engagement
RDT	Rapid Diagnostic Test
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health plus Nutrition
RRT	Rapid Response Team
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SAPHS	State Action Plan for Health Security
SARA	Service Availability and Readiness Assessment
SBA	Skilled Birth Attendant
SCBU	Special Care Baby Unit
SCH	State Council on Health
SDG	Sustainable Development Goal
SEMSAS	State Emergency Medical Services and Ambulance System
SIMEX	Simulation Exercise
SMC	Seasonal Malaria Chemoprevention
SMOH	State Ministry of Health
SOP	Standard Operating Procedure
SORMAS	Surveillance Outbreak Response Management and Analysis System
SPAR	State Party Self-Assessment Annual Reporting

Abbreviation	Meaning
SRH	Sexual and Reproductive Health
SWAP	Sector-Wide Approach
TB	Tuberculosis
THE	Total Health Expenditure
TPT	Tuberculosis Preventive Treatment
TWG	Technical Working Group
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
VASA	Verbal and Social Autopsy
VII	Vaccine Independence Initiative
VVF	Vesico-Vaginal Fistula
WAHO	West African Health Organisation
WASH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organization

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Executive Summary

The 2026 Joint Annual Review (JAR) Statistical Book assesses the third year of implementation of the Health Sector Strategic Blueprint (HSSB), the operational framework of the Nigeria Health Sector Renewal Investment Initiative (NHSRII). It covers January to September 2026 and tracks performance across the HSSB's four pillars and three enablers, its 27 priority initiatives and 265 strategic interventions.

The review is anchored on the Health Sector Renewal Compact signed on 12 December 2023 by the Federal Government, all 36 State Governors, the FCT Administration and development partners, and reaffirmed through the Compact Addendum, which extended the partnership to Local Governments (ALGON), the private sector, traditional and religious institutions and civil society. Under the Compact, signatories committed to a Sector-Wide Approach (SWAp) built on one plan, one budget, one report and one conversation; to align all resources with the HSSB; to measure NHSRII progress using the NDHS, the Mini-DHS and quarterly performance reports; and to build a national health data ecosystem that serves as one source of truth. This summary assesses performance against those commitments.

Overall assessment

Three years in, the Compact has delivered its clearest results in governance, coordination and system-building. The architecture of mutual accountability is now in place and functioning at federal and state levels, and every state and development partner is aligned with the NHSRII Compact. Facility-reported maternal, neonatal and under-five deaths are falling, particularly where MAMII and BHCPF investments are concentrated. However, these gains are not yet visible in population-level outcomes, which remain far from SDG 3 targets. Progress in the final year of the HSSB will depend on closing four cross-cutting gaps: domestic financing and budget execution, the health workforce, the enforcement of standards, and the completeness of the data needed to evaluate the NHSRII at end-term.

Key achievements against Compact commitments

Effective governance, coordination and mutual accountability (Pillar I)

- **Compact expanded and strengthened.** The Compact Addendum was signed, bringing ALGON, the private sector and traditional and religious institutions into the partnership. The revised Compact now integrates a Code of Conduct for partner coordination, with onboarding under way across states.
- **Full alignment of signatories.** All in-country donor partners and all 36 states and the FCT are aligned with the NHSRII Compact (100% in both 2025 and 2026). Partner commitments rose from 34.0% to 41% of total AOP cost.
- **One conversation institutionalised.** All states and the FCT conducted a state JAR in 2026 (up from 90% in 2025), and the share held on schedule in the July window

rose from 50% to 73%. The 2025 National JAR convened more than 1,000 delegates, against about 450 in 2024. The MOC is replicated in all states and the FCT, and 90% of recommendations from federal quarterly performance dialogues were implemented (85% in 2025).

- **Policy follow-through.** Implementation of prior-year NCH resolutions rose from 60% to 75%, and the share of State Councils on Health held rose from 10% to 35%.
- **One plan.** All implementing entities have an AOP. States conducting AOP quarterly reviews rose from 56.8% to 81.1%, the AOP funding gap fell from 19.6% to 10%, and the share of AOP cost allocated to PHC rose from 24.3% to 35%.
- **One report.** The State of Health of the Nation Report which highlights the progress of the NHSRII and its effect on the health of all Nigerians and residents has been produced yearly and presented to Mr. President, the National Assembly, Governors, and all Nigerians in line with the provisions of the National Health Act 2014. The report draws from all key routine and periodic data sources.

Efficient, equitable and quality health service delivery (Pillar II)

- **Maternal deaths falling in facilities.** Nationally, facility-reported maternal deaths declined from 5,391 in 2024 to 4,455 in 2025 and 3,370 in 2026.
- **Improvement in child survival.** Nationally, facility-reported neonatal deaths fell by 22% (7,210 to 6,080).
- **Growing PHC revitalisation.** 3,504 PHCs were revitalised in 2026, against 1,610 in 2025. BHCPF PHCs meeting Level 2 standards rose from 21% to 38%, skilled attendance at delivery in BHCPF facilities rose from 87.7% to 96.3%, and maternal deaths in BHCPF facilities fell from 698 to 409. In MAMII LGAs, 91% of BHCPF facilities now have at least two midwives or CHEWs (12% in 2025), and 99% are linked to the emergency referral system.
- **Frontline workforce capacity.** 78,142 PHC frontline health workers have been trained cumulatively, 65% of the overall 120,000 target.
- **Strong disease programme performance.** HIV viral suppression among people on ART stood at 95%, and new HIV cases fell from 108,230 to 70,356. TB treatment success reached 95%, and WHO-recommended molecular diagnostics are now available in all 774 LGAs. ACT treatment covered 96.6% of confirmed malaria cases.
- **Emergency transport expanded.** The public fleet grew from 502 vehicle ambulances to 656, plus 383 tricycle and 14 boat ambulances, including 79 advanced life-support ambulances for federal tertiary hospitals. Emergency transport is now active in all 33 MAMII states, and states with an operational emergency medical team rose from 81% to 89%.

- **Improved financial protection.** Health insurance enrolment rose from 21.1 million to 24.1 million, with 3.1 million vulnerable people covered through the BHCPF. FP and BEmONC are now in the NHIA benefit package, 771 PHC financial management officers have been deployed, and the share of diagnosed cancer patients accessing the Cancer Health Fund rose from 0% to 21%.

Unlocking the health value chain (Pillar III)

- **Local manufacturing is gaining momentum.** PVAC has commissioned 10 factories, concluded 12 technology transfers and 30 strategic partnerships, and built a pipeline of more than 90 companies worth over $5 billion. Financing includes $75 million unlocked for near-term disbursement, $1 billion from Afreximbank and €1 billion from the EIB, and over ₦24 billion in tax waivers for 75 manufacturers.
- **New domestic production lines.** Local LLIN production rose from zero to 2 million nets from two new plants. Four RUTF plants are certified, 51 products have transitioned to local production under the NAFDAC 5+5 policy, and the first local vaccine clinical trial has started.
- **Regulation and supply chains.** NAFDAC sustained WHO Maturity Level 3, and 99.76% of product batches tested met control standards. The national stock-out rate fell from a baseline of 40% to below 25%, and all 37 states and the FCT have functional central medical stores.

Health security (Pillar IV)

- **Faster detection and coordination.** Under NAPHS 2.0, functional PHEOCs rose from 86.5% to 94% of states (35 established). Under the 7-1-7 framework, detection within 7 days rose from 78% to 87% and notification within 1 day from 85% to 89%. SORMAS operates in over 3,720 facilities, IDSR completeness is 94%, PCR testing has expanded from 5 to 29 laboratories, and 7 genomic sequencing centres are active.
- **Domestic funding for emergencies.** The government approved over ₦700 million for Ebola preparedness in June 2026 and ₦10 billion for the response after the index case was confirmed on 20 October 2026.
- **Climate and health leadership.** Nigeria ranked 2nd of 117 countries on the 2026 Healthy NDC Scorecard. The Health National Adaptation Plan (2025–2030) has been domesticated by 21 states, up from 15.

The three enablers

- **Data and digitisation.** The NHTDAO has been established and the FHIR standard adopted. Facilities reporting electronically to DHIS2 rose from 34% to 72%, and the national data quality score is 90.9%.

- **Health financing.** State health budget allocations rose from ₦2.48 trillion (2025) to ₦3.55 trillion (2026) , and the share of BHCPF appropriation disbursed rose from 11% to 26.9% by mid-year.
- **Culture and talent.** FMoHSW staff trained on the Performance Management System rose from 79.93% to 90%, and health DAPs trained on the Performance Monitoring System from 90% to 92%. The average appraisal score of top health sector leadership rose from 73% to 85%, and National Health Fellows 2.0 has been deployed across all 774 LGAs.

Key areas for improvement

- **Population health outcomes remain below targets.** The MMR stands at 572 per 100,000 live births (SDG target below 70), with a heavier rural burden (656) than urban (444). Under-five mortality is 110 and neonatal mortality 41 per 1,000 live births, against targets of 25 and 12. Only 50.0% of births are assisted by a skilled provider and 47.8% take place in a health facility.
- **Immunisation, family planning and nutrition needs further improvement.** Penta 3 coverage is 54.8% and full immunisation 40% (NMDHS 2025). The proportion of zero-dose children rose from 28% to 33%, and BCG coverage fell from 69% to 62%. Modern contraceptive prevalence is 18.3%, the adolescent birth rate is 69 per 1,000, and 42.1% of children under five are stunted.
- **Domestic financing falls short of the Compact's ambition.** Although the federal health allocation rose from ₦2.48 trillion in 2025 to ₦3.55 trillion in 2026, health remains under-prioritised in public budgets. States devoted only 6.98% of actual spending to health and executed 61.74% of their health budgets in 2025. Government health expenditure is 5.6% of total government spending, against the Abuja target of 15%. Implementation of the government-funded share of AOP activities fell from 38.4% to 35%, and only 33.1% of the BHCPF appropriation had been disbursed by mid-year.
- **Health insurance coverage lags behind population growth.** Coverage stands at 10.1% of the population, against a 2027 target of 20% and a 2023 baseline of 9%.
- **The health workforce crisis persists.** The training of frontline health workers has stalled in 2026 (approximately 10,000) compared to 63,233 in 2025. Health workforce migration continues to pose significant challenges. Most Federal tertiary hospitals report that staff attrition remains a challenge
- **Facilities are being assessed for standards but not certified.** No PHC, public secondary or private facility has been issued a certificate of standards, and only 28% of federal tertiary facilities hold provisional certificates. Although 2,500 PHCs are BEmONC-ready, none is certified. No regulatory register is yet interoperable with the National Health Workforce Registry.

- **Service gaps persist for NCDs and PMTCT.** Only 16.1% of public facilities offer hypertension services and 15.7% diabetes services, falling to 13.6% and 12.9% at PHC level. Reported ART coverage among pregnant women fell from 61% to 40%, and pregnant women with viral suppression from 95% to 79%. TB notifications reached 45.8% of target, and TB preventive therapy 51.4%.
- **Outbreak response is suboptimal. Despite improving emergency preparedness, response times to disease outbreaks are slow.** Only 22% of public health events met the 7-day early response target, and 19% met all three 7-1-7 targets. SPAR scores are weakest for human resources, food safety and chemical events (40% each), while IPC and risk communication are (46.7% each). Lassa fever recorded a case fatality ratio of 23.6%; cholera (70,947 suspected cases across 35 states) and diphtheria (16,556 confirmed cases) remain widespread; and Nigeria confirmed an Ebola index case in October 2026.
- **The "one source of truth" is not yet achieved.** Parallel data systems continue to proliferate despite the NCH resolution adopting DHIS2 as the sole aggregation platform. DHIS2 reporting timeliness fell from 88% to 79.7%, EMR and interoperability indicators remain pending, and several SDG 3 and programme indicators (HIV, TB, NCD mortality and the UHC service coverage index) could not be reported for 2026.
- **Accountability follow-through is uneven.** Despite efforts to improve accountability and transparency in the course of implementation of the NHSRII as evidenced by conduct of quarterly review meetings, joint annual review meetings and ministerial oversight and State oversight meetings, significant gaps exist in data available and used to drive the reviews.
- **Institutional reforms on culture and talent within MDAs are stalled.** Limited evidence is available on implementation of Performance Management System targeting health workers in both federal, state and LGAs; federal staff performance target dropped from 82.1% to 71%, while satisfactory performance ratings fell from 82% to 80%.

Table ES.1: Progress on selected HSSB tracer indicators against 2027 targets

Indicator	Baseline (2023)	Achievement (2024–26)	Target (2027)
NCH governance and oversight meetings held annually	1	3 (75%) on track	4
State of Health of the Nation reports disseminated	1	2 (50%) on track	4
Stakeholder membership of the Ministerial Oversight Committee	60%	80%	90%
Population covered by health insurance	9%	10.1%	20%
Frontline health workers trained (cumulative)	–	78,142 (65%)	120,000
Health commodities produced in Nigeria through government support	25%	38% (2025)	40%

Indicator	Baseline (2023)	Achievement (2024–26)	Target (2027)
Maternal mortality ratio (per 100,000 live births)	512 (NDHS 2018)	572 (NDHS 2024)	<70 (SDG 2030)

Source: HSSB results framework

Priorities for 2027, the final year of the HSSB

- **Ramp up interventions to crash Maternal and Newborn deaths.** Intentionally increase the number of BHCPF facilities (2-3 per Ward) in high burden LGAs and close the gap in institutional SBAs (ensure that only skilled birth attendants take deliveries especially in BHCPF facilities.
- **Grow domestic financing.** Reverse the decline in the federal health allocation, raise state health spending and budget execution, and accelerate BHCPF releases, in line with the Compact's one-budget commitment.
- **Establish the National HRH Programme.** Institute the HRH programme with a national programme manager and operational plan, that include costed workforce absorption and retention plans in every state to stem migration and attrition.
- **Issue certificates of standards now.** States and LGAs should issue certificates to qualifying primary and secondary facilities immediately, starting with the 2,500 BEmONC-ready PHCs, while the Standards Tertiary Committee continue to issue certificates of standards to qualified tertiary facilities
- **Convert system gains into outcomes.** Aggressively pursue an integrated approach to service delivery that will ensure integrated counselling, screening, testing and treatment especially for women and children under-five.
- **Deliver one source of truth before the end-term evaluation.** Enforce DHIS-2 as the sole aggregation platform, link EMRs and registries to it, and close the indicator gaps identified in this report.
- **Speed up outbreak response.** Meet the 7-day early response target under 7-1-7, strengthen state rapid response teams and sustain financing for the Ebola response.
- **Deepen mutual accountability.** Institutionalise review mechanisms such as quarterly dialogues and Joint Annual Review at Federal, State and LGA level, and ensure that such reviews are driven by complete and timely data.

The Compact has built the platform for a unified, accountable health sector. This 2026 JAR Statistical Book shows where that platform is working and where it is not. The evidence it presents should guide federal, state and local governments, development partners, the private sector and communities as they plan, budget and act in 2027, the final year of the HSSB. The sector must aim to improve measurable gains in survival, service coverage and financial protection, which the end-term NDHS will assess.

INDICATORS UNDER SPOTLIGHTS

This section identified key priority areas and urgent attention needs.

Table ES.2: Key issues spotlighted in 2026, rationale and recommendations

Key Issues to be Spotlighted in 2026	Rational for spotlighting	Recommendations
POOR UPTAKE OF ANC SERVICES ANC services (at least 4 ANC visits) remain poor across the country, with 13 of 36 states and FCT below the 50% lowest threshold.	Nationally, the share of women completing 4 recommended ANC visits among those who have ANC1 has risen steadily from 39.0% in 2023 to 53.2% in 2026. However, roughly 1 in 2 women who attend a first ANC visit do not complete the full 4-visit schedule. Going by Zones, there is a 29-point gap separating the highest (South West; 69.1%) and lowest (North Central; 40.2%) performing zones, pointing to uneven ANC follow-up systems and access across regions. At the state level, there is a 70-point gap separating the highest (Lagos; 96.2%) and lowest (Benue; 26.7%) performing.	More coordinated and integrated health promotion intervention such as community-led line-listing of pregnant women, incentive-based system for pregnant women etc.
LIMITED MEASUREMENT OF NON-COMMUNICABLE DISEASES	Evidence is limited for national planning for growing incidences of cardiovascular diseases, cancers, diabetes and kidney diseases, chronic respiratory diseases, neurological and mental health disorders, musculoskeletal disorders, digestive and liver diseases. Current measurements	Holistic and integrated data collection and management at Community, PHCs, Secondary and Tertiary levels of care, leveraging technology such as EMR.
Weak Regulation of Food and Drugs	Despite efforts by NAFDAC, there are growing is growing public concerns over suspected either fake, substandard and adulterated medicines and beverages as well as unwholesome or unsafe food products. Available evidence does not reflect a holistic system for ensuring strict manufacturing standards, statutory regulation, and safety management. Adapted coverage measures are recommended.	NAFDAC to partner with Universities and public health institutions in regulatory activities. State and LGAs should be strengthened to play their roles in food, drinking water, drug and chemical regulations.

Data Sources Methodology and Analytical Approach

The Department of Health Planning, Research and Statistics (DHPRS) of the Federal Ministry of Health and Social Welfare (FMoHSW) coordinated the methodology for the 2026 JAR Statistical Book. An inaugural meeting was held in August 2026 to establish the task force and five subcommittees, including the Data subcommittee, which coordinated data collection, analysis, validation, and reporting.

The primary review period covered January to September 2026, while data from earlier reporting periods were included where relevant to support trend analysis and comparison. Routine health service data were obtained from the national DHIS2 instance and presented as FASTR-adjusted outputs. The FASTR approach compares the number of services recorded with the number expected based on historical trends and seasonal patterns. Its statistical procedures account for variations among health facilities, unusual observations, missing data, and incomplete reporting.

Population-based estimates were obtained from the Nigeria Demographic and Health Survey (NDHS) and the Mini Demographic and Health Survey (Mini-DHS). Programme data were submitted by departments, agencies and parastatals (DAPs) at the federal and subnational levels, while information on the number and distribution of health facilities was obtained from the Nigeria Health Facility Registry (NHFR). Information on citizens' experiences of healthcare services was drawn from the annual Patient Perception Survey.

Data submitted by state and federal tertiary hospitals were based on the facilities' administrative records and reported as received. Values outside the expected range were flagged for verification rather than altered without documented justification. Where routine health information and population-based survey estimates differed, both values were presented, with the relevant reporting year and data source clearly identified. This approach preserves transparency and enables readers to interpret differences arising from the methods, coverage, and reporting periods of the respective data sources.

LIMITATIONS

The JAR Statistical Book presents a point-in-time assessment based on data available during the reporting cycle. Some datasets may be revised subsequently as additional reports are received, validation exercises are completed, and updated information becomes available. Interpret the findings in relation to the stated data sources, reference periods, and methodological considerations.

Differences in reporting cycles, data sources, indicator definitions, and denominators affected the comparability of some results. Incomplete or delayed submissions from states and federal tertiary health facilities also limited the scope of analysis for certain indicators. In addition, differences between routine administrative data and population-based survey estimates may reflect variations in methodology, coverage, reference periods, and data quality.

These limitations do not diminish the value of the findings; rather, they highlight areas for improvement within Nigeria's health information system. Strengthening data completeness and timeliness, harmonising indicator definitions and reporting periods, improving subnational reporting systems, and institutionalising routine data quality assessments and data triangulation will enhance the reliability, comparability and usefulness of future JAR Statistical Books.

PART I

BACKGROUND AND NATIONAL HEALTH PROFILE



Chapter 1

COUNTRY PROFILE AND DEMOGRAPHIC OVERVIEW



1.1 Nigeria's Geography, Political Structure and Population

Nigeria's population is estimated at 238.2 million in 2026, with annual growth of 2.4%, reflecting sustained demographic growth driven by relatively high fertility levels and population momentum. Persons under 25 years accounted for more than 60% of the population (NPC, 2026; Figure 1).

6th	3.03%	4.9M (2.4%)
World Population Rank	% of World Population	Annual Population Growth Rate %

Figure 1: Nigeria's Geography and Population

Nigeria has 36 States plus the Federal Capital Territory (FCT) with a total of 774 Local Government Areas (LGAs) across the states, which serve as key administrative and health planning units (Figure 2).

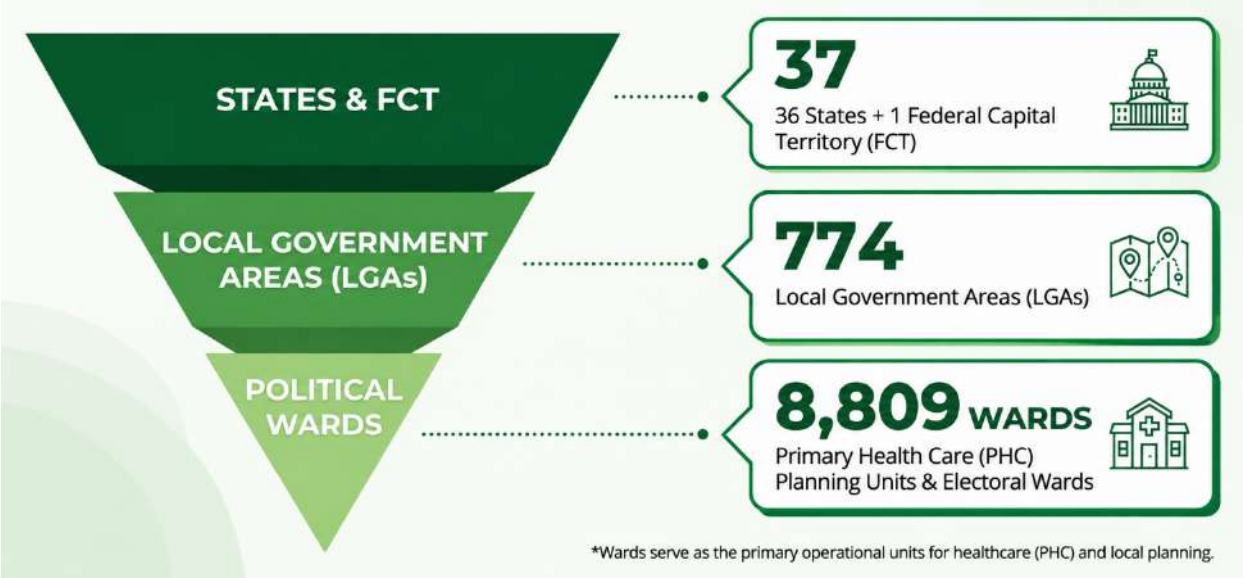


Figure 2: Nigeria administrative hierarchy for Primary Health Care (PHC) planning

1.2 Population Size, Growth and Demographic Characteristics

The size, growth and age structure of a population determine the scale and type of health services a country needs. A large and young population places sustained demand on maternal, newborn, child and adolescent health services, while the pace of population growth affects how quickly coverage targets can be reached. Demographic indicators therefore provide the context for interpreting health sector performance throughout this report (Figure 3).

Table 1.1: Population demographic indicators

Core Indicator	2025	2026	Data Source
Total projected population (millions)	232.7	238.2	NPC 2025–2026
Median population age (years)	19.2	19.3	NPC 2025–2026
Youth population, aged 15–29 (millions)	64.2	66.3	NPC 2025–2026
Urban population (% of total)	50.9%	51.1%	NPC 2025–2026
Infants under one year, millions (% of population)	–	9.0 (3.8%)	
Sex ratio (males per 100 females)	105.4	105.5	NPC 2025–2026
Total fertility rate, national (births per woman aged 15–49)	4.8	4.2	NDHS 2023-24; 2025–26 NMDHS
Total fertility rate (urban)	3.9	3.6	NDHS 2023-24; 2025–26 NMDHS
Total fertility rate (rural)	5.6	4.9	NDHS 2023-24; 2025–26 NMDHS
Life expectancy at birth, both sexes (years)	55.9	56.6	NPC 2025–2026
Life expectancy at birth, male (years)	55.0	55.6	NPC 2025–2026
Life expectancy at birth, female (years)	56.9	57.6	NPC 2025–2026

Figure 3: Projected Population by age and gender. Source NPC

1.3 Population Density and Urbanisation

Population density and urbanisation influence how easily people can reach health facilities and how services should be distributed. Fast-growing urban areas face pressure on infrastructure, water, sanitation and housing, while sparsely populated rural areas often face longer travel distances and fewer health workers. Understanding these patterns helps planners place facilities, staff and commodities where they are most needed (Figure 4).

66 million	19 years	34 million	58 million
Youth Population	Median age of Nigeria's population	Children Under 5 Years	Women of childbearing age

Table 1.2: Population density and urbanisation indicators

Core Indicator	2025	2026	Data Source
National population density (persons per km²)	251.9	257.9	NPC 2025–2026
Highest state population density (persons per km²)	4,270.4	4,345.6	NPC 2025–2026
State with highest density	Lagos	Lagos	NPC 2025–2026
Lowest state population density (persons per km²)	72.1	74.1	NPC 2025–2026
State with lowest density	Taraba	Taraba	NPC 2025–2026
Urban population (% of total)	50.9%	51.1%	NPC 2025–2026
Rural population (% of total)	49.1%	48.9%	NPC 2025–2026
Annual rate of change in urban share, 2025–26 (%)	-	0.24%	NPC 2025–2026
Urban population growth, 2025–26 (%)	-	2.63%	NPC 2025–2026

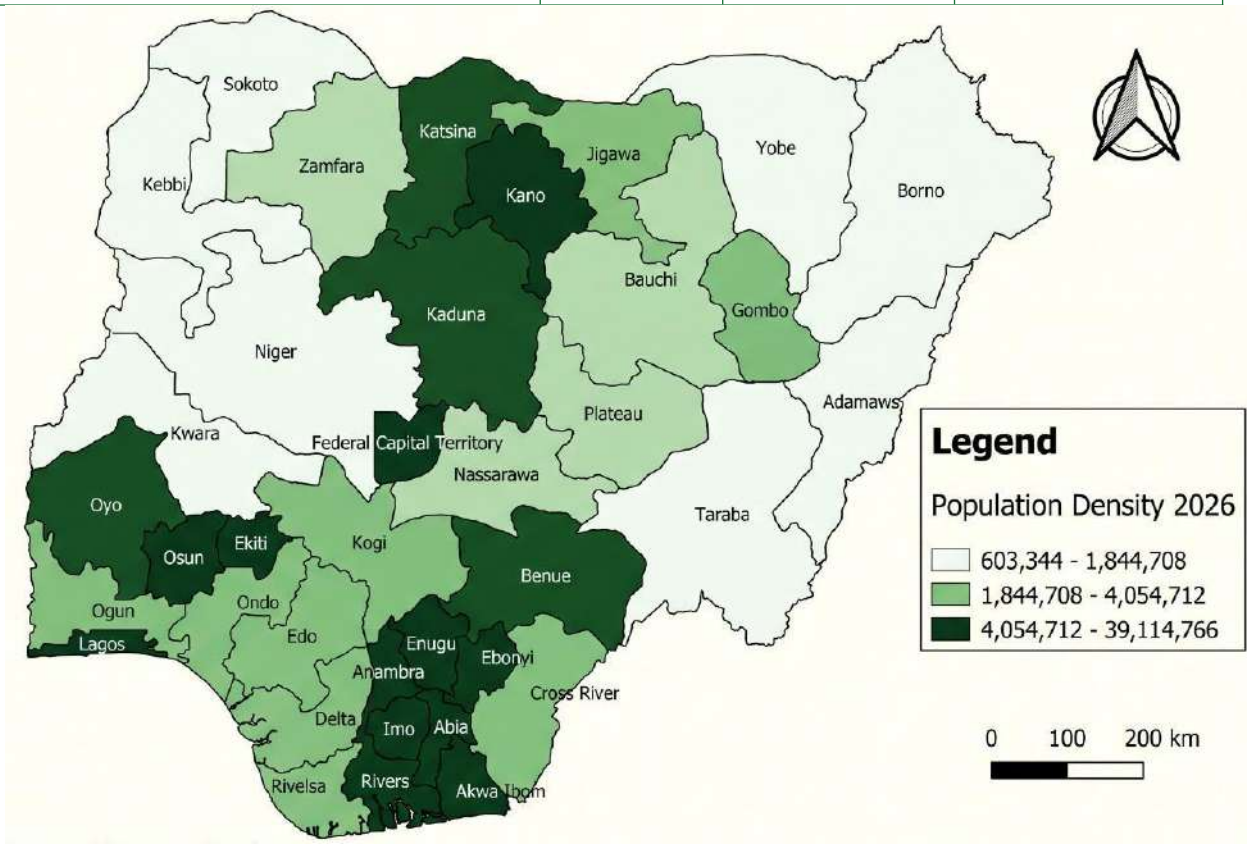


Figure 4: Population Density by State. Source: NPC population projection, 2026.

1.4 Socioeconomic Determinants of Health

Socioeconomic indicators reflect access to education and essential services that shape population wellbeing. Adult literacy stands at 62%, while 47% of female students complete secondary school, highlighting persistent educational and gender gaps (Figure 5).

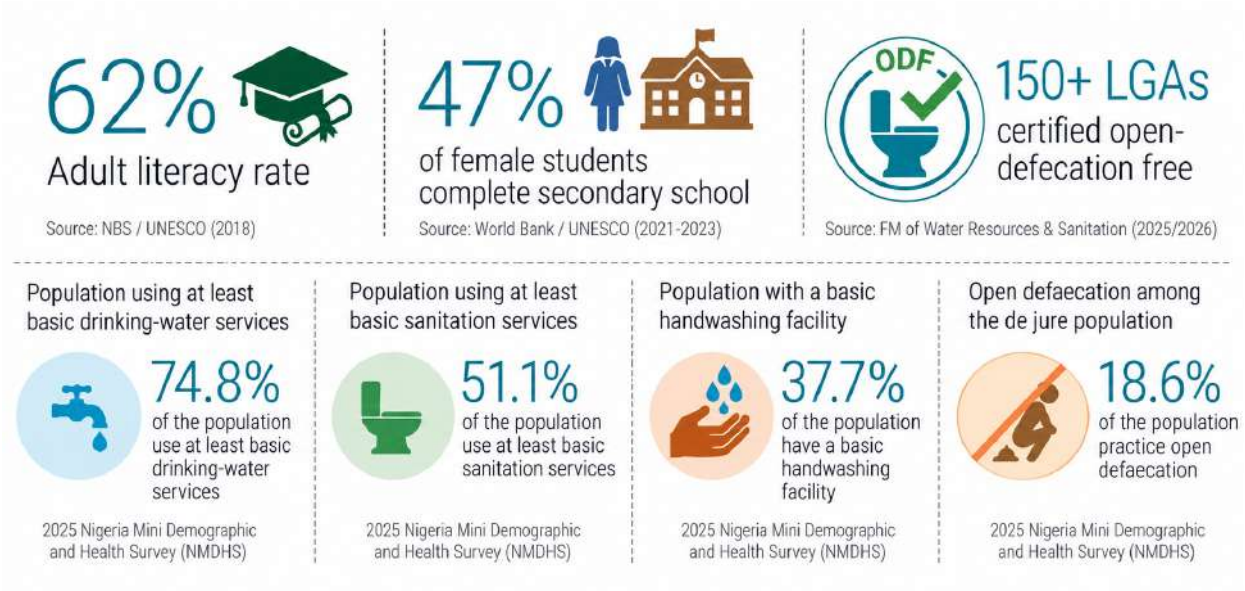


Figure 5: Core Socio-Demographic estimates

Access to basic services also remains limited: 74.8% of the population use basic drinking-water services, 51.1% have basic sanitation, 37.7% have access to basic handwashing facilities and 10% have access to basic water, sanitation, and hygiene services. Open defecation remains at 18.6%, despite more than 150 LGAs being certified open-defecation-free (Figure 6).

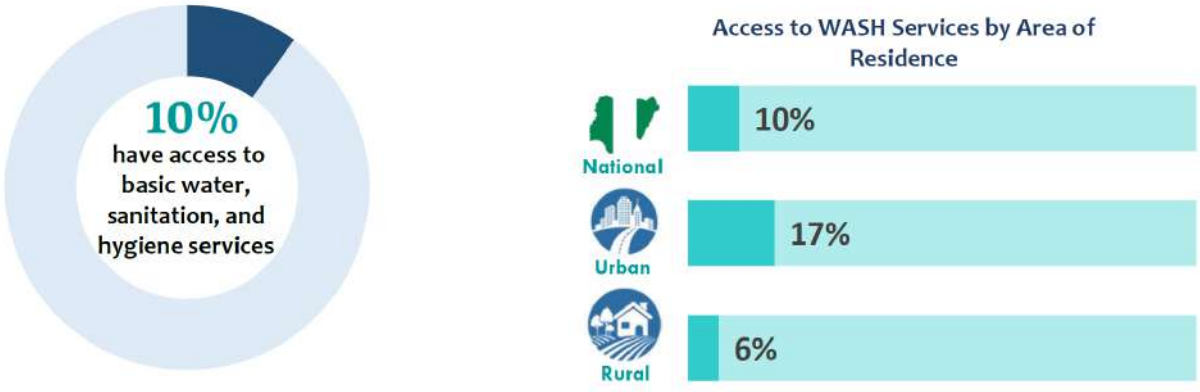


Figure 6: Access to Basic WASH Services

1.5 Poverty, Inequality and Health Equity Indices

Household out-of-pocket spending and poverty levels determine whether people can afford care when they need it, which is central to Universal Health Coverage (UHC). Sources

include the National Health Accounts, the National Health Insurance Authority (NHIA), the Demographic and Health Surveys and the National Bureau of Statistics (NBS).

Table 1.3: Poverty, inequality and health equity indicators

Core Indicator	Value	Data Source
Out-of-pocket health expenditure	71.9% (2023)	National Health Account
Population covered by approved health insurance scheme	Approximately 9%	National Health Insurance Authority (NHIA)
Health insurance coverage among women aged 15–49 years	5% (2025 NMDHS)	Nigeria NMDHS, 2025
Health insurance coverage among men aged 15–49 years	4% (2025 NMDHS)	Nigeria NMDHS, 2025
Government health expenditure per capita	Data not available	Data not available
National multidimensional poverty rate	63% (133 million people)	National Bureau of Statistics (NBS)
Multidimensional poverty by state performance	27% in Ondo to 91% in Sokoto	National Bureau of Statistics (NBS)

These gaps carry through to health service coverage as seen from the survey data (Figure 7).

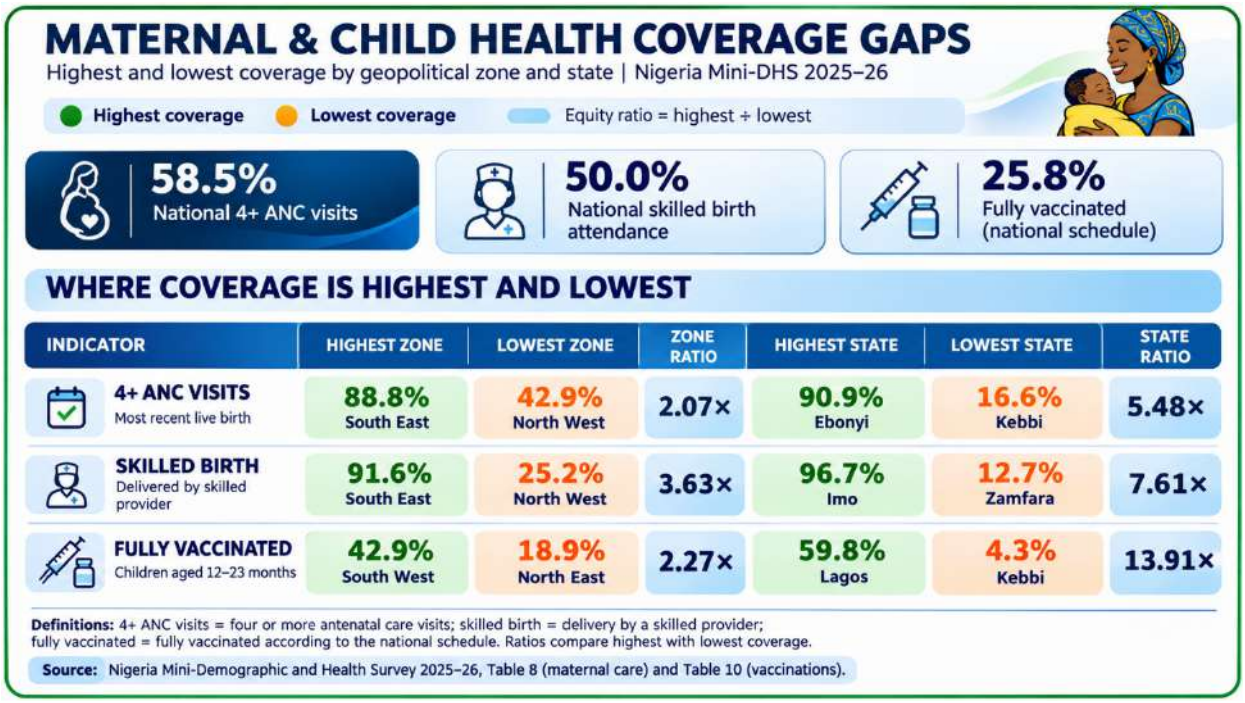


Figure 7: Health service coverage across zones and states. Source NMDHS 2025-26.

Chapter 2

THE NIGERIAN HEALTH SYSTEM — STRUCTURE AND ARCHITECTURE



2.1 Health System Governance and Organisational Structure

Nigeria's health system is organised across three tiers of government: federal, state and local government in accordance with the National Health Act 2014 and other relevant health policies and legislation. The Federal Ministry of Health and Social Welfare (FMoHSW) provides national policy direction, coordination, technical guidance and regulatory oversight, and supports the delivery of tertiary healthcare services through its agencies and federal health institutions (Figures 8 and 9).

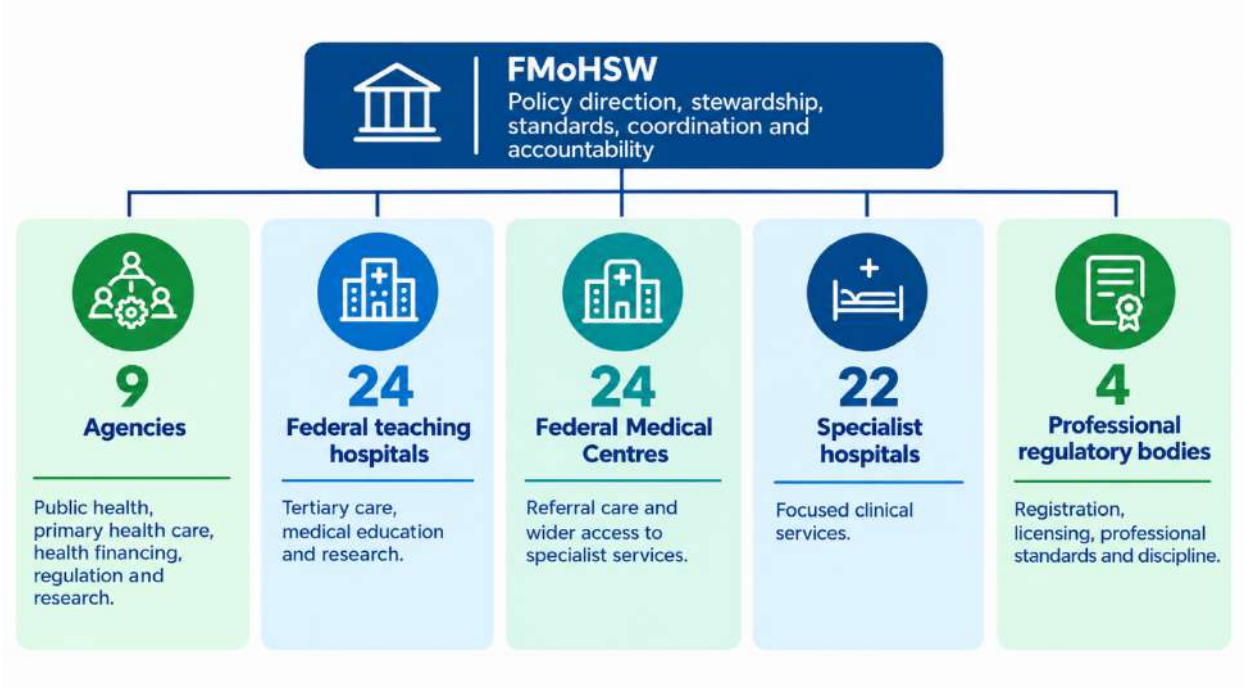


Figure 8: Federal Ministry of Health and Social Welfare: agencies, institutions and regulatory bodies

Chapter 2

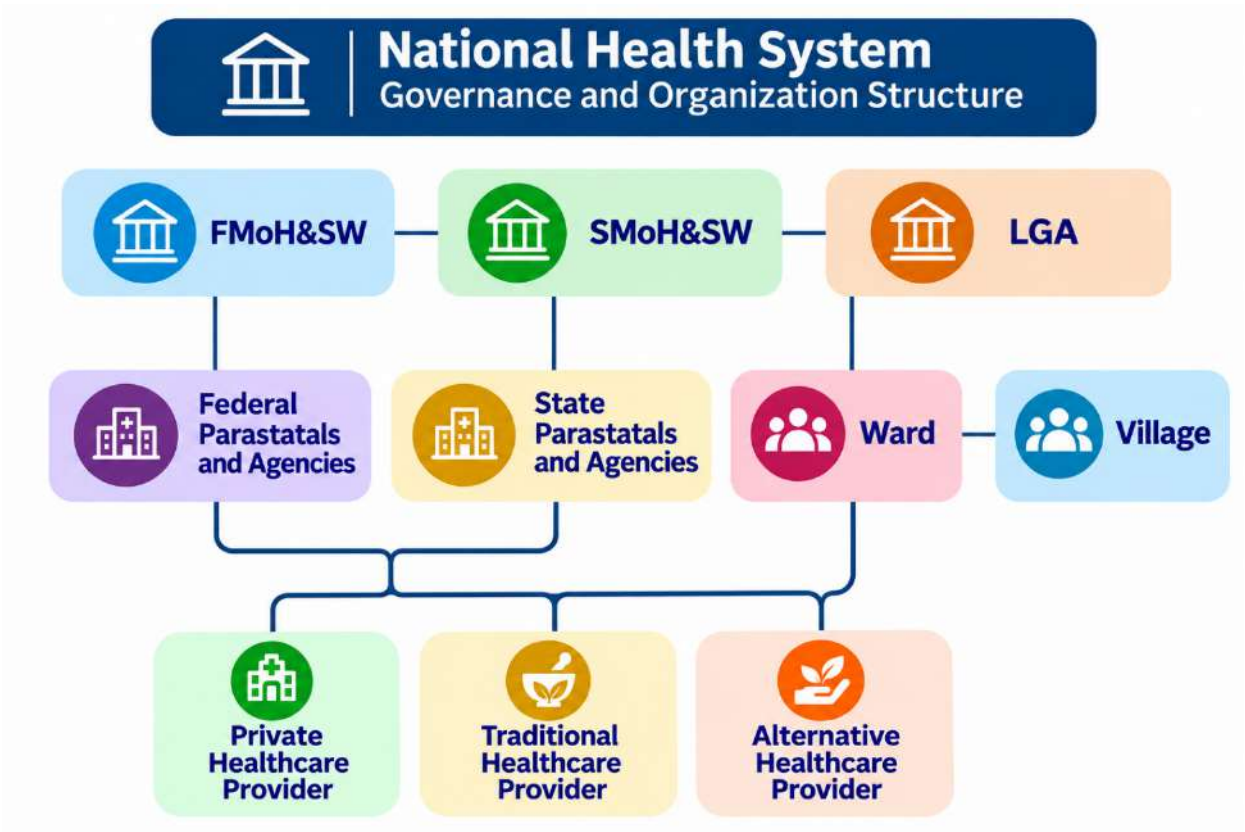


Figure 9: The National Health System-National Health Act 2014

At State level, the health system comprises 36 State Ministries of Health and the FCT Health and Human Services Secretariat, 37 State Social Health Insurance or Contributory Schemes, 37 Hospital/Health Services Management Boards, 37 State Primary Health Care Development Agencies/Boards, State health facility regulatory agencies, 37 Public Health Emergency Operations Centres, and health facilities providing all levels of care. The states more than 1,300 accredited or provisionally approved public and private health training institutions, listed by 12 federal professional regulatory bodies, and offering 1,951 training programmes.

Local Government Health Authorities are functional in all 774 Local Government, overseeing the functionality of Primary Healthcare Centres, and the Ward Development/Health Committees as well as Village Health Committees where operational.

Private Healthcare providers continue to dominate service provision with over 11,000 health facilities, and the growth of digital health in the country. However, the growth and performance of traditional, alternative and complementary healthcare providers remain a grey area in the year under review.

Other Governance body empowered by the National Act (See Annex) are listed in the Table below:

Table 2.1: Governance bodies empowered by the National Health Act 2014

Body	Status
National Council on Health (NCH) & the Technical Committee of the NCH	Functional
National Tertiary Health Institutions Standards Committee (NTHISC)	Functional
Emergency Medical Treatment Committee of the BHCPF	Functional
National Health Research Committee (NHRC)	Functional
National Health Research Ethics Committee (NHREC)	Functional
Institutional Health Research Ethics Committees (HRECs)	Functional
FCT Health Information Committee	Functional
National Drugs Formulary and Essential Drugs List Review Committee	Functional
Independent Tissue Transplantation Committees	Established

Bodies referenced

The NHAct 2014 recognises nine bodies whose roles, mandate, or procedure; mostly depend on other laws, regulations, or state action to exist in practice.

Table 2.2: Bodies referenced in the National Health Act 2014

Body	Role implied by the Act
Ward health committees	Component of the National Health System; implied channel for community participation at ward level
Village health committees	Component of the National Health System at community level
Local government health authorities	Receive BHCPF funds via State PHC Boards; implement HRH distribution programmes; subject to fund withholding
Boards of State and FCT Agencies	Channel BHCPF funds from NPHCDA to LGAs and Area Councils
Boards of Agencies & Parastatals including Tertiary hospital boards	Responsible for providing institutional governance and oversight within their respective mandates.

The health system is currently being governed through the NHSRII which is a reform launched in December 2023. It is implemented through the Sector Wide Approach and guided by the HSSB (Figure 10).

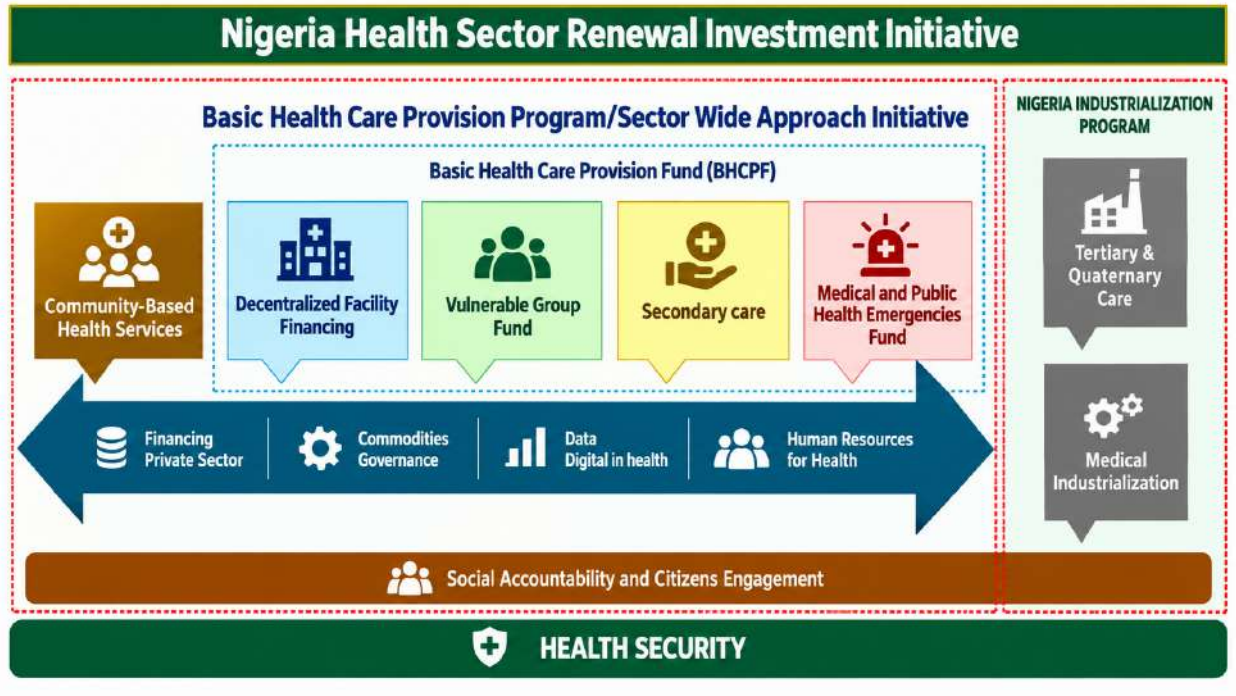


Figure 10: Components of the Nigeria Health Sector Renewal Investment Initiative (NHSRII)

2.2 Health Sector Strategic Blueprint (HSSB)

The Health Sector Strategic Blueprint (HSSB) operationalises the Nigeria Health Sector Renewal Investment Initiative (NHSRII) to save lives, mitigate physical and financial hardship, and produce health for all Nigerians. Structured across four interconnected strategic pillars: Effective Governance, Efficient, Equitable and Quality Health Systems, Unlocking Value Chains, and Health Security. The framework is reinforced by three foundational enablers: Data and Digitisation, Health Financing, and Culture and Talent Transformation within MDAs.

The HSSB organises 27 priority initiatives and 265 strategic interventions tracked systematically through the national Monitoring, Evaluation, Accountability, Research, and Learning (MEARL) plan across all tiers of the federation (Figure 11).

Chapter 2

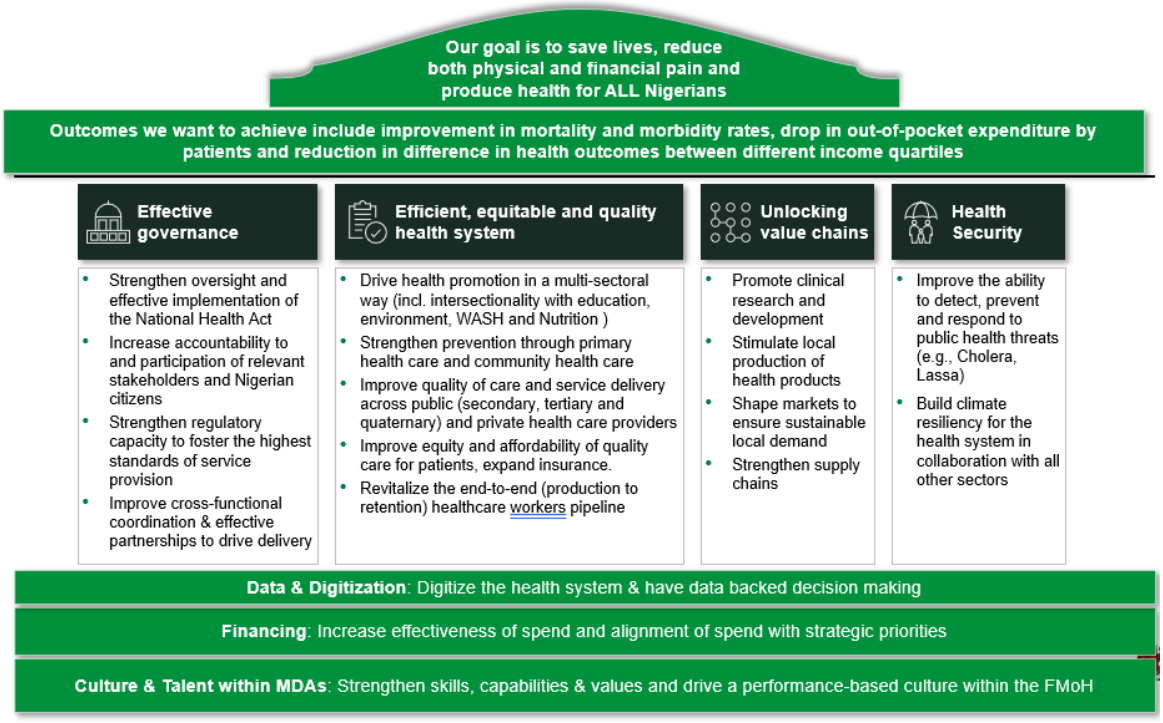


Figure 11: The Health Sector Strategic Blueprint

Chapter 3

HSSB IMPLEMENTATION PROGRESS



3.1 Tracking the Progress of 2024–2025 JAR Resolutions

The progress on the resolutions and commitments arising from the 2024 and 2025 JAR cycles was reviewed to assess implementation, document achievements, and identify outstanding actions. The findings below provide a consolidated overview of implementation status across key priority areas and establish a basis for follow-up during the 2026 review cycle (Figure 12).

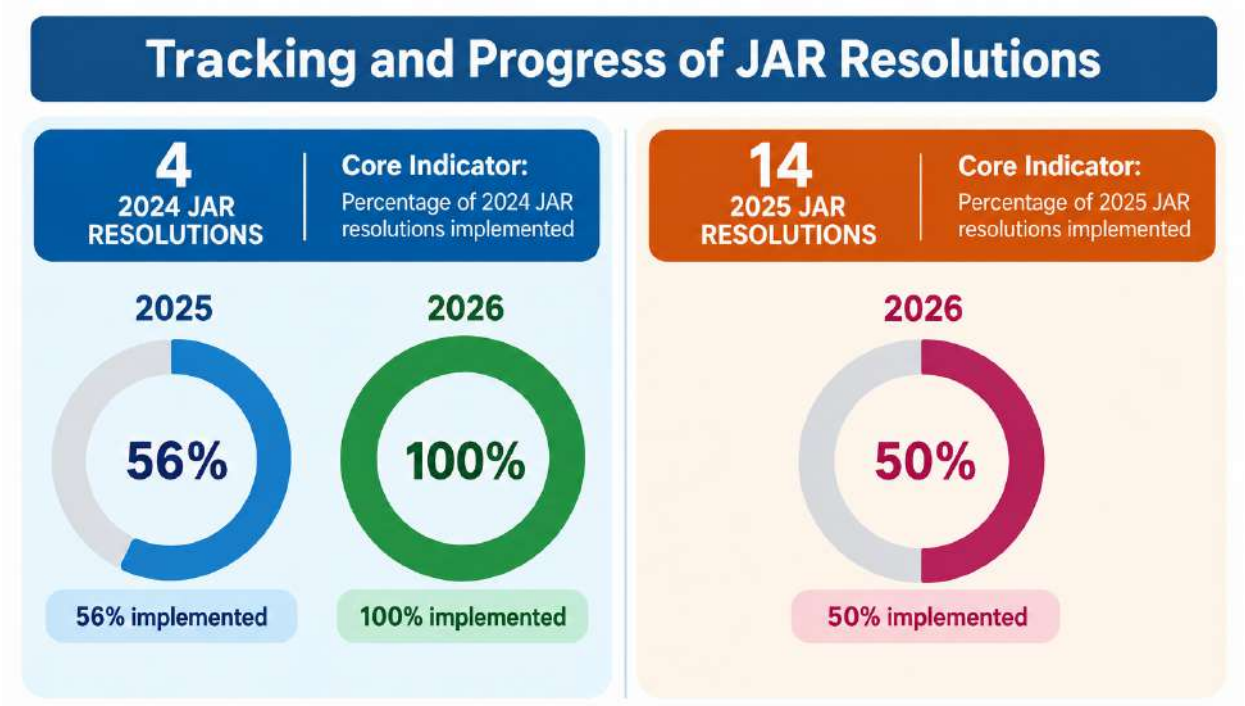


Figure 12: Implementation status of 2024 and 2025 JAR resolutions

Chapter 3

STATUS OF IMPLEMENTATION OF 2024 JOINT ANNUAL REVIEW RESOLUTIONS

Table 3.1: Status of Implementation of 2024 JAR Resolutions

S/N	Resolutions	Progress/ Milestone	Current Status
1	To track the performance of the NHSRII, the FMoHSW should plan and conduct annual mini surveys which would track progress against baseline indicators using building on NDHS 2023 data.	Mini-DHS conducted every 2 years for cost-effectives; 2025 conducted with Kano deep dive. Next is 2027 mini-DHS.	Implemented
2	Future JARs should focus on evaluating health sector performance on key indicators and progress against set milestones in alignment with the NHSRII and SWAp framework - collaboratively brainstorming on innovative solutions to address ongoing challenges, disseminating best practices from the health sector across all levels; as well as celebrating exemplars, and fostering peer learning.	Annual Health Statistics (JAR) produced collaboratively to drive joint evaluation of the health sector.	Implemented
3	Stakeholders to be involved include Federal and State ministries of health and their Agencies; Regulatory and Professional bodies; other relevant government bodies such as the ministries of Environment, Finance, Budget and Economic Planning, Women affairs and Social Development, pharmaceutical and technology companies, private health practitioners, traditional leaders, development and implementing partners, media and citizens.	Broader stakeholders including all stakeholders proposed were invited and participated in the 2025 JAR and being invited to the 2025 JAR meeting.	Implemented
4	Future JARs will begin at the State level, aligning with the annual AOP and budgeting cycle in Q3 (July). The national JAR will take place in Q3 (August), and key resolutions from the JARs will be integrated into the finalised AOPs for the upcoming year.	Some States conducted their JAR before the 2025 JAR, while in 2026, all States and the FCT conducted their JAR before the National JAR.	Implemented

Chapter 3

STATUS OF IMPLEMENTATION OF 2025 JOINT ANNUAL REVIEW RESOLUTIONS

Table 3.2: Status of Implementation of 2025 JAR Resolutions

S/N	Resolution	Progress / Milestone	Current Status
1	Operationalise the UHC Compact Addendum by Q1 2026 through a co-created implementation framework with clear Ask-and-Offer commitments and a robust tracking mechanism.		**Implemented (100%)**
2	Consider adopting biometric verification across all PHCs and health insurance platforms to eliminate ghost workers and strengthen attendance management.	NHIA has adopted the National Identification Number (NIN) as a mandatory criterion for enrolee enrolment. However, States are yet to implement the recommendation of the use of biometric verification for PHC workers.	**Ongoing (50%)**
3	Enhance HRH transparency and performance, drawing from the Gombe model (to be formalised at the National Council on Health (NCH).	**i.** Task team established under the SWAp HRH TWG to coordinate scale-up of the Gombe State model. **ii.** Implementing Partners mobilised to support development of a blueprint for replication across other states. **iii.** Capacity Connect engaged as co-lead of the task team, leveraging its ongoing support to Gombe, Kaduna and Kano States. **iv.** Training on Health Workforce Performance and Productivity commenced in Gombe State. **v.** Alignment secured among MDCN, the National Postgraduate Medical College and FMoHSW to enable Medical Officers to perform emergency obstetric and paediatric procedures. The Task-Shifting and Task-Sharing Policy and implementation plan have been revised to reflect this, with clearly defined modalities for roll-out.	**Ongoing (70%)**
4	Strengthen integrity, transparency and fiduciary controls by rolling out digital expenditure tracking and biometric attendance across all BHCPF-supported facilities by Q3 2026, supported by empowered oversight committees.		Not started (0%
5	Improve data quality and use for action by implementing robust quality assessment plans, optimising DHIS2, and strengthening data culture and management practices across levels.	States have been supported with EMR deployment to over 4,500 facilities, while States and the private sectors have also digitalised more facilities in 2026. Interoperability layer for linkage to the DHIS-2 have been developed to link the NHFR and all EMRs to the DHIS-2	Ongoing (40%)

S/N	Resolution	Progress / Milestone	Current Status
6	Advance HRH reforms by establishing a National HRH Programme and exploring deployment of new cadres of the future health workforce aligned with Nigeria's emerging service-delivery priorities and long-term economic ambitions, including value chain optimisation, regulation and management.	Implementation framework being developed for the establishment of the National HRH programme, while training of Biomedical scientists and paramedics gained significant focus in 2026.	**Ongoing (30%)**
7	Accelerate and scale the MAMII programme nationally; close the financing gap through domestic resource mobilisation and private-sector resource pooling; strengthen SBBC and community engagement; and expand to new LGAs guided by mini-DHS data, with full scale-up of MPCDSR and referral systems by Q4 2026.	**Domestic resource mobilisation:** A maternal health financing roundtable was convened with government, development partners and civil society to identify sustainable financing and accountability mechanisms. The National Maternal Survival Investment Plan has been analysed in four states, with plans to extend the analysis to other MAMII states. **Private-sector resource pooling:** A private-sector compact has been developed, with organisations expressing interest in supporting HRH, infrastructure, commodities and equipment. MTN Group Foundation and the Gates Foundation announced plans for a maternal health multiplier platform. **SBBC scale-up:** The Safer Birth Bundle of Care expanded from 6 facilities in 2 states in 2025 to 117 facilities in 10 states in 2026. An implementation guideline has been developed and integrated into the Team OB/Team Neo framework. **Community engagement:** Approximately 2,000 CBHWs have been deployed across five states to identify pregnant women and generate demand for services. Six additional states have signed MoUs and are preparing for CBHW deployment. **MPCDSR:** Secondary and tertiary facilities across 100 MAMII LGAs in 11 states have completed MPCDSR training, reactivated committees and commenced reporting through the NOQA platform. **Referral systems:** The RESMAT emergency transport and referral system has been rolled out across all 172 MAMII LGAs, with over 5,000 emergency cases dispatched.	**Ongoing (70%)**
8	**Improve access to and quality of SRH through policy domestication, sustainable financing, community engagement and stakeholder collaboration.**		Ongoing (75%)

S/N	Resolution	Progress / Milestone	Current Status
	a. Domesticate and disseminate key policies (SToP, VAPP, TSTS, etc.) across remaining states by leveraging the Governors' Forum, First Ladies' Forum and targeted sensitisation of state health leaders and traditional and religious leaders, while reviewing constitutional provisions to reinforce the fundamental right to life.	The SToP Guidelines and VAPP protocol have been launched and domesticated in 2 of 8 states. The remaining 6 states are at various stages of validation, finalisation and stakeholder engagement, with dissemination planned across all 8 implementing states in November 2026.	**Ongoing**
	b. Integrate SRH (family planning, post-abortion care) into maternal health service delivery at all levels.	FP/PAC has been integrated across all 250 SRH-supported facilities, with over 2,000 providers demonstrating competency and more than 4,000 referrals generated through strengthened provider capacity, supportive supervision and referral systems.	**Implemented**
	c. Urgently address family planning stockouts and strengthen sustainable SRH financing through a total market approach, leveraging the DRF for paying clients, ensuring full SRH coverage under BHCPF, and prioritising vulnerable groups for free or subsidised services.	Commodity availability improved across 80 supervised BEmONC facilities, and 72 government stakeholders were trained in forecasting and quantification. States are strengthening DRF systems to support sustainable commodity financing and availability. Financing mechanisms are increasingly being integrated into state systems, including BHCPF, BENSHIA and DRF, alongside efforts to sustain free FP services. However, a comprehensive total-market financing approach is yet to be fully institutionalised across all states.	**Ongoing**
	d. Apply a life-cycle approach to SRH programming to ensure state-specific prioritisation and contextualisation, including integrating post-menopausal care into key policies and programmes.	A life-cycle approach to SRH, including post-menopausal care, has been integrated into the RH Policy. The policy is being finalised for launch at the NCH.	**Ongoing**
	e. Deploy CSOs to strengthen community awareness, shift harmful norms and drive demand for SRH services, while addressing socio-economic determinants of maternal mortality, such as girls' and women's education, through coordinated multi-sectoral collaboration.	Community mobilisation has expanded, with 1,275 Youth Champions deployed, over 34,000 Little Sisters reached with SRH information, and more than 10,000 community, peer and advocacy activities conducted. 31,503 pregnant women were line-listed, 12,972 referred for ANC, and 3,427 adolescents linked to Big Sisters.	**Implemented**
9	Deploy and scale the PHC Financial Management System and explore linkages with financial institutions to improve real-time visibility and mitigate fiduciary risks.	Deployed PHC FMS in 21 states. Recently obtained MOC approval to proceed with plans to integrate the system with financial institutions.	Ongoing(60%)

S/N	Resolution	Progress / Milestone	Current Status
10	Expand health insurance coverage and equity programmes by enforcing employer insurance mandates for all organisations engaging with government, scaling equity schemes, digitising enrolment and claims, and enrolling 5 million Nigerians, including 1 million additional vulnerable persons, by end-2026.	-As of Q3 2026, Health Insurance in Nigeria has expanded to 24,098,965 enrolees, increase over 16,797,451 recorded in Q4 2023. As of Q3 2026, 3,182,943 vulnerable Nigerians were enrolled in health insurance under the BHCPF across all 36 states and the FCT, up from 2,285,288 in Q3 2025. As of Q3 2026 8,619,230 vulnerable Nigerians are covered under all equity programmes (Including BHCPF) up from 6,600,000 in Q3 2025 -Enrolment into NHIA programmes is now fully digitised and accessible through the Authority's dedicated online portal: https://enrolment.nhiaonline.com	Ongoing (80%)
11	Advance local manufacturing and supply-chain resilience by operationalising Medipool, incentivising private-sector investment, and transitioning at least 20 priority commodities to local production with five new manufacturing plants operational by 2026.	Significant progress has been made in advancing local manufacturing, strengthening supply-chain resilience and mobilising private-sector investment. **a. Expansion of local manufacturing capacity** Six manufacturing facilities with new production capacity were reported in 2026: four new plants (Abbott Diagnostics, Harvestfield Industries, Vestergaard and Badawiyya Pharmaceuticals) and two expansions (Sam Pharmaceuticals and Apex Gases), covering pharmaceuticals, diagnostics, LLINs and medical oxygen. **b. Increased domestic production of health commodities** At least nine health commodities are produced in Nigeria through government initiatives, including dual-active-ingredient LLINs, RDTs (HIV, malaria, hepatitis B, etc.), beta-lactams, calibrated drapes and essential medicines, with production involving Vestergaard, Harvestfield, NASENI-Troment, Codix Bio, Abbott/Afrimedical, JAWA, FeedRich, Sam Pharmaceuticals and Badawiyya Pharmaceuticals. **c. Operationalisation of Medipool and market-shaping mechanisms** • Medipool signed the Service Level Agreement with the Federal Government in Q1 2026, formally commencing its mandate as the country's	**Ongoing (70%)**

S/N	Resolution	Progress / Milestone	Current Status
		Group Purchasing Organisation. • Medipool has commenced procurement of commodities on behalf of the government at federal and state levels. • Qualified local manufacturers are continually being onboarded to the Medipool procurement platform. The Market Shaping through Pooled Procurement initiative (launched July 2026) is being implemented as an 18-month pilot across 23 states with functional Drug Management Agencies, covering commodity prioritisation, state and partner engagement, and development of the pooled procurement framework. **d. Private-sector investment mobilisation** PVAC has developed a healthcare value-chain investment pipeline of 90+ projects valued at more than US$5 billion. Development finance facilities include US$1 billion from Afreximbank and €1 billion from EIB; US$75 million has been drawn down from the Afreximbank pool for 12 projects that have advanced to term-sheet level. PVAC is establishing a US$200 million Healthcare Fund for smaller-scale companies and projects below typical DFI ticket sizes, and has formed strategic partnerships, including with the Healthcare Federation of Nigeria, to increase private investment in local manufacturing. **e. Fiscal incentives for manufacturers** Under the Executive Order on local manufacturing, ₦24 billion in tax waivers were approved between March 2025 and June 2026, benefiting 75 manufacturers. In Q3 2026, PVAC commissioned a midline evaluation of the Executive Order, to be followed by a stakeholder dissemination session to validate findings and agree next steps. **f. Entry into regional manufacturing and research platforms** • The PVAC-led Nigeria Clinical Research Consortium (NCRC) was recognised as a regional hub within CEPI's regional clinical research network, a milestone for organising Nigeria's clinical research	

S/N	Resolution	Progress / Milestone	Current Status
		ecosystem and pandemic preparedness. Further work is needed to translate this into tangible research and health security outcomes. • NCRC became a member of the Africa Clinical Research Network (ACRN), giving Nigerian institutions access to clinical trial opportunities, technical support, training and collaboration with African and international research partners. **g. Strategic partnerships for manufacturing and workforce capacity** • 12 technology transfer efforts are underway at PVAC for mRNA vaccines, RDTs, LLINs, SRH commodities, APIs, excipients, essential medicines and nutrition supplements, among others. • Manufacturer prequalification support initiatives activated, connecting local manufacturers to technical assistance and regulatory hand-holding platforms.	
12	Nigeria committed to the full release of its counterpart funding for vaccine procurement and to meeting its obligations under the revised Accountability Framework.	**Full release not yet met, but** implementation is in progress, with releases behind schedule (October 2026). Nigeria has maintained its 2026 vaccine procurement appropriation at US$188.2 million. However, only ₦10 billion (approximately US$7 million, about 4% of the appropriation) has been released as part payment towards the planned 40% release. To sustain procurement, the country has relied on a US$50 million Vaccine Independence Initiative (VII) advance and US$7.2 million in reprogrammed World Bank IMPACT funds. With IMPACT bridge financing exhausted, US$60.9 million is urgently required for Gavi co-financing and VII repayment, plus a further US$60 million by 31 December 2026 for Q1 and Q2 2027 procurement. Timely release is critical to preventing projected year-end stockouts of essential vaccines and syringes and to meeting commitments under Resolution 12 and the revised Accountability Framework (AF 3.0).	**Ongoing (30%)**

S/N	Resolution	Progress / Milestone	Current Status
13	**Strengthen State and LGA delivery systems to improve readiness, responsiveness and accountability in the following areas:**		Ongoing (65%)
	(i) State-level resource mobilisation, focal accountability and performance tracking.	States have shown improvement in their budget allocation and expenditure, while all States conducted their joint annual reviews	Ongoing
	(ii) Emergency response capacity, by scaling NEMSAS and RESMAT and ensuring all PHCs meet minimum readiness standards for CEmONC and timely referral.	NEMSAS has scaled up RESMAT services to 171 of 172 MAMII LGAs	**Ongoing**
	(iii) Inter-agency collaboration across NPHCDA, NHIA, NCDC, NMEP, NAFDAC and other key actors to strengthen integrated service delivery and facility readiness.	The year 2026 recorded significant inter-agency collaboration between key agencies in the health sector especially in BHCPF implementation, Polio eradication, malaria vaccination and emergency preparedness.	Ongoing
	(iv) Accountability for Drug Revolving Funds (DRFs) to eliminate leakages, curb corruption and ensure uninterrupted access to essential medicines.	No available data	
14	As part of resource pooling, mutual accountability and transparency from the portfolio review, stakeholders will: **a.** Institute data-guided monitoring and fund allocation informed by periodic resource mapping, National Health Accounts and public expenditure review at national level, and State Resource Mapping and State Health Accounts. **b.** Support strengthening of the public expenditure framework review (World Bank). **c.** Establish iterative joint updates beyond the Joint Annual Review so partners can adjust programming and reallocate resources proactively. **d.** Optimise state-level investments, particularly to unlock HOPE-PHC incentives and strengthen frontline service delivery (all Development Partners). **e.** Advance a government co-financing arrangement with bilateral partners.	**a.** An online platform/dashboard developed for Resource Mapping and Expenditure Tracking (RMET) complemented by an offline Excel reporting tool to strengthen routine monitoring and reporting. 2023/2024 National Health Accounts Study completed, while 2025 National Health Accounts Study commenced, alongside Disease-specific Health Accounts for HIV, Tuberculosis, and Malaria. **e**. The USG–GoN Health Cooperation MoU was signed on 19th December 2025, establishing a five-year bilateral health cooperation framework (2026–2030). Implementation has commenced.	Ongoing (50%)

3.2 Tracking the Progress of 2025 Spotlights

Table 3.3: Progress on key issues spotlighted in 2025

Key Issues Spotlighted in 2025	Progress so far	Recommendations
WEAK REGULATIONS States are not issuing certificates of standards in line with the provisions of the National Health Act 2014; qualifying facilities that have been assessed to be BeMONC and CeMONC ready should be issued COS. **25% of tertiary facilities had provisional COS issued.**	Assessment is increasing but the certificates are still not issued. The book of standards for secondary facilities has been developed and approved, and that for tertiary facilities has been developed by the FMoHSW and the Standards Tertiary Committee	States/LGA can print and issue Certificates of Standards (COS) to qualifying primary and secondary facilities immediately. While Standards Tertiary Committee issues to Tertiary facilities.
LINKING PLANS TO HEALTH EXPENDITURE Annual Operation Plans were limited in informing health budgets due principally to delays in the commencement of the development process and in resolving bottlenecks in the implementation of the NHSRII.	Data informed service packs drawn from FASTR analysis have been developed and shared to all 37 states for resource prioritisation for the AOP.	Follow-up measures to make sure that State budgets align with their workplans
POOR BLOOD BANK SERVICES Only 30 blood banks are registered by the regulatory agency NBTS across the country.	Engagement with blood bank service providers and NBTS has improved. Currently, 18 blood banks are fully registered, with an additional 15 that are awaiting approval. This brings the current total to 33 blood banks, with more expected to come on board.	This should take a push approach, and efforts should be intensified.
WEAK REFERRAL SYSTEM Emergency referrals are delayed or impossible due to the lack of emergency transport options. Only 502 public ambulances and 21 private ambulances were functional in 2025.	· Procured and distributed 79 advanced life-support ambulances to federal tertiary health facilities. · Procured and deployed 145 tricycle ambulances to support the Rural Emergency Service and Maternal Transport system in hard-to-reach communities. · Procured and deployed six boats to support the Rural Emergency Service and Maternal Transport system in riverine communities. · 581 (Vehicle Ambulances) · 273 (Tricycle Ambulances) · 4 (Boat Ambulances) · 32 Private ambulances	Kano now has an assembly plant for Ambulance production. Partnership with the private sector for local assembly of ambulance vehicles should be a key approach towards self-sufficiency.
NATIONAL HRH PROGRAMME Shortage of HRH, and continued utilisation of alternative healthcare such as TBA services and its attendant complications such as VVF. The 2025 JAR session had as one of its key resolutions that a National HRH programme should be established.	States have implemented interventions to engage more staff. This, however, is not uniformly coordinated across all levels of care. The NPHCDA has also put a framework in place for staffing PHCs.	Make pronouncement of establishment of National HRH Programme.

Chapter 4

PROGRESS ON UHC, SDG 3 AND GLOBAL HEALTH COMMITMENTS



4.1 Sustainable Development Goal 3 Health Scorecard

The SDG 3 Health Scorecard presents Nigeria's progress against key global health targets and indicators aligned with the 2030 Sustainable Development Goals. The scorecard covers priority areas including maternal and child health, communicable and non-communicable diseases, universal health coverage, immunisation, health financing, health workforce, and health security. It compares available 2025 and 2026 data against SDG 3 targets to highlight progress, remaining gaps, and areas requiring continued monitoring and investment to support achievement of Universal Health Coverage and Nigeria's global health commitments.

Table 4.1: SDG 3 health scorecard

SDG Target	Key Health Indicator(s)	2030 Target	2025 (as reported in 2025)	2026 (latest available data)	Data Source
SDG 3.1: Reduce maternal mortality	Maternal mortality ratio	<70 deaths per 100,000 live births	512 deaths per 100,000 live births (NDHS 2018)	572 deaths per 100,000 live births (VASA 2024)	*VASA 2024*
	Births attended by skilled health personnel	Universal access to skilled birth attendance	46% (NDHS 2024)	50.0% of live births in the two years preceding the 2025 NMDHS	*NMDHS, 2025*
SDG 3.2: End preventable newborn and child deaths	Under-five mortality rate	≤25 deaths per 1,000 live births	110 deaths per 1,000 live births (NDHS 2024)	110 deaths per 1,000 live births	*NDHS 2024*
	Neonatal mortality rate	≤12 deaths per 1,000 live births	41 deaths per 1,000 live births (NDHS 2024)	41 deaths per 1,000 live births	*NDHS 2024*
SDG 3.3: End communicable diseases	HIV incidence and treatment coverage	95-95-95	Data not available	Data not available	
	Tuberculosis incidence and treatment success	End TB epidemic	Data not available	Data not available	

SDG Target	Key Health Indicator(s)	2030 Target	2025 (as reported in 2025)	2026 (latest available data)	Data Source
	Malaria prevalence	End malaria epidemic	Data not available	15%	Malaria Indicator Survey
	Hepatitis B/C and NTD interventions	Reduce communicable disease burden	Hep B 8.3%, Hep C 3.6% NTD (Hydrocele 79%, Lymphoedema 75%, LF 65%, Trachoma 84%, Oncho 34%, Schisto 0%, STH 0%)	Hep B 7.3% Hep C 4% NTD (Hydrocele 78%, Lymphoedema 79.3%, LF 74.8%, Trachoma 87%, Oncho 52%, Schisto 0%, STH 0%)	HIV NDARS NTD PROGRAMME Report 2026, WHO Joint Application Package 2026, 2026 TEMF Report
SDG 3.4: Reduce premature mortality from NCDs and promote mental health	Premature mortality from cardiovascular disease, cancer, diabetes and chronic respiratory diseases	Reduce by one-third by 2030	Data not available	Data not available	
	Suicide mortality and mental health indicators	Promote mental well-being	Data not available	Data not available	
SDG 3.5: Prevent and treat substance abuse	Treatment coverage for substance use disorders	Strengthen prevention and treatment services	Data not available	Data not available	
SDG 3.6: Reduce road traffic injuries	Death rate due to road traffic injuries	Halve global deaths and injuries from road traffic accidents	Data not available	Data not available	
SDG 3.7: Universal access to sexual and reproductive healthcare	Modern contraceptive prevalence and adolescent birth rate	Universal access to reproductive health services	Data not available	mCPR: 18.3% among currently married women aged 15–49; adolescent birth rate: 69 births per 1,000 women aged 15–19. Demand for family planning satisfied by modern methods: 41.3% among currently married women.	NMDHS, 2025
SDG 3.8: Achieve Universal Health Coverage	Government Budget Transfers to Social Health Insurance (SHI-G) as % of Social Health Insurance (SHI)	Government on-budget contributions for Social Health Insurance	49.8% (2023)	50.6% (2024)	2023/2024 National Health Accounts
	Population covered by health insurance	Universal financial protection	≈21.1 million enrolled (NHIA 2024)	24 Million	NHIA

SDG Target	Key Health Indicator(s)	2030 Target	2025 (as reported in 2025)	2026 (latest available data)	Data Source
	Out-of-pocket expenditure as a share of Current Health Expenditure (%)	Reduce financial hardship from healthcare cost and OOP% to less than 20%	65.7% (2023)	62.2% (2024)	2023/2024 National Health Accounts
SDG 3.9: Reduce illness and deaths from pollution	Mortality from air, water and soil pollution	Substantially reduce pollution-related deaths	Data not available	Data not available	
SDG 3.a: Strengthen tobacco control	Tobacco control implementation	Implement WHO Framework Convention on Tobacco Control	Data not available	Data not available	
SDG 3.b: Access to medicines, vaccines and health technologies	DTP3/Penta3 immunisation coverage; essential medicines availability	≥90% vaccine coverage and access to essential medicines	DTP3/Penta3 ≈74% (WHO/UNICEF 2024)	DPT-HepB-Hib (Penta) 3: 54.8% of children aged 12–23 months vaccinated at any time before the survey	NMDHS, 2025
SDG 3.c: Increase health financing and health workforce	Health worker density and distribution	120,000 frontline health workers	Data not available	Data not available	
SDG 3.d: Strengthen health security and emergency preparedness	IHR core capacities, AMR surveillance and outbreak preparedness	Strengthen early warning and emergency response capacity	Data not available	Data not available	

PART II

PILLAR I: LEADERSHIP AND GOVERNANCE



PILLAR ONE: STRATEGIC OBJECTIVES AND ACHIEVEMENTS

Table 4.2: Pillar I strategic objectives and indicators

Strategic Objectives	Indicator	Baseline (2023)	Target (2027)	Cumulative Achievement (2024-2026)
Strengthen oversight and effective implementation of the National Health Act	Number of planned Governance/Oversight structure meetings (NCH) held annually	1	4	3(75%)
Increase accountability to and participation of relevant stakeholders and Nigerian citizens	Number of State of Health of the Nations report developed and disseminated to Presidency, National Assembly, Governors and all Nigerians	1	4	2 (50%)
Strengthen regulatory capacity to foster the highest standards of service provision	Development of minimum /essential standard for service delivery at all levels of care	0	3	23 (75%)
Improve cross-functional coordination & effective partnerships to drive service delivery	Stakeholders' membership of the ministerial oversight committee (MOC)	60%	90%	80%

**The membership of the MOC includes government, CSOs, DPG and private sector.

Chapter 5

GOVERNANCE STRUCTURES, OVERSIGHT AND ACCOUNTABILITY



5.1 National Council on Health (NCH)

The National Council on Health (NCH) is recognised as the highest and State Councils on Health (SCHs) indicators track policy coordination, meeting convening, and resolution implementation within the health sector. The National Council on Health session was not due in the 2025 cycle (0%) and is scheduled for November 2026. Prior-year NCH resolutions implemented increased from 60% in 2025 to 75% in 2026, a 15-percentage-point increase.

At the state level, State Councils on Health held increased from 10% in 2025 to 35% in 2026, a 25-percentage-point increase. Prior-year SCH resolutions completed were 60% in 2025 and 75% in 2026.

Table 5.1: National Council on Health indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of National Council on Health sessions held	0% (not due in cycle)	To be held in November 2026	NCH Report
Percentage of prior-year NCH resolutions implemented	60%	75%	
Percentage of State Councils on Health held	10%	35%	SCH Report
Percentage of prior-year SCH resolutions completed (%)	0%	Data not available	
Percentage of States using national guidelines for the conduct of SCH meetings	Data not available	Data not available	
Percentage of submitted memos meeting the criteria in the revised NCH/SCH guidelines	Data not available	Data not available	

5.2 Compact delivery and Ministerial Oversight Committee (MOC)

The Ministerial Oversight Committee (MOC) is a governance structure comprising the leadership of the Ministry, heads of agencies, representatives of the State commissioners of health, state health agencies, partners, civil society organisations and the private sector. The MOC meets quarterly to discuss matters related to the implementation of the BHCPF

and other key HSSB interventions. MOC is replicated in all the states and the FCT (Figure 13).

Table 5.2: Ministerial Oversight Committee and Federal performance indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of Quarterly Ministerial Oversight Committee meetings held	100%	75%	MOC Secretariat
Percentage of Quarterly Performance Dialogue meetings held	75%	75%	
Percentage of recommendations from federal quarterly performance dialogues implemented	85%	90%	
Percentage of Ministerial Compact Deliverables tracked to completion	Data not available	80%	
State oversight Committee			
Number of States that held all quarterly (Q1-Q3) Oversight Committee meetings*	Data not available	15 (41%)	2026 JAR state submissions
Number of states that held SCH **	Data not available	9 (24%)	
Percentage of National Council on Health (NCH) resolutions implemented by the States***	Data not available	70.8% of state own target	

Note:

*Abia, Adamawa, Akwa Ibom, Delta, Gombe, Imo, Kano, Kogi, Kwara, Niger, Plateau, Rivers, Sokoto, Taraba, Yobe

** Abia, Ebonyi, Edo (2), Katsina (3), Nasarawa, Oyo, Plateau, Sokoto, Ogun

*** Reported median by 25 states

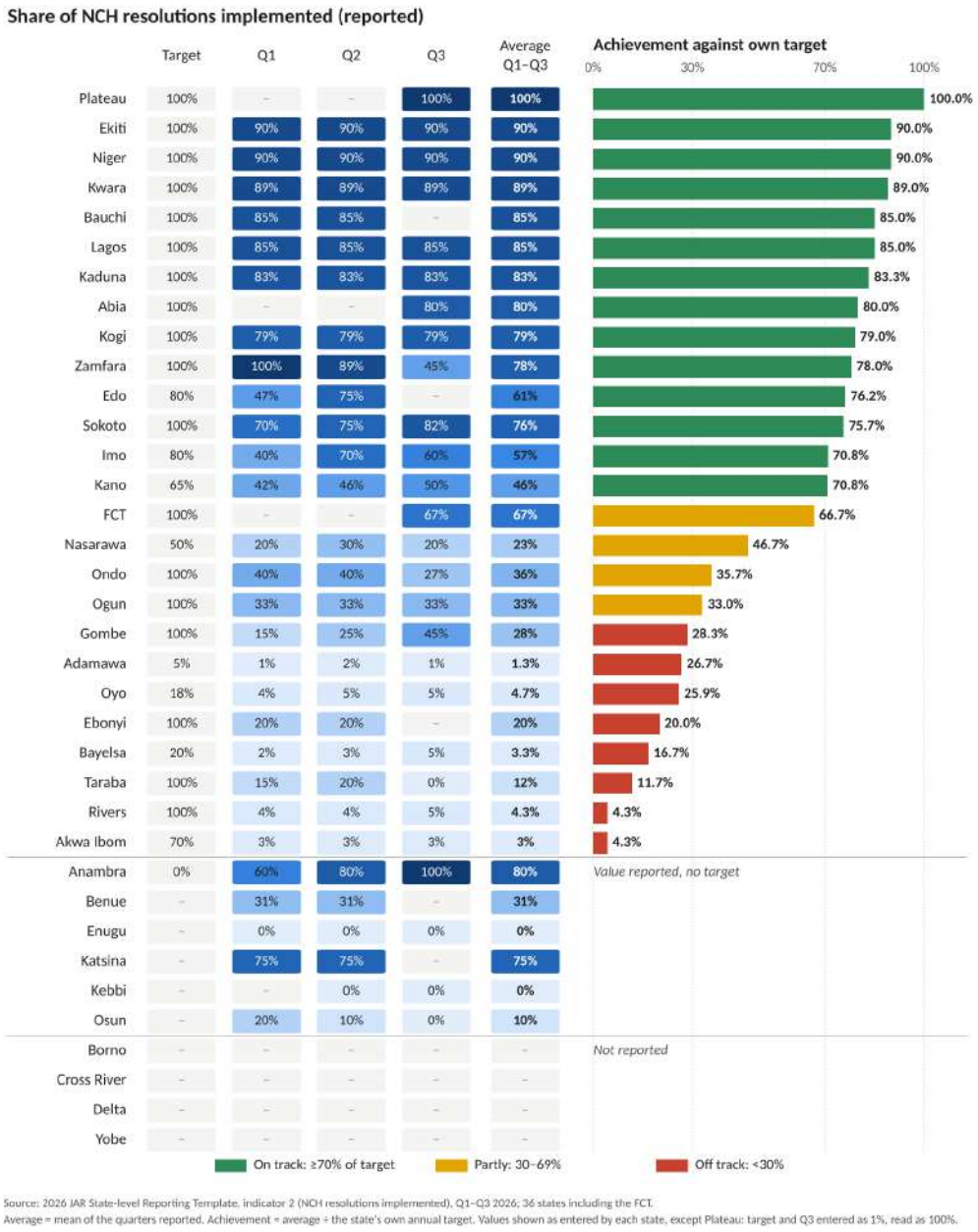


Figure 13: Percentage of National Council on Health (NCH) resolutions implemented, by state, Q1–Q3 2026. Source: 2026 JAR state submissions

5.3 Joint Annual Reviews

The Joint Annual Reviews (JARs) provide an important platform to review health-sector performance, engage stakeholders, and inform planning and budgeting processes. The JAR is conducted at both Federal and State levels. In 2026, 100% of states and the FCT conducted JARs, which is an increase from 90% in 2025.

Table 5.3: State-level Joint Annual Review indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of States/FCT that conducted a Joint Annual Review	90%	100%	JAR tracker for 2026 and State JAR Report
Percentage of States that have conducted the JAR based on the NHSRII and SWAp framework in collaboration with relevant stakeholders	100%	100%	
Percentage of State JARs conducted according to schedule, July window	50%	73%	
Percentage of States/FCT with a functional health sector planning cell	50%	70%	
Percentage of State JAR reports submitted within the federal reporting window	Data not available	81%	
Percentage of State JAR reports meeting the national quality assessment standard	Data not available	100%	

5.4 Development Partner Coordination

Development partners provide a significant share of the technical and financial support to Nigeria's health sector, which makes effective coordination essential to avoid duplication and fragmented investments. Under the Sector-Wide Approach (SWAp), the government and partners commit to the principle of one plan, one budget, one report and one conversation, with resources aligned to national priorities. This critical role in the course of the implementation of the NHSRII is undertaken by the SWAp coordination office.

Table 5.4: Development partner coordination

Core Indicator	2025 Achievement	2026 Achievement
Percentage of donor partners in-country that align with NHSRII compact	100%	100%
Percentage of states and FCT that align with NHSRII compact	100%	100%
Total amount pooled by the SWAp office (US$)	$1.18 billion	Data not available
Percentage of partners' commitment as share of total AOP cost	34.0%	41%
Number of Partner joint missions conducted	Data not available	50%

5.5 Implementation of Bilateral and Multilateral Commitments

Nigeria engages with other countries through bilateral agreements and with regional and global bodies such as the West African Health Organisation (WAHO), the World Health Assembly (WHA) and the United Nations General Assembly (UNGA). These engagements bring technical cooperation, financing and shared accountability for regional and global health goals. Tracking their implementation shows how international commitments support national health priorities under the HSSB

5.5.1 Bilateral Cooperation

Table 5.5: Bilateral cooperation agreements and implementation status

Country	Areas of cooperation	Duration	Status	% Implementation
MOUs				
Brazil	1. Health system research, evidence, synthesis and knowledge translation 2. Human milk bank and maternal and child health programmes 3. Health care financing mechanism 4. Technical exchange with the Nigeria centre for diseases control and prevention 5. Development of human resources for health 6. Digital health, including mHealth, AI diagnostics and interoperable electronic health records 7. Combating malaria, tuberculosis and NTDs through vector control, vaccination drives and educational outreach 8. Epidemiology surveillance and diseases modelling strengthens public health response 9. Joint evaluation of Farmanuhos/Fiocruz's capacity to produce medecines 10. Manufacturing capacity for medicines and vaccines 11. Collaborative research on multicentre clinical trials targeting diseases of mutual interest, such as zika virus, yellow fever, malaria and other related 12. Training of Nigeria health professionals in Brazil in maternal and child health, primary care and diseases 13. Wolbachia project (mosquitos incapable of transmitting dengue and other arbovirus	June 2025 – 2029	Active but stalled	10%

Country	Areas of cooperation	Duration	Status	% Implementation
Turkey	1. Cooperation on hospital management, head and neck surgery 2. Strengthening of health system 3. Health science, health research and health statistics 4. Public health and private health service 5. Fight against communicable and non-communicable diseases and immunisation 6. Training health personnels and developing joint projects on safe motherhood and training skills and neonatal resuscitation programme for prevention of maternal and infant mortality 7. Planning of human resources and capacity building in the field of health 8. Information technology systems with particular focus on hospital information systems 9. Organisation of emergency first aid programmes and exchange of information and experience on health services in emergencies and disasters 10. Short training in health personnel 11. Researching investment opportunities in Nigeria in the field of drugs, medical devices and medical consummables promoting private sector investors in these fields 12. Exchange of information and health investments 13. Cooperation on health tourism	February 2022 – 2027	Active but stalled	15%

Country	Areas of cooperation	Duration	Status	% Implementation
Kingdom of Spain	1. Experience sharing on managing HIV 2. Experience sharing sessions on managing tuberculosis infections 3. Experience sharing on managing SARS -CoV-2 infection 4. Experience sharing sessions on epidemiological surveillance 5. Experience sharing on managing health alerts and emergency preparedness and response 6. Experience sharing session on implementing the international health regulations 7. Professional exchange programme to improve the training of health professionals 8. Experience and good practice sharing sessions on improving qualities of medical care at the health centres of the two countries 9. Experience sharing sessions on patient safety, with particular focus on training experiences and safe clinical practices	June 2022 – 2027	Active but stalled	10%
China	1. Health Policies and Standards for Pharmaceuticals and Medical devices; 2. Medical services, Public Health services (including Infectious Disease Prevention and Control); 3. Traditional Medicine; 4. Talent Training; 5. Products for Diagnosis, Prevention, and Treatment of Infectious Diseases; 6. Digital Intelligence Health; 7. Maternal and Child Health; 8. Other areas of cooperation as mutually determined.			
U.S.A				

Country	Areas of cooperation	Duration	Status	% Implementation
Algeria	1. Roll back Malaria programme 2. HIV/AIDS Control, Tuberculosis and other related infections 3. Immunisation 4. Drug policy, control, manufacturing, import and export 5. Traditional medicine 6. Port health services 7. International health relationship and coordination 8. Health information systems 9. Non-Communicable disease control 10. Health sector reform 11. Human health resource development 12. Health research	January 2002-2027	Inactive	
MoAs				
North Korea (to be reviewed)	1. Public health issues which include communicable diseases, non-communicable diseases, primary healthcare, emerging and re-emerging diseases 2. Institutional capacity building in health management information system, tertiary and specialised care system, human resource for development, drug control and drug manufacturing, maternal and child health, vaccine development and production, research and development. Emergency preparedness and response 3. Biotechnology development and ophthalmology		Dormant	

Country	Areas of cooperation	Duration	Status	% Implementation
Tunisia	1. Health service provision on pastoralist and semi pastoralists 2. Infectious disease prevention and control 3. Diseases surveillance 4. Export of hospital services 5. Cooperation in sector of pharmaceuticals and drugs 6. Human resource development 7. Establishment of direct cooperation between hospital institutions 8. Exchange of information, experience and expertise in the field of reproductive health and population 9. Exchange visits of studies and investigation between officials in both countries 10. Other mutual areas of agreements		Proposed	
Proposed				

Country	Areas of cooperation	Duration	Status	% Implementation
Zimbabwe	1. Technical and professional education and training of health professionals 2. Multi sectoral response and management to epidermic and pandemic and mechanism for joint procurement and capacity building for manufacturing medicines 3. Health sector reforms including strengthening capacity for public hospitals 4. Research and development in health matters 5. Surveillance, prevention, control and management 6. Management of national emergency situations that require health interventions 7. Cooperation in dealing in medicines and medical supplies through the national pharmaceutical Company of Zimbabwe (NatPharm) 8. Exchange of information on pharmaceutical and related medical supplies, rational drug use, medicines regulation and control, drug logistics management information systems storage and distribution system and health technology 9. Special care and referrals of patients 10. Development centration and management of human resources for health 11. Healthcare financing mechanisms 12. Medicines and medical supplies financing mechanisms 13. Immunisation campaigns 14. Collaboration on food safety, control and fortification 15. Health system management 16. Health regulations 17. Laboratory forensic pathology and blood services 18. Reproductive, maternal, neonatal child and adolescent health 19. Capacity building and any other agreed areas of cooperation		Proposed	
Qatar				

Country	Areas of cooperation	Duration	Status	% Implementation
Botswana	1. HIV / AIDS management; Botswana's best practices shared with Nigeria 2. Digital health 3. Human resources for health 4. Maternal and child health collaborative initiatives to reduce maternal and infant mortality 5. Health governance 6. Pharmaceutical and medical devices		Proposed	
Mozambique	1. Primary healthcare delivery 2. Infectious diseases control, prevention and treatment of malaria and tuberculosis 3. Maternal and child health joint programmes 4. Traditional medicines research and safe integration 5. Pharmaceutical and Medical services 6. Human resources for health			
Austria	1. Safeguard, promote, and enhance cooperation in the field of public health 2. Encourage and support cooperation on health sector reform, public and private health organisation, health economy and health financing systems, communicable diseases control and prevention, national health programmes on maternal and child health 3. Exchange information and share experience concerning legislation and regulation in the field of public health and other issues of mutual interest 4. Support cooperation and direct relation between public and private institutions / organisation in both countries on research and technical know-how in public health affairs 5. Strengthen cooperation on international health in multilateral context	August 2011 – 2013	Inactive	
Multisector Cooperation				

Country	Areas of cooperation	Duration	Status	% Implementation
Germany				
United Kingdom	1. Building of six specialised hospitals in selected existing tertiary hospitals in the six geopolitical zones of the country	2026 - 2031	Active but stalled	15%
Canada				

5.5.2 Multilateral Commitments (WAHO, WHA, UNGA)

Table 5.6: Multilateral commitments (WAHO, WHA, UNGA) and implementation status

Areas of cooperation	Status	% Implementation
WHA79.4: Steatosis liver disease: a missing piece in the global noncommunicable disease response	Data not available	Data not available
WHA79.5: Global action to advance health equity for people with haemophilia and other bleeding disorders		
WHA79.8: Precision medicine: a path towards targeted, personalised and equitable care		
WHA79.9: Strengthening equitable access to diagnostic imaging through teleradiology	Ongoing	40%
WHA79.10: Reducing the burden of stroke: strengthening prevention, acute care, rehabilitation and health system readiness	Ongoing	40%
WHA79.11: Advancing smart, efficient pharmacovigilance as an essential tool for robust, sustainable, resilient and responsive health systems, for everyone, everywhere.	Ongoing	20%
WHA79.12: WHO Global Code of Practice on the International Recruitment of Health Personnel	Ongoing	60%
WHA79.13: Radiation and health: strengthening global protection, preparedness and response	Ongoing	60%

Chapter 6

REGULATORY CAPACITY AND STANDARDS ENFORCEMENT



6.1 Health Facility Certification — Standards Compliance Rate

Health facility certification confirms that a facility meets the minimum standards of infrastructure, staffing, equipment and service quality required for its level of care. Certification applies across primary, secondary and tertiary facilities, including those owned by government, private providers and public-private partnerships. It gives patients, health financing schemes and regulators a credible basis for confidence that services are delivered safely and to an acceptable standard.

Table 6.1: Health facility certification and standards compliance indicators

Core Indicator	2025 Achievement	2026 Achievement
Percentage of PHC facilities issued certificates of standards	0%	0%
Percentage of Public secondary facilities issued certificates of standards	0%	0%
Percentage of Private facilities issued certificates of standards	0%	0%
Percentage of Federal tertiary facilities issued provisional certificates of standards	23% (20 of 84)	28%
Percentage of Tertiary facilities, (state-owned and private), issued certificates of standards	0% for state-owned and private	0%

Source: https://hfr.fmohconnect.gov.ng/

6.2 Human Resources For Health Regulation

There are 14 Professional regulatory bodies responsible for ensuring that professional standards are upheld across public and private practice. They regulate the curriculum of training, provide guidance on conduct of practice, institutionalise licensure, set the standard for institutions of training in-terms of equipment needed for training and the carrying capacity of the institutions.

Table 6.2: Human resources for health regulation indicators

Core Indicator	2025 Achievement	2026 Achievement
Percentage of public and private health training institutions (schools and colleges) that are accredited	Data not available	100%
Percentage of public schools/colleges of health issued waivers to train double the number of health workers (doctors, nurses/midwives etc.)	Data not available	40%
Percentage of Practising health professionals fully licensed	95%	96%
Number of certificates of good standing issued to migrating health workers	Data not available	Data not available
Percentage of regulatory bodies that have fully digitised registers of health workers they regulate	20%	50%
Percentage of Regulatory registers interoperable with the National Health Workforce Registry	Data not available	0%

6.3 Radiation and Nuclear Safety Regulation (NNRA)

The Nigerian Nuclear Regulatory Authority (NNRA), established under the Nuclear Safety and Radiation Protection Act of 1995, regulates the use of ionising radiation in Nigeria. In the health sector, it licenses and inspects facilities that use diagnostic imaging, radiotherapy and nuclear medicine equipment to protect patients, health workers and the public from unnecessary radiation exposure. Its oversight also ensures that facilities designate radiation protection officers and that the radiation exposure of workers is monitored.

Table 6.3: Radiation and nuclear safety regulation indicators

Core Indicator	2025 Achievement	2026 Achievement
Number of radiation-emitting medical practices licensed by NNRA	474	600
Percentage of licensed radiation practices inspected within the statutory cycle	75%	85%
Percentage of radiotherapy and nuclear medicine installations holding a current NNRA licence	50%	70%
Number of radiation workers enrolled in occupational dose monitoring	4,000	4,500
Percentage of health facilities with a designated radiation protection officer	85%	90%

Source: Nigeria Nuclear Regulatory Authority

6.4 Food and Drug Regulation

Effective regulation of food, water, medicines, cosmetics and other health products is the first safeguard against unsafe and substandard goods reaching the public. Licensing, marketing authorisation and import controls show how well products are screened before they enter the market, while quality testing, pharmacovigilance, complaint handling, recalls and prosecutions show how closely they are monitored once in circulation.

Table 6.4: Food and drug regulation indicators

Core Indicator	2025 Achievement	2026 Achievement
Percentage of food & water processing companies with required registrations and valid operating licences	Data not available	Data not available

Core Indicator	2025 Achievement	2026 Achievement
Percentage of medicines (essential medicines/antibiotics) that meets quality standard	Data not available	Data not available
Percentage of cosmetics that meets quality standards. (Local and Imported)	Data not available	Data not available
Percentage of food samples tested that meet approved safety standards.	Data not available	Data not available
Percentage of imported medicines meeting applicable authorisation, documentation, and inspection requirements.	Data not available	Data not available
Percentage of complaints received and investigated or resolved within the 72hrs	Data not available	Data not available
Number of suspected violators successfully prosecuted	Data not available	Data not available
Number of sampled products found to be falsified or substandard.	Data not available	Data not available
Percentage of recalled products successfully removed from the supply chain within the required time.	Data not available	Data not available
Percentage of Federal tertiary health facilities with schedule I narcotics	Data not available	Data not available
Number of outlets visited with Pharmacovigilance and Post-market surveillance of health products (medicines, vaccines and other health-related products)	Data not available	Data not available
Proportion of Marketing Authorisation decisions taken within 240 Days for New registration of Drug product	Data not available	Data not available

6.4.1 Product Registration and Analysis

The National Agency for Food and Drug Administration and Control (NAFDAC) is responsible for analysing and registering drugs, vaccines, medical devices and other regulated products before they reach the Nigerian market. Efficient and timely registration protects public safety while supporting market access for quality products. This section presents the Agency's performance in product analysis and registration.

Table 6.5: Product registration and analysis indicators

Core Indicator	2025 Achievement	2026 Achievement
Number of drug products analysed within the defined timeline (Number)	8,914	Total is **3,523**
Food products analysed within the defined timeline (number) within 120 days	20,531	Total is **17,862**
Number of Vaccine products analysed	686	Total is **289**
Number of Marketing authorisation decisions taken within 240 days for new drug registration	1385	Total is **1,589**
Median time to marketing authorisation decision (days)	Data not available	Data not available
Number of Registration applications received in the reporting year	Data not available	Data not available

Source: NAFDAC.

6.4.2 Pharmacovigilance, Post-Market Surveillance and Enforcement

Pharmacovigilance and post-market surveillance ensure that medicines and health products remain safe and of good quality after they reach the market. Enforcement action against substandard and falsified products is essential to this work. This section presents NAFDAC's performance in monitoring product safety and enforcing regulatory compliance.

Table 6.6: Pharmacovigilance, post-market surveillance and enforcement indicators

Core Indicator	2025 Achievement	2026 Achievement
Number of Outlets visited for post-market surveillance (number)	18,953	Total is **18,705**
Number of adverse drug reaction reports received and processed	12,779	8,444
Number of substandard and falsified products detected through post-market surveillance	47	23
Number of Product batches recalled or withdrawn from circulation	17	1
Percentage of product batches tested that met national and international control standards	95.29% (566 of 594)	99.76% (420 of 421)
Number of States/FCT covered by at least one post-market surveillance round	36 + FCT	36 + FCT
Number of Commodity classes covered by an integrated QA/QC protocol	3 (antimalarial, TB, HIV)	Data not available

Source: PCN, DPS (state level) and NAFDAC.

6.5 Medical Device Regulation and Quality Assurance

Medical devices and in-vitro diagnostics should be regulated to ensure their quality and safety throughout their life cycle. As the range of devices in use grows, a strong regulatory and quality assurance system becomes increasingly important. This section presents progress in strengthening the regulation and quality assurance of these products.

Table 6.7: Medical device regulation and quality assurance indicators

Core Indicator	2025 Achievement	2026 Achievement
Number of Medical devices registered in the reporting year	249	313
Percentage of medical devices registered within the defined timeline	73.1% (182 of 249)	70.4% (239 of 313)
Number of In-vitro diagnostic products evaluated before market authorisation	Data not available	6
Number of device manufacturers and importers holding a current licence	249	239
Number of device adverse event reports received	Data not available	Data not available
Number of Device recalls or field safety corrective actions issued	Data not available	Data not available

Chapter 7

HEALTH POLICY, PLANNING AND ANNUAL OPERATIONAL PERFORMANCE



7.1 Implementation of State and Federal Annual Operational Plans

Annual Operational Plans (AOPs) are a critical coordination tool under the one-plan principle that help translate national and state health sector priorities into costed activities with clear responsibilities, timelines and funding sources. Quarterly reviews of these plans track implementation and help redirect resources to where they are most needed (Figure 14).

Table 7.1: Implementation of state and federal annual operational plans

Core Indicator	2025 Achievement	2026 Achievement	Data Source
[1] Percentage of federal DAPs conducting AOP quarterly performance review	0%	13.4%	National AOP Quarterly Review Submission Tracker FMOH National Digital AOP Tool/Excel AOP
Number of states conducting AOP quarterly performance review	56.8%	83.8%	
Percentage of implementing entities (Federal, State, LGA, Facility etc) with AOP	100%	100%	
Number of states AOP aligned with HSSB and NHSRII priorities (number)	37 of 37	37 of 37	
Percentage of States/FCT with development partner funding commitment in the costed AOP	90%	100%	
Percentage of AOPs with LGA and health facility plans consolidated	62%	80.9%	
Proportion of States that developed their AOP with stakeholders and required technical assistance	100%	100%	
Total Cost of AOP (National)	₦3.68T	₦6.05T*	
Total Cost of AOP (Federal)	₦1.53T	₦1.70T*	
Total Cost of AOP (States & FCT)	₦2.15T	₦3.25T*	
Total Cost of AOP (LGA)	₦305.4B	₦1.10T*	
Percentage of AOP total cost allocated to the PHC level	24.3%	38.2%	
Percentage of AOP total cost allocated to secondary and tertiary level	20.2%	12.2%	

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of AOP total cost allocated to governance, administration and support services	55.5%	49.7%	
Percentage of Government commitment as share of total AOP cost	46.4%	52.0%	
Percentage of Partners' commitment as share of total AOP cost	34.0%	19.9%	
Percentage of AOP funding gap	19.6%	27.5%	
Percentage implementation of AOP budget, aggregate (%)	46.4%	Q1: 21.4% Q2: 26.3% Q3: 60.7%	
Overall percentage of Implementation of AOP activities, aggregate	44.7%	49%Q1: 27.6% Q2: 40.1% Q3: 25.1%	
AOP Budget Performance by Funding Source			
Percentage of AOP budget implemented — government commitment	28.0%	Q1: 15.4% Q2: 22.1% Q3: 23.9%	FMOH National Digital AOP Tool/Excel AOP
Percentage of AOP budget implemented — partners' commitment	69.7%	Q1: 48.4% Q2: 52.6% Q3: 8.0%	
Percentage of AOP budget implemented — joint commitment	44.3%	Q1: 8.9% Q2: 4.5% Q3: 8.2%	
Share of AOP Activities Implemented by Funding Source			
Percentage of AOP activities implemented — government commitment	38.4%	35%/Q1: 29.1% Q2: 47.2% Q3: 40.1%	FMOH National Digital AOP Tool/Excel AOP
Percentage of AOP activities implemented — partners' commitment (%)	50.5%	55.8%/Q1: 51.4% Q2: 60.4% Q3: 67.2%	
Percentage of AOP activities implemented — joint commitment	43.7%	45%/Q1: 39.5% Q2: 52.8% Q3: 40.7%	
Percentage of recommendations from AOP quarterly reviews implemented and incorporated into subsequent quarter plans	5.4%	45.3%	

Source: National AOP Quarterly Review submission Tracker

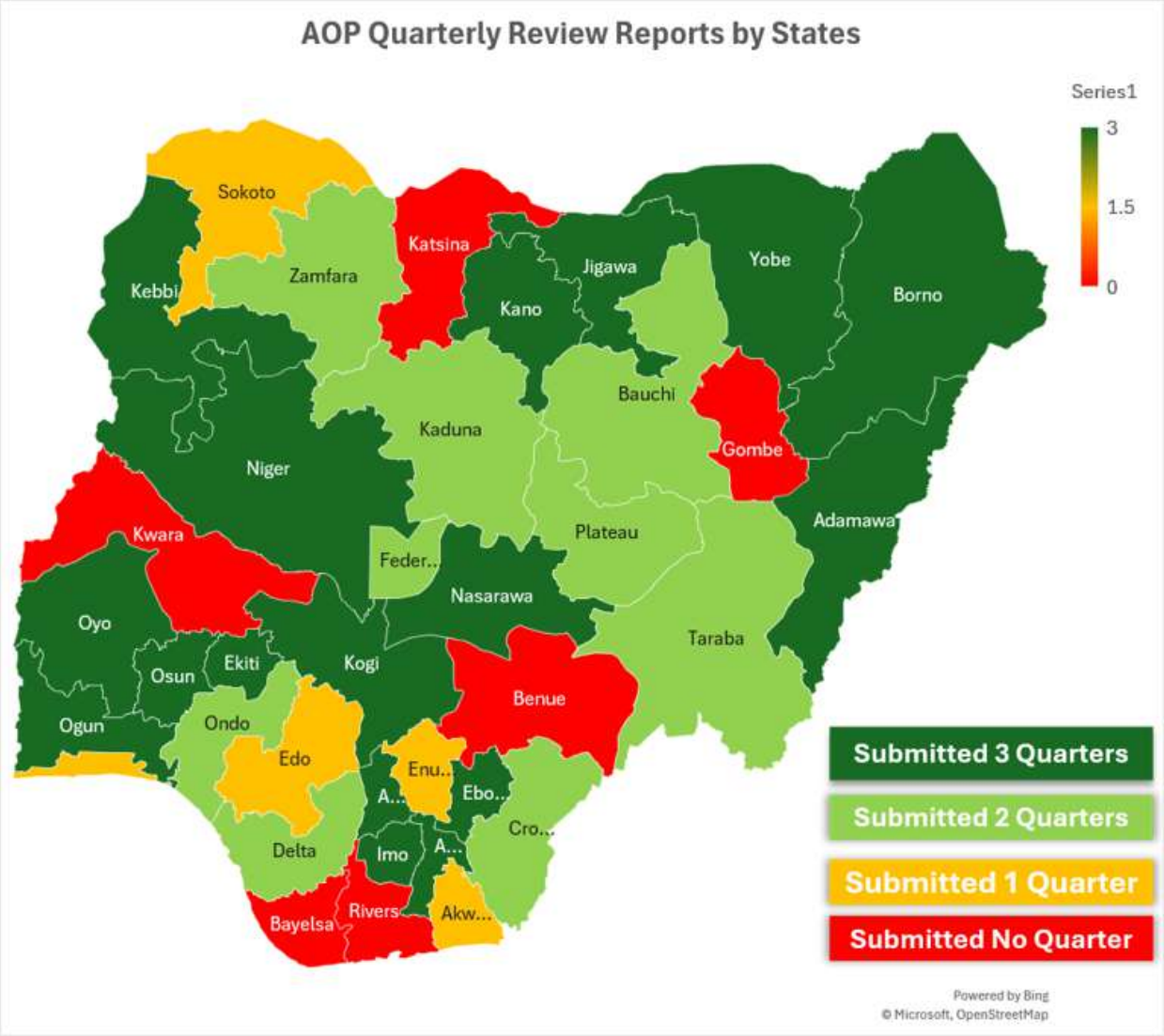


Figure 14: AOP quarterly review report submission by state, 2026

Chapter 8

CITIZEN ENGAGEMENT, RIGHTS AND FEEDBACK MECHANISMS



8.1 Patient Satisfaction and Quality of Care Survey Results

Patient satisfaction is a reflection of the overall citizens' level of acceptance, participation and confidence in the health system. Positive experiences of care (respectful treatment, short waiting times, affordable services and available medicines) build trust that drives service utilisation. The health sector is tracking patient perception of the health system through independent periodic assessments.

Table 8.1: Patient satisfaction and quality of care survey results

Core Indicator	2025 (Phase 1) Achievement	2026 (Phase 1) Achievement
Patient perception survey sample size (respondents)	2,657 across 36 states and FCT	2,610 across 36 states and FCT
Percentage of respondents rating overall quality of care positively	75%	71%
Percentage of respondents reporting 1–5 facility visits in the past year	64%	65%
Percentage of respondents reporting use of preventive and sexual health services	26%	27%
Percentage of respondents spending under one hour during a health visit	73%	67%
Percentage of respondents reporting delays and inefficiencies in service delivery	22%	20%
Percentage of respondents assured of access to affordable quality care when sick	48%	43%
Percentage of respondents who believe government values public input in health decisions	47%	46%
Percentage of respondents confident in government management of health emergencies	67%	67%
Percentage of respondents reporting health insurance coverage	12%	25%
Percentage of respondents Reporting That the Health System Trajectory Is Getting Better Over the Past Two Years	55%	52%

Source: Nigeria Voice Survey, October 2026, NOIPOLLS

8.2 Community Engagement and Social Accountability Mechanisms

Community engagement and social accountability mechanisms give citizens a voice in planning, monitoring and improving health services. Structures such as Ward Development Committees, citizen engagement sessions, civil society monitoring and published citizens' budgets help to make services more responsive and the use of resources more transparent. These mechanisms strengthen trust between communities and health authorities and support the effective use of funds such as the BHCPF.

Table 8.2: Community engagement and social accountability indicators

Core Indicator	Baseline	2025 Achievement	2026 Achievement	Data Source
Number of key citizen engagement sessions held	11	150	180	
Number of feedback received from citizens on CMH and HMSH on social media accounts	1,500	75	Data not available	
Percentage of feedback from citizens and stakeholders adopted and implemented	Data not available	60%	Data not available	
Percentage of States/FCT with functional Ward Development Committees	Data not available	Data not available	Data not available	
Number of BHCPF supported PHCs with quality improvement teams that include the WDC Chairman	Data not available	230 (8 states)	Data not available	FMoHSW SRH Update, Q3 2026 MOC

8.3 Grievance Redress Systems

Health-related rights frameworks and grievance redress systems allow citizens to raise complaints and seek redress when services fall short of expected standards. In Nigeria, these include SERVICOM (the Service Compact with All Nigerians) in public health institutions. Timely, transparent grievance resolution protects citizen's' rights and holds providers accountable for quality of care

Table 8.3: Grievance Redress System indicators

Core Indicator	Baseline	2025 Achievement	2026 Achievement	Data Source
Percentage of health-related grievances addressed by SERVICOM or other mechanisms	57.7%	90%	71% (Q1&Q2 only)	SERVICOM
Number of Functional communication channels operationalised at health MDAs	84	85% of DAPs	84 (94% of 2026 target)	
Number of officers and federal health institutions awarded for outstanding performance	31	Data not available	Data not available	
Percentage of grievances resolved within the SERVICOM service standard timeframe	Data not available	Data not available	Data not available	
Number of NHIA complaints received and tracked	Data not available	Data not available	2,209 (H1 2026)	NHIA Half-Year 2026 Complaint Report

Core Indicator	Baseline	2025 Achievement	2026 Achievement	Data Source
Percentage of NHIA complaints resolved within 48 hours	Data not available	Data not available	82% (1,811)	
Number of enrolees refunded following complaints	Data not available	Data not available	69 (₦4.43M from 42 facilities)	

Pillar I — Key Achievements

- Compact expanded and fully aligned bring onboard ALGON, the private sector and traditional and religious institutions into the partnership, and all development partners, 36 states and the FCT remain aligned with the NHSRII Compact.
- Institutionalisation of once conversation with all states and the FCT holding a state JAR in 2026 (90% in 2025)·
- The Ministerial Oversight Committee (MOC) has been replicated in all states and the FCT, promoting mutual accountability mechanisms functioning with over 80% of recommendations from federal quarterly performance dialogues being implemented.
- Stronger policy follow-through with implementation of prior-year NCH resolutions rising, same with the share of State Councils on Heal
- One plan and one report are beginning to take shape as all implementing entities have an AOP

Pillar I — Challenges

- Subnational accountability remains weak. State-level RMET is still nascent, and completion of State Council on Health resolutions is not actively tracked and monitored.
- Standards are assessed but not certified. No PHC, public secondary or private facility has been issued a certificate of standards, and no regulatory register is yet interoperable with the National Health Workforce Registry.
- Citizen’s confidence rating on the quality of care appears to be declining

Pillar I — Recommendations for 2027

- States and LGAs should certify qualifying primary and secondary facilities, starting with the 2,500 BEmONC-ready PHCs
- Ensure every federal DAP conduct AOP quarterly reviews, with results tabled at the MOC

PART III

PILLAR II: EFFICIENT AND QUALITY HEALTH SERVICE DELIVERY



PILLAR II STRATEGIC OBJECTIVES AND ACHIEVEMENTS

Table 8.4: Pillar II strategic objectives and indicators

Strategic Objective	Indicator	Baseline (2023)	Target (2027)	Achievement (2024-2026)
Drive health promotion in a multi-sectoral way (incl. intersectionality with education, environment, WASH and Nutrition)	Percent reduction in obesity	14.5%	12%	Data not available
	Number of states with established State Committees of Food and Nutrition	Data not available	Data not available	Data not available
	Number of states with active State Multisectoral Plans of Action	Data not available	Data not available	Data not available
Strengthen prevention through primary health care and community health care	Percent increase in physical activity	67%	80%	Data not available
	Percent reduction in vaccine-preventable deaths/diseases	41%	32%	Data not available
	Reduced prevalence of communicable diseases	0%	20%	Data not available
	Reduced prevalence of NCDs	16.8%	14%	Data not available
Improve quality of care and service delivery across public (secondary, tertiary and quaternary) and private health care providers	Percentage of babies with birth weight recorded before discharge Percentage of women receiving a prophylactic uterotonic immediately after birth	Data not available	Data not available	Data not available
Improve equity and affordability of quality care for patients, expand insurance	Percentage of population covered by health insurance	10.1%	20%	10%
Revitalise the end-to-end (production to retention) healthcare workers' pipeline	Number of frontline health workers newly licensed	Data not available	Data not available	Data not available
	Number of frontline health workers in public and private service	Data not available	Data not available	Data not available

Chapter 9

SERVICE AVAILABILITY, READINESS AND INFRASTRUCTURE



9.1 HEALTH FACILITY OVERVIEW

The Nigeria Health Facility Registry (NHFR)[1] recorded 40,265 health facilities nationwide in 2026, of which only those validated through the ongoing revalidation exercise are currently confirmed. Ownership distribution showed PHCs remain predominantly public while secondary facilities are largely private. Tertiary facilities continue to be mainly public (Figure 15).

Table 9.1: Health facility infrastructure

Core Indicator	2026 (NHFR)
Number of primary health centres	-
Number of secondary health facilities	-
Number of tertiary health facilities	-
Number of quaternary hospitals	-
Total number of verified health facilities	**40,265**

Table 9.2: Health facilities by ownership

Disaggregation by ownership (2026 NHFR)	Public	private	Corporate	Faith-based
Primary health Centres	18,855	5,781	Not reported	Not reported
Secondary health facilities	1,155	5,235	Not reported	Not reported
Tertiary health facilities	89	87	Not reported	Not reported

[1] Federal Ministry of Water Resources (FMWR), Government of Nigeria, National Bureau of Statistics (NBS) and UNICEF (2022). *Water, Sanitation and Hygiene: National Outcome Routine Mapping (WASHNORM) 2021: A Report of Findings.* FCT Abuja. Nigeria

Table 9.3: Health facilities and diagnostic services

Other facilities	2025	2026
Number of Laboratories and diagnostic services registered (MLSCN)	4,000	Data not available
Number of Registered functional blood banks nationwide (NBTS)	30	33



Figure 15: Distribution of verified health facilities across states. Source: NHFR 2026

9.2 PHC Service Availability and Readiness Assessment

To provide up-to-date snapshots of primary health care (PHC) facility performance, a rapid telephone survey of health facilities was conducted in August 2026 as part of the Frequent Assessments and System Tools for Resilience (FASTR) initiative making a total of three survey rounds. It assesses the availability and readiness of primary health care (PHC) services, including service availability, infrastructure, essential commodities and equipment, qualified health workforce, organisational capacity (governance and coordination, quality improvement, community engagement, and financing), and resilience to recent external shocks (Figures 16–21).



Figure 16: PHC facility survey: targeted sample size and facilities interviewed, Rounds 1–3

Key findings

Medical supply availability improved, while vaccine availability declined. Infrastructure and provider training remain key gaps. There exist regional gaps with South East leading in supplies and service availability, while the North East and North West continue to lag in service provision

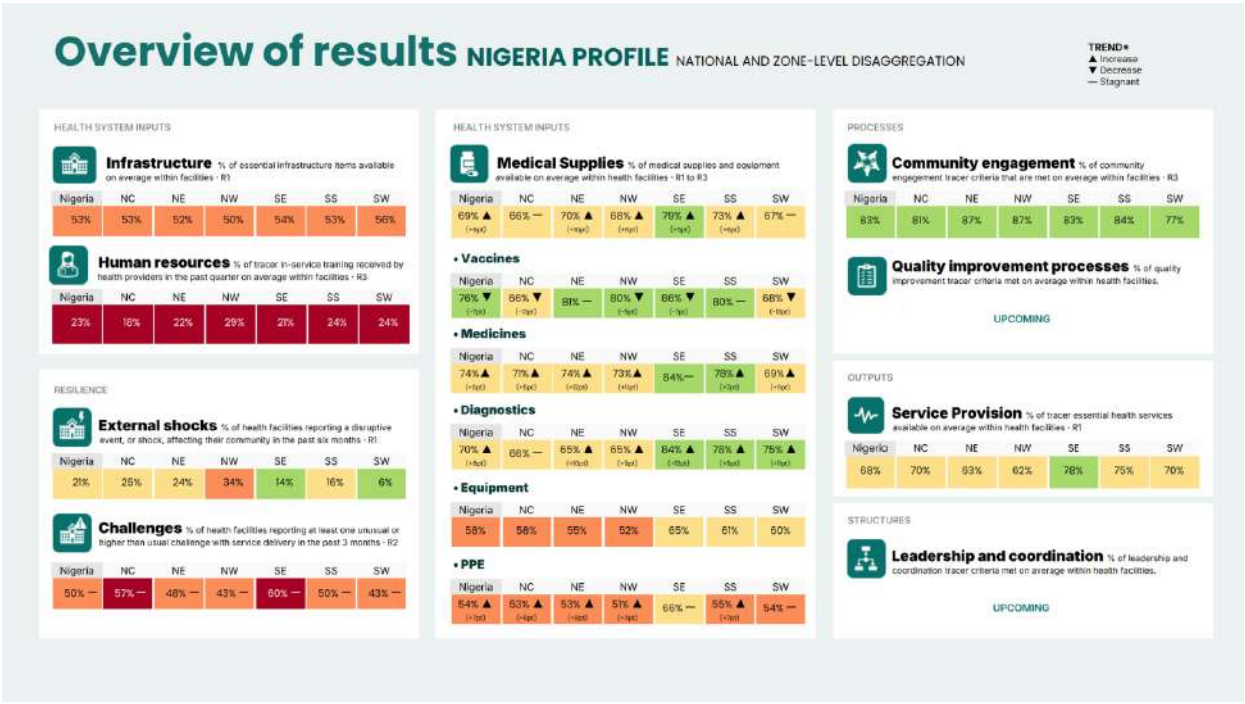


Figure 17: Overview of PHC facility survey results, national and zonal

Chapter 9

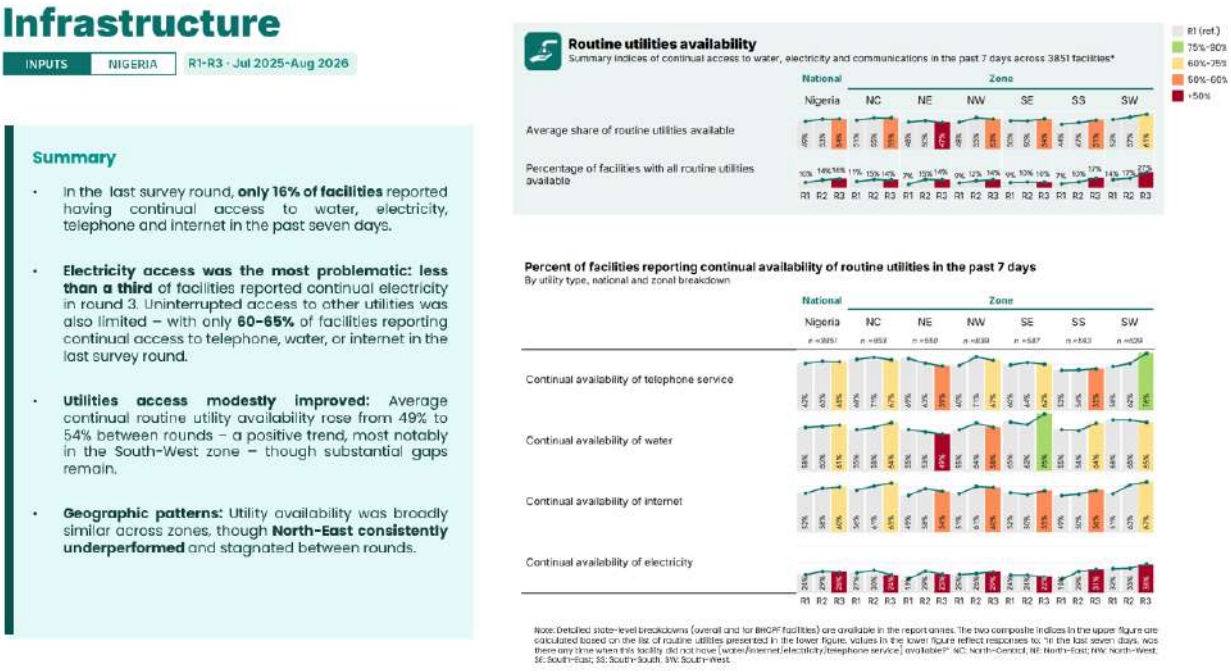


Figure 18: PHC routine utilities availability, Jul 2025–Aug 2026

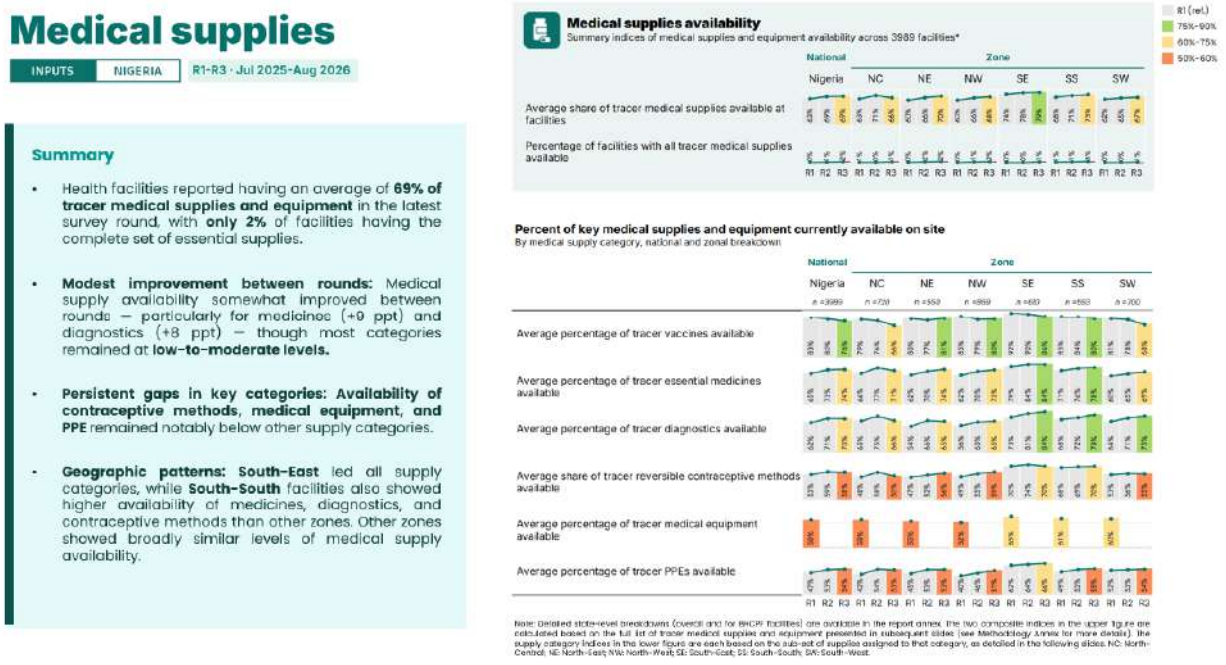


Figure 19: PHC medical supplies and equipment availability, Jul 2025–Aug 2026

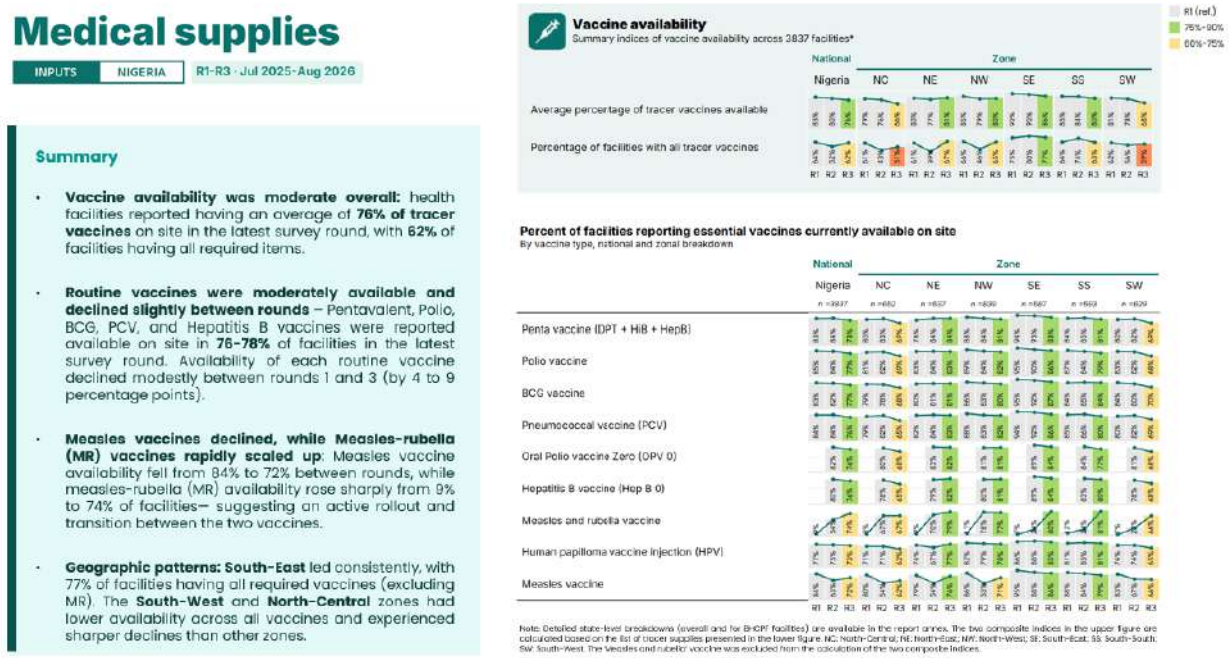


Figure 20: PHC vaccine availability, Jul 2025–Aug 2026

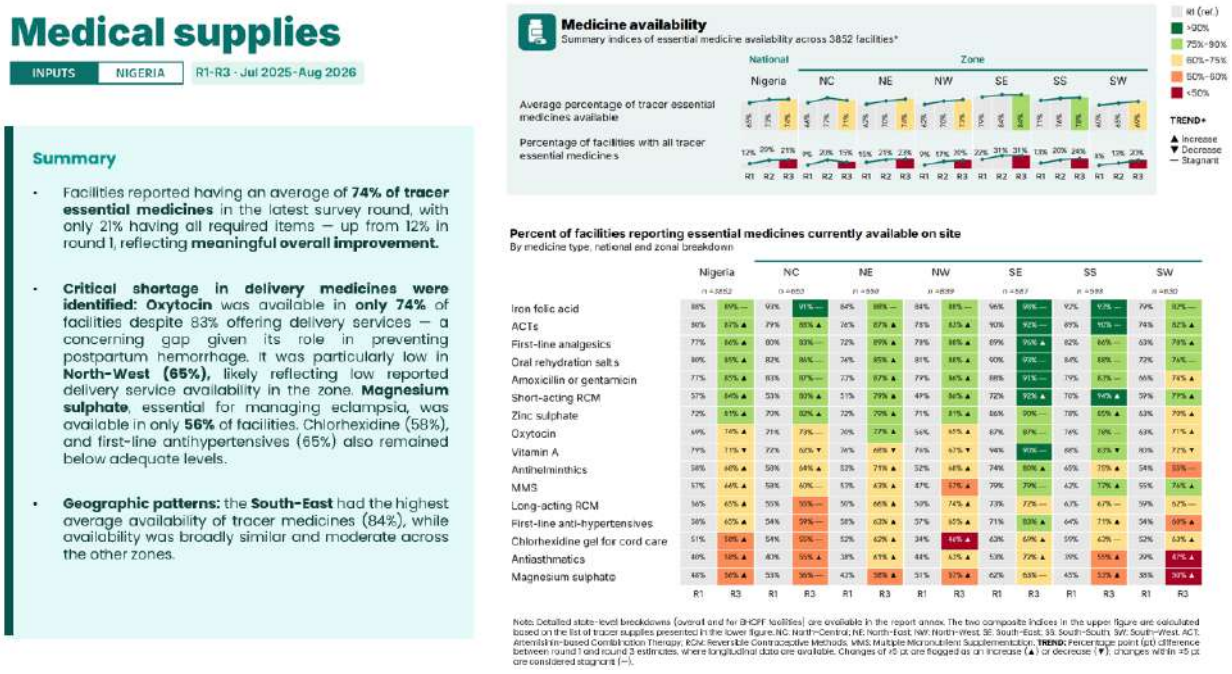


Figure 21: PHC essential medicine availability, Jul 2025–Aug 2026

9.3 Functional Bed, Equipment and Utilities Availability

Functional beds, equipment and basic utilities such as water, sanitation and electricity are the foundation of a facility's ability to deliver safe, quality care. Bed occupancy and average length of stay further indicate how efficiently hospital capacity is being used. Together,

these measures show whether facilities are ready to meet patient demand at each level of care.

Table 9.4: Functional bed, equipment and utilities availability

Core Indicator	2025 Achievement	2026 Achievement
Number of Functional beds, tertiary	Data not available	20,000
Number of Functional beds, secondary	Data not available	127,025
Number of Functional beds, PHC	Data not available	145,729
Percentage of Bed occupancy rate, federal tertiary facilities	59%	Data not available
Average length of stay, federal tertiary facilities (days)	7	Data not available
Percentage of Facilities with functional water, sanitation and power utilities	Data not available	Data not available

Source: NHFR

9.4 BEmONC/CEmONC Readiness and Service Utilisation

The assessment of facilities with the aim to ensure standards continued in 2026. PHCs are being assessed for Basic Emergency Obstetric and Newborn Care (BEmONC) signal functions, while secondary health facilities are assessed for Comprehensive Emergency Obstetric and Newborn Care (CEmONC) signal functions.

Table 9.5: BEmONC/CEmONC readiness and service utilisation

Core Indicator	2025 Achievement	2026 Achievement
Number of BEmONC ready PHCs	1,774	2,500
Percentage of BEmONC ready PHCs that are certified	0%	0%
Number of CEmONC-ready secondary facility that are certified	0	1,800
Percentage of CEmONC ready secondary facility that are certified	0%	0%
Number of Secondary facilities meeting quality of care criteria for CEmONC	308	Data not available
Number of Refurbished and empanelled CEmONC facilities	232	Data not available
Number of Refurbished CEmONC facilities demonstrating service readiness and energy efficiency	Not reported in 2025	Data not available
Number of Women receiving CEmONC services	16,719,609	Data not available
Number of Neonates receiving CEmONC services	1,456,923	Data not available

9.5 HUMAN RESOURCES FOR HEALTH

9.5.1 Health Workforce Stock and Distribution

A health workforce of adequate size, skill mix and distribution is the backbone of health service delivery. The health sector actively tracks the stock of licensed health professionals and how they are engaged across the public and private sectors. It also tracks recruitment and vacant positions, all which shape the ability of facilities to meet their staffing needs.

Table 9.6: Health workforce stock and distribution

Core Indicator	Baseline	2025 Achievement	2026 Achievement
Percentage of Licensed doctors currently engaged (public sector)	73.6%	72.8%	Data Not Available
Percentage of Licensed nurses and midwives engaged (public sector)	74.9%	Data not available	
Percentage of Licensed pharmacists engaged (public sector)	35.4%	Data not available	
Percentage of Licensed medical laboratory professionals engaged (public sector)	70.6%	68.1%	
Percentage of Licensed community health practitioners and CHEWs engaged (public sector)	95%	68.9%	
Number of Doctors currently engaged (private sector)	8,392	8,945	
Number of Nurses and midwives engaged (private sector)	19,999	Data not available	
Number of Newly recruited health workers	15,345	Data not available	
Number of Funded but vacant health worker positions in the public sector	Data not available	Data not available	

9.5.2 Doctor-to-Population and Nurse-to-Population Ratios

Health worker-to-population ratios show how many doctors, nurses and other professionals are available relative to the population they serve. The World Health Organization uses a threshold of 44.5 doctors, nurses and midwives per 10,000 population as a benchmark for achieving universal health coverage. Comparing these ratios across states, sectors and urban and rural areas highlights inequities in workforce distribution.

Table 9.7: Doctor-to-population and nurse-to-population ratios

Core Indicator	Baseline	2025 Achievement	2026 Achievement
Medical doctor density (per 10,000 population)	*2.42*	*2.60*	Data Not Available
Nurse density (per 10,000 population)	*4.52*	Data not available	
Pharmacist density (per 10,000 population)	*0.70*	*0.80*	
Medical laboratory science professional density (per 10,000 population)	*0.61*	*0.82*	
Community health practitioner density (per 10,000 population)	*8.95*	*1.62*	
Dentist density (per 10,000 population)	*0.14*	*0.15*	
Radiographer density (per 10,000 population)	*1.1*	*0.13*	
Health record officer density (per 10,000 population)	*0.11*	Data not available	
Public-private distribution of licensed medical doctors (%)	*73.6 – 26.4%*	*72.8% - 27.2%*	
Urban-rural distribution of licensed public analysts (%)	*100% - 0%*	*100% - 0%*	
Workforce density ratio, highest-density state: lowest-density state (doctors per 10,000)	*FCT 9.14 - Jigawa 0.49*	Data not available	

9.5.3 Health Worker Production and Training Institutions Output

Health training institutions, including medical schools, nursing and midwifery schools and colleges of health technology, produce the new health workers needed to sustain and expand the workforce. Their output must keep pace with population growth, service expansion and the loss of staff through attrition and migration. Accreditation by the relevant regulatory councils ensures that graduates meet the required professional standards (Figures 22 and 23).

Table 9.8: Health worker production and training institutions output

Core Indicator	Baseline	2025 Achievement	2026 Achievement
Number of accredited health training institutions nationally	536	Data not available	Data Not Available
Number of annual graduate output, medicine	3,776	3420	
Number of annual graduate output, nursing and midwifery	39,994 (Nursing & Midwives)	22,650 (nursing only)	
Number of annual graduate output, community health cadres	35,846	Data not available	

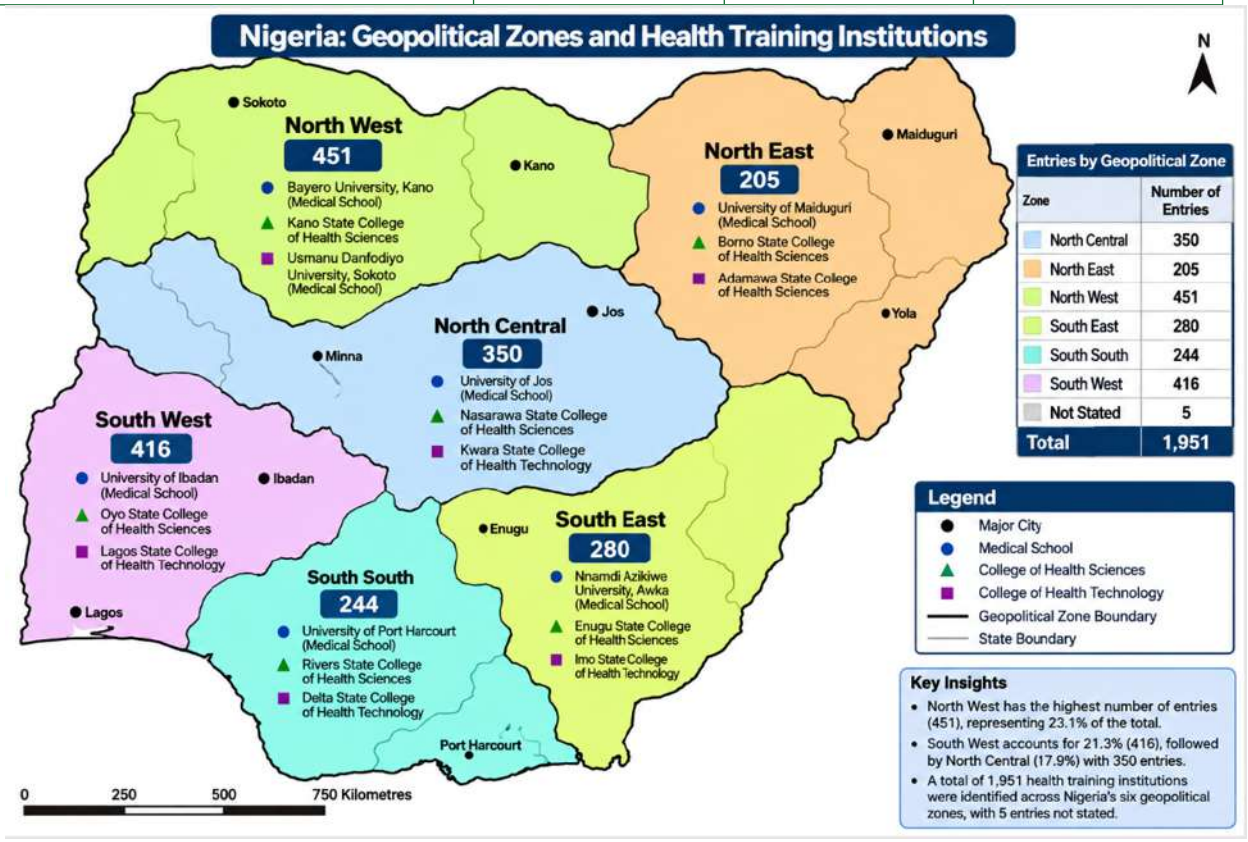


Figure 22: Health training programmes by various institutions by geopolitical zone, Nigeria

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Geopolitical zone	State	CHPRBN	NMCN	PCN	MLSCN	HIRORBN	MRTB	MDCN	DTRBN	RRBN	IPAN	ODORBN	DTHRBN	Total listings	Bodies present (of 12)
North Central	Benue	15	5	7	8	5	1	1	1	0	0	0	0	43	8
	FCT	2	10	1	3	1	5	4	0	2	4	0	0	32	9
	Kogi	3	7	4	1	2	0	0	0	0	0	0	0	17	5
	Kwara	12	7	7	9	5	4	1	2	1	0	2	2	52	11
	Nasarawa	9	2	5	6	5	0	2	2	4	0	2	1	38	10
	Niger	20	4	7	8	8	1	0	1	0	0	0	0	49	7
	Plateau	9	7	5	8	6	1	2	1	3	1	0	0	43	10
	Zone total	70	42	36	43	32	12	10	7	10	5	4	3	274	12
North East	Adamawa	4	2	4	2	2	0	0	1	1	0	0	0	16	7
	Bauchi	13	7	5	7	6	1	1	4	1	0	0	1	46	10
	Borno	5	5	5	3	2	3	2	1	1	0	0	1	28	10
	Gombe	10	3	8	2	3	1	1	3	0	0	0	0	31	8
	Taraba	5	4	4	2	2	1	0	0	1	0	0	0	19	7
	Yobe	2	3	2	2	3	3	1	1	0	0	0	0	17	8
	Zone total	39	24	28	18	18	9	5	10	4	0	0	2	157	10
North West	Jigawa	7	0	6	2	3	3	1	2	1	0	1	0	26	9
	Kaduna	24	11	13	12	17	4	3	6	4	1	1	4	100	12
	Kano	18	14	11	15	12	8	3	5	2	0	6	3	97	11
	Katsina	9	5	7	5	9	0	0	4	1	0	0	1	41	8
	Kebbi	7	5	5	2	3	0	1	1	0	0	1	0	25	8
	Sokoto	6	8	3	3	7	1	1	4	3	0	0	2	38	10
	Zamfara	4	4	5	3	5	1	0	2	0	0	0	1	25	8
	Zone total	75	47	50	42	56	17	9	24	11	1	9	11	352	12
South East	Abia	4	12	5	5	2	2	3	0	1	1	1	0	36	10
	Anambra	5	12	10	7	3	4	4	1	2	1	0	0	49	10
	Ebonyi	6	9	3	5	3	3	3	0	4	0	1	0	37	9
	Enugu	9	16	6	7	1	4	5	1	4	1	0	1	55	11
	Imo	5	21	2	5	2	2	2	1	0	1	3	0	44	10
	Zone total	29	70	26	29	11	15	17	3	11	4	5	1	221	12
South South	Akwa Ibom	3	8	5	2	2	2	1	0	1	0	0	0	24	8
	Bayelsa	2	0	3	3	1	1	2	2	0	0	0	0	14	7
	Cross River	12	9	4	7	5	3	1	1	2	0	2	0	46	10
	Delta	1	10	3	2	3	2	2	1	1	1	2	0	28	11
	Edo	6	15	9	7	2	3	6	1	1	1	2	0	53	11
	Rivers	3	7	6	5	2	2	5	1	0	5	2	1	39	11
	Zone total	27	49	30	26	15	13	17	6	5	7	8	1	204	12
South West	Ekiti	5	6	7	6	7	1	2	3	2	0	2	1	42	11
	Lagos	5	8	11	4	3	11	5	2	2	25	1	1	78	12
	Ogun	10	10	8	10	5	5	2	5	1	7	2	2	67	12
	Ondo	9	6	4	5	4	4	2	2	2	1	1	1	41	12
	Osun	16	11	9	16	11	8	5	4	1	0	0	1	82	10
	Oyo	7	10	7	8	4	5	3	3	3	1	0	1	52	11
	Zone total	52	51	46	49	34	34	19	19	11	34	6	7	362	12
State not stated		1	0	0	0	0	2	0	0	0	0	1	0	4	3
Nigeria (national)		293	283	216	207	166	102	77	69	52	51	33	25	1,574	12

Institutions per regulatory body: 0 | 1–2 | 3–5 | 6–10 | 11–15 | 16+

Total listings (state): <20 | 20–39 | 40–59 | 60–79 | 80+

Bodies present (of 12): ≤6 | 7–8 | 9–10 | 11 | 12

Gold cell = regulatory body has no listed training institution in the state (coverage gap). Grey rows are zone totals; green row is the national total (not colour-graded).

Regulatory bodies

- CHPRBN — Community Health Practitioners Registration Board of Nigeria
- NMCN — Nursing and Midwifery Council of Nigeria
- PCN — Pharmacists Council of Nigeria
- MLSCN — Medical Laboratory Science Council of Nigeria
- HIRORBN — Health Records Officers Registration Board of Nigeria
- MRTB — Medical Rehabilitation Therapists Board of Nigeria
- MDCN — Medical and Dental Council of Nigeria
- DTRBN — Dental Technologists Registration Board of Nigeria
- RRBN — Radiographers Registration Board of Nigeria
- IPAN — Institute of Public Analysts of Nigeria
- ODORBN — Optometry and Dispensing Opticians Registration Board of Nigeria
- DTHRBN — Dental Therapists Registration Board of Nigeria

Source: Health Training Institutions – Master List (regulatory-body lists, 2023–2025). All accreditation statuses counted. Total listings = sum across bodies; an institution

Figure 23: Health Training institutions listed by each health regulatory body, by state and geopolitical zone, Nigeria

9.5.4 Attrition, Brain Drain and Japa Syndrome

Attrition refers to the loss of health workers through resignation, retirement, death or migration, and it reduces the capacity of the health system to deliver care. In recent years, the outward migration of Nigerian health professionals, popularly known as “Japa”, has m risen, with doctors, nurses and other cadres moving mainly to high-income countries. Tracking attrition and migration trends helps the government to plan replacement, retention and workforce management strategies.

Table 9.9: Health worker attrition and migration indicators

Core Indicator	Baseline	2025 Achievement	2026 Achievement
Licensed doctors migrating in the reporting year (number)	3,919	3,746	Data Not Available
Top destination countries for doctors and dentists	United Kingdom (4,627), Canada (934), United States (561), Australia (188), United Arab Emirates (140) and Ireland (113)	United Kingdom (2,038), Canada (854), United States (354), Australia (189), Ireland (89) and United Arab Emirates (60)	
Top destination countries for nurses and midwives	United States (8,613), United Kingdom (7,463), Canada (5,603), Saudi Arabia (1,231), Ireland (399) and United Arab Emirates (399)	United States (3,960), United Kingdom (2,986), Canada (1,302), Saudi Arabia (850), Ireland (419) and Qatar (360)	
Top destination countries for pharmacists	Canada (765), United Kingdom (196), Australia (88), United States (53), Ireland (30) and United Arab Emirates (9)	Canada (765), United Kingdom (196), Australia (88), United States (53) and Ireland (30)	
Top destination countries for medical laboratory science cadres	United Kingdom (5,029), Canada (1,686), United States (1,363), Ireland (932) and United Arab Emirates (331)	Canada (6,393), United Arab Emirates (2,010), Ireland (1,500), United States (1,052) and United Kingdom (410)	
Verification letters issued to health professionals for outward migration (number)	Data not available	More than 3,000 doctors requested letters of good standing in 2022	
Annual health workforce attrition rate (%)	10.99%	Data not available	
Net change in public-sector health workforce stock (number)	Data not available	Data not available	

Source: NHWP Data Tool

9.5.5 Retention Strategies and Policy Interventions

Retention strategies aim to attract and keep health workers in post, particularly in rural and hard-to-reach areas. These include costed retention plans, rural and hardship allowances, continuing professional development, and timely recruitment into vacant positions. The National Policy on Health Workforce Migration, approved in 2024, provides a framework for managing migration while strengthening retention.

Table 9.10: Health worker retention strategies and policy interventions

Core Indicator	2025 Achievement	2026 Achievement
Number of States with a costed health workforce retention plan	Data not available	Data not available

Core Indicator	2025 Achievement	2026 Achievement
Number of Health workers receiving rural or hardship posting allowances	Data not available	Data not available
Number of Health workers on structured continuing professional development pathways	Data not available	Data not available
Percentage of Public-sector health worker positions filled within 6 months of advertisement	Data not available	Data not available
Percentage of Health workers retained in post 24 months after recruitment	Data not available	Data not available

9.5.6 Community Health Workers and PHC Workforce

Community health workers and PHC staff, such as Community Health Extension Workers (CHEWs) and Community Health Officers, deliver most frontline services, particularly in rural and underserved areas. Their availability determines whether PHC facilities can provide the minimum package of essential services, including maternal and child health care. Ongoing recruitment and training, including under the BHCPF and the Maternal Mortality Reduction Innovation Initiative (MAMII), continue to strengthen this frontline workforce.

Table 9.11: Community and PHC workforce

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of Frontline health workers trained on integrated health care service	63,233	78,142	NPHCDA Technical Report
Number of CHEWs trained on integrated health care services	Data not available	Data not available	
Number of Skilled birth attendants recruited as ad-hoc PHC staff	2,935	Data not available	
Percentage of BHCPF facilities in MAMII LGAs with at least 1 laboratory technician	20%	Data not available	
Number of Frontline state health workers, excluding volunteers	Data not available	Data not available	
Percentage of PHC facilities meeting the minimum staffing standard for their level	Data not available	Data not available	

Chapter 10

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH + NUTRITION



Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH+N) is the main policy thrust of Nigeria and at the heart of NHSRII implementation. This section reviews progress in key RMNCAH+N indicators using routine facility-based data and population-based surveys to assess performance, identify gaps, and inform priority actions to accelerate progress towards national targets.

10.1 Family Planning

Family planning is a core component of reproductive health and one of the most cost-effective investments for improving maternal, newborn and child survival. It allows women and couples to choose the number, timing and spacing of their pregnancies through access to information, counselling and a range of modern contraceptive methods. Within Nigeria's health sector, family planning services are delivered through public, private and community-based channels, and their reach is monitored through household surveys and routine facility data (Figures 24–27).

Table 10.1: Family planning indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Modern contraceptive use, all women aged 15–49 (%)	13.1%	15.1%	NMDHS 2025-26
Modern contraceptive prevalence, currently married women aged 15–49	15.3 %	18.3%	
Unmet need for family planning (%) currently married women aged 15–49	21.0%	43.1	
Unmet need for family planning (%) all women age 15–49	15.7%	15.6%	
Demand for family planning satisfied by modern methods, currently married women aged 15–49 (%)	**37.1%**	41.3%	
Routine Measure (Facility-based)			
New family planning acceptors (Facility)	7,747,595	6,376,917*	

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Core Indicator	2025 Achievement	2026 Achievement	Data Source
Females using modern contraception (Facility)	9,234,613	7,193,603*	

*DHIS2 (FASTR Adjusted Jan-Sep 2026)

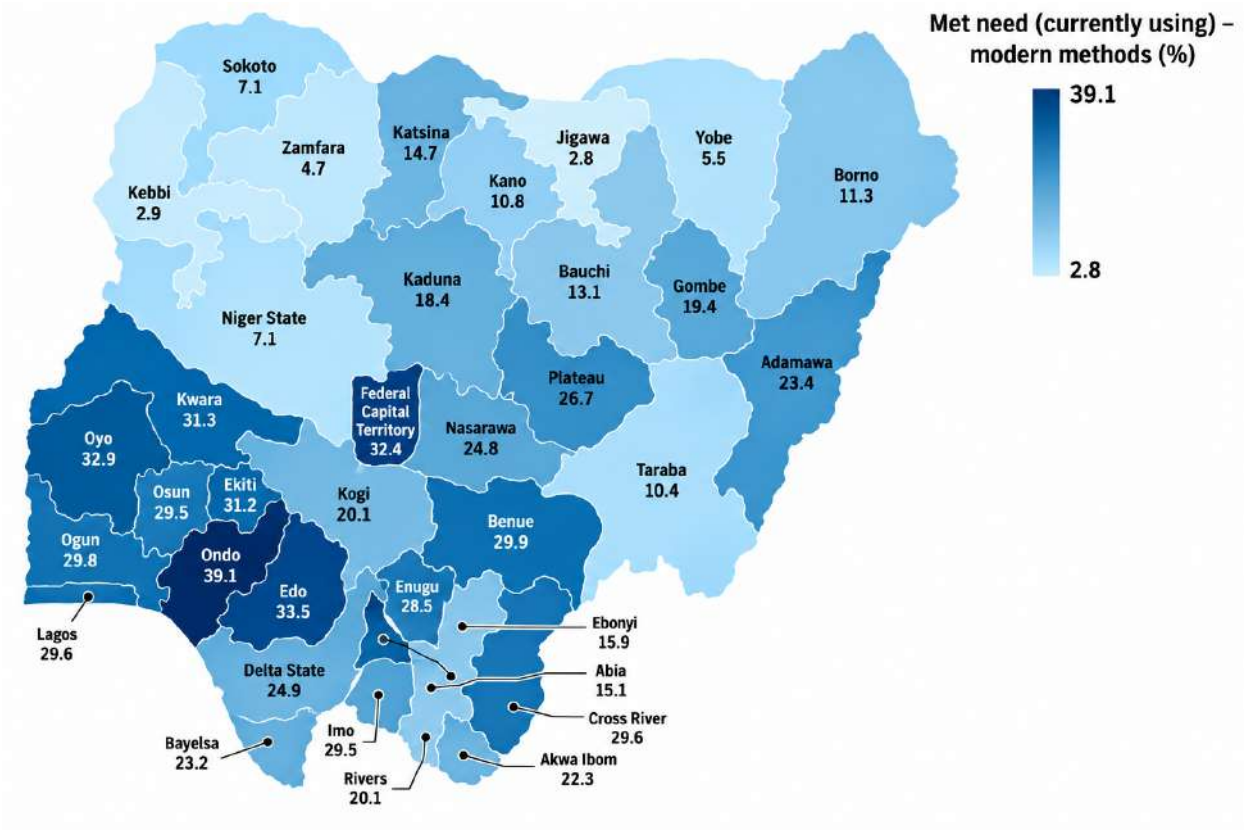


Figure 24: Met need for modern contraceptive methods (%) by state, NMDHS 2025–26

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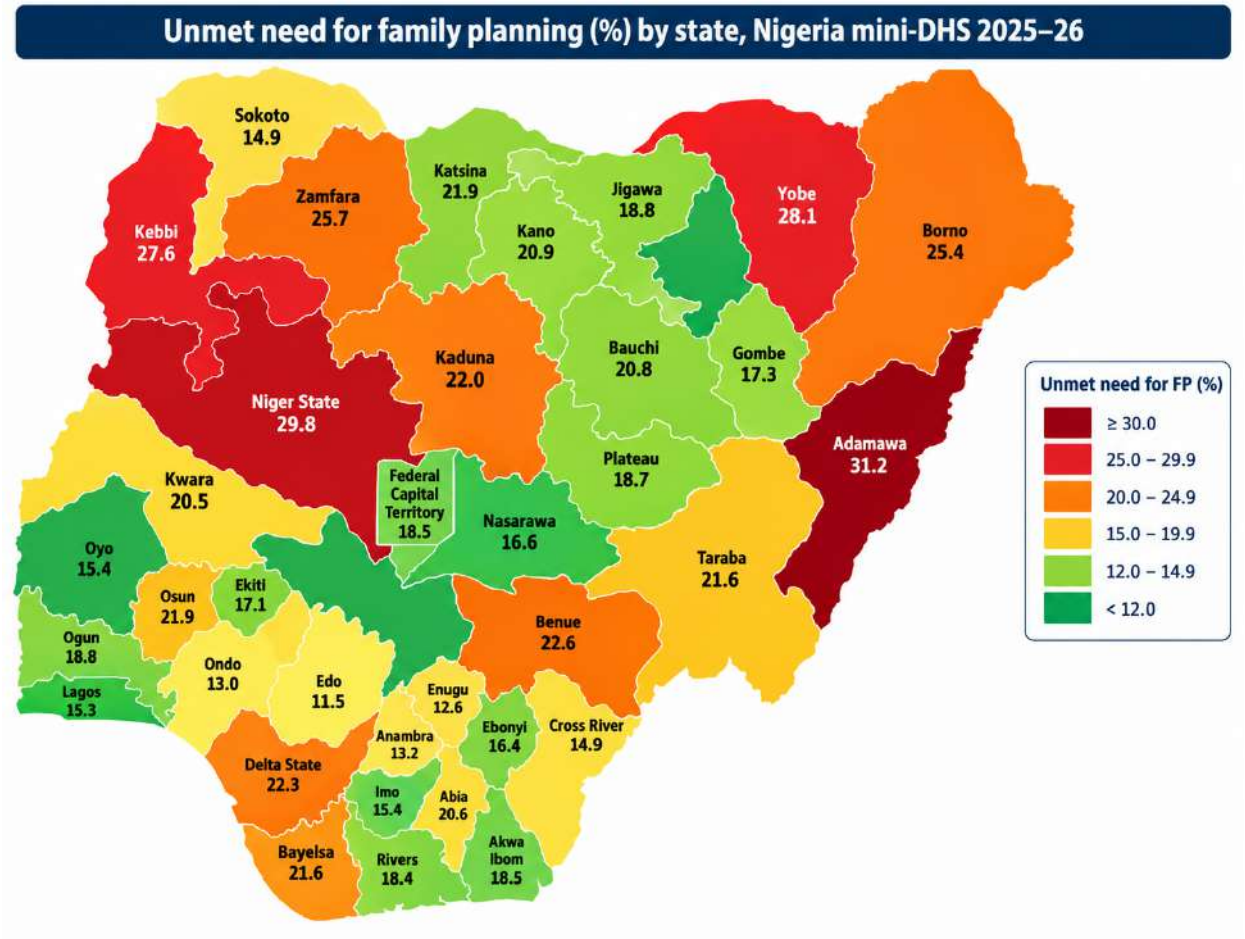


Figure 25: Unmet need for family planning (%) by state, NMDHS 2025–26

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RMNCAH SERVICE COVERAGE

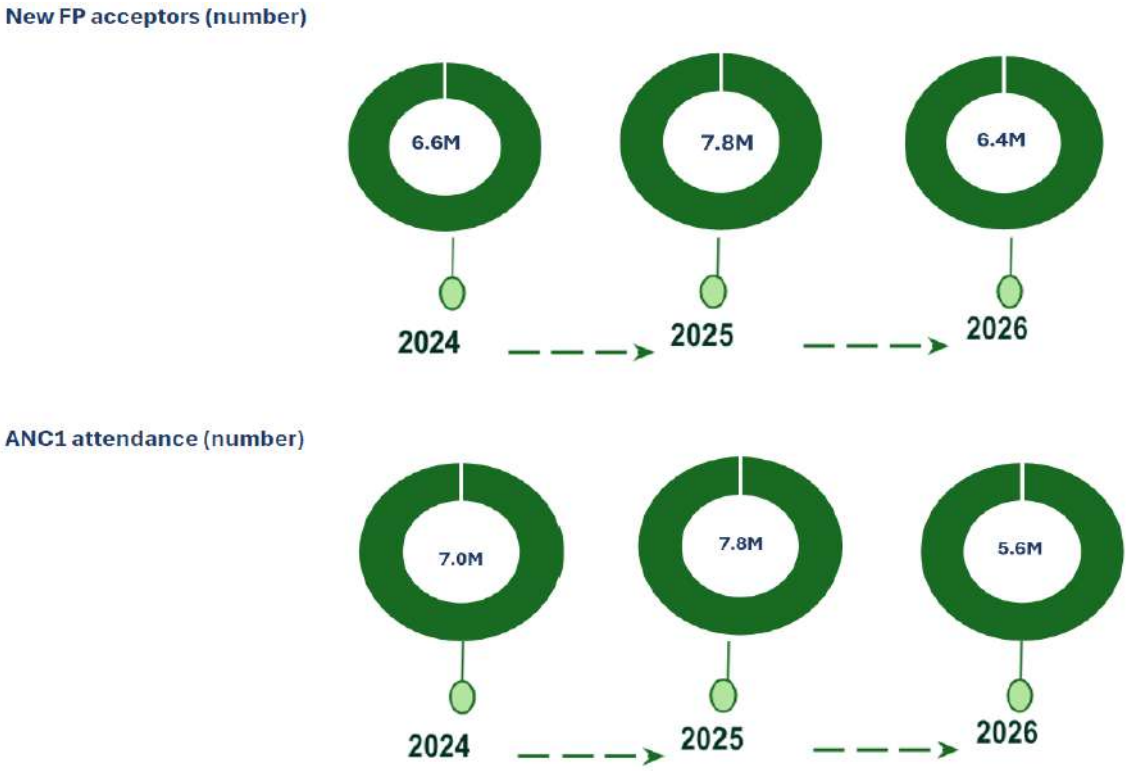


Figure 26: New family planning acceptors and ANC1 attendance, 2024–2026

Source: DHIS2 (FASTR Adjusted)

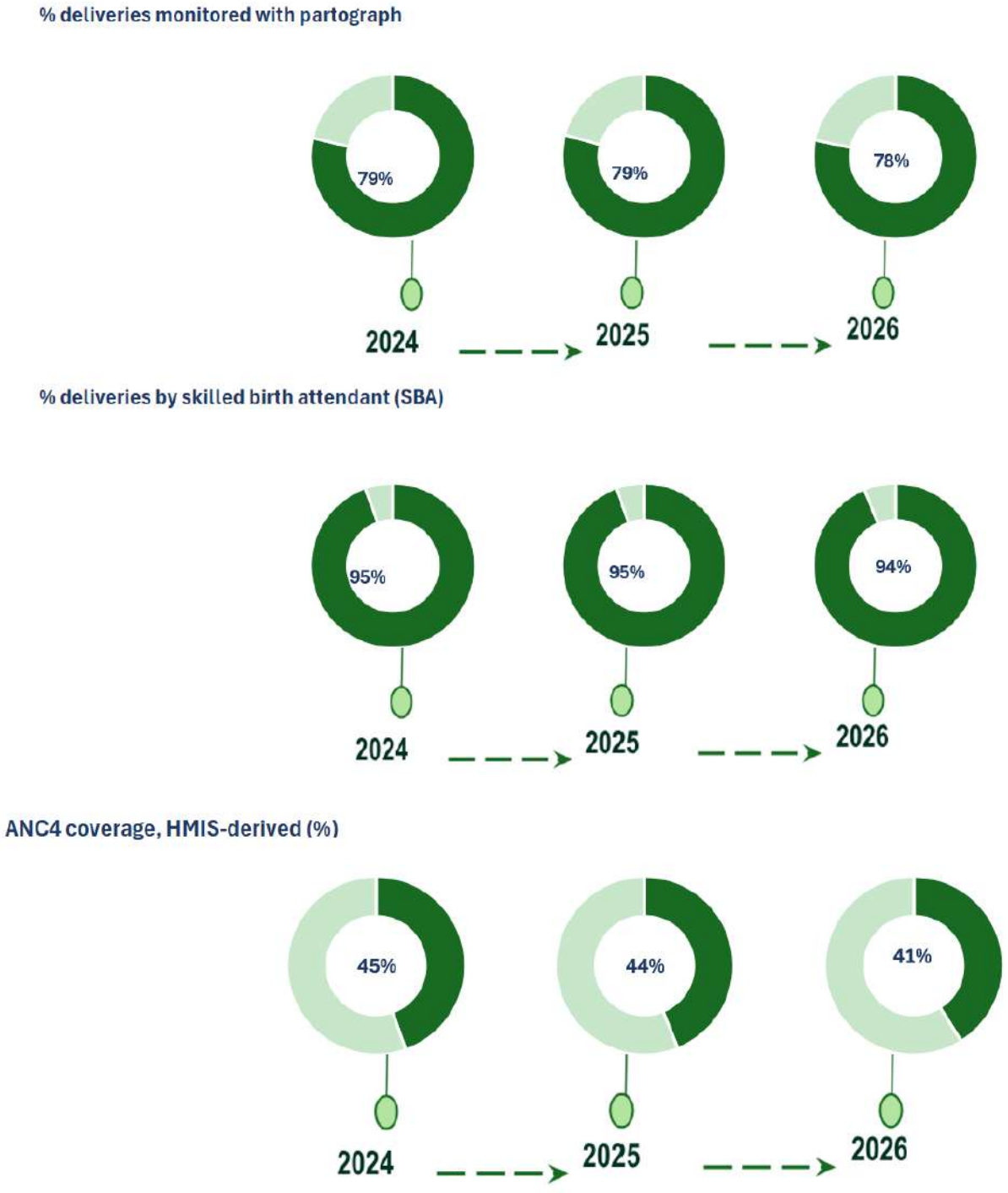


Figure 27: Deliveries monitored with a partograph, deliveries by a skilled birth attendant (%), and ANC4 coverage 2024–2026

Source: DHIS2 (FASTR Adjusted)

10.1.1 Family Planning Uptake, Contraceptive Prevalence and Unmet Need

More new family planning acceptors were recorded in 2026, compared to 2025. Facilities reported 5,320,072 new family planning acceptors between January and September 2026, against 4,191,483 between Q1-Q3 for the year 2025. August 2026 recorded the highest monthly volume in the series (Figure 28).

The monthly volume increased steadily from 2024 to 2025 and continued to rise in 2026, Q4 2026 was 16% above the same period of 2025, with the strongest growth in Q1. Quarterly volumes grew in every quarter of 2025, with the largest rise in Q4 (13%)

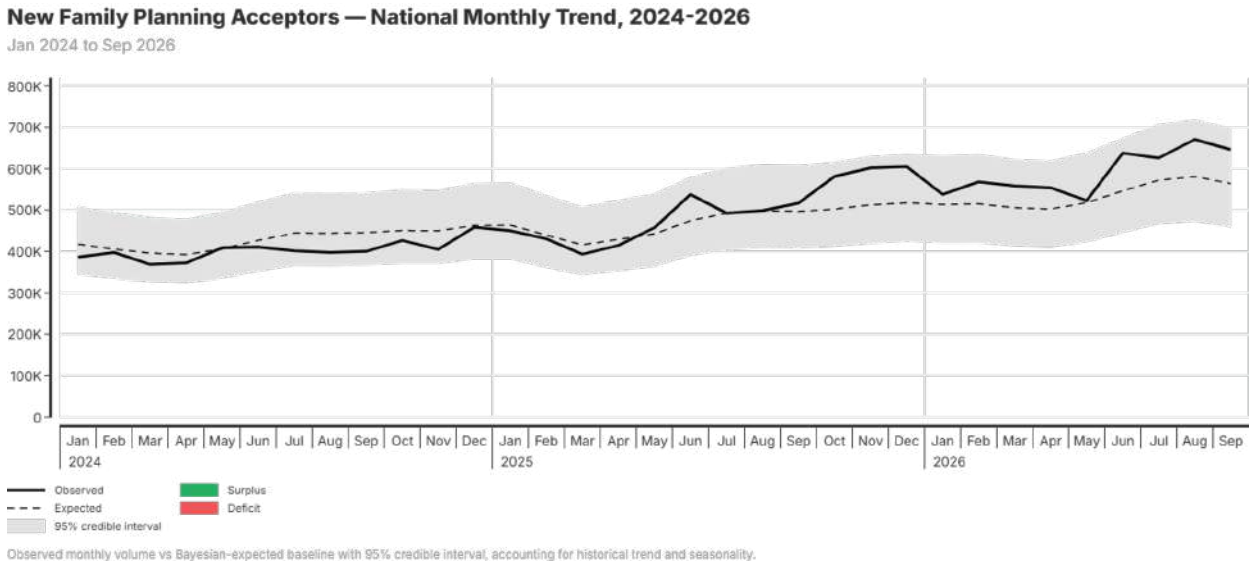


Figure 28: New family planning acceptors, national monthly trend, Jan 2024–Sept 2026

Source: DHIS2 (FASTR Adjusted analysis)

All six zones recorded growth in new acceptors over three years. The Northwest led in both volume and growth, rising by about two-thirds over the period, while the southern zones remained relatively flat at lower levels (Figure 29).

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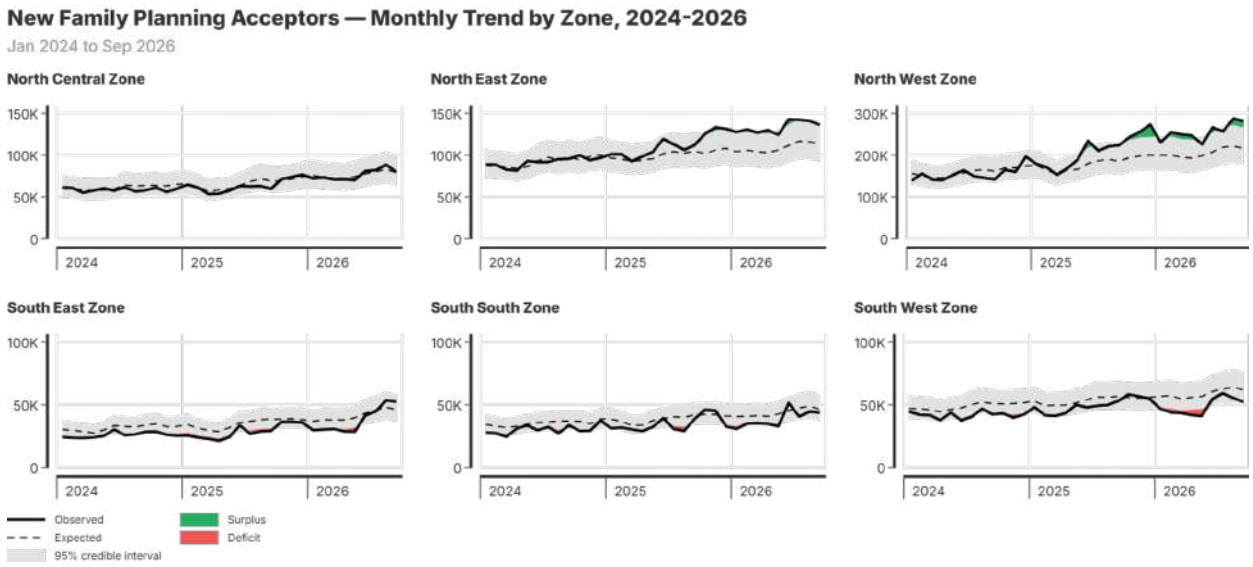


Figure 29: New family planning acceptors by geopolitical zone, monthly, Jan 2024–Sept 2026

Source: DHIS2 (FASTR Adjusted analysis)

With an average of about 7.3% a quarter, new family acceptors rose in every quarter of 2025, peaking in Q4. Q1 2026 eased slightly from that peak but remained 18% above Q1 2025, and Q2 2026 stayed above its 2025 level. The major drop was in 2026 Q1 after the 2025 Q4 peak, and numbers then recovered to a new high by 2026 Q3 (Figure 30).



Figure 30: New family planning acceptors by quarter, with quarter-on-quarter change, 2025–2026

Source: DHIS2 (FASTR Adjusted analysis)

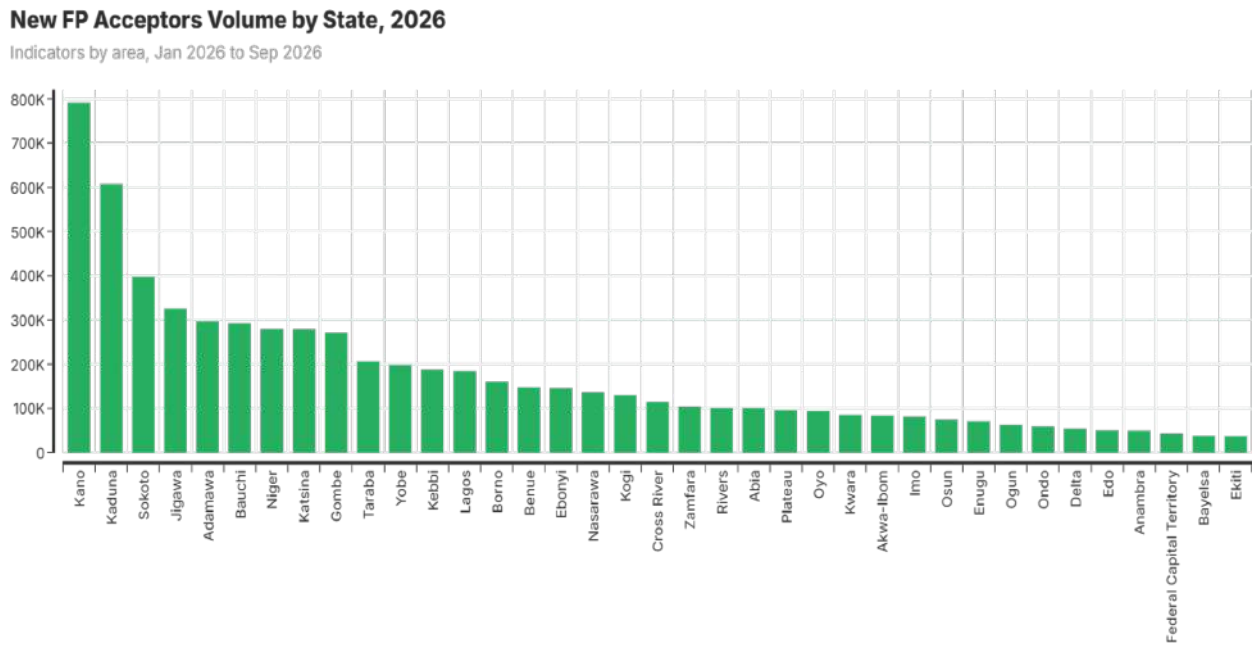


Figure 31: State-level distribution of new Family Planning Acceptors

Source: DHIS2 (FASTR Adjusted)

New acceptors were concentrated in the northern states, led by Kano, Kaduna and Sokoto, which together accounted for 28% of the 2026 total. Southern states, notably Ekiti and Bayelsa, recorded the lowest uptake (Figure 31).

Demand for modern methods is tracked through clients counselled, used as a proxy because no percentage is computed. Counselling reached 12,062,233 clients between January–September2026. Both new acceptors and modern contraceptive users rose from 2024 to 2025, with further gains in 2026. Growth was stronger among contraceptive users and users consistently outnumbered new acceptors by about 1.4 to 1 (Figure 32).

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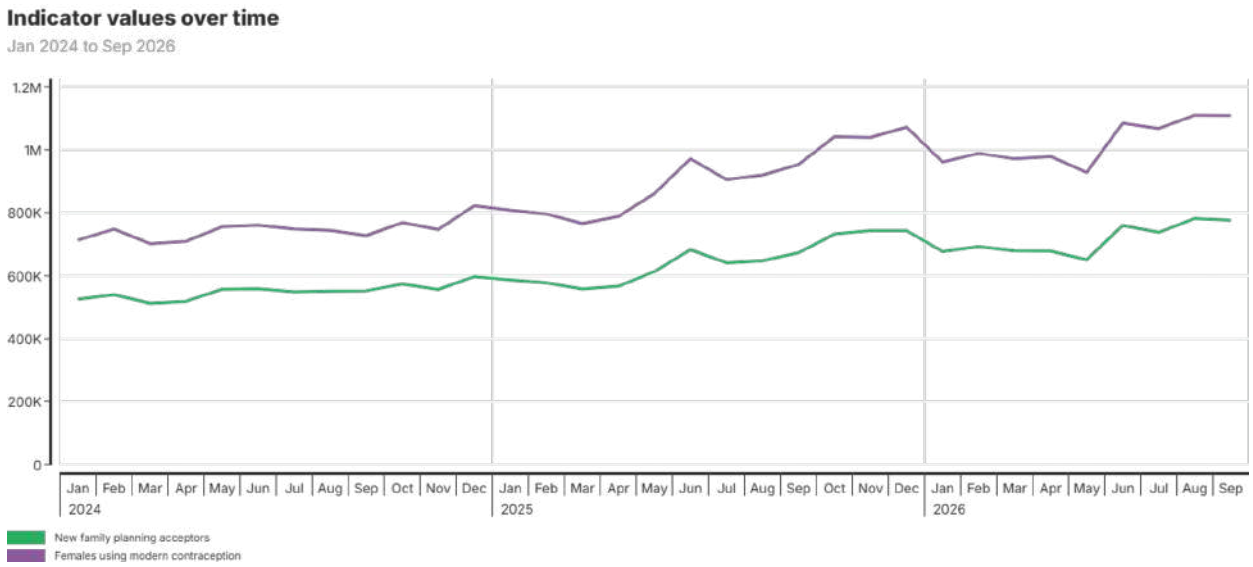


Figure 32: Trends in New Family Planning Acceptors and Demand for Modern Contraceptives . Source: DHIS2 (FASTR Adjusted)

NMDHS 2025-26 estimated modern contraceptive use at 18.3% among currently married women aged15–49, 15.1% among all women aged 15–49, and 34.7% among sexually active unmarried women. Unmet need for family planning was 20.4%, 15.6% and 43.1% in these three groups, respectively. Among currently married women, 41.3% of demand for family planning was satisfied by modern methods (Figure 33)

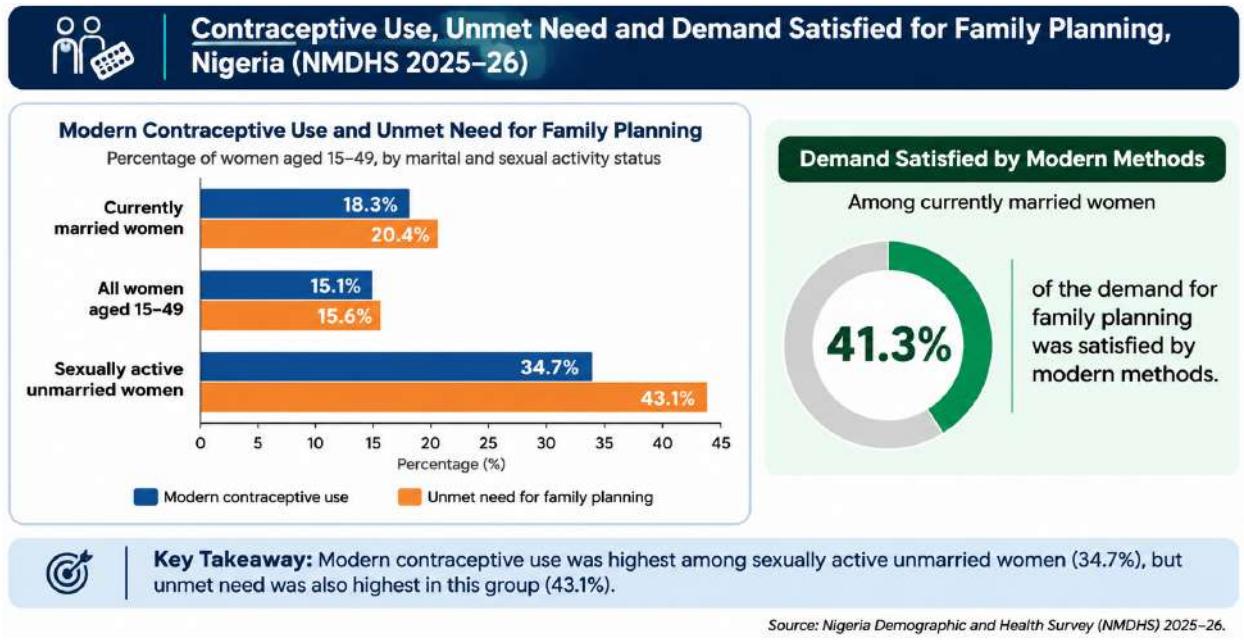


Figure 33: Family Planning: Use, Unmet Need and Demand

Source: NMDHS 2025-26

10.2 Antenatal Care Coverage

Antenatal care (ANC) gives pregnant women regular contact with skilled health providers to monitor the health of mother and baby, prevent and treat complications, and prepare for birth. Since 2016, the World Health Organization has recommended a minimum of eight ANC contacts, with the first contact in the first trimester. Despite this recommendation, available data trends indicate that completing even four ANC visits (ANC4) remains a challenge.

Table 10.2: Antenatal care coverage

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Population-based data			
ANC first visit: at least one ANC visit from any provider for their most recent live birth in the preceding two years (%)	73.7%	76.8%	2023-24 NDHS; 2025–26 NMDHS
ANC from a skilled provider, most recent live birth in previous two years (%)	62.5%	70.7%	2023-24 NDHS; / 2025–26 NMDHS
Four or more ANC visits, most recent live birth in previous two years (%)	52.4%	58.5%	2023-24 NDHS; / 2025–26 NMDHS
Eight or more ANC visits, most recent live birth in previous two years (%)	16.4%	20.2%	2023-24 NDHS; / 2025–26 NMDHS
ANC package of services (Malaria) IPTp 3 (%)	31%	33%	2021 NMIS; 2025 NMIS
Pregnant women who slept under an ITN last night (%)	49.6	54.0	2021 NMIS; 2025 NMIS
Routine Measure (Facility -based)			
ANC package of services (Testing for HIV, Syphilis & Viral Hepatitis) (%)	(83%, 70%, 18%)	(94%, 84%, 63%)	NDARS
ANC package of services (Syphilis, Rhesus, Anaemia etc)	Data not available	Data not available	–
Total number of ANC1 attendance	7,764,670	6,434,129*	*DHIS2 (FASTR Adjusted Jan-Sep 2026)
Number of ANC4 visits, national	3,867,244	2,926,023*	*DHIS2 (FASTR Adjusted Jan-Sep 2026)
ANC4 coverage estimate, national (HMIS-derived, %)	43.9%	41.1%*	*DHIS2 (FASTR Adjusted Jan-Sep 2026)
Fourth ANC visits, MAMII LGAs (number)	995,952	747,118*	*DHIS2 (FASTR Adjusted Jan-Sep 2026)
Number of Antenatal care contacts at or before 20 weeks	6,535,748	3,192,419*	*DHIS2 (FASTR Adjusted Jan-Sep 2026)
Number of Antenatal care contacts after 20 weeks	9,332,319	4,542,486*	*DHIS2 (FASTR Adjusted Jan-Sep 2026)
Contacts booked before 20 weeks as share of all ANC-1 contacts (%, derived)	40.5%	40.9%*	*DHIS2 (FASTR Adjusted Jan-Sep 2026)
Contacts booked after 20 weeks as share of all ANC-1 contacts (%, derived)	59.5%	59.1%*	*DHIS2 (FASTR Adjusted Jan-Sep 2026)

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Completeness of antenatal care reporting (%)	79.1%	78.4%*	–

Nationally, the share of women completing all 4 recommended ANC visits among those who start ANC1 has maintained a steady pattern over the years, as fewer women who started ANC are never returned. Roughly 1 in 2 women who attend a first ANC visit do not complete the full 4-visit schedule. However there has been a steady rise from 39.0% in 2023 to 53.2% in 2026 (Figure 34).

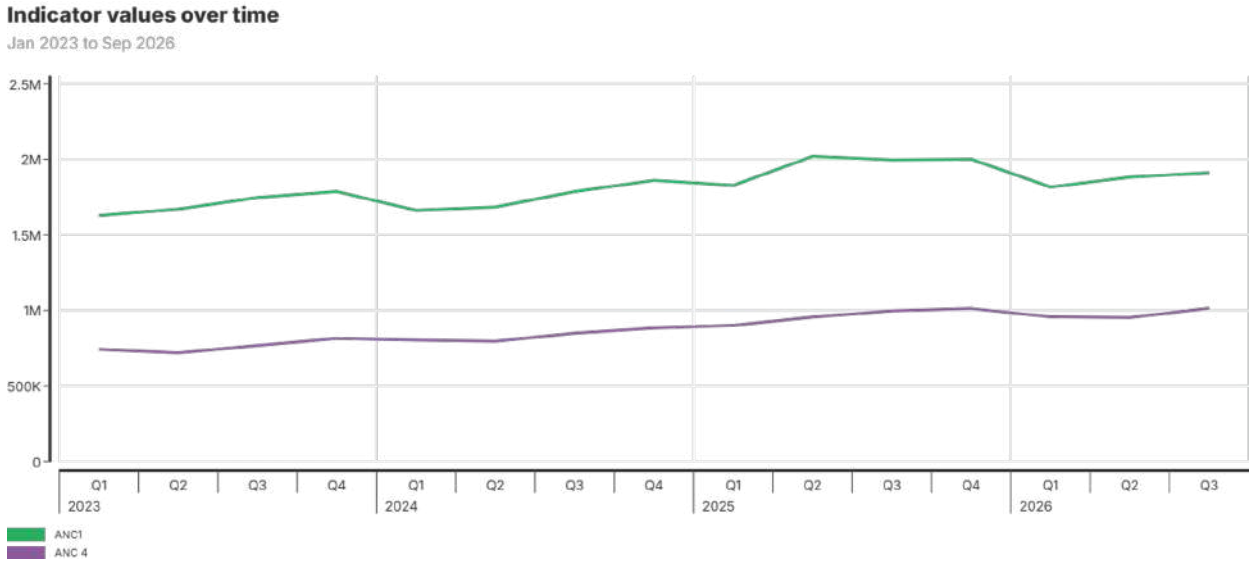


Figure 34: Trends in Antenatal Service Utilisation, 2023–2026 (ANC1 and ANC4). Source: DHIS2 (FASTR Adjusted)

The population-based NMDHS 2025–26 found that 70.7% of women aged 15–49 with a live birth in the preceding two years received ANC from a skilled provider for their most recent live birth (Figure 36). Four or more ANC visits were reported by 58.5%, including 20.2% with eight or more visits. These measures use all women with a recent live birth as the denominator and differ from the routine ANC4-to-ANC1 completion ratio.

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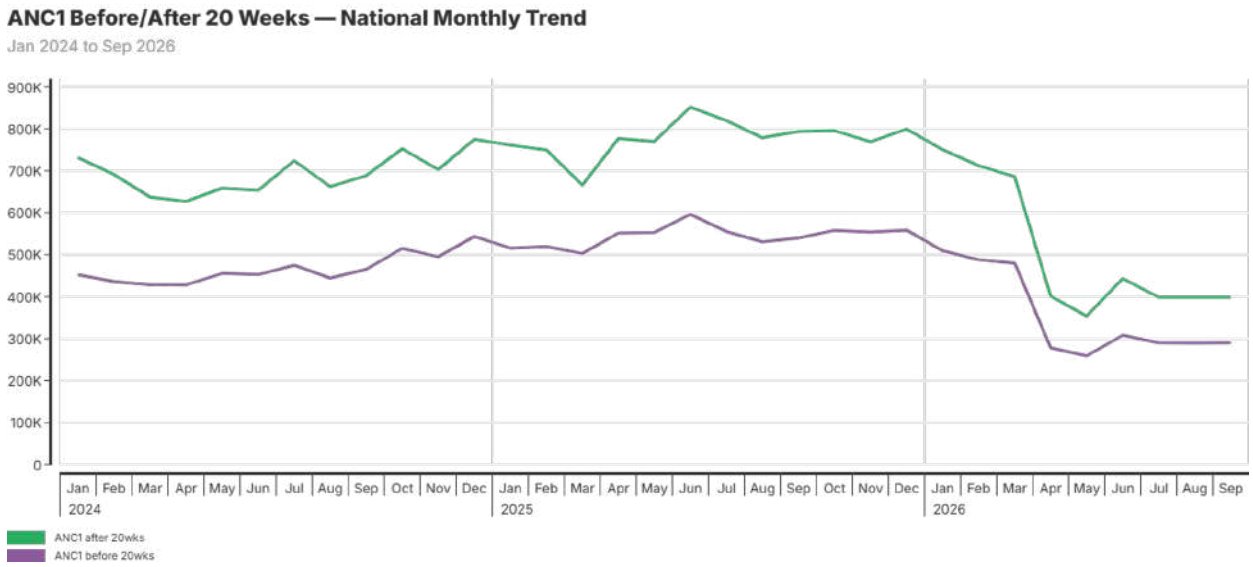


Figure 35: Trends in Antenatal Service Utilisation, 2024–2026 (ANC) before and after 20weeks

Source: DHIS2 (FASTR Adjusted)

ANC1 attendance before 20 weeks consistently exceeded late booking from January 2024 to December 2025, with both indicators generally increasing. However, both declined sharply from April 2026, with slight recovery by September 2026 (Figure 35).

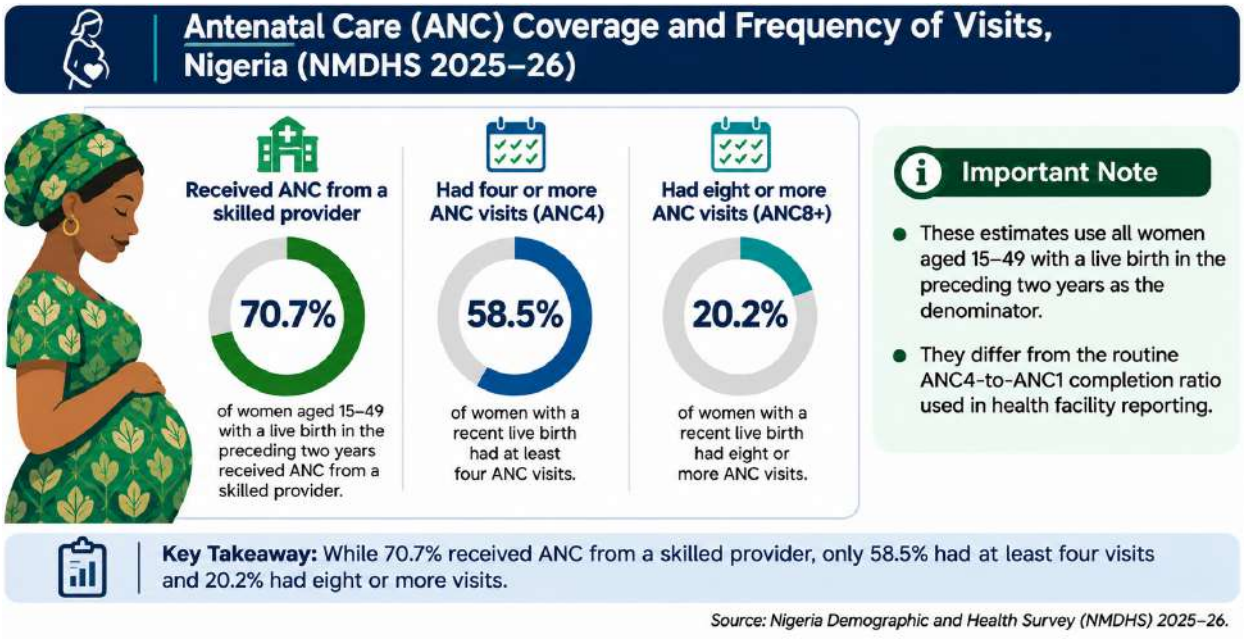


Figure 36: Antenatal Service Utilisation coverage

Source: NMDHS, 2025-26

This trend is similar across zones and States. Nationally, ANC4 completion varies across states, with several states recording substantial gaps between ANC1 attendance and ANC4 completion. Lagos recorded the highest completion rate (99%), while Benue (33%)

and Bauchi (34%) recorded the lowest. Kano had the highest ANC1 attendance, but only 53% of women returned for four ANC visits (Figure 37).

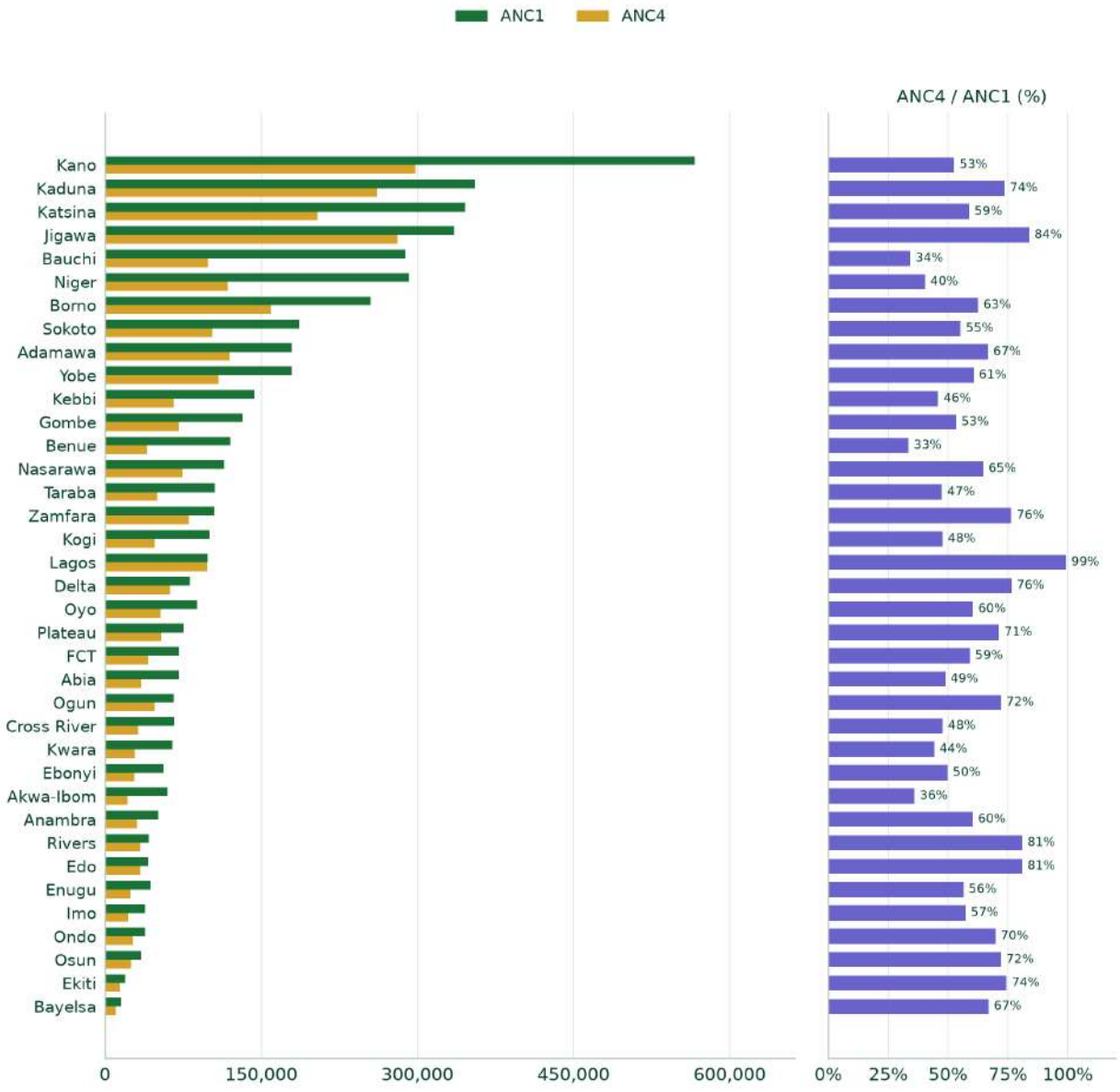


Figure 37: State-level distribution of ANC1 and ANC4

Source: DHIS2 (FASTR Adjusted analysis)

ANC1 visits are maintaining a slightly steady rise while ANC4 visits are almost flat, and the gap seems to be getting wider. Coverage at ANC4 hasn't improved, even though more women are coming in for a first visit (Figure 38). Overall, the service volume appears to drop in 2026 compared to 2025.



Figure 38: Comparative trend of ANC visits, Q1 2025 – Q3 2026

Timing of ANC visits

Compared with 60% last year, there seems to be a drop in the number of women who attended ANC before 20weeks. In most states, more than half of women make their first antenatal visit after 20 weeks. Only Gombe (55%), Borno (54%) and Lagos (50%) have half or more booking early. Late booking is worst in the North-West, especially Kano (28%) and Katsina (32%) (Figure 39).

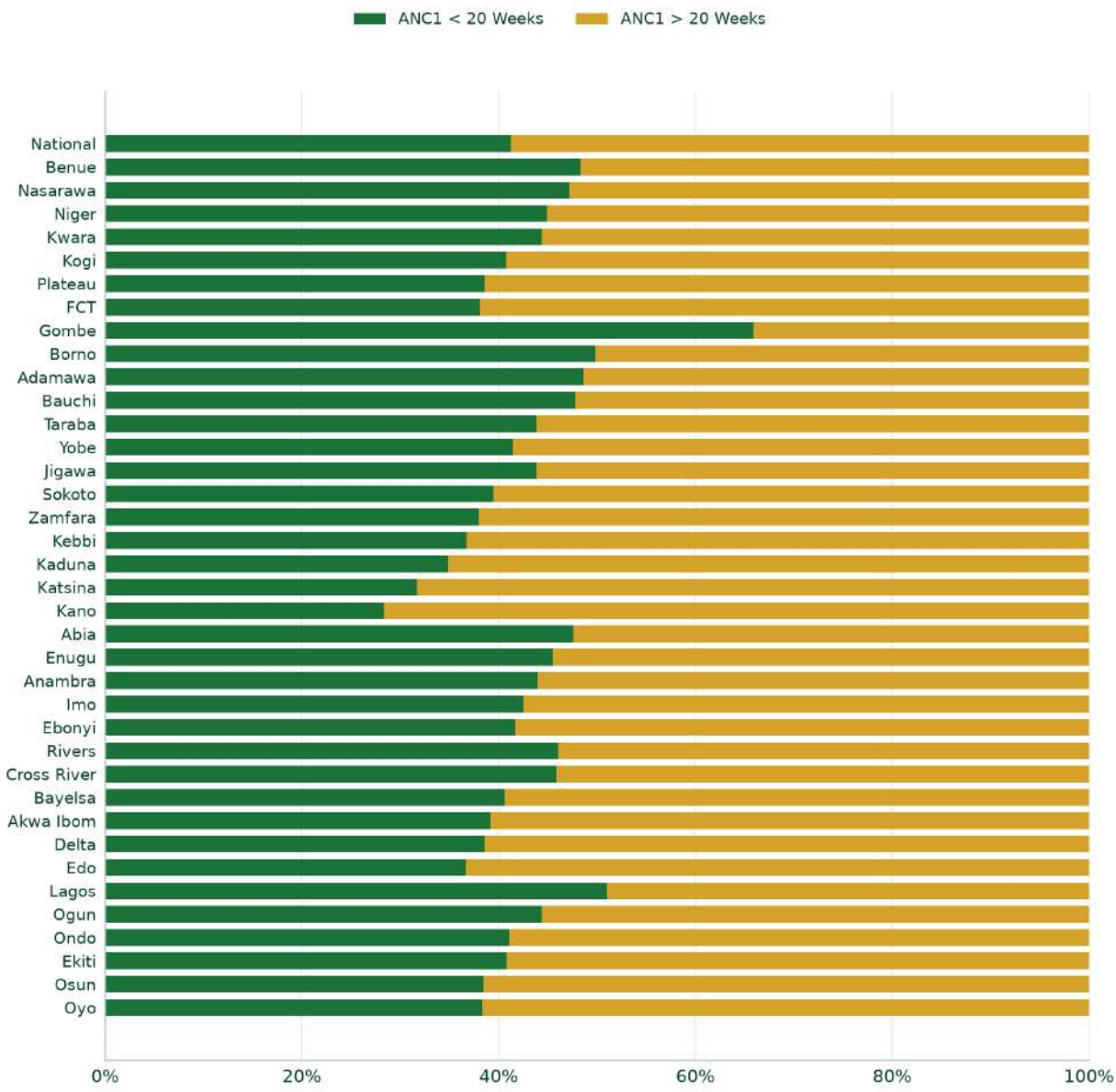


Figure 39: Timing of ANC1 visits across states (%), 2026

Source: DHIS2 (FASTR Adjusted)

ANC contacts before and after 20 weeks rose from 2024 to 2025 but fell sharply from April 2026. Q1 2026 remained close to 2025, while Q2 and Q3 were about half the volumes of the same periods in 2025. The trend is similar for states and BHCPF facilities. The share of early bookings did not change (Figure 35).

10.3 Skilled Birth Attendance and Facility Delivery Rates

Childbirth is the period of greatest risk for both mother and newborn, and many maternal and newborn deaths occur around the time of birth. Delivery in a health facility with a skilled birth attendant, such as a doctor, nurse or midwife, allows complications to be recognised

early and managed or referred promptly. Skilled birth attendance and facility delivery rates are therefore core indicators of progress in maternal and newborn health.

Table 10.3: Skilled birth attendance and facility delivery

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of women age 15–49 who had a live birth that received antenatal care (ANC) from skilled providers	63	70.7	*NDHS 2023-24; 2025–26 NMDHS*
Percentage of Live births delivered by a skilled provider	45.7	50.0%	
Percentage of Live births delivered in a health facility	43.3	47.8%	
Percentage of Live births delivered by caesarean section	5.6	7.0%	
Routine Measures (Facility-based)			
Number of Institutional deliveries	3,655,369	2,955,430*	
Percentage of Institutional delivery coverage estimates	~45% (projected survey)	43%*	
Percentage of Institutional skilled birth attendance (iSBA)	94%	94%*	
Number of Deliveries attended by iSBA	3,453,618 of 3,655,369	2,771,339 of 2,955,430*	
Number of Caesarean section deliveries	242,482 (6.6% of total delivery)	61,477 (2.1% of total delivery)*	
Reported deliveries monitored with a partograph (%)	79% (2,890,577 of 3,655,369)	78% (2,306,238 of 2,955,430 institutional deliveries)*	

*DHIS2 (FASTR Adjusted Jan-Sep 2026)

Facility-based deliveries attended by skilled birth attendants stood at 93.0% in 2025 but declined to 86.6% in 2026. Despite the generally upward trend in monthly service volumes, both institutional deliveries and skilled birth attendance recorded a decline in 2026 compared with 2025, including a reduction in quarter-on-quarter performance (Figures 40 and 41). The two indicators track each other almost identically throughout the period.

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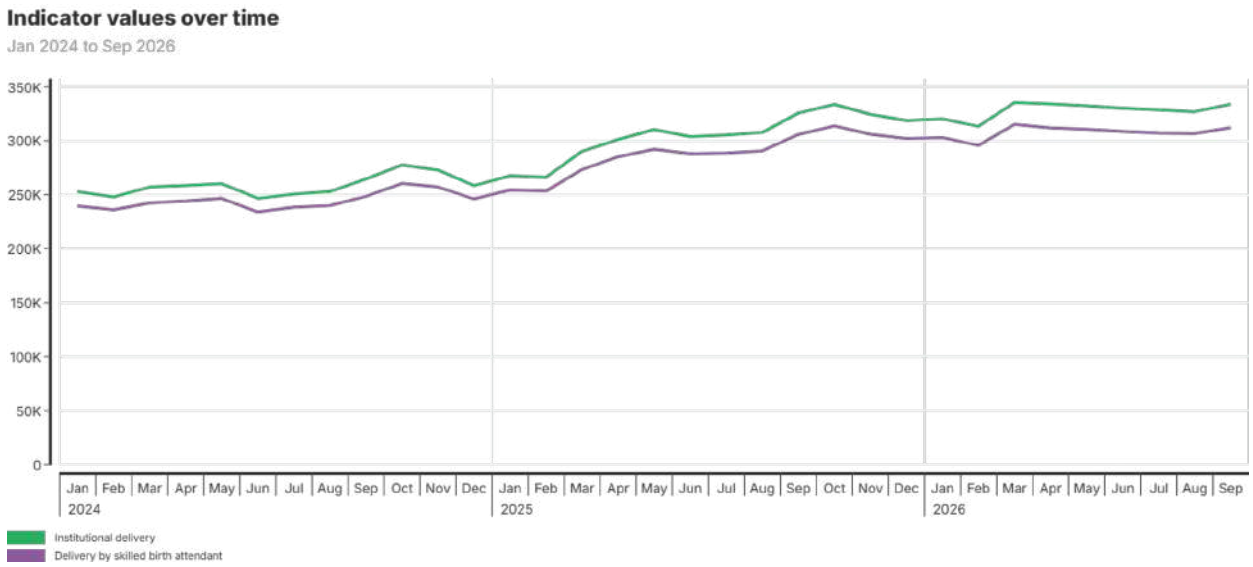


Figure 40: Trend of deliveries attended by a skilled birth attendant, 2024-2026

Source: DHIS2 (FASTR Adjusted)

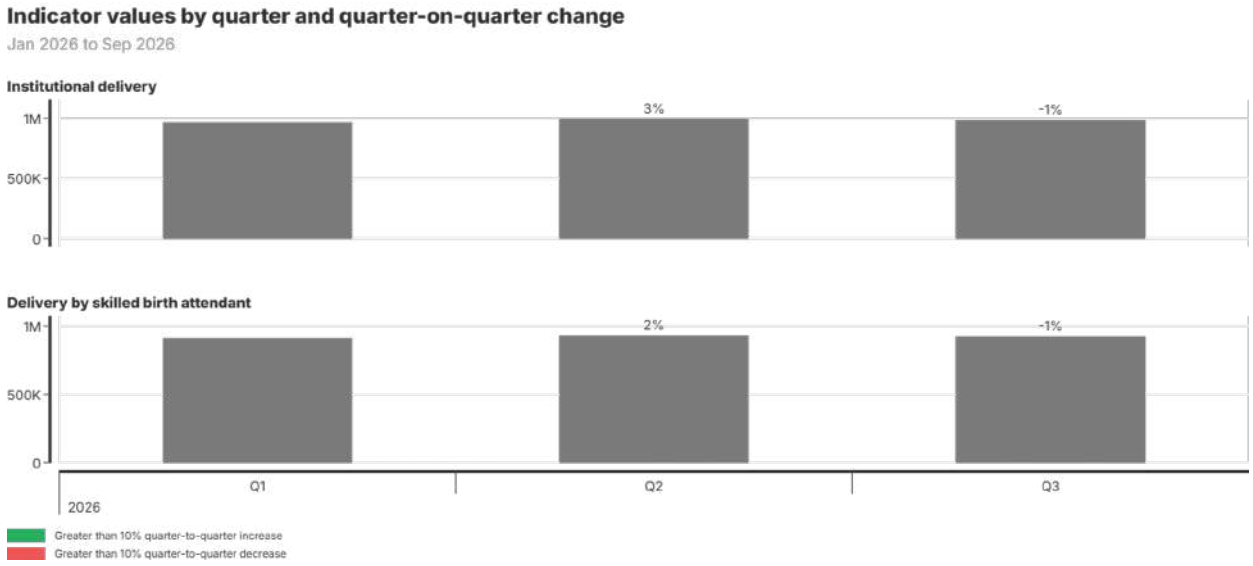


Figure 41: Institutional delivery and delivery by skilled birth attendant by quarter, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

In the 2025–26 NMDHS, 50.0% of live births in the two years before the survey were assisted by a skilled provider, 47.8% occurred in a health facility, and 7.0% were delivered by caesarean section (Figure 42). These population-based estimates include births outside facilities and should be distinguished from the administrative percentages.

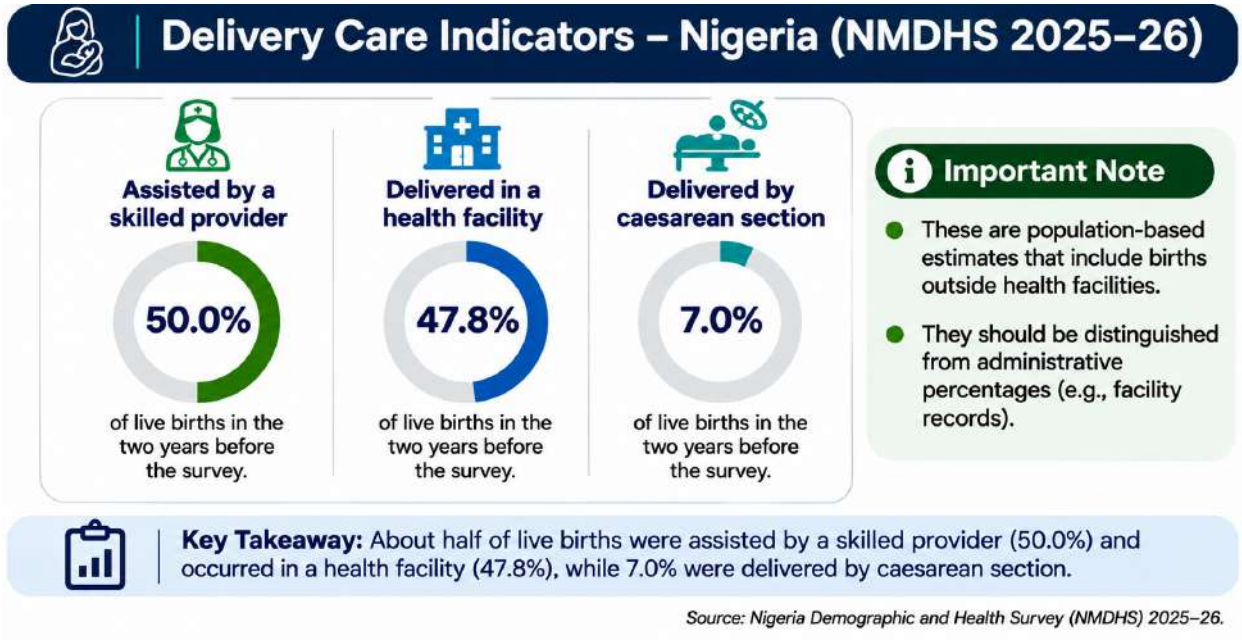


Figure 42: Delivery care indicators, NMDHS 2025–26

Institutional deliveries and skilled birth attendance remained relatively stable across most geopolitical zones in 2026, with the North West recording the highest service volumes, while the South South and South West experienced notable quarter-on-quarter fluctuations, particularly declines in Q3 (Figure 43).

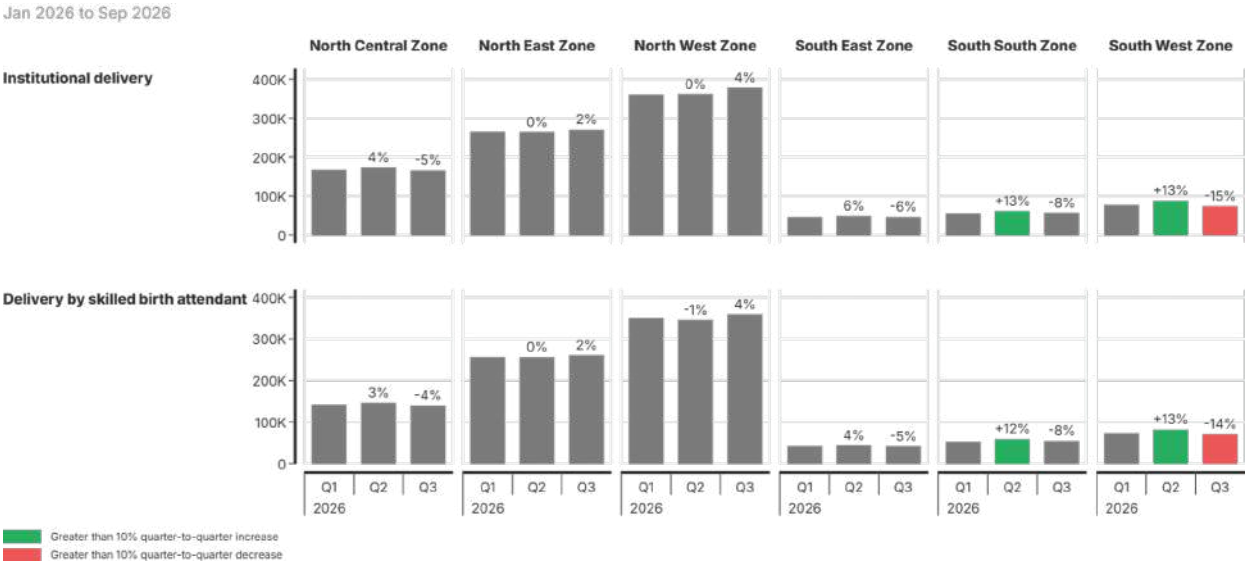


Figure 43: Institutional delivery and delivery by skilled birth attendant by zone and quarter, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Across all geopolitical zones, between January 2024 and September 2026, delivery by skilled birth attendants (SBA) closely tracked institutional delivery volumes. The North Central zone displayed the most pronounced persistent gap between institutional deliveries and SBA coverage. The southern zones on the other hand recorded lower and fluctuating

volumes but maintained closer alignment between facility-based births and skilled attendance throughout the period.

For the North Central zone, Benue, Kwara, and Kogi reported near-perfect alignment, where the number of deliveries by SBA are almost identical throughout the entire reporting period. Benue stands out among the states in the zone while Niger state is the furthest from alignment (Figure 44).

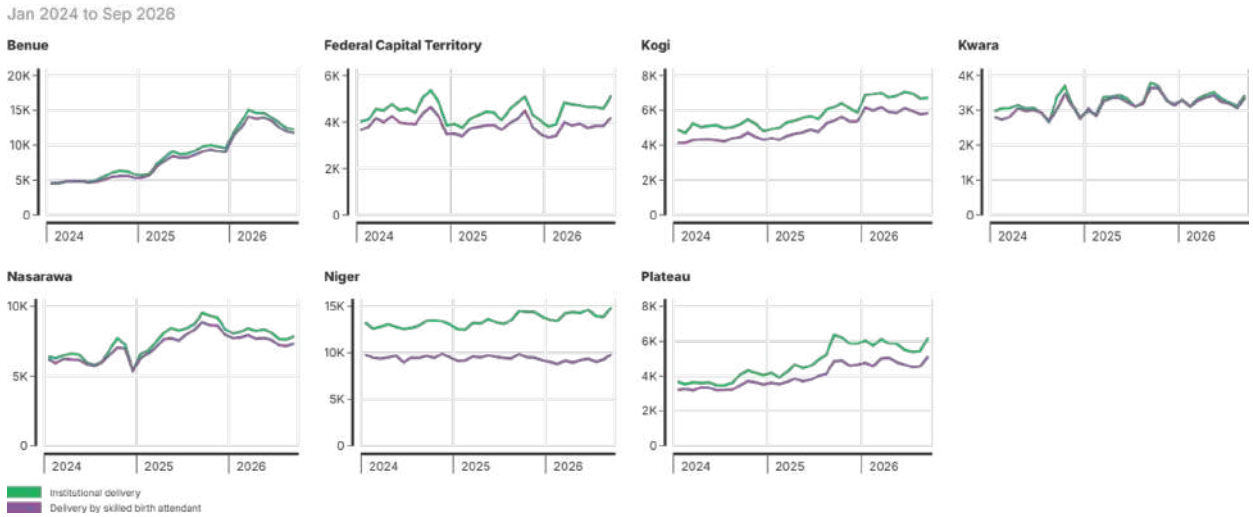


Figure 44: Trends in Institutional Deliveries and Skilled Birth Attendant Deliveries by State, Central Zone, Jan 2024–Sep 2026

Source: DHIS2 (FASTR Adjusted)

Northeast zone displays exceptionally tight overall convergence between facility deliveries and skilled assistance. Adamawa, Bauchi, and Yobe show the closest alignment, with SBA and institutional delivery, while Taraba and Borno displayed the widest disparities (Figure 45).

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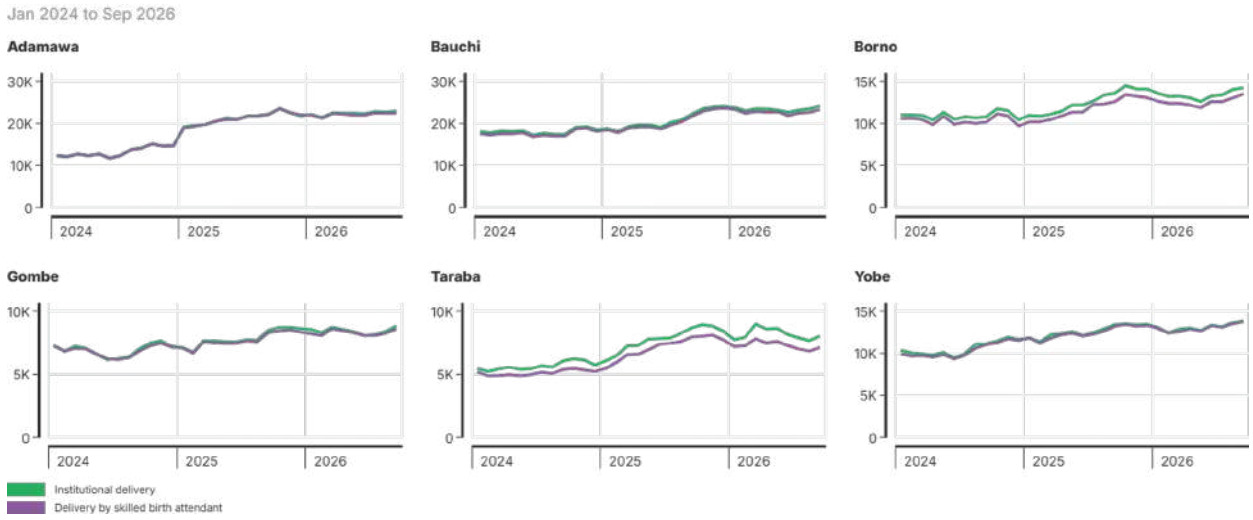


Figure 45: Trends in Institutional Deliveries and Skilled Birth Attendant Deliveries by State, North East Zone, Jan 2024–Sep 2026

Source: DHIS2 (FASTR Adjusted)

Deliveries attended by the SBA across the Northwest zone had a very close match of almost 1:1 on the zonal aggregate. Jigawa, Kaduna, Kano, Kebbi, Sokoto, and Zamfara all demonstrated near-flawless alignment, ensuring virtually 100% of facility births are taken by skilled personnel. Katsina state is the only outlier in the zone (Figure 46)

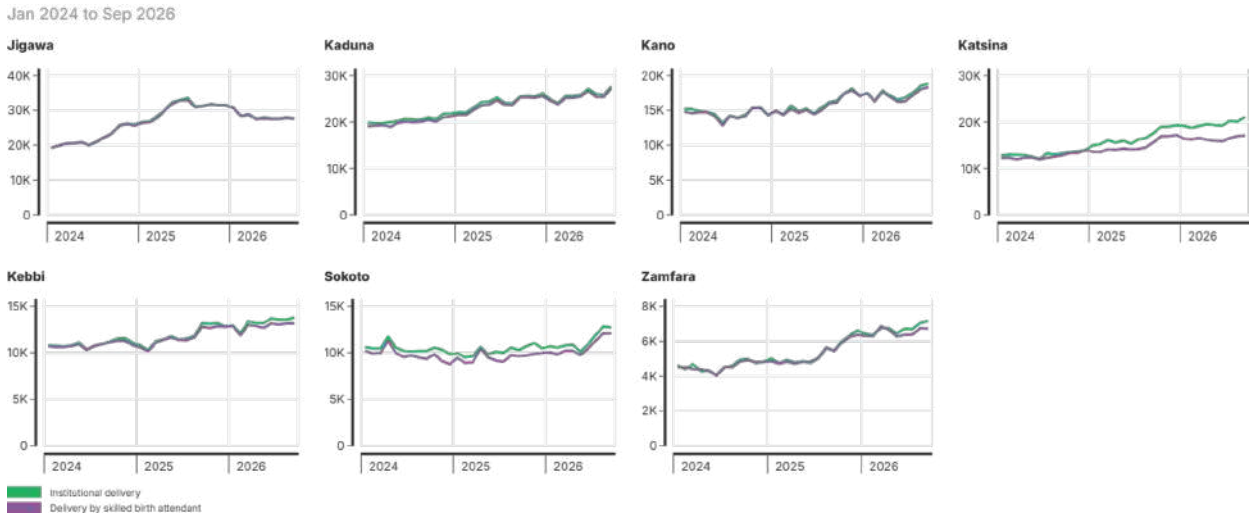


Figure 46: Trends in Institutional Deliveries and Skilled Birth Attendant Deliveries by State, North West Zone, Jan 2024–Sep 2026

Source: DHIS2 (FASTR Adjusted)

For Southeast, the gap between institutional births and SBA narrowed largely into 2025 and 2026. Ebonyi and Anambra demonstrated the strongest alignment with Enugu state having the widest gap from alignment between deliveries that was taken by SBA (Figure 47).

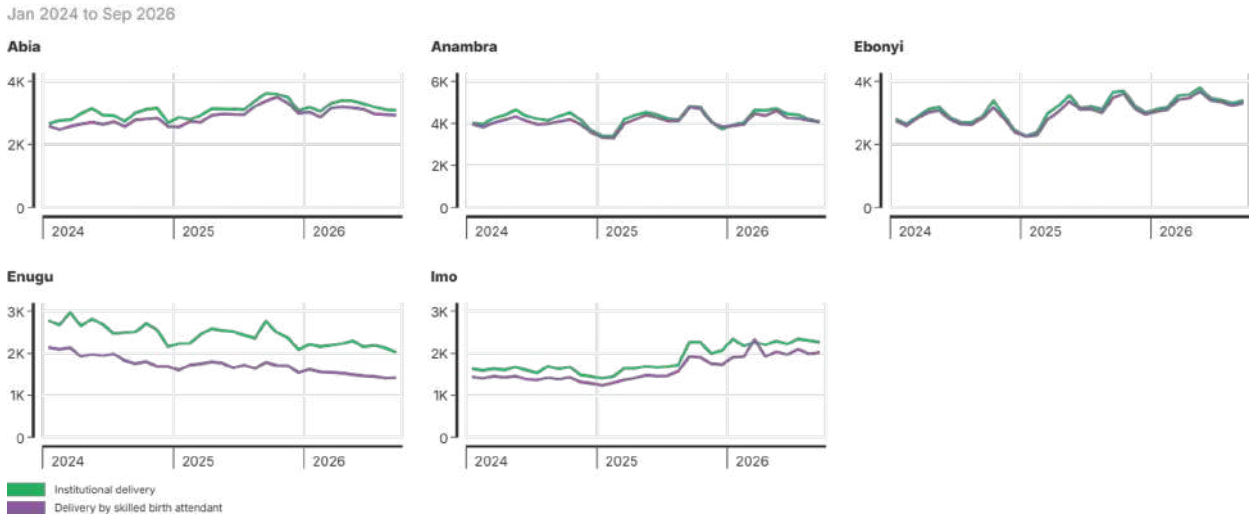


Figure 47: Trends in Institutional Deliveries and Skilled Birth Attendant Deliveries by State, South East Zone, Jan 2024–Sep 2026

Source: DHIS2 (FASTR Adjusted)

The South South reflected strong overall harmony between facility births and skilled attendants. Bayelsa and Cross River reported a near-perfect alignment, with SBA lines mirroring institutional births continuously. Akwa Ibom was the furthest from achieving alignment, showing an enduring, visible gap between institutional births and skilled attendance across all 32 months (Figure 48).

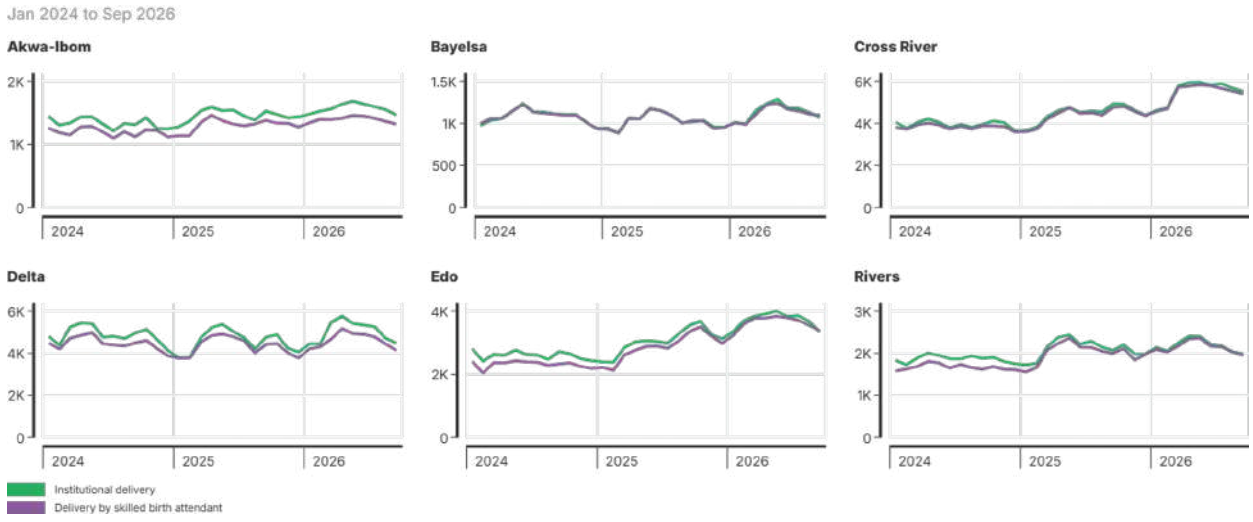


Figure 48: Trends in Institutional Deliveries and Skilled Birth Attendant Deliveries by State, South South Zone, Jan 2024–Sep 2026

Source: DHIS2 (FASTR Adjusted)

The Southwest zone maintained an overall high alignment between facility delivery rates and skilled attendance at the zonal level. Lagos is exceptionally well-aligned, Oyo and Ekiti following closely with institutional deliveries and skilled attendance. The curves were practically identical across the entire period. Osun presents the most severe deficit

nationwide, with a large number of facility deliveries per month unattended by skilled personnel (Figure 49).

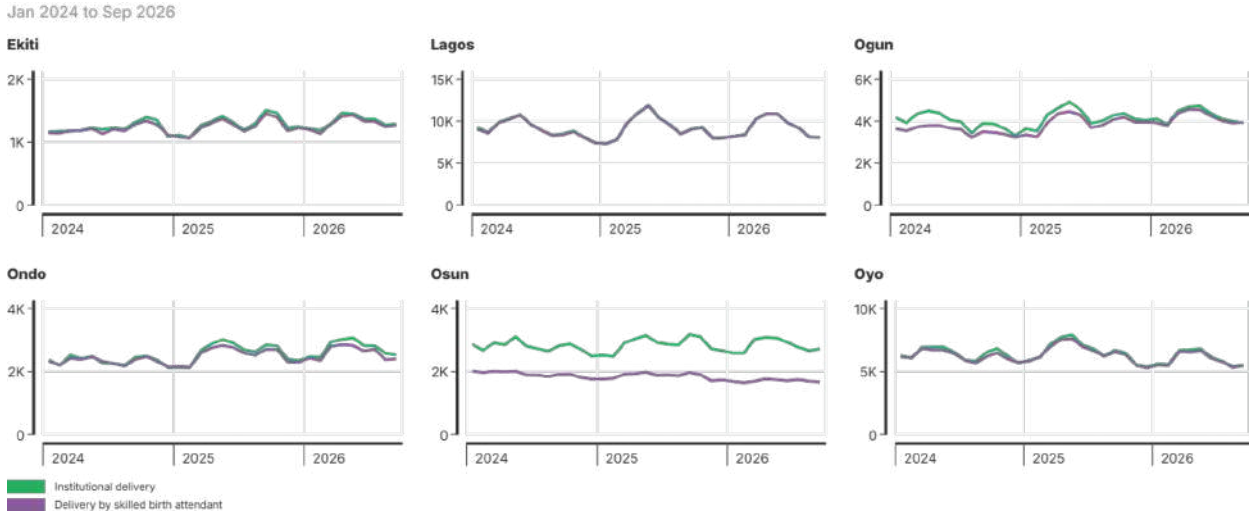


Figure 49: Trends in Institutional Deliveries and Skilled Birth Attendant Deliveries by State, South West Zone, Jan 2024–Sep 2026

Source: DHIS2 (FASTR Adjusted)

10.4 Vaginal Delivery and Caesarean Section

Vaginal delivery remains the predominant mode of childbirth, while caesarean section is an essential intervention for managing obstetric complications and preventing maternal and newborn deaths. Trends in caesarean section rates, alongside the use of partographs to monitor labour, provide important insights into the quality of intrapartum care and access to essential emergency obstetric service.

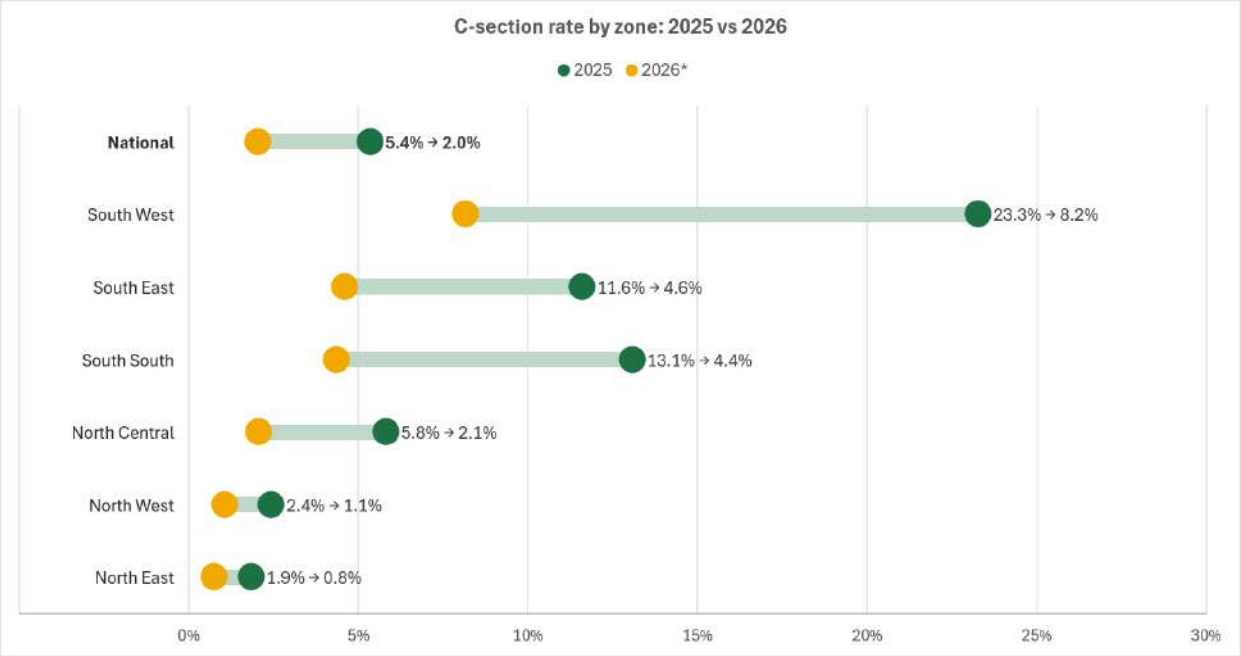


Figure 50: Caesarean section rate by zone, 2025 vs 2026

Source: DHIS2 (FASTR Adjusted)

Caesarean sections accounted for 5.4% of reported deliveries in 2025 and 2.0% in 2026. The highest and lowest zonal caesarean section rates were 23.3% (South West) and 1.9% (North East) in 2025, and 8.2% (South West) and 0.8% (North East) in 2026 (Figure 50). Reported deliveries monitored with a partograph were 68.3% in 2025 and 75.4% in 2026 (Figure 51).

10.5 Deliveries monitored with Partograph

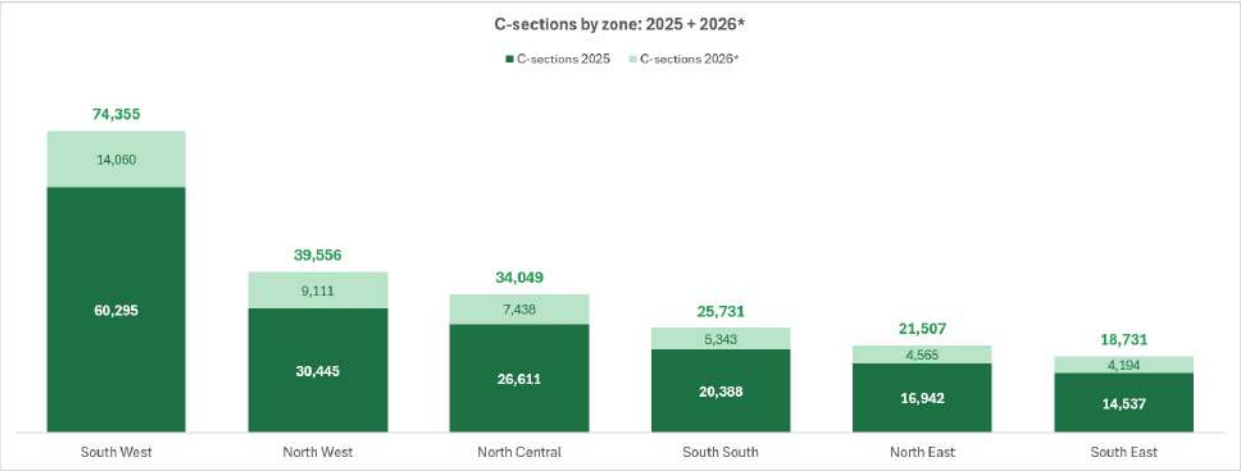


Figure 51: Caesarean sections by zone, 2025 and 2026

Source: DHIS2 (FASTR Adjusted)

Nationally, institutional deliveries monitored with partograph showed a steady upward trajectory over the last three years. Both total institutional deliveries and partograph-

monitored deliveries exhibited steady overall growth from 2024 before witnessing a slight dip that was observed in 2026, with partograph utilisation closely tracking delivery volume (Figure 52).

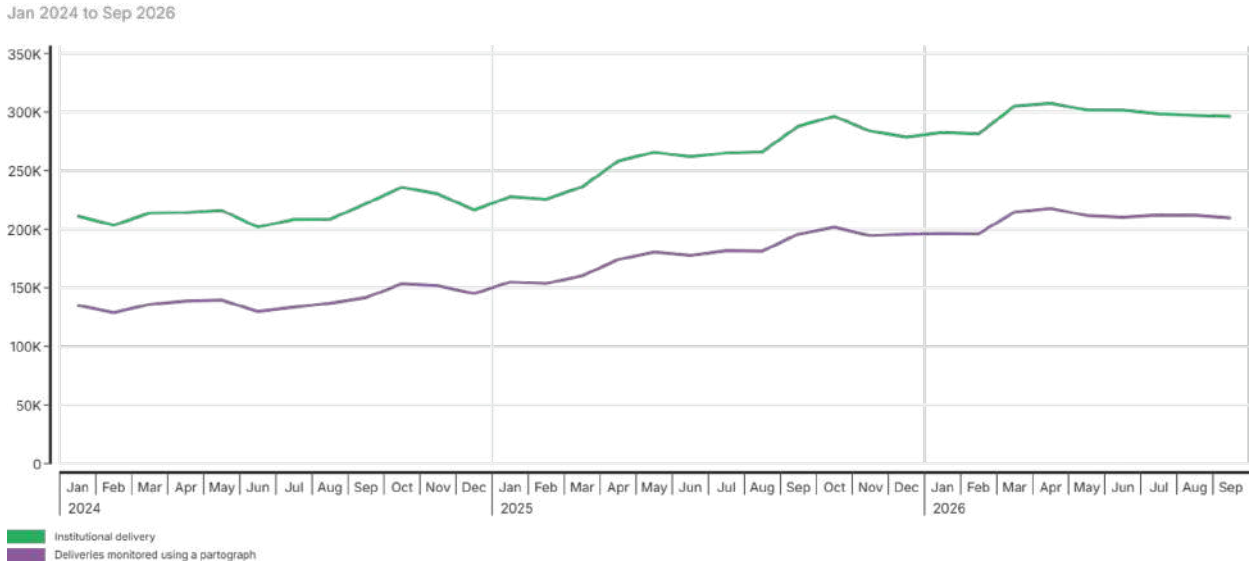


Figure 52: Institutional deliveries and deliveries monitored using a partograph, Jan 2024–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Across the geopolitical zones, Northeast demonstrated best performance in the monitoring deliveries with the use of Partograph, following by Northwest and Southwest while Northwest recorded the highest gaps (Figure 53)

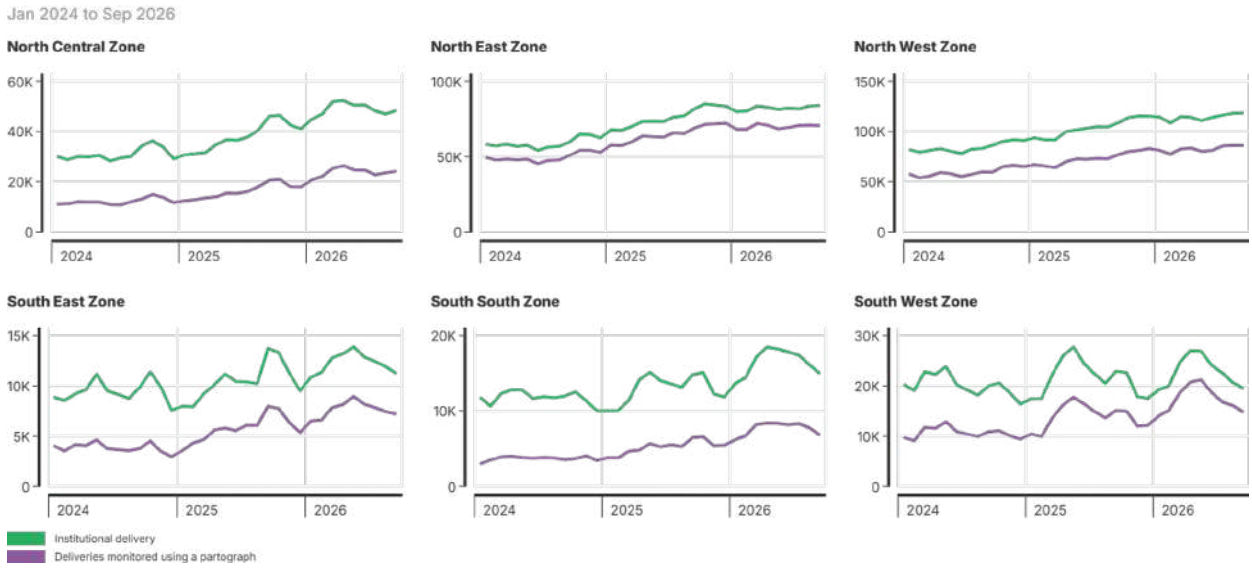


Figure 53: Institutional deliveries and deliveries monitored using a partograph by zone, Jan 2024–Sept 2026

Source: DHIS2 (FASTR Adjusted)

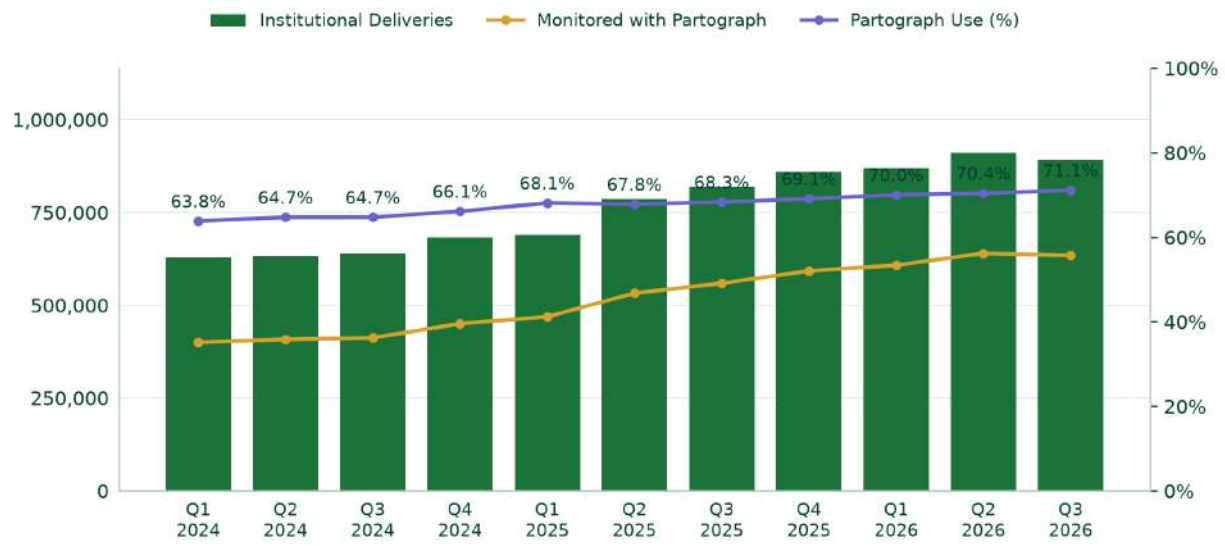


Figure 54: Partograph use by quarter, Q1 2024–Q3 2026

Source: DHIS2 (FASTR Adjusted)

There's a steady, gradual improvement in partograph use from 63.8% (Q1 2024) to 71.% (Q3 2026) , a continuous upward trend over two and half years (Figure 54).

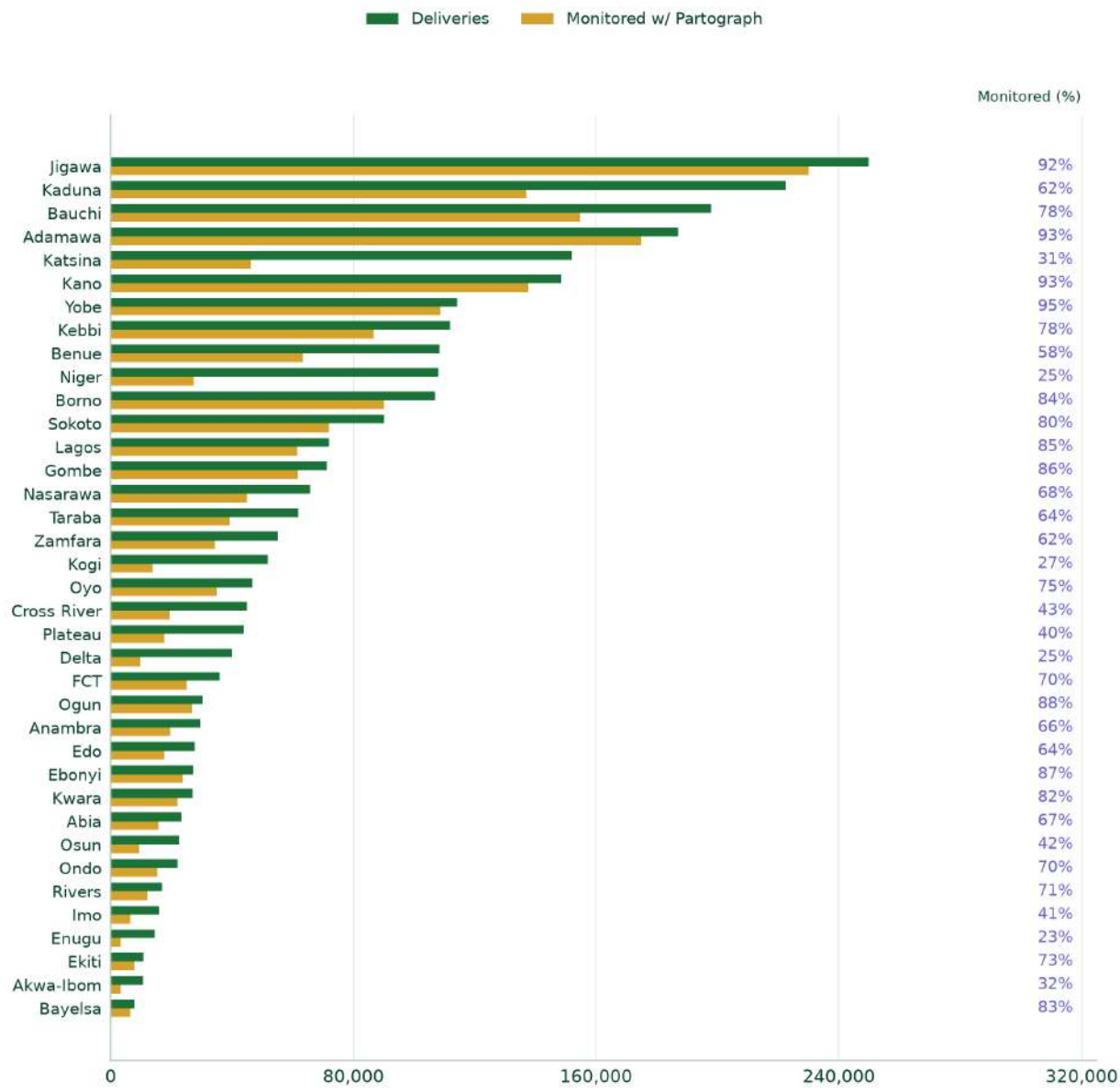


Figure 55: Deliveries monitored with a partograph, by state

Partograph use varied widely across the states. States like Jigawa (96%), Kano (99%) and Bauchi (86%) recorded high use. Enugu (23%), Niger (26%), Delta (27%), Kogi (29%) and Katsina (32%) monitor fewer than a third of deliveries (Figure 55).

10.6 Maternal Morbidity And Mortality

A maternal death is the death of a woman during pregnancy, childbirth or within 42 days of the end of pregnancy from causes related to or aggravated by the pregnancy. Most maternal deaths are preventable through quality antenatal care, skilled care at birth and timely emergency obstetric care. Maternal morbidity, including conditions such as obstetric fistula, also has lasting effects on women's health, wellbeing and livelihoods. Mortality measurements typically done in Nigeria every 5 years remain valid for programming and

planning, however figures from routine measures (DHIS2) indicate the general status of mortality in facilities across the country. The reported figures may have data quality issues that include underreporting or overreporting, but the information is generally reliable.

Note: FASTR adjustments are not applicable to mortality measures.

Table 10.4: Maternal morbidity and mortality indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Population-based data			
% of pregnant women aged 15–49 had anaemia	50.2%	Not reported	2024 NDHS
% of women aged 15–49 had ever been told by a health professional that they had high blood pressure or hypertension	0.2%	8.1%	NMDHS 2025-2026
Maternal Mortality	572	572	2024 VASA
Causes of Maternal Mortality (%)			
Obstetric haemorrhage	38%	38%	2024 VASA
Undetermined/unspecified maternal death	16%	16%	2024 VASA
Pregnancy with abortive outcome	15%	15%	2024 VASA
Non-obstetric complications	14%	14%	2024 VASA
Hypertensive disorders in pregnancy, childbirth, and the puerperium	11%	11%	2024 VASA
Pregnancy-related infection	6%	6%	2024 VASA
Other obstetric complications	0%	0%	2024 VASA
Routine Measures (Facility-based)			
Number of Facility maternal deaths	3,689	3,370*	
Quarterly maternal deaths, Q1 to Q3 (number)	1,244 falling to 1,213	1,018 increased to 1,303*	
Facility maternal mortality ratio (per 100,000 live births)	124.2	≈130.0*	
Malaria in Pregnancy (number)	1,968,66	1.340,31*	
Number of Postpartum haemorrhage cases, federal tertiary facilities	16,964	Data not available	–
Diabetes in Pregnancy	Data not available	Data not available	–
Number of Women diagnosed with vesico-vaginal fistula	2,226	3,409*	
Number of Women who had surgeries for Fistula repairs	1,707	1,559*	
Percentage of Women diagnosed with VVF who were treated	77%	91%*	
Percentage of Facilities with a functional MPCDSR committee	Data not available	Data not available	–

*DHIS2 (Jan-Sep 2026)

Routine health facility data recorded 3,370 maternal deaths during the 2026 (Q1-Q3) reporting period, down from 4,455 in 2025 and 5,391 in 2024. This represents a 17% decline in 2025 and a further 27% decline in 2026, indicating a sustained downward trend in reported facility maternal deaths (Figure 56). VASA survey data shows an overall

Maternal Mortality Ratio of 572 deaths per 100,000 live births, driven by a higher rural burden (656 per 100,000) relative to urban locations (444 per 100,000) (Figure 57).

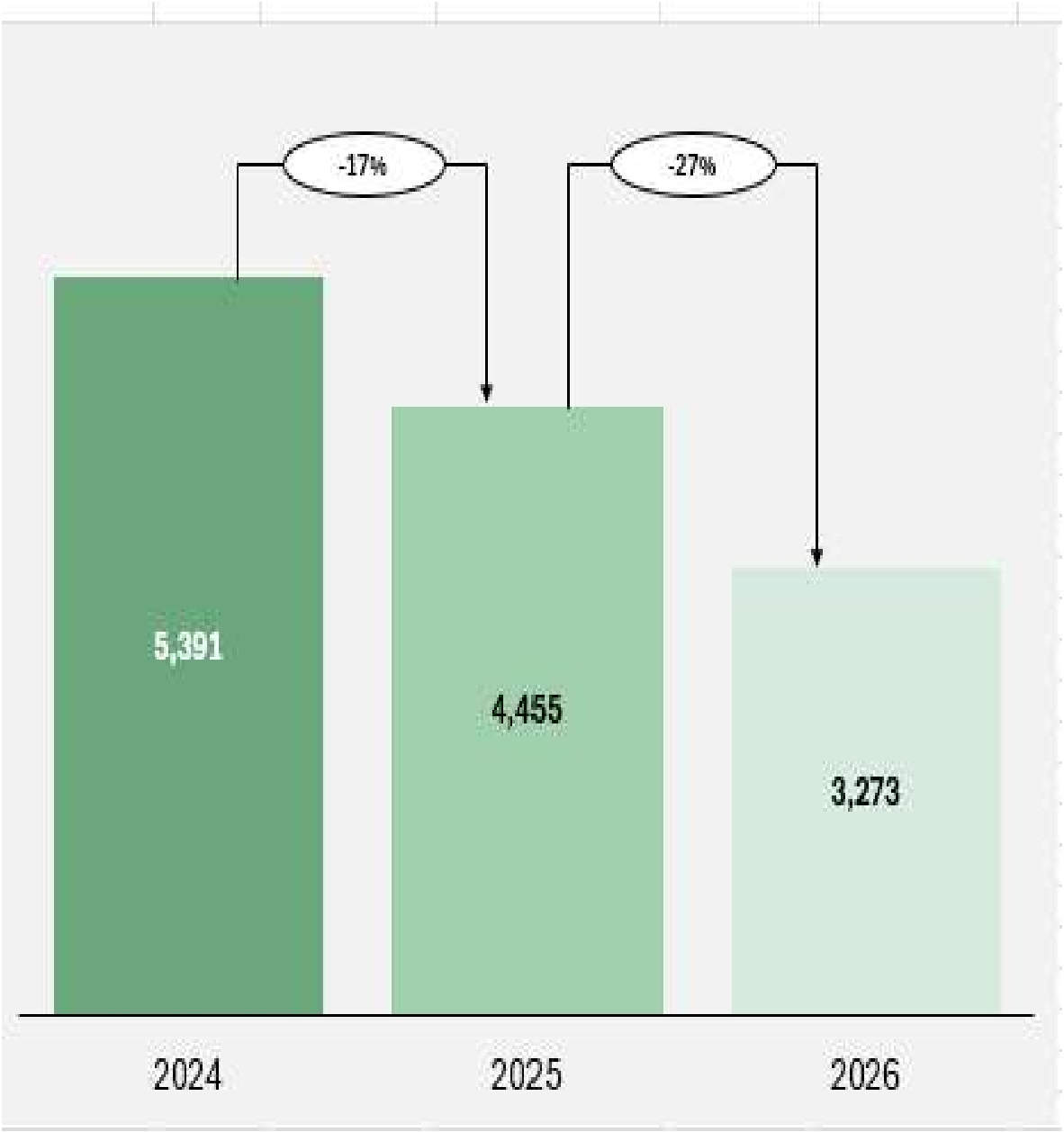


Figure 56: Reported facility maternal deaths, 2024–2026 Source: DHIS2

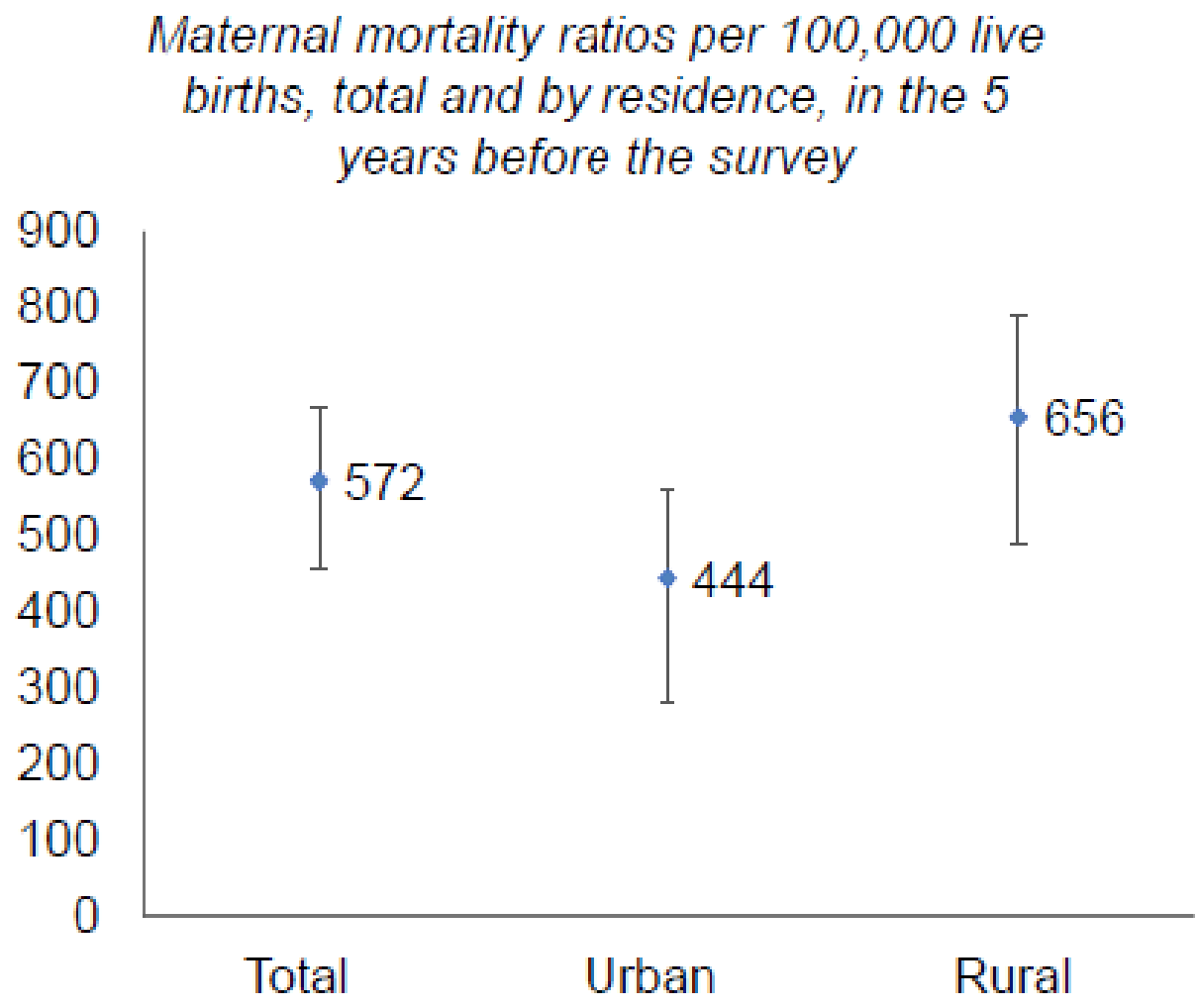


Figure 57: Maternal Mortality ratio Source: VASA 2024

Across quarters, Maternal mortality ratio (MMR) and the number of maternal deaths have generally declined since Q4 2024, following peaks in Q2 2024. By Q3 2026, MMR had fallen by approximately 46% to 128 per 100,000 live births, while maternal deaths declined by about 40% to 947 (Figure 58).

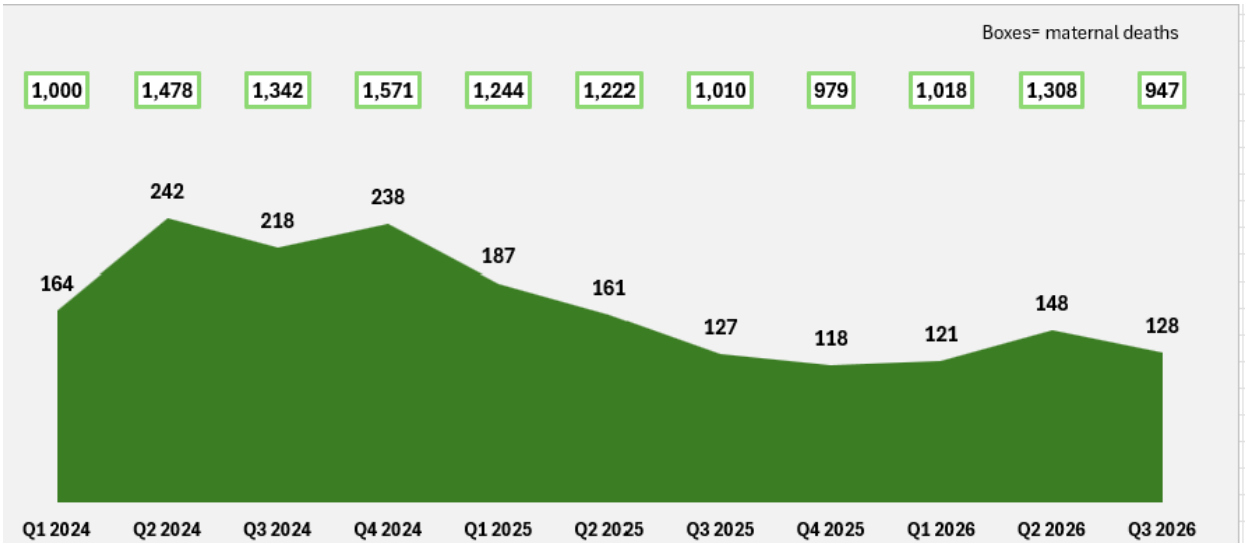


Figure 58: Facility maternal mortality ratio and maternal deaths by quarter, Q1 2024–Q3 2026

Source: DHIS2

Regarding maternal morbidity, 3,060 women were diagnosed with vesico-vaginal fistula (VVF) in 2026, compared with 4,350 in 2025. The proportion of women diagnosed with VVF who received surgical repair was 56.8% in 2026, down from 59.0% in 2025. A total of 1,737 women had surgeries for fistula repair in 2026, compared with 2,564 in 2025.

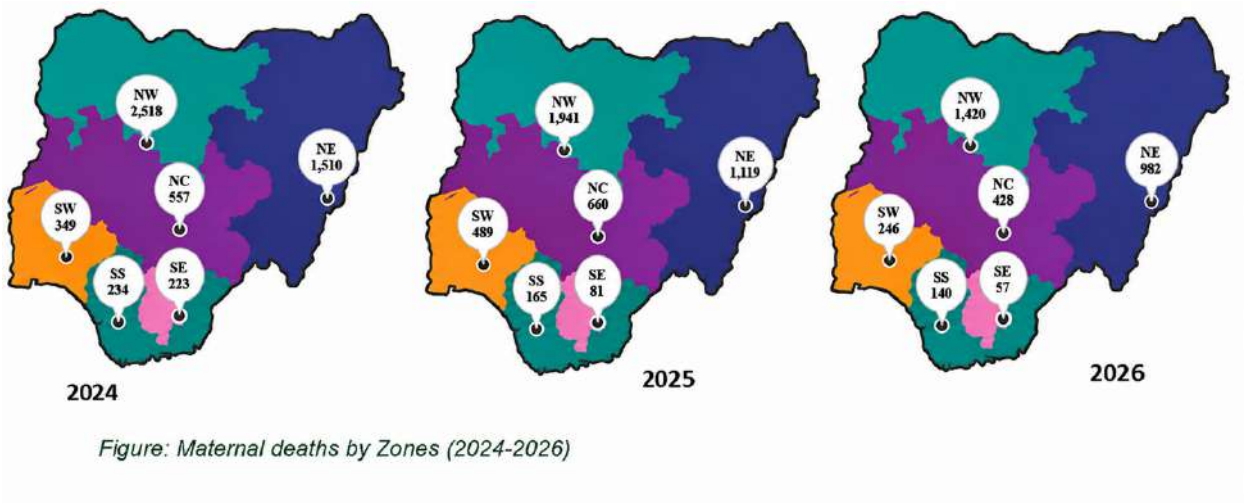


Figure 59: Reported Maternal deaths by Zones (2024-2026)

Source: DHIS2

Across the geopolitical zones, maternal deaths were concentrated in the Northwest and Northeast for the past three years, together accounting for approximately three in four of reported deaths in 2026. Unlike the national trend, these two zones recorded increases in maternal deaths, while the southern zones reported substantially fewer deaths (Figures 59 –61).

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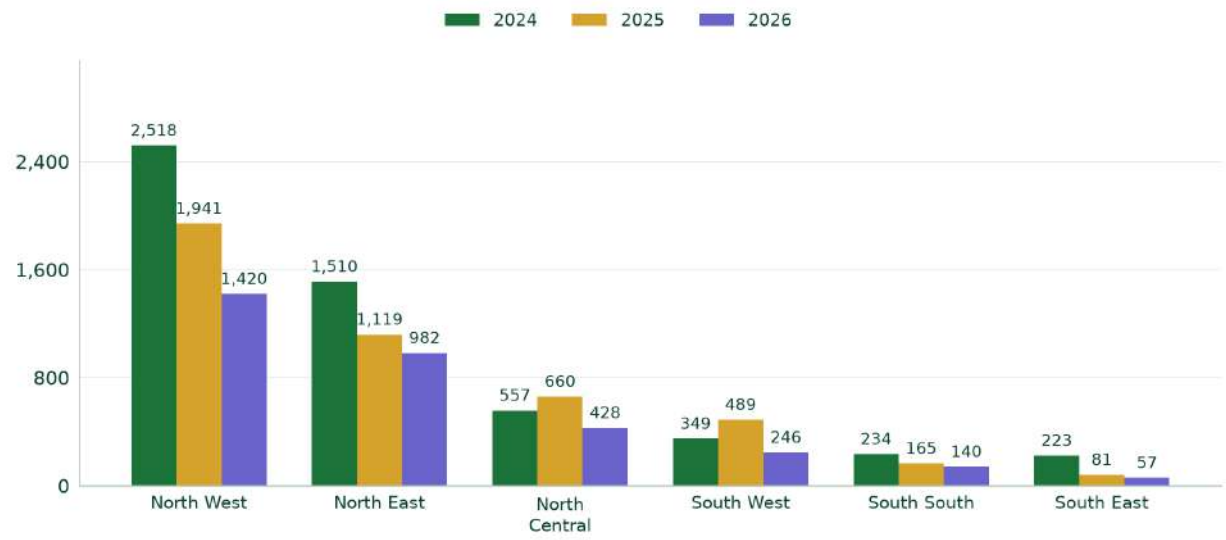


Figure 60: Trend in reported maternal deaths by zone, 2024–2026

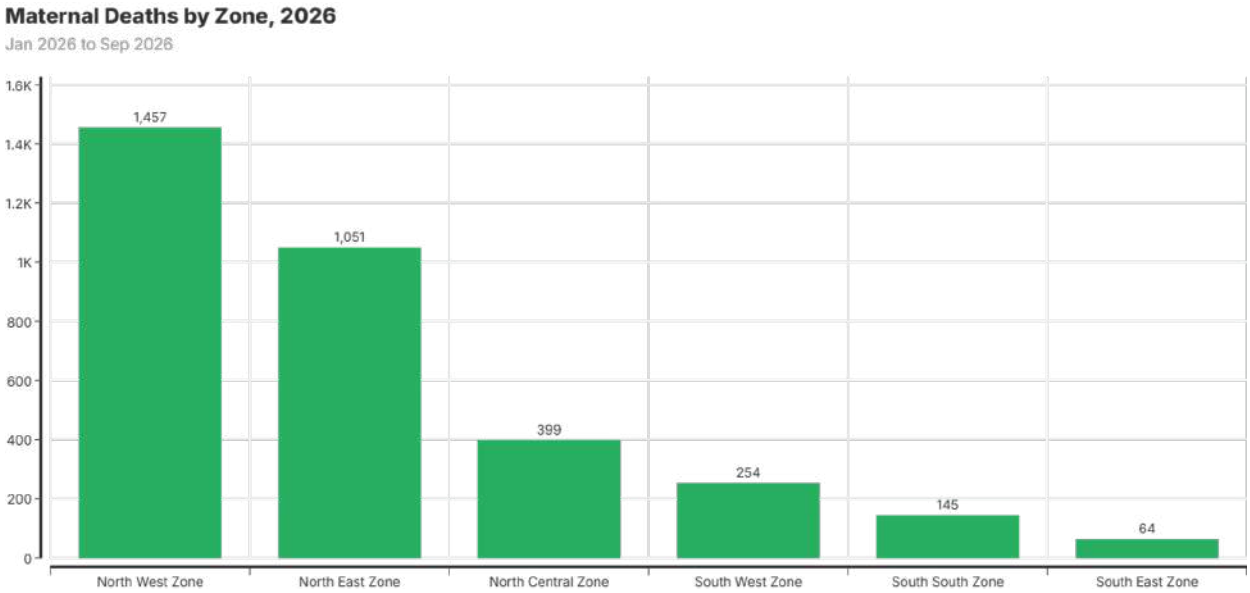


Figure 61: Maternal deaths by Zones (2026)

Source: DHIS2

Five northern states (Kano, Borno, Jigawa, Yobe and Katsina) accounted for nearly half of maternal deaths in 2026. Most southern states reported fewer than 50 deaths (Figures 62 and 63).

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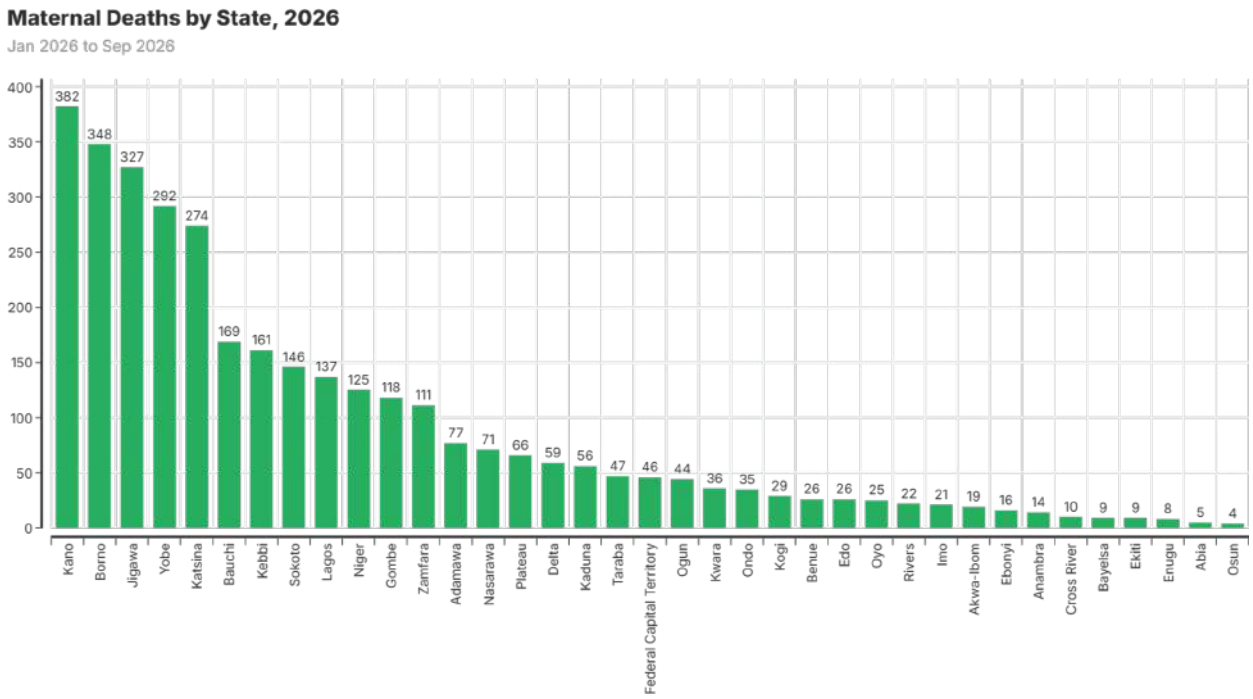


Figure 62: Maternal deaths by States (2026)

Source: DHIS2

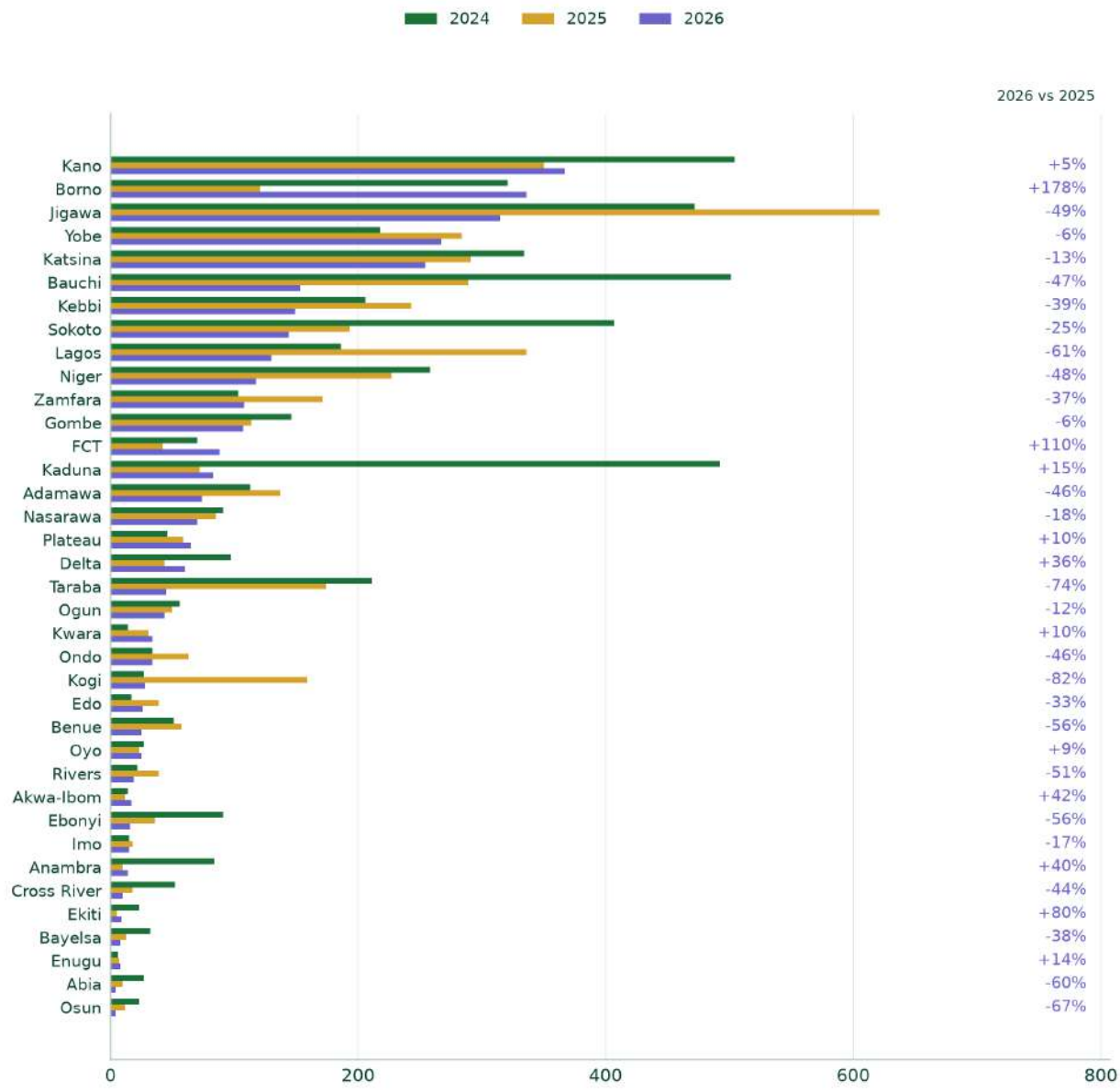


Figure 63: Maternal deaths by States changes between 2026 and 2025 (2024-2026)

Source: DHIS2

10.7 Neonatal and Child Health

The first month of life and early childhood are the periods when children are most vulnerable to illness and death. Essential newborn care, timely postnatal checks, and the prevention and treatment of common childhood illnesses such as pneumonia, diarrhoea and malaria are central to child survival. This subsection presents indicators on the coverage of these services for newborns and young children.

Table 10.5: Neonatal and child health indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Population-based data			
Percentage of Women with a postnatal check in the first two days after their most recent live birth	53% (state average)	49.4%	2025–26 NMDHS
Percentage of Newborns with a postnatal check in the first two days after birth, most recent live birth	56% (state average)	47.5%	2025–26 NMDHS
Children under 5 who slept under an ITN last night (%)	41.2	44.9	MIS, 2021; MIS 2025
Febrile children diagnosed with malaria by a healthcare provider (%)	Data not available	34.6	MIS, 2021; MIS 2025
Febrile children who took an antimalarial and received an ACT (%)	73.9	65.7	MIS, 2021; MIS 2025
Malaria prevalence by microscopy, children 6–59 months (%)	22.3	15.2	MIS, 2021; MIS 2025
Malaria prevalence by RDT, children 6–59 months (%)	39.6	35.1	MIS, 2021; MIS 2025
Severe anaemia (Hb <8.0 g/dl), children 6–59 months (%)	8.0	Data not available	MIS, 2021; MIS 2025
Routine Measures (Facility-based)			
Vaginal Delivery (Deliveries Spontaneous Vaginal Delivery) (number)	2,916,360	2,479,146*	
Assisted/Caesarean Delivery (Deliveries assisted) (number)	84,270	67,241*	
Post-natal Care	Data not available	Data not available	–
Neonatal Asphyxia	Data not available	Data not available	–
Neonatal Sepsis/Tetanus	Data not available	Data not available	–
Preterm LBW	Data not available	Data not available	–
SSNB	Data not available	Data not available	–

*DHIS2 (FASTR Adjusted) Jan to Sep 2026

10.8 Immunisation Coverage and Trends

Immunisation is one of the most cost-effective public health interventions, protecting children against diseases such as measles, diphtheria, pertussis, polio and tuberculosis. Nigeria's routine immunisation programme delivers a schedule of vaccines through health facilities and outreach services, complemented by supplementary campaigns. Coverage indicators show how well the programme reaches every child, including those who have not received any routine vaccine (zero-dose children).

Table 10.6: Immunisation coverage indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Population-based data			
Percentage of Children aged 12–23 months fully vaccinated with basic antigens	43% (NDHS 2024: 39%)	39.7%	2025–26 NMDHS

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of Children aged 12–23 months fully vaccinated according to the national schedule	19.8%	25.8%	2025–26 NMDHS
Percentage of Children aged 12–23 months with no DPT-HepB-Hib first dose, zero-dose proxy	28%	33.8% (derived as 100 − 66.2% Penta 1 coverage)	Derived from 2025–26 NMDHS
Routine Measure (Facility-based)			
Percentage of Live births that received BCG	69% (6,098,527 doses); 2024: 72%	62% (5,643,805 doses); FASTR: 104% administrative, 45% projected (5,824,172 doses)*	
Percentage of Penta 1 coverage estimate	71% (2024: 75%)	115.3% administrative; 41% projected*	
Percentage of Penta 3 coverage estimate, projected	68%	93% (Q1), 103% (Q2), 104% (Q3), administrative; 32.6% projected	
Number of Penta 1 doses given	8,831,626	7,114,713*	
Number of Penta 3 doses given	5,994,418	6,729,033*	
Children fully immunised under 1 year (Measles 1 Coverage by proxy) (number)	5,680,884	5,882,188 fully immunised under 1 (count); Measles 1: 5,146,343*	
Fully immunised, Measles 1 (number)	7,358,904	5,807,103*	

*DHIS2 (FASTR Adjusted) Jan to Sep 2026

The number of live births, individual vaccine doses (BCG, Penta 1, Penta 3), and fully immunised children have consistently declined both nationally and across all geopolitical zones between 2025 and 2026. Geographically, the northern zones (particularly the Northwest) continue to account for the largest overall volume of both births and vaccinated children. The national percentage of children aged 12–23 months who are fully immunised increased from 78% to 83%, driven by coverage improvements across five of the six zones (Figure 64)

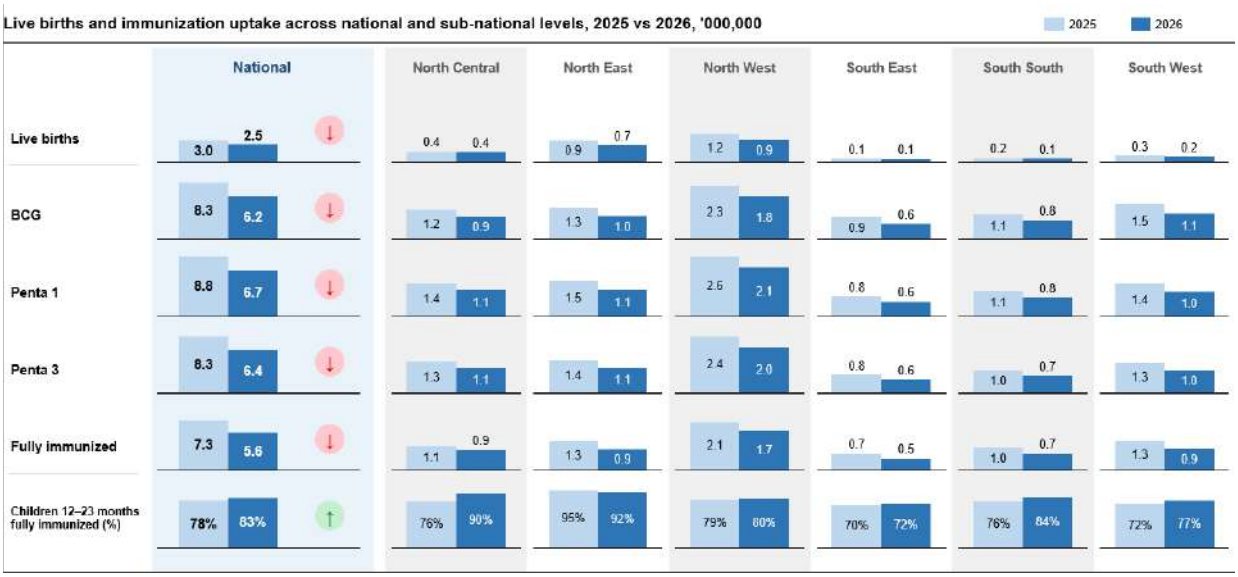


Figure 64: Live births and immunisation uptake at national and sub-national levels (2025 – 2026)

Source: DHIS2 (FASTR Adjusted)

Full immunisation coverage among children aged 12–23 months was 43% in 2025 (NDHS 2024: 39%) and 40% in 2026 (NmHDS) (Figure 65).

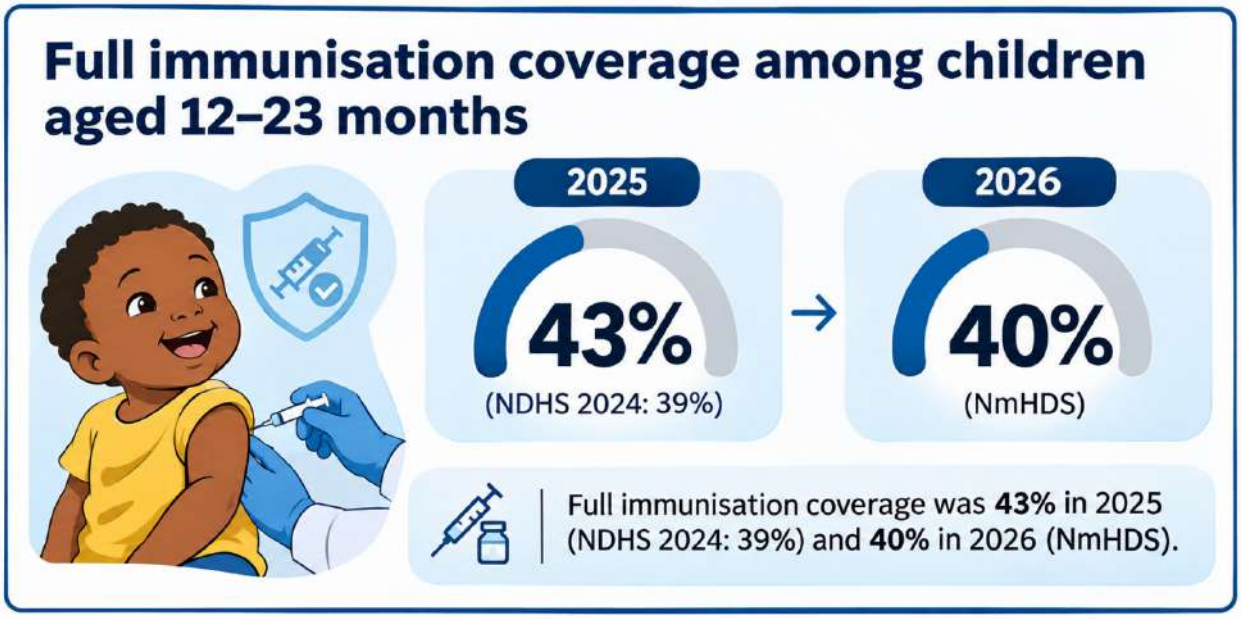


Figure 65: Fully immunisation coverage among children 12-23 months

Source: NMDHS 2025-26

Penta 3 doses followed the same zonal pattern as Penta 1. Penta 3 is about 94% of Penta 1 doses nationally, lowest in the South South (91%) with Kano, Kaduna and Katsina leading on Penta 3 doses, and Bayelsa the lowest (Figures 66 and 67).

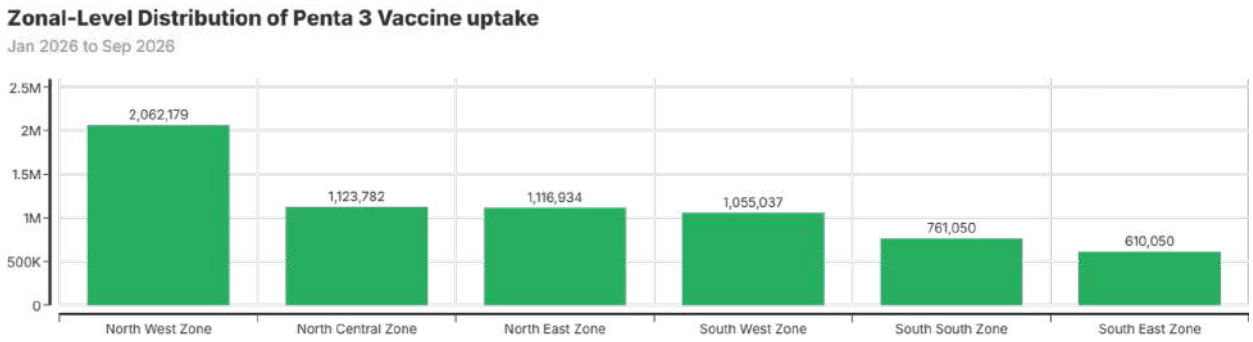


Figure 66: Penta 3 doses by geopolitical zone, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

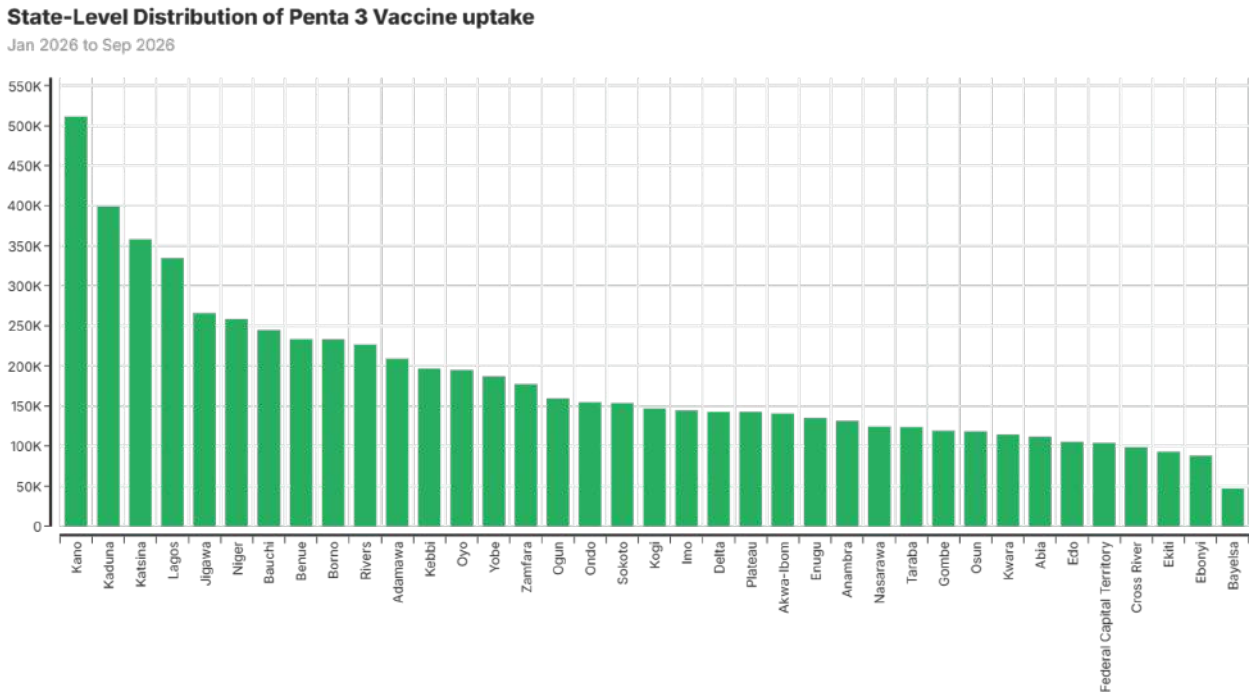


Figure 67: Penta 3 doses by state, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

BCG volumes remained close to expected levels in all zones, with small surpluses in the northern zones in mid-2026 (Figure 68).

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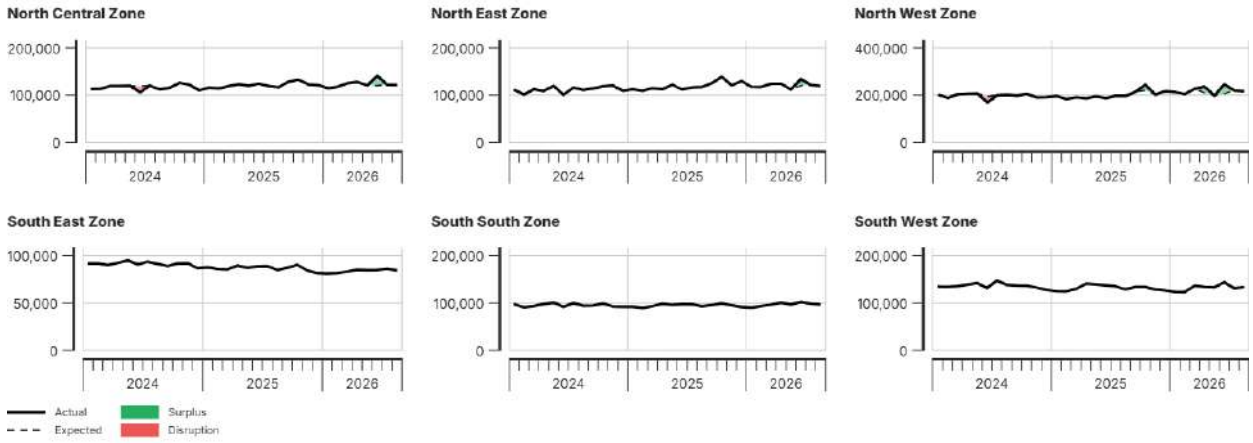


Figure 68: BCG doses, actual against expected volume by geopolitical zone, Jan 2024–Aug 2026

Source: DHIS2 (FASTR Adjusted)

Fully immunised children under one year remained stable through 2024–2025 and increased in Q2 2026, about 9% above Q2 2025. Monthly full immunisation volumes were stable through 2024–2025 and rose in 2026, peaking in June. January–August 2026 was 5% above the same period of 2025. Full immunisation followed the expected trend until May 2026, with a marked surplus in June before returning close to expected levels (Figure 69).

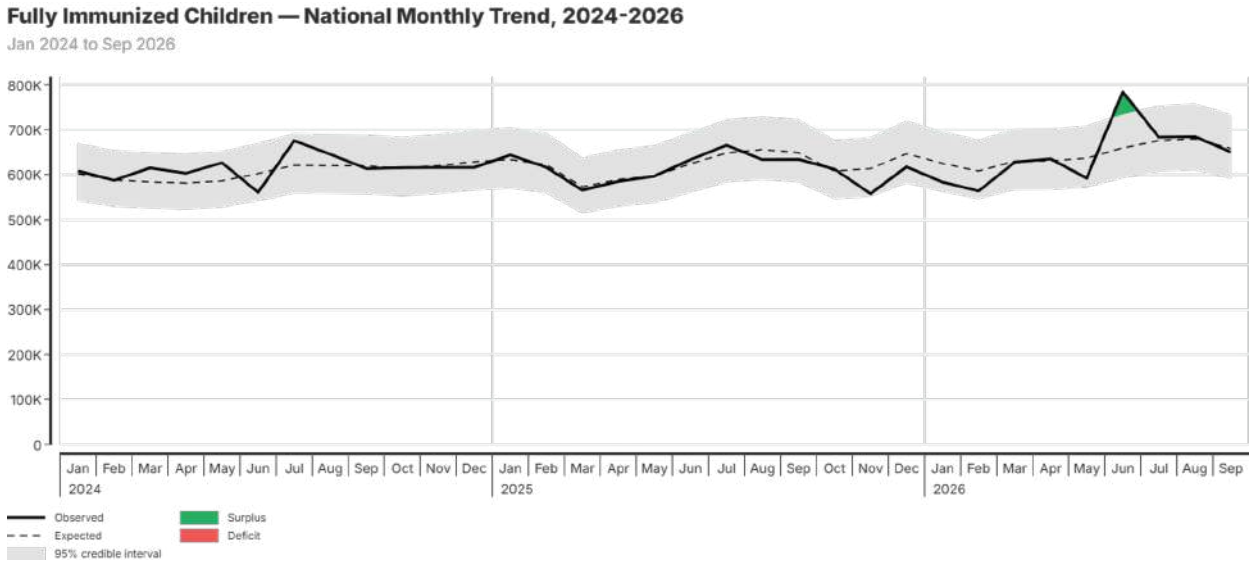


Figure 69: Fully immunised children under one year, monthly, Jan 2024–Sept 2026

Source: DHIS2 (FASTR Adjusted)

The North West recorded the highest number of fully immunised children (29%), with North Central, South West and North East at similar levels. The South East recorded the lowest (Figure 70).

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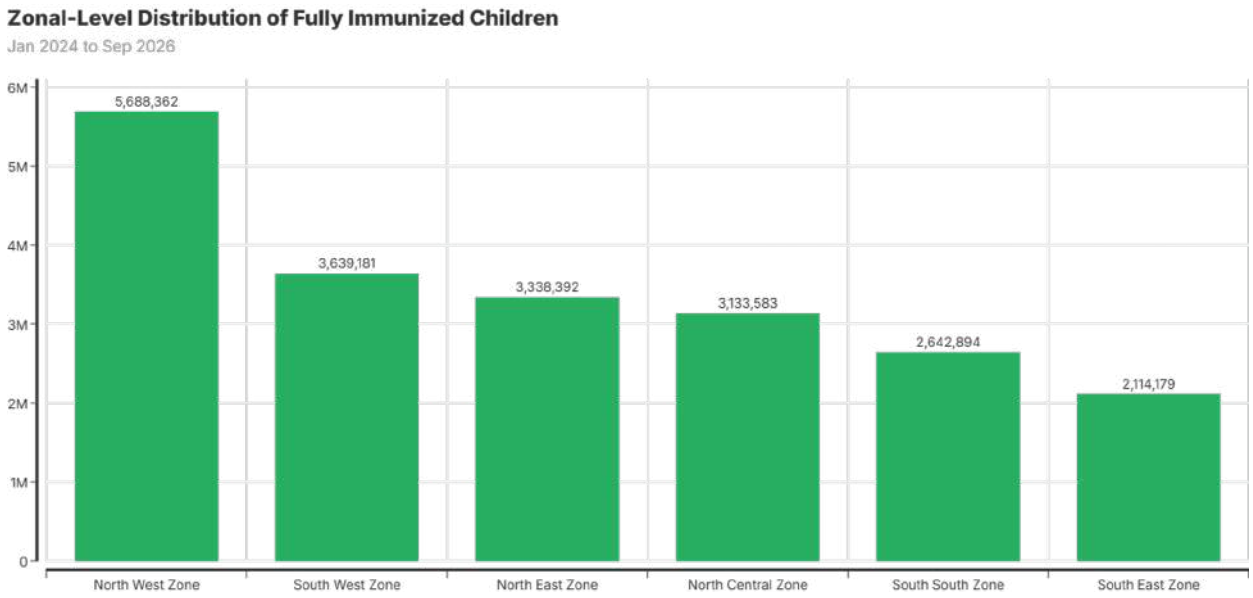


Figure 70: Fully immunised children by geopolitical zone, Jan–Sept 2026

Source: FASTR analysis of DHIS2

Kano, Katsina and Lagos recorded the most fully immunised children, while Bayelsa recorded the fewest. Volumes were more evenly spread across states than for other services (Figure 71).

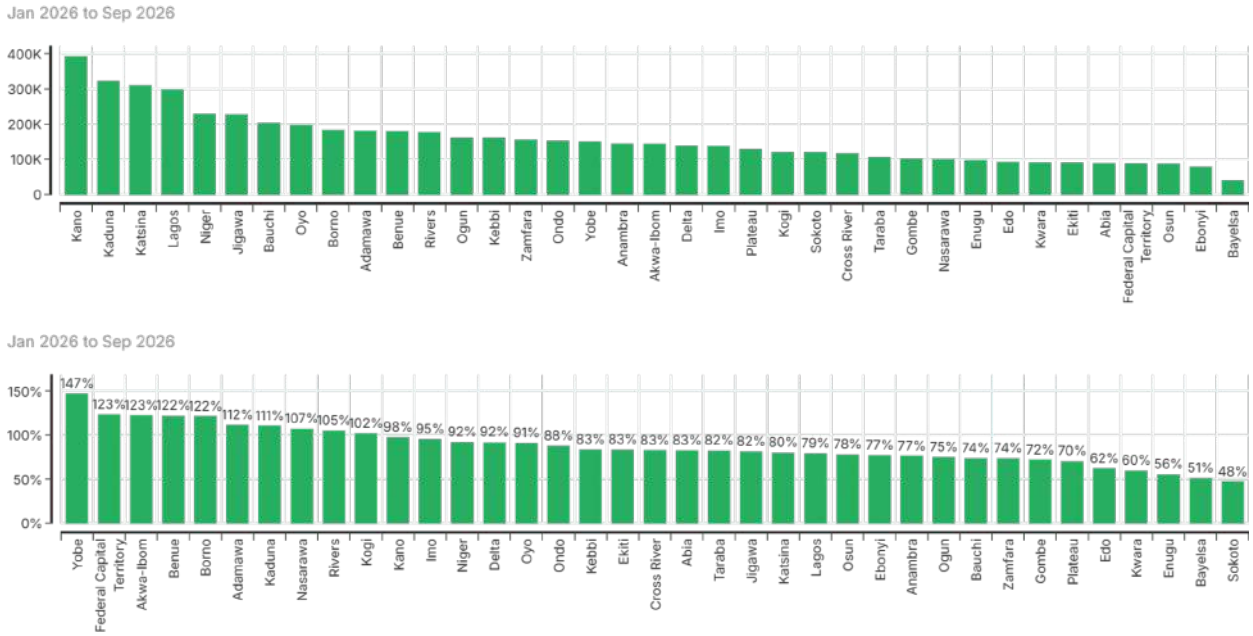


Figure 71: Fully immunised children by state, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Observed population-based coverage in the 2025–26 NMDHS was 68.1% for BCG, 66.2% for Penta 1 and 54.8% for Penta 3 among children aged 12–23 months. Coverage with all basic antigens was 39.7%, while 25.8% were fully vaccinated according to the report's national-schedule definition, which excludes rotavirus for comparability. No vaccinations of

any kind were reported for 29.4%. Measles second-dose coverage among children aged 24 –35 months was 38.2%.BCG coverage of live births declined on both measures from 2024 to 2026. Administrative coverage remained above 100%, while the projected estimate fell to 45% (Figure 72).

These are observed survey estimates and are distinct from the routine and projected estimates above.

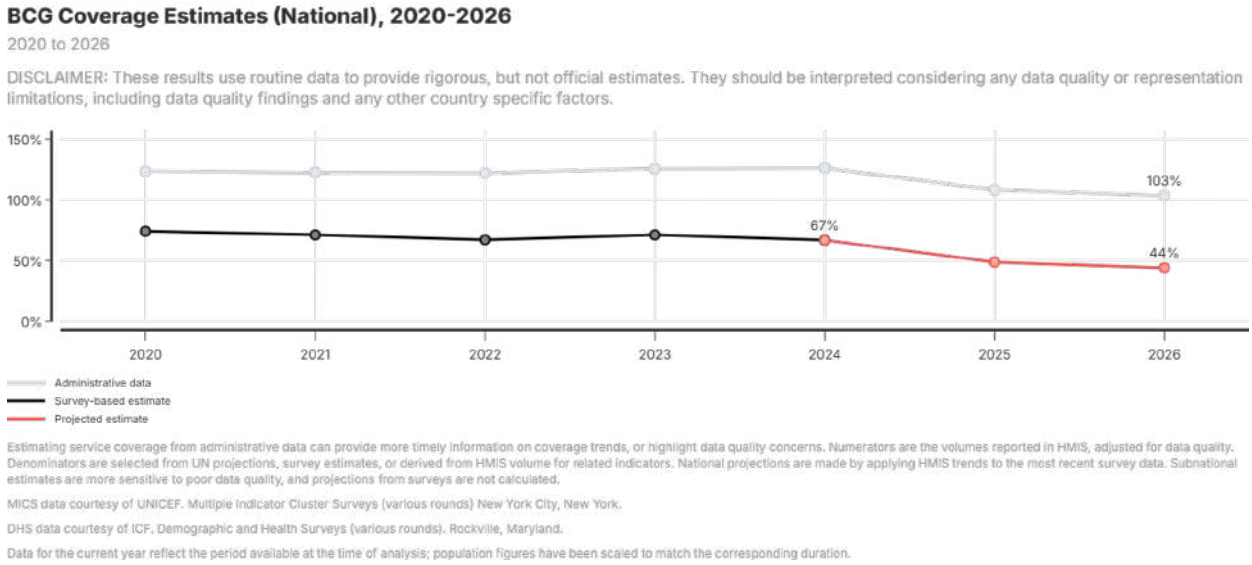


Figure 72: BCG coverage estimates from HMIS and survey, 2020–2026

Source: DHIS2 (FASTR Adjusted)

Penta 3 coverage exceeded 100% in North Central, North East and North West, while South East and South West were below 90%. Full immunisation was lowest in the South East (78%) (Figure 73).

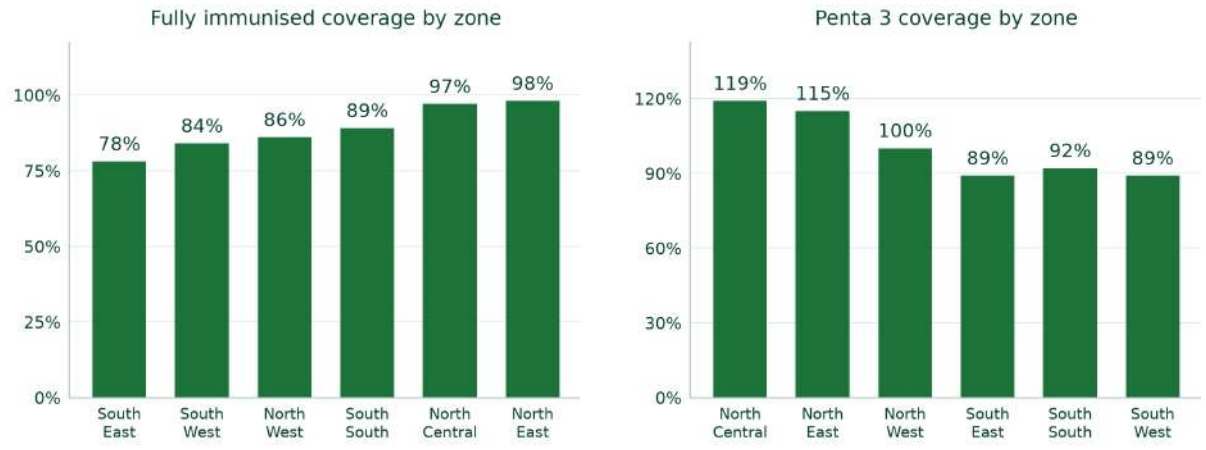


Figure 73: Penta 3 and full immunisation coverage by geopolitical zone, 2026 (HMIS-based)

Source: DHIS2 (FASTR Adjusted)

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Penta 3 coverage improved through 2026 at national and zonal levels, rising from 93% in Q1 to 104% in Q3. By Q3, every zone was at or above 90% (Figure 74).



Figure 74: Penta 3 coverage by geopolitical zone and quarter, 2026 (health sector scorecard)

Source: DHIS2 (FASTR Adjusted)

States with Penta 3 coverage at or above 90% increased from 19 in Q1 to 27 in Q2 and Q3 2026, while states below 80% fell from 8 to 4. Coverage above 100% in several states, notably the FCT (240%), indicates denominator issues (Figure 75).



Figure 75: Penta 3 coverage by state and quarter, 2026

Source: DHIS2 (FASTR Adjusted)

HMIS-based estimates showed continued declines in coverage. BCG coverage decreased from 69% in 2025 (72% in 2024) to 62% in 2026, while Penta 1 coverage declined from 71% (75% in 2024) to 67%. Projected Penta 3 coverage fell from 68% to 63%, remaining below the global routine immunisation ambition of 90% (Figures 76 and 77).

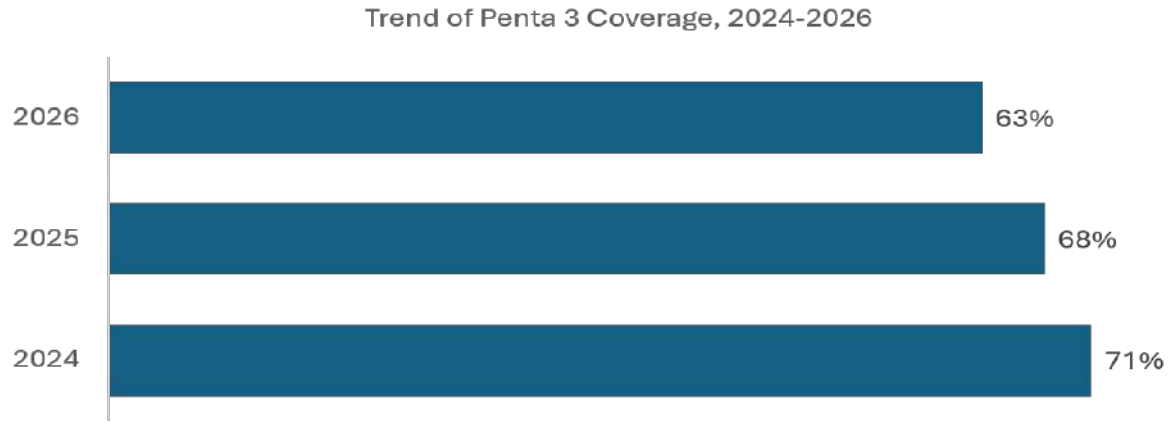


Figure 76: Trend of Penta 3 coverage, 2024–2026



Figure 77: Annualised administrative Penta 3 coverage, DHIS2, 2024–2026

Projected Penta 3 coverage declined from 71% in 2024 to 63% in 2026. The number of states in the green band decreased while those in the yellow band increased, with no state in the red band.

10.9 Neonatal and Child Mortality

Neonatal and child mortality rates are widely used measures of population health and of how well the health system protects its youngest members. The neonatal period, the first 28 days of life, carries the highest risk of death, mainly from complications of preterm birth, birth asphyxia and infections. The Sustainable Development Goals call on all countries to reduce neonatal mortality to 12 or fewer deaths per 1,000 live births and under-five mortality to 25 or fewer by 2030.

Table 10.7: Neonatal and child mortality indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Population-based data			
Neonatal mortality rate (facility) (per 1,000 live births)	41	Data not available	2024 NDHS
Infant mortality rate (per 1,000 live births)	63	Data not available	2024 NDHS

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Under-five mortality rate (per 1,000 live births)	110	Data not available	2024 NDHS
Causes of neonatal mortality (0–28 days)			
Cause of neonatal mortality (Physician-coded VA (PCVA)	Value		Data Source
Neonatal infections (sepsis, pneumonia and meningitis combined)	44%		VASA (2019)
Intrapartum injury (birth asphyxia)	21%		VASA (2019)
Prematurity-related complications	7%		VASA (2019)
Causes of infant mortality (1–11 months)			
Causes of infant mortality (Physician-coded VA (PCVA)	Data Source		Data Source
Diarrhoea	21.5%	-	VASA (2019)
Malaria	20.2%	-	VASA (2019)
Pneumonia	12.6%	-	VASA (2019)
Other causes	45.6%	-	VASA (2019)
Causes of under-five mortality			
Causes of U-5 Mortality (Physician-coded VA (PCVA)	Data Source	Causes of U-5 Mortality	Data Source
Malaria (23%)	VASA (2019)	Sepsis.	(VASA, 2024)
Diarrhoeal diseases (17%)	VASA (2019)	Pneumonia	(VASA, 2024)
Pneumonia (10%)	VASA (2019)	Malaria	(VASA, 2024)
Routine Measure (Facility-based)			
Number of Reported neonatal deaths	7,210	6,080*	
Infant mortality (%)	7.4%	6.3%*	
Number of Reported under-five deaths	Q1 3,820; Q2 3,672; Q3 4,215	12,156 (Jan to Sep total); Q1 2,983; Q2 4,881*	

*DHIS2 (Jan-Sep 2026)

Reported neonatal deaths generally increased from 2024 through 2025 before decreasing in 2026. Facility reported neonatal deaths increased by 15%, from 6,288 in 2024 to 7,210 in 2025. In 2026, neonatal deaths fell to 5,594, representing a 22% decrease from 2025 (Figure 78). Both routine and survey data shows that neonatal outcomes have not followed a steady downward path but instead fluctuate over time suggesting that improvements in neonatal survival are fragile and require consistent, long-term health system interventions to sustain gains.

The 2025–26 NMDHS does not estimate neonatal or other mortality rates. It does provide postnatal care measures: 49.4% of women received a check in the first two days after their most recent live birth, and 47.5% of newborns received a check in that period. Both mother and newborn received checks for 43.5% of most recent live births).

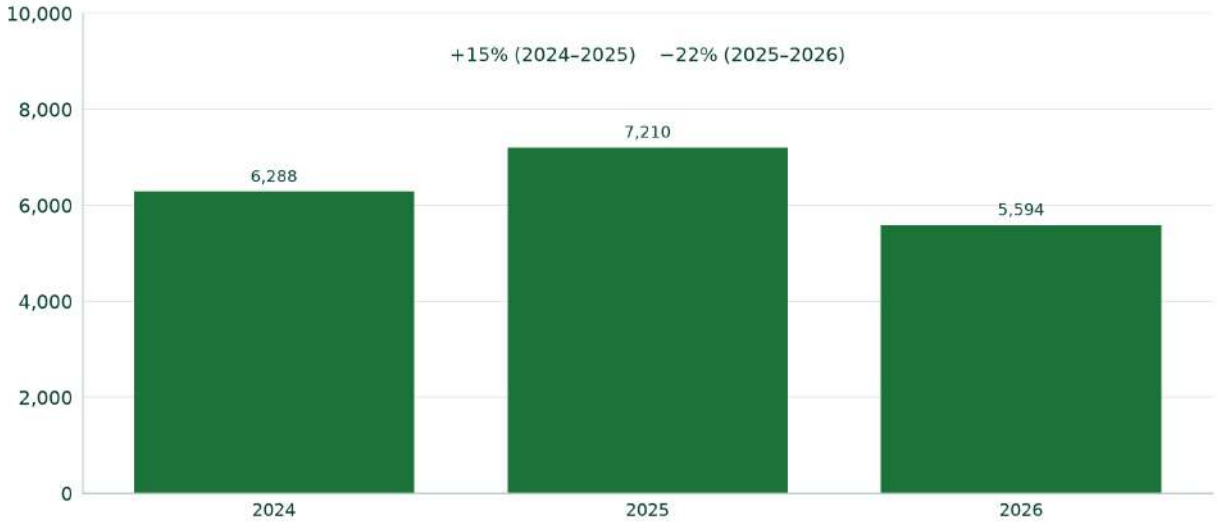


Figure 78: Neonatal death and changes over the years (2024 – 2026) Source: DHIS2

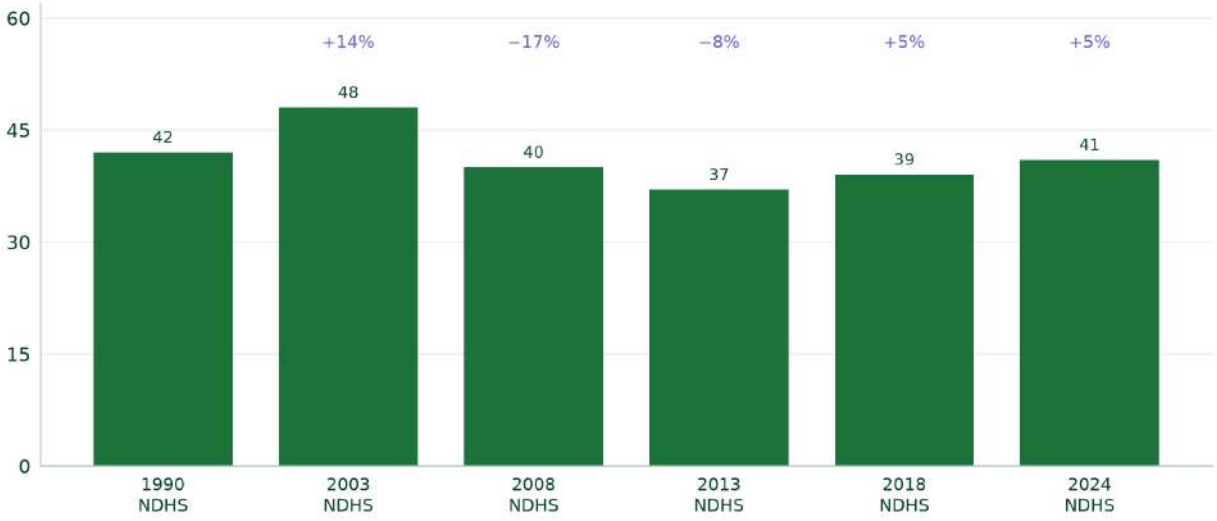


Figure 79: Neonatal mortality (deaths per 1,000 live births) Source: NDHS 2024

Across quarters, reported neonatal deaths peaked at 2,108 in Q2 2026 before declining to 1,618 in Q3 2026. The reported neonatal mortality rate declined from 2.7 to 2.2 per 1,000 live births. The rate went down slightly. It started at 2.7 per 1,000 in Q1–Q2 2024, reached its lowest point of 2.0 in Q4 2025, and is 2.2 in Q3 2026, about 19% lower than at the start (Figure 80). The reported rate is substantially lower than national estimates for Nigeria (Figure 79). These figures should be interpreted as trends in reported deaths rather than a reflection of the true burden of neonatal mortality.

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Boxes = neonatal deaths; rate per 1,000 live births

Figure 80: Neonatal Mortality rate, quarter on quarter (2024 – 2026)

Source: DHIS2

Across the geopolitical zones, neonatal deaths were concentrated in the Northwest and Southwest, which together accounted for the overall neonatal death nationally. Approximately three in four of reported deaths in 2026 were attributed to both zones. Unlike the national trend, these two zones recorded increases in neonatal deaths, while the southeast and South south zones reported substantially fewer deaths (Figures 81 and 82).

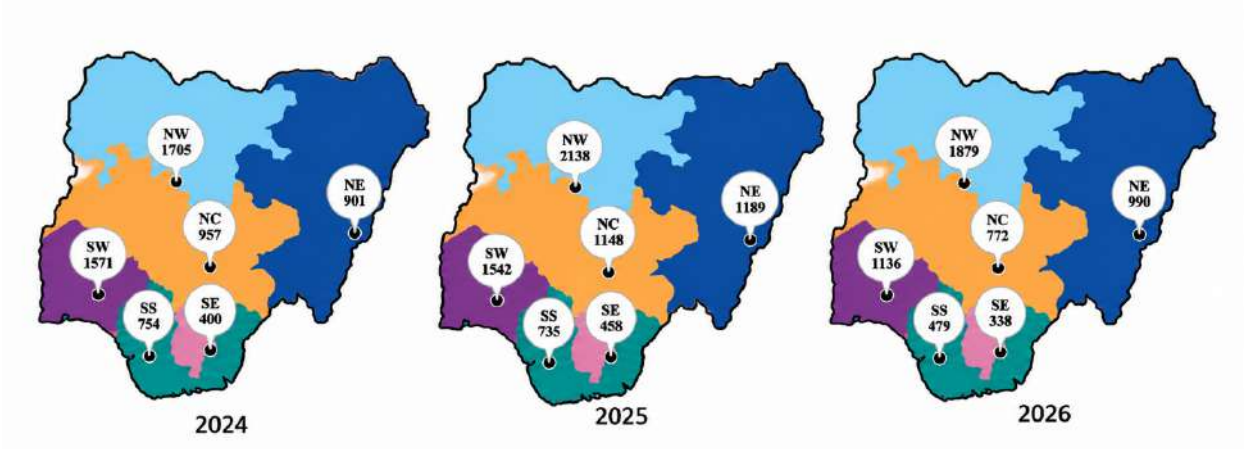


Figure 81: Map of reported neonatal deaths by zone, 2024–2026

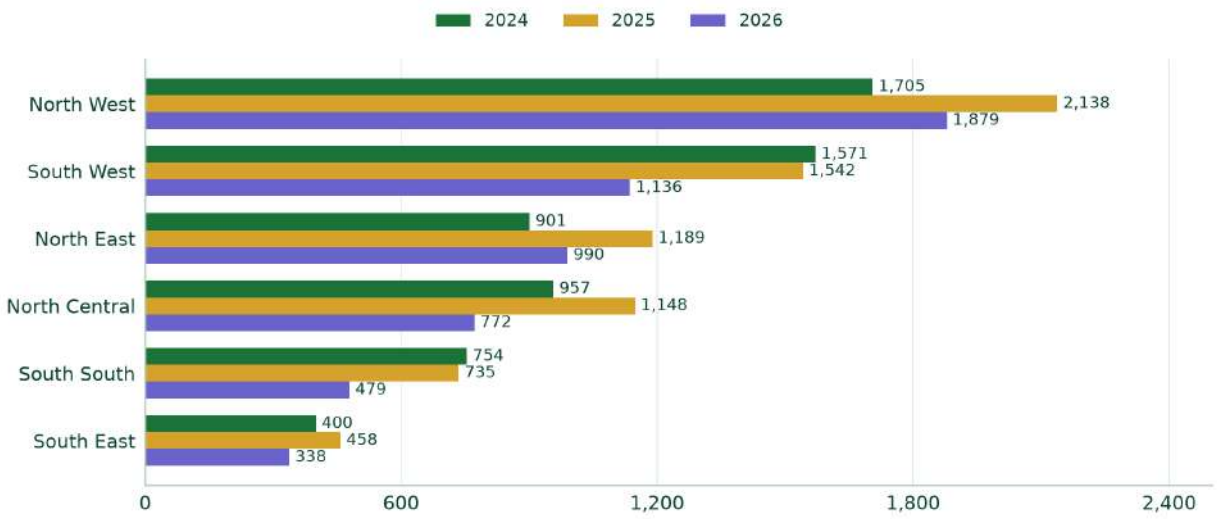


Figure 82: Neonatal deaths by Zones (2024-2026)

Source: FASTR DHIS2

The NDHS 2024 map strongly aligns with the routine data for the **Northwest**, which had the highest concentration of severe neonatal mortality rates (Figure 83) (e.g., Kano at 59, Jigawa at 53, and Kebbi at 49 per 1,000 live births). This is not the same for Southwest as NDHS data shows that the **Southwest** generally experiences the lowest mortality rates across the country (with states like Ondo at 3, Oyo at 17, and Lagos at 25). While it may be said that the Northwest is driven by genuinely high mortality risks, the same may not be said for Southwest's large share in routine reporting as this may likely reflect higher birth density or reporting related issues rather than high risk of neonatal death.

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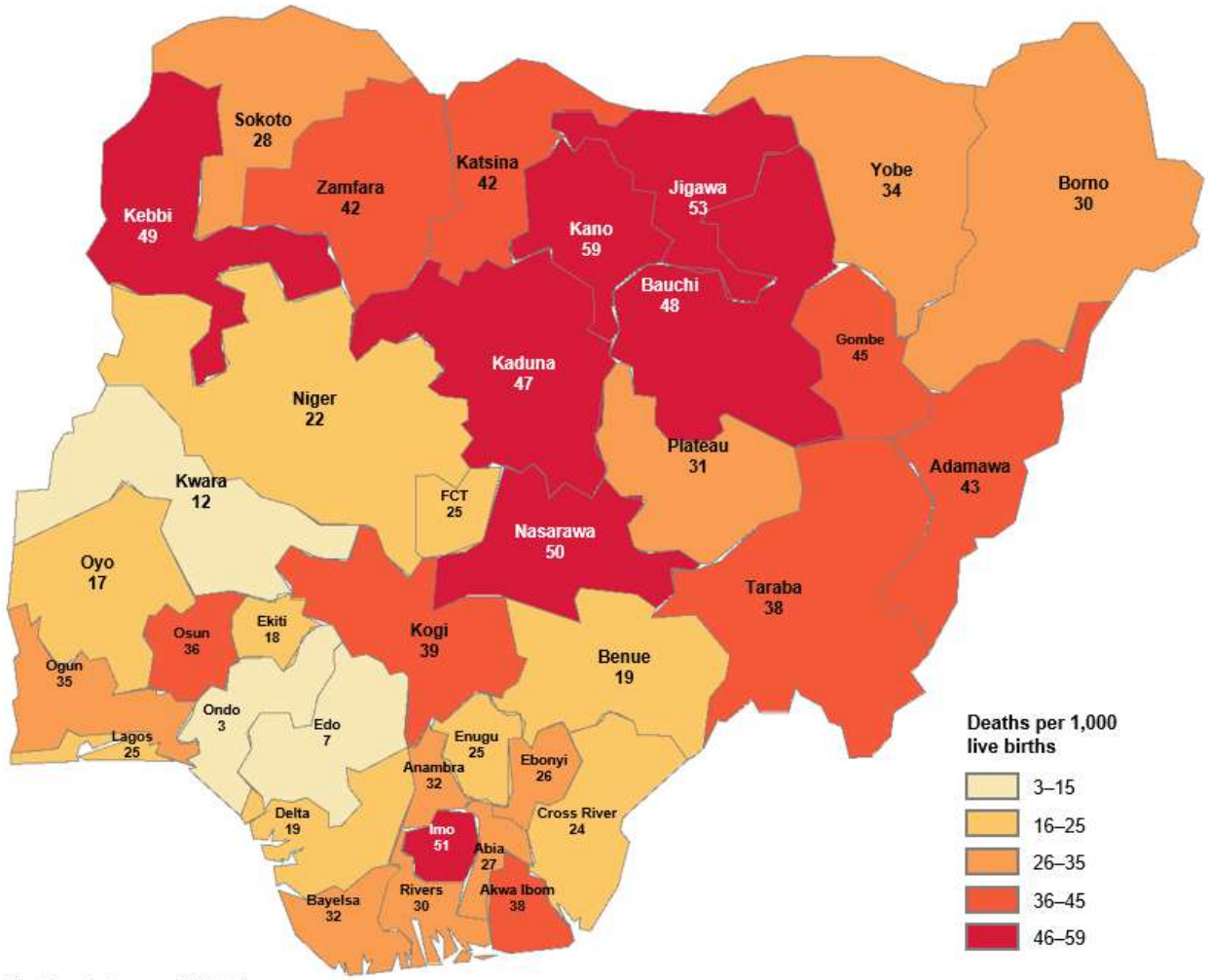


Figure 83: Neonatal mortality by States (deaths per 1,000 live births) Source: NDHS 2024

Across the states, reported neonatal deaths declined in 2026 following an increase in 2025, with most states recording reductions. Bayelsa, Benue, Kebbi, Cross River, Nasarawa and Kogi recorded substantial declines between 2025 and 2026. However, deaths remained concentrated in Lagos, Zamfara and Jigawa, which together accounted for nearly 30% of reported deaths. Zamfara recorded a marked increase, while smaller increases were also observed in the FCT and Osun (Figure 84).

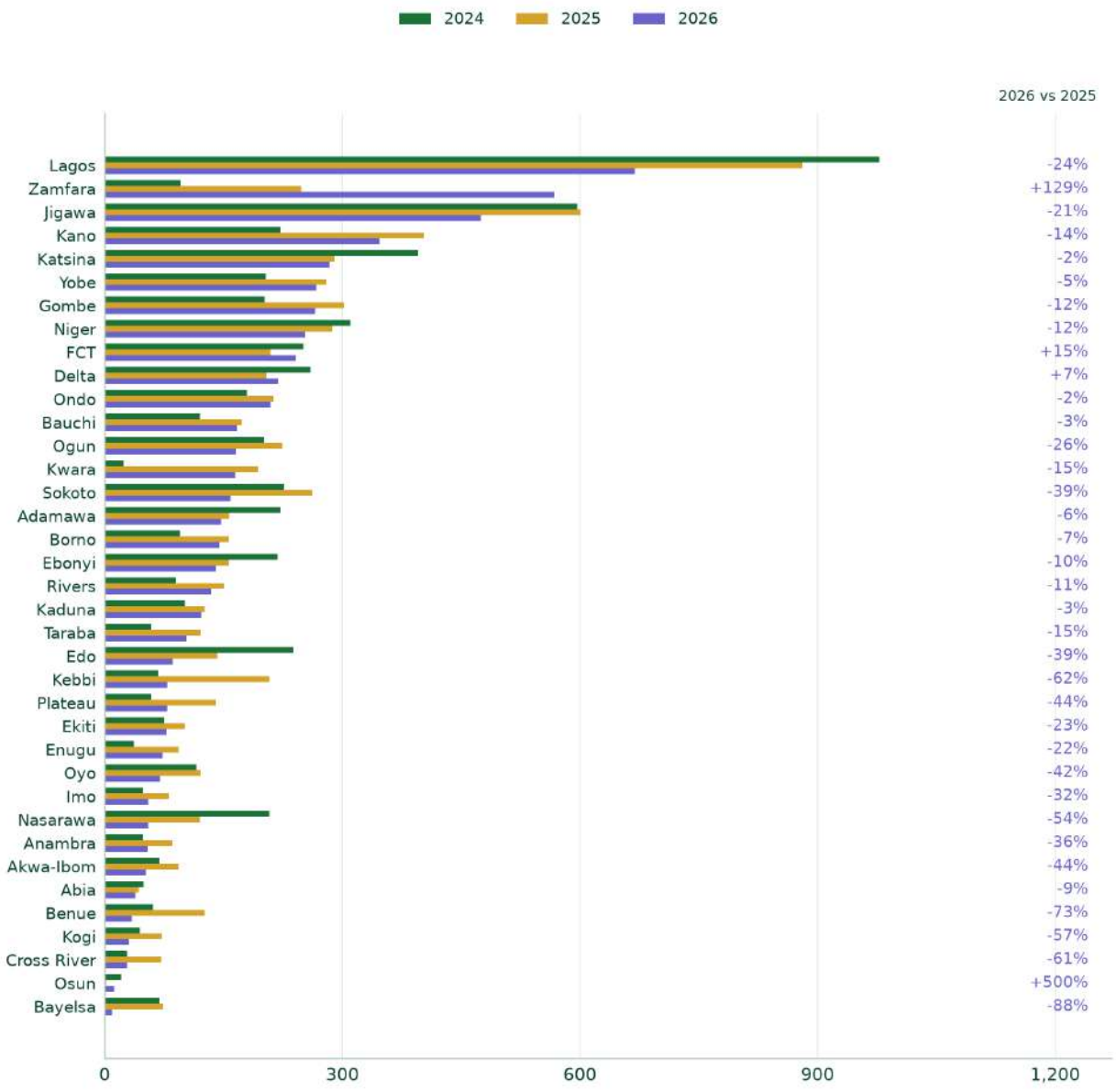


Figure 84: Neonatal death and changes between 2026 and 2025 (2024 – 2026)

Source: DHIS2

10.10 UNDER FIVE MORTALITY- FACILITY DEATHS AND TRENDS

Nationally, reported deaths under-5 declined by 7% between 2024 and 2025 and 25% between 2025 and 2026. The first three quarters of 2026 indicate a further reduction of about 5% compared with the same period in 2025. Reported deaths remain concentrated in the northern zones.

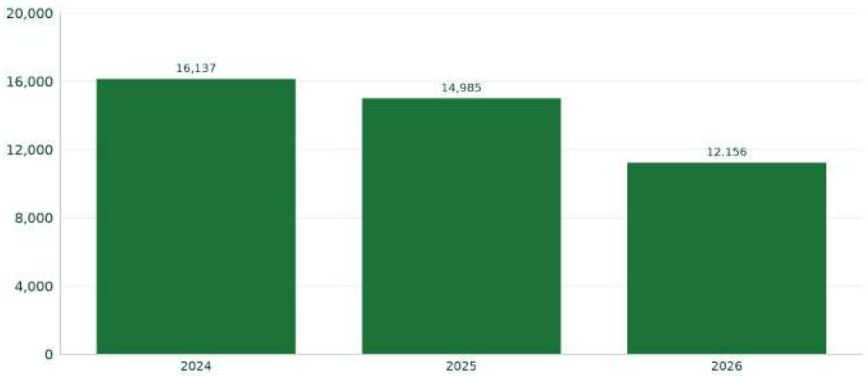


Figure 85: Reported under-5 deaths, 2024–2026 Source: FASTR analysis of DHIS2

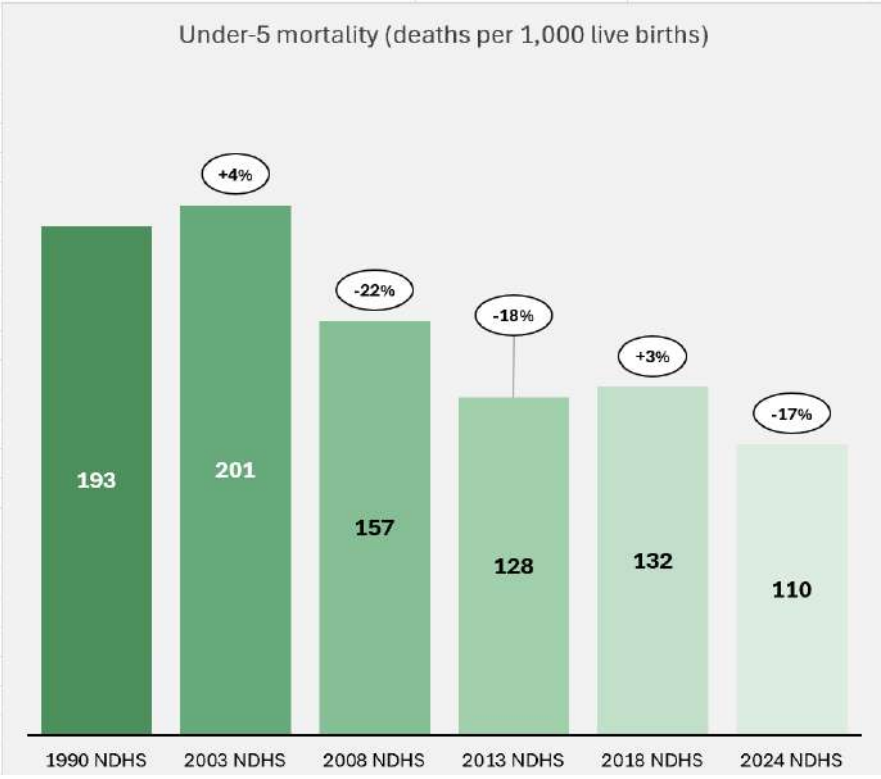


Figure 86: Under-5 mortality (deaths per 1,000 live births) Source: NDHS 2024

The NDHS 2024 figure (110 deaths per 1,000) aligns with the downward trajectory seen in routine data (Figure 86). Routine data suggests that the pace of decline accelerated after 2024, with particularly strong improvements in 2025–2026. This combination of survey and routine data indicates both success in reducing child mortality nationally.

Across the quarters, reported under-5 deaths fell by about 7% between 2024 and 2025 (Figure 85). The decline did not continue into 2026. A low first quarter was followed by a sharp rise in Q2 2026, the highest quarter in the series, and Q3 2026 was almost the same as Q3 2025. Cumulative deaths for the first three quarters of 2026 were about 3% higher than in the same period of 2025.

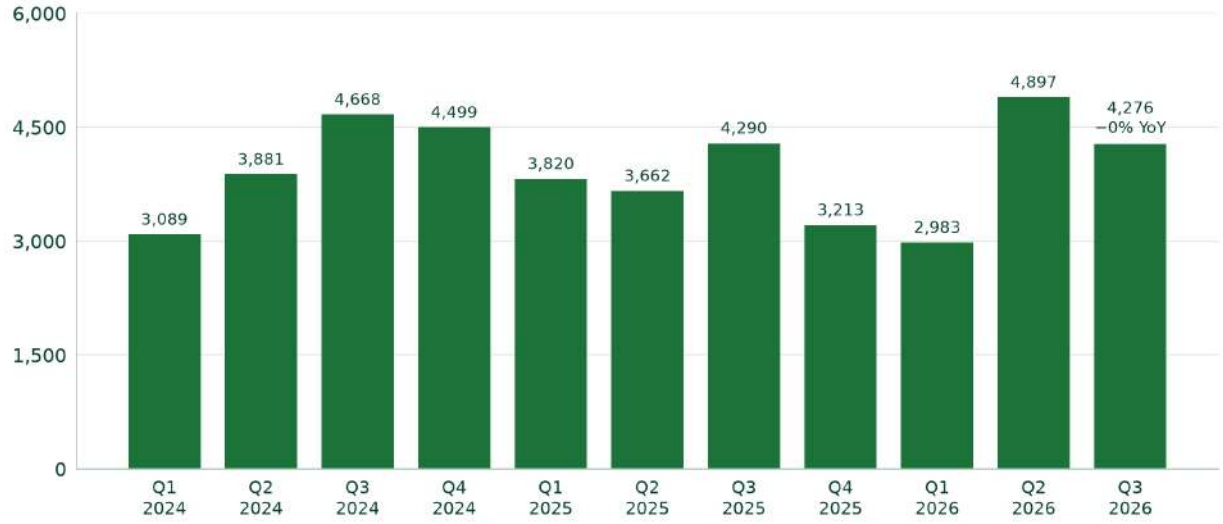


Figure 87: Trend in Under-5 Deaths by Quarters (2024 – 2026)

Source (DHIS2)

Over the 11 quarters, under-5 deaths show no clear long-term trend. Figures rise and fall sharply from quarter to quarter, with peaks in Q3 2024 and Q2 2026. The trend line rises slightly, but it explains less than 2% of the variation (Figure 87).

Across the zones, the North West accounted for the largest share of Under-5 deaths in 2026 (43%), despite a 10.0% decline in 2025 and a further 35.4% decline in 2026 (41.9% overall since 2024) (Figure 88). The North East remained largely unchanged over the period, so its share rose from 24% in 2024 to 35% in 2026. The South South recorded the largest proportional decline (57%) over the two years. Together, the three northern zones accounted for 88% of deaths in 2026 (Figure 89).

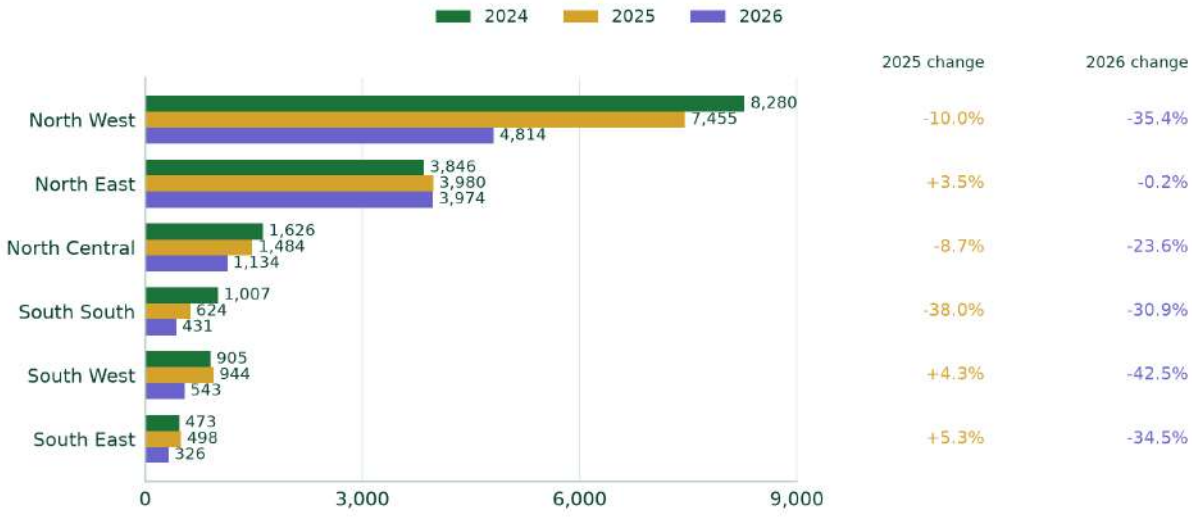


Figure 88: Reported under-5 deaths by zone and annual change, 2024–2026

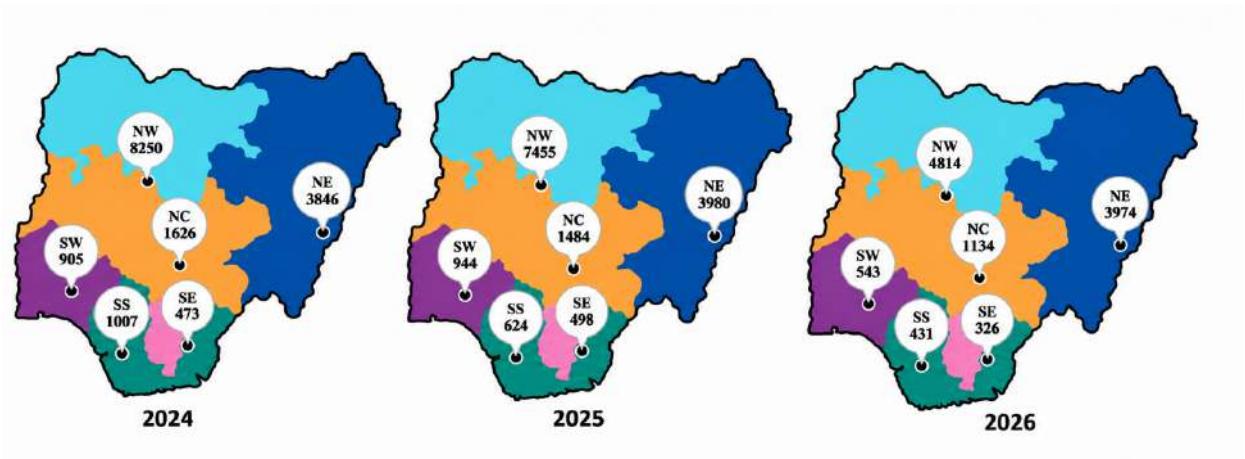


Figure 89: Under-5 Deaths by Zones (2024 – 2026)

Source: DHIS2

According to NDHS 2024, Under-five mortality rates were substantially higher across the northern states, particularly in the Northwest and Northeast, where Jigawa (161), Kebbi (159), Kano (158) and Gombe (157 deaths per 1,000 live births) recorded the highest rates (Figure 90). In contrast, southern states generally recorded lower rates. Routine data from 2024–2026 similarly showed a concentration of under-five deaths in the northern zones, which accounted for 88% of reported deaths in 2026 (Figure 89).

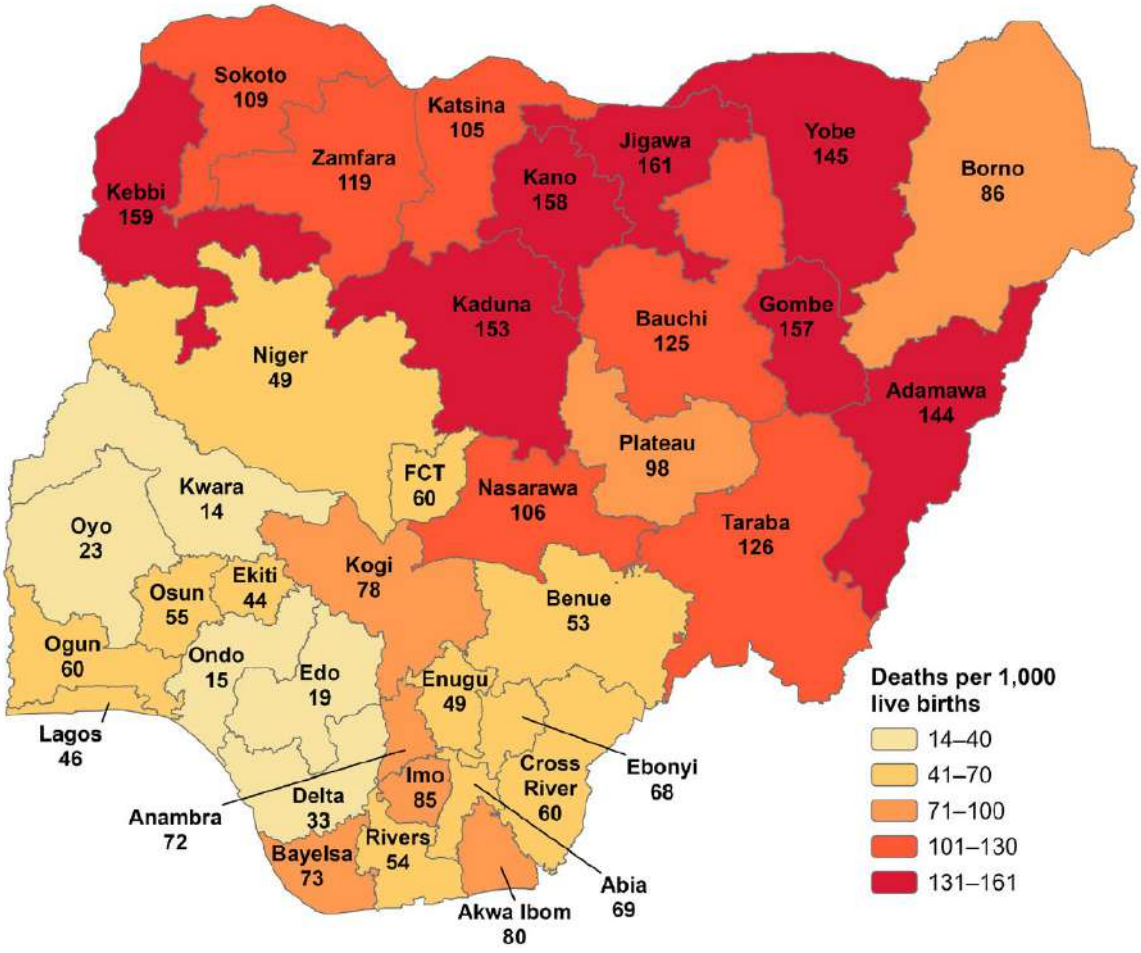


Figure 90: Under-5 mortality by state (Deaths per 1,000 live births for the 10-year period before the survey). Source: NDHS 2024

Seven states recorded increases in the number of reported Under-5 deaths between 2025 and 2026. Taraba had the largest, rising by 987% (from 142 to 1,543. Other states that reported increases were Imo (+58%), FCT (+20%), Zamfara (+19%), Borno (+16%) and Edo (+14%). Kwara also appears in red at +0%, reflecting a slight increase from 217 to 218 (Figure 91).

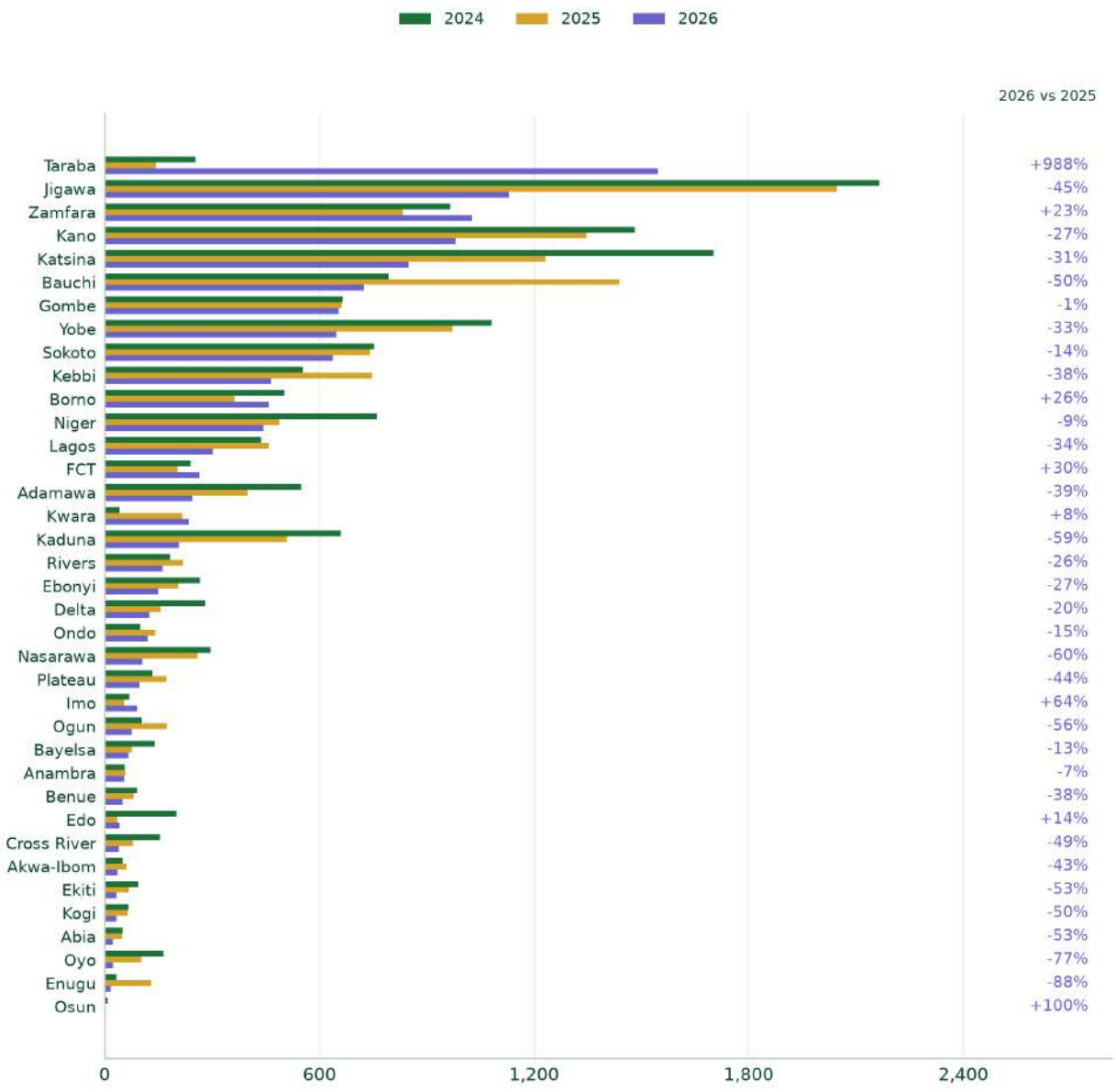


Figure 91: Reported under-5 deaths by state, 2024–2026

The states that reported decreases in the number or reported Under-5 deaths were Enugu (−88%), Bauchi and Kaduna (−61% each), and Jigawa (−52%). Osun recorded a 100% decline, from one reported death to zero (Figure 92)

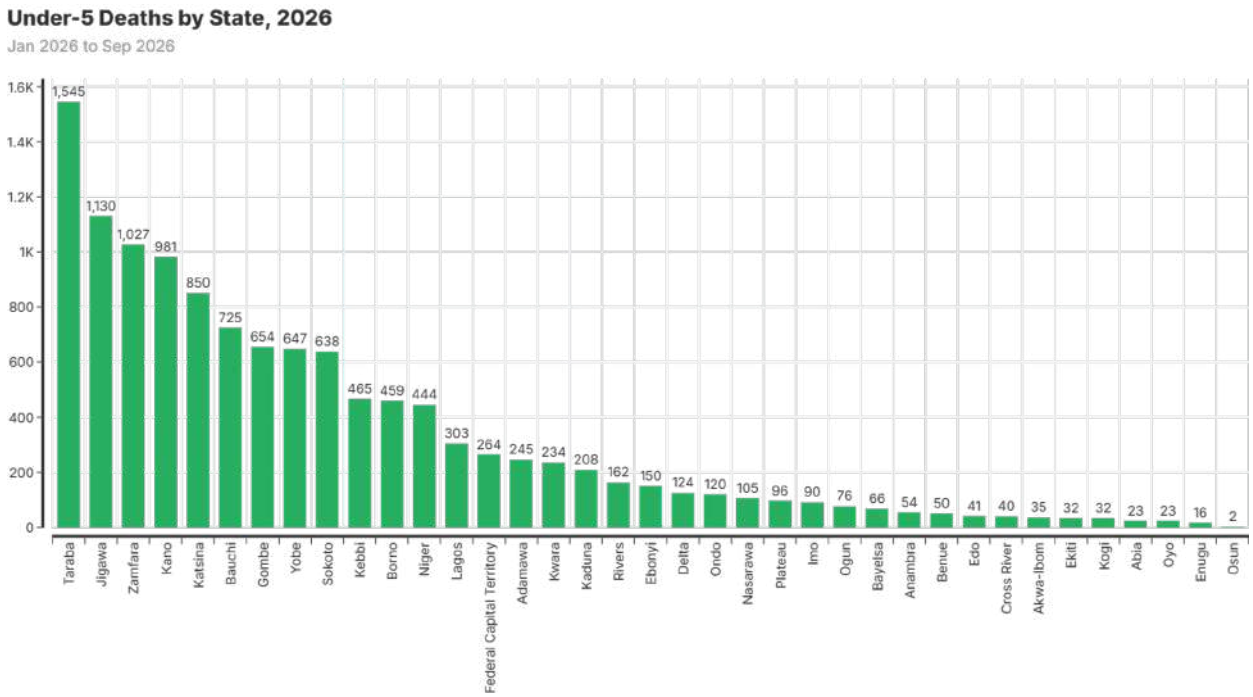


Figure 92: Under-5 Deaths by States (2026)

Source: DHIS2

10.11 Adolescent and Youth Sexual Health Services

Adolescents, defined by the World Health Organization as people aged 10–19 years, make up a large share of Nigeria's population. Adolescent- and youth-friendly sexual and reproductive health services help young people avoid unintended pregnancy, sexually transmitted infections and the health risks associated with early childbearing. Expanding the number of facilities and trained health workers offering these services is key to improving adolescent health outcomes.

Table 10.8: Adolescent and youth sexual health services

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Adolescent birth rate, 15–19 years (per 1,000 women)	Data not available	9%	(NmDHS)
Number of Health facilities providing adolescent-friendly health services	Data not available	Data not available	
Number of Adolescents aged 10–19 receiving sexual and reproductive health services	Data not available	Data not available	
Number of Adolescent family planning acceptors using modern contraception aged 15–19	Data not available	1,098,428	DHIS2 (FASTR Adjusted, Jan-Sep, 2026)
Number of Antenatal contacts among women aged under 20	Data not available	Data not available	
Number of Health workers trained on adolescent-friendly service delivery	Data not available	1000 in selected 8 states	

10.12 Nutrition — Stunting, Wasting, SAM, RUTF and Micronutrient Supplementation

Good nutrition during pregnancy and early childhood is essential for child survival, growth and development. Undernutrition, including stunting, wasting and micronutrient deficiencies, increases the risk of illness and death and has lasting effects on learning and productivity. This subsection covers the main nutrition services, including the treatment of severe acute malnutrition (SAM) with ready-to-use therapeutic food (RUTF), vitamin A supplementation and micronutrient supplementation in pregnancy

Table 10.9: Nutrition indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Babies put to breast within 1 hr of birth with skin-to-skin to keep warm	35.5%	2,170,135 (47.3%)	2024 NDHS; 2025 NMDHS
Children 0-6 months receiving EBF (%) Exclusive Breastfeeding	28.8%	6,114,256 (34.2%)	
Children 6-23 months who are receiving a minimum dietary diversity (%)	12.4%	17.9%	
Percentage of Under-5 stunting prevalence	40%	42.1%	
Percentage of Under-5 wasting prevalence	8%	4.8%	
Percentage of Under-5 underweight prevalence	27%	22.2%	
Percentage of Youngest children aged 6–23 months living with their mother receiving minimum dietary diversity	12.4%	17.9%	
Percentage of Youngest children aged 6–23 months receiving a minimum acceptable diet	6%	8.8%	
Percentage of Most recent live births with skin-to-skin contact immediately after birth	17%	26.4%	
Percentage of Children born in the preceding two years put to breast within one hour of birth	35.5%	47.3%	
Percentage of Youngest children aged 0–5 months living with their mother exclusively breastfed	28.8%	34.2%	
Routine Measures (Facility-based)			
Number of Children 6–59 months reached with vitamin A supplementation	42,449,039	40,487,323*	*DHIS2 (FASTR Adjusted, Jan-Sep, 2026)
Number of Children 6–23 months who received micronutrient powder	433,447	844,866*	
Number of Children under 5 admitted for SAM treatment	439,200	805,089*	
Number of children under 5 identified with SAM	Data not available	Data not available	
Number of children under 5 with SAM referred for treatment	Data not available	Data not available	
Number of children under 5 with SAM who died during treatment	Data not available	Data not available	

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Vitamin A doses administered per quarter	~3 million (2024 Q1: ~7 million)	Q1 3,458,724; Q2 4,393,297; Q3 2,426,675 Total - 10,278,696*	
Children 12–59 months given deworming tablets	Data not available	11,751,770*	
Pregnant women who received Multiple Micronutrient Supplement	Data not available	10,170,748 (IFA/MMS during ANC; quarters sum to 11,213,375)*	
Facilities offering nutrition assessment, counselling and support (number)	Data not available	Data not available	
Facilities passing baby-friendly initiative certification (number)	Data not available	Data not available	
Number of states with established State Committees of Food and Nutrition	36+ FCT	36+ FCT	
Number of states with active State Multisectoral Plans of Action	36+ FCT	36+ FCT	

*DHIS2 (FASTR Adjusted, Jan-Sep, 2026)

NMDHS estimated that 42.1% of children under five were stunted, 4.8% were wasted and 22.2% were underweight. Minimum dietary diversity was achieved by 17.9% of youngest children aged 6–23 months living with their mother; 8.8% received a minimum acceptable diet (Figure 93).

For children born in the two years preceding the 2025–26 NMDHS, 47.3% were put to the breast within one hour of birth. Skin-to-skin contact immediately after birth was reported for 26.4% of most recent live births, a separate measure. Among youngest children aged 0–5 months living with their mother, 34.2% were exclusively breastfed during the day and night preceding the interview.

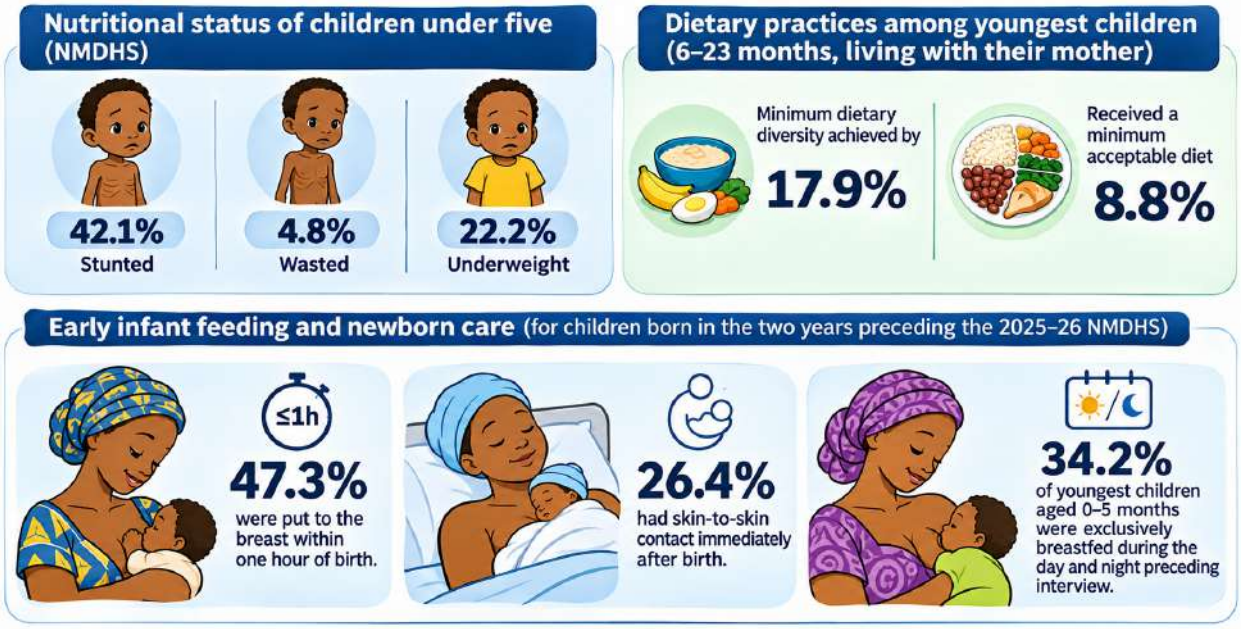


Figure 93: Child Nutrition, Dietary Diversity and Infant Feeding Practices. Source: 2025-26 NMDHS

Vitamin A supplementation 40.5 million children aged 6–59 months in 2026, down 4.6% from 42.4 million in 2025. Monthly coverage peaked during campaign periods, while non-campaign months recorded lower volumes than in 2025 (Figure 94). Quarterly doses also remained below 2025 levels, with all three quarters falling short of expected coverage (Figure 95)

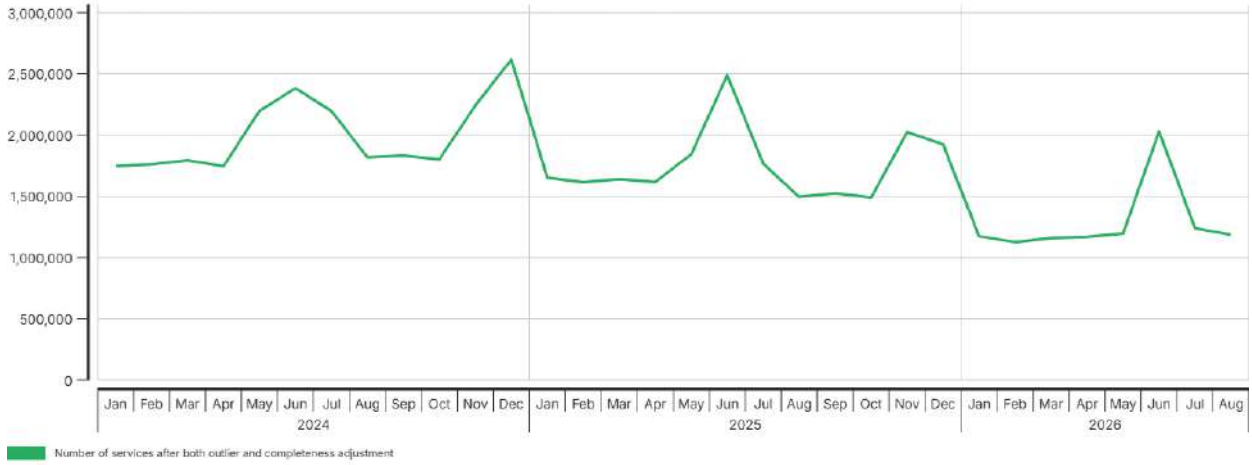


Figure 94: Children 6–59 months reached with vitamin A supplementation, Jan 2024–Aug 2026

Source: DHIS2 (FASTR Adjusted)

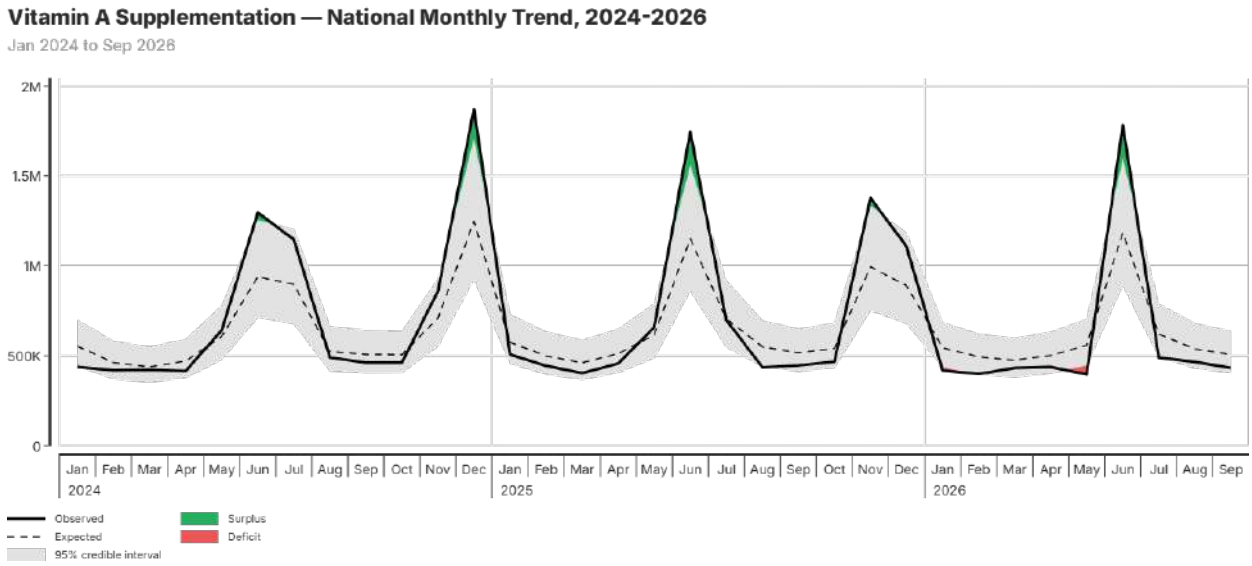


Figure 95: Vitamin A doses, actual against expected volume, quarterly, 2024–2026 (Q3 2026 covers Jul–Sep)

Source: DHIS2 (FASTR Adjusted)

Across the zones, North Central and Southsouth administered about 50% of all vitamin A doses in each quarter of 2026, while the South East recorded the lowest volumes (Figure 96).



Figure 96: Vitamin A doses by geopolitical zone and quarter, 2026 (Q3 2026 covers Jul–Sep)

Source: DHIS2 (FASTR Adjusted)

Across the states, Lagos, Rivers, and Ondo Benue led vitamin A distribution in 2026, while Ogun and Zamfara recorded the lowest volumes (Figure 97)

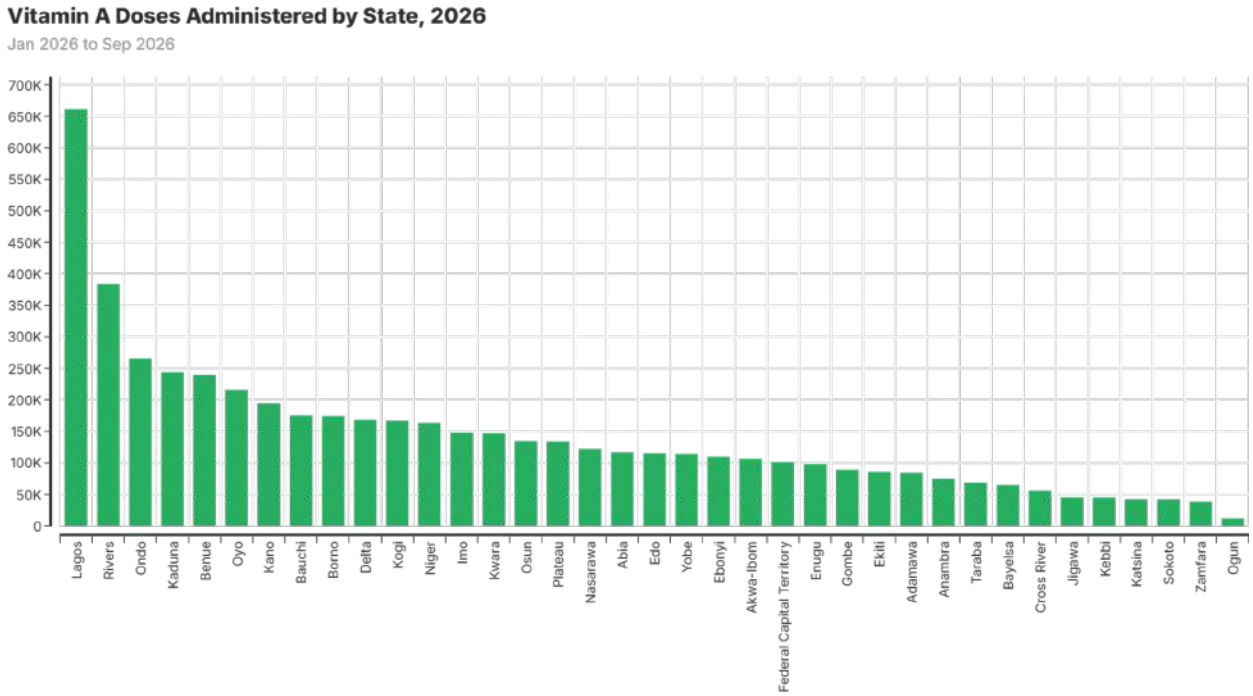


Figure 97: Vitamin A doses by state, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Micronutrient powder supplementation nearly doubled in 2026, reaching 845,000 children aged 6–23 months. Deworming tablets reached 11.8 million children aged 12–59 months. MMS/IFA supplementation during ANC totalled 11.2 million, peaking in Q2 (Figure 98). The North West accounted for the largest share of MMS/IFA recipients (41%), driven by Kano, Kaduna and Jigawa (Figures 99 and 100).

MMS/IFA supplementation rose sharply from Q1 to Q2 2026 (+53%).

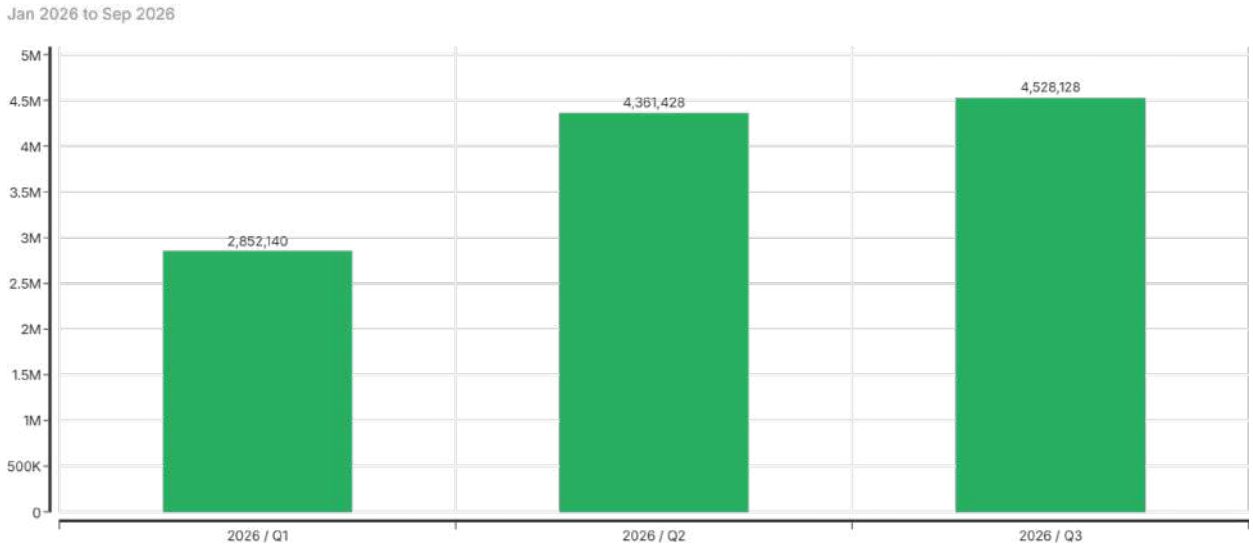


Figure 98: Pregnant women receiving MMS/IFA supplementation during ANC by quarter, 2026

Source: DHIS2 (FASTR Adjusted)

Geographically, North West accounted for 41% of MMS/IFA recipients, followed by the North East. The South East recorded the fewest.

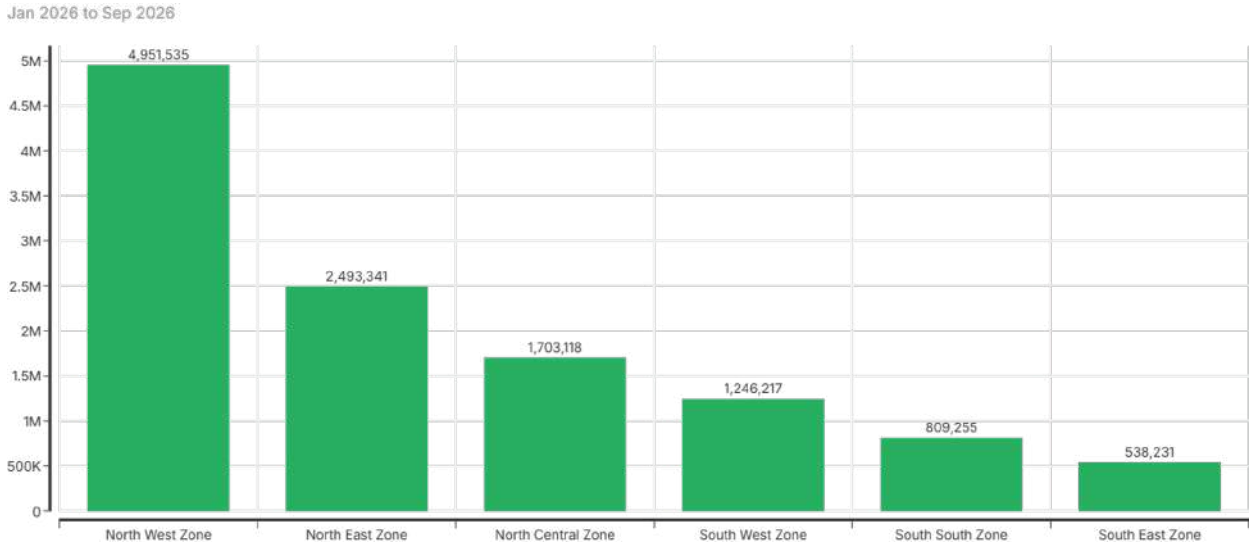


Figure 99: Pregnant women receiving MMS/IFA supplementation by geopolitical zone, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

At the sub-national level, Kano, Kaduna and Jigawa recorded the highest numbers of MMS/IFA recipients, while Bayelsa and Imo recorded the fewest.

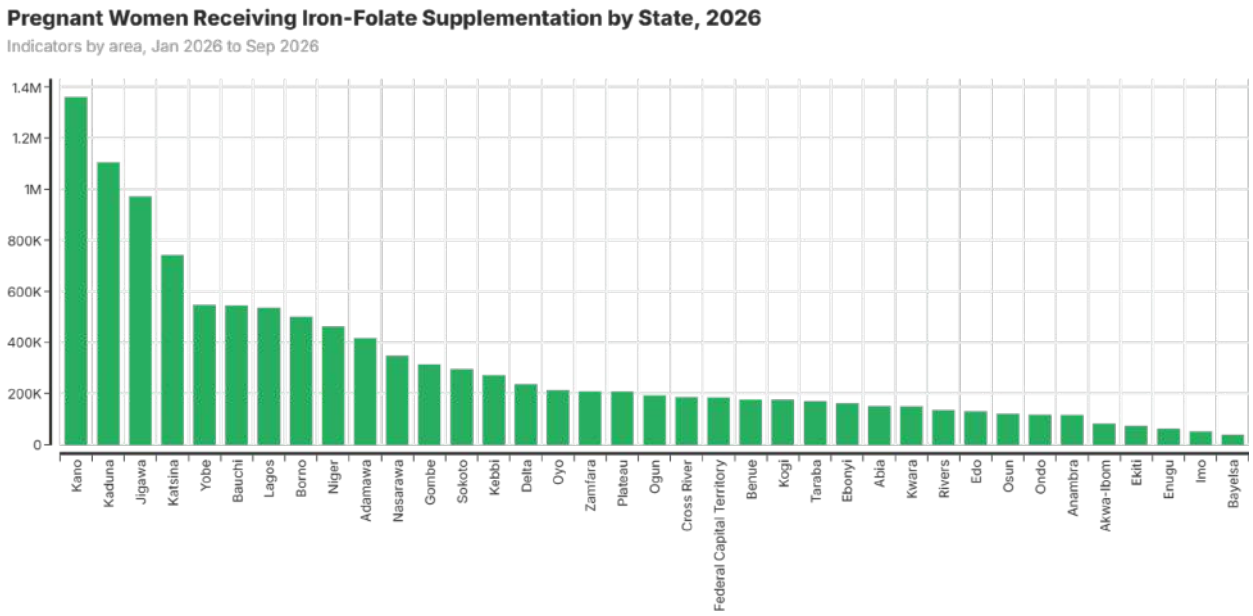


Figure 100: Pregnant women receiving MMS/IFA supplementation by state, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

SAM admissions rose sharply between 2020 and 2023, then stabilised at a high level (Figure 101). Q1–Q2 2026 were slightly below the same quarters of 2025 (−7% and −3%).

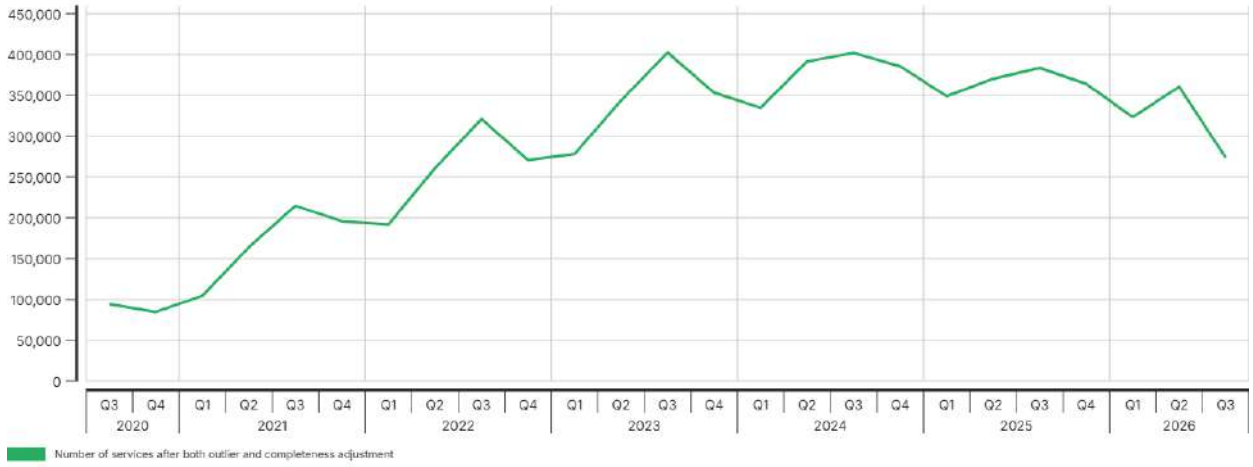


Figure 101: SAM admissions, quarterly, Q3 2020–Q3 2026 (Q3 2026 covers Jul–Sep)

Source: DHIS2 (FASTR Adjusted)

SAM admissions were overwhelmingly concentrated in the North West and North East (97%), with very few admissions in the other zones (Figure 102).

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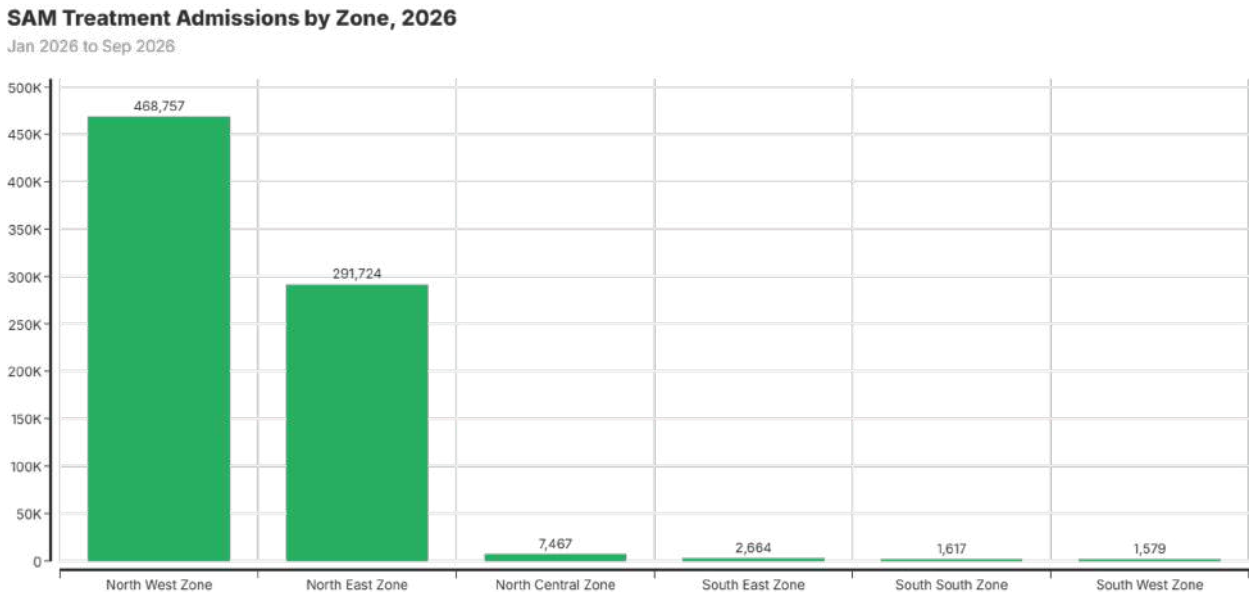


Figure 102: SAM treatment admissions by geopolitical zone, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Admissions in the North West and North East rose from Q1 to Q2 2026 before falling in the two-month Q3. The other zones remained low throughout (Figure 103).

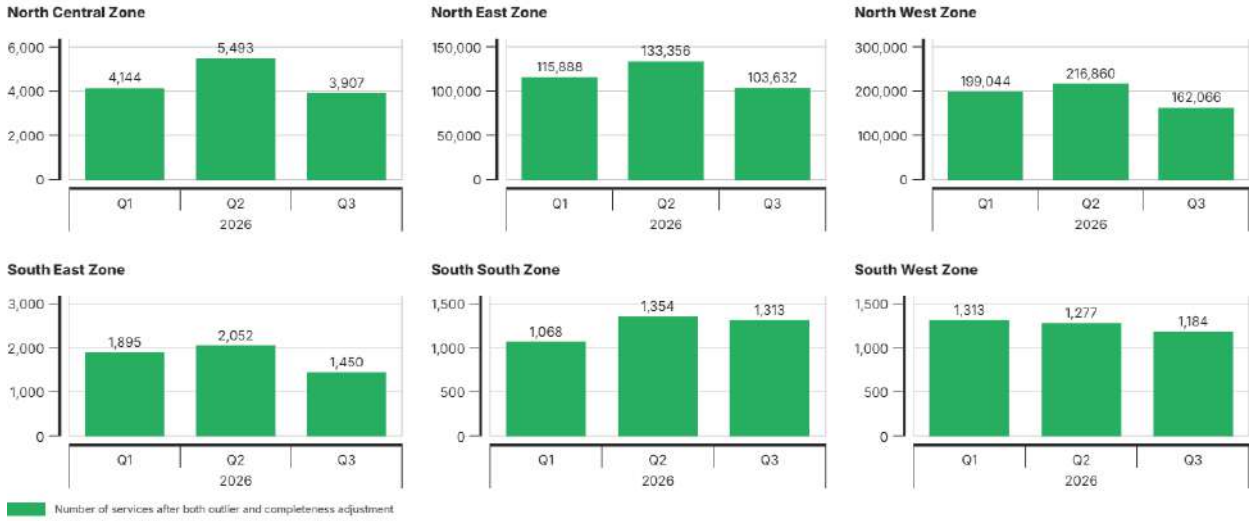


Figure 103: SAM admissions by geopolitical zone and quarter, 2026 (Q3 2026 covers Jul–Sep)

Source: DHIS2 (FASTR Adjusted)

Admissions in the North West and North East rose from Q1 to Q2 2026 before falling in the two-month Q3. The other zones remained low throughout.

Borno, Sokoto and Zamfara accounted for nearly two-thirds of SAM admissions, while southern states reported very few (Figure 104).

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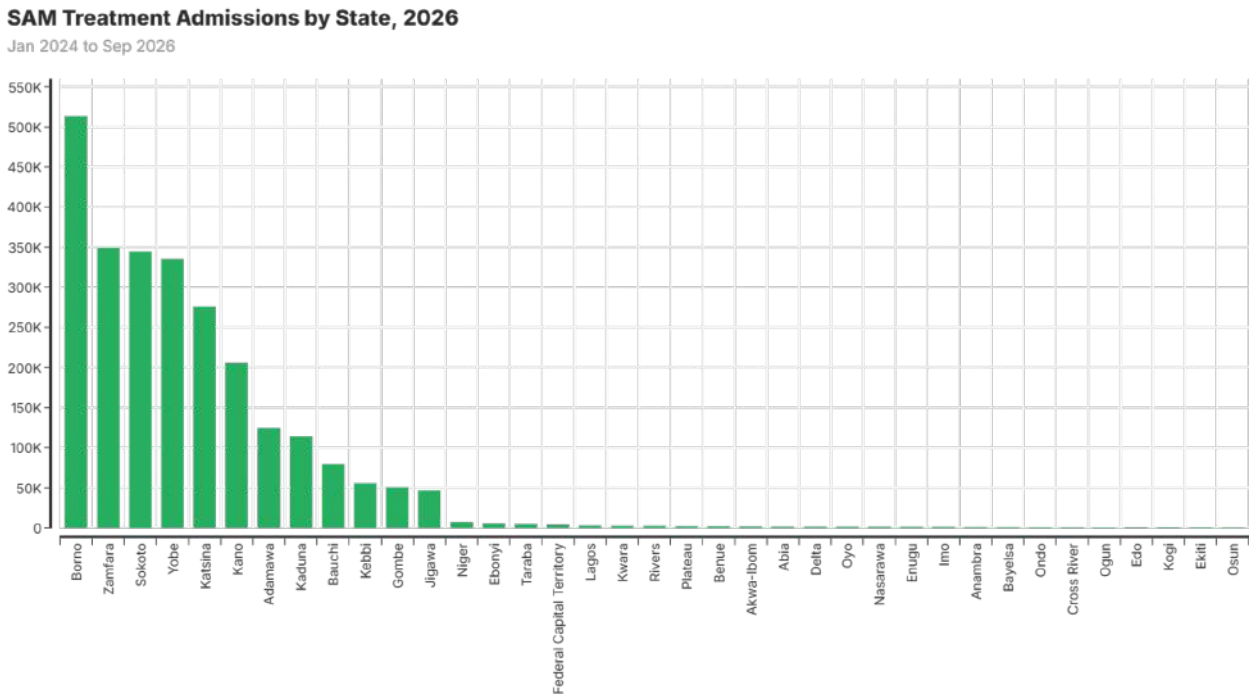


Figure 104: SAM treatment admissions by state, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Compared with the expected numbers, SAM admissions were broadly stable over 2024–2026, with January–August 2026 close to 2025 (−1%). Admissions dropped in early 2026 and rose again from March to July (Figure 105).

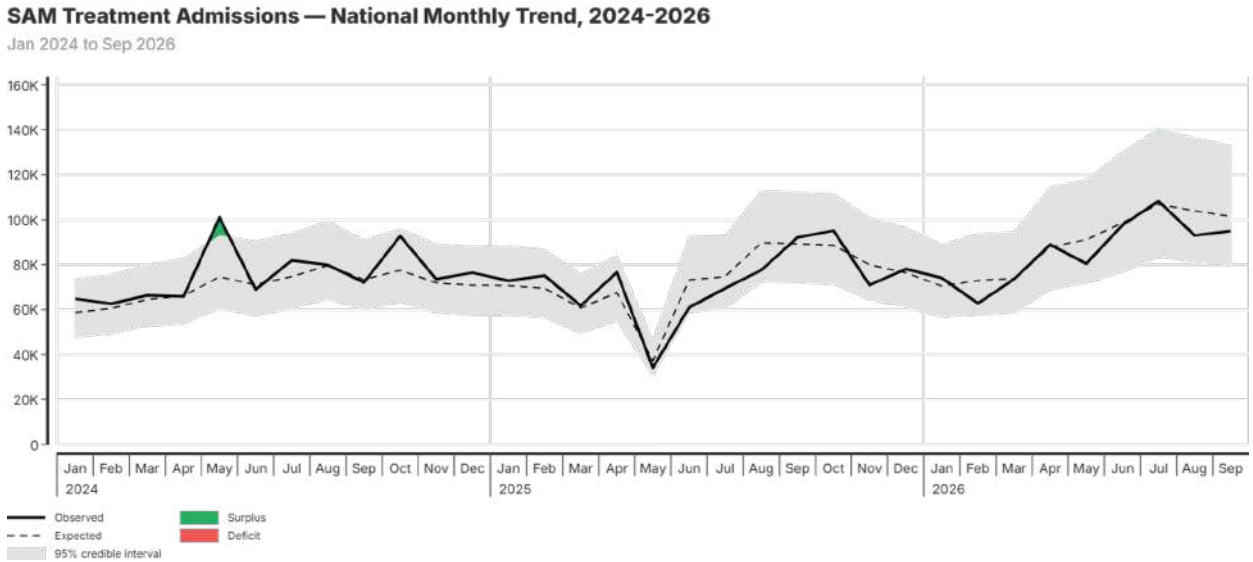


Figure 105: Under-five children admitted for SAM treatment, Jan 2024–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Chapter 11

COMMUNICABLE DISEASE PREVENTION AND CONTROL



11.1 Malaria — Incidence, Mortality, Interventions and Trend Analysis

Malaria is a preventable and treatable disease transmitted through the bites of infected female Anopheles mosquitoes, and Nigeria carries the largest share of the global malaria burden. Young children and pregnant women face the greatest risk of severe illness and death. The national response relies on vector control with insecticide-treated nets, preventive treatment for pregnant women and children, and prompt testing and treatment of all suspected cases.

Table 11.1: Malaria indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Malaria prevalence by microscopy, children 6–59 months (%)	22.3	15.2	NMIS 2021; NMIS 2025
Malaria prevalence by RDT, children 6 –59 months (%)	39.6	35.1	
Children under 5 with fever in the 2 weeks before the survey (%)	37[a]	25.2	
Severe anaemia (Hb <8.0 g/dl), children 6–59 months (%)	8.0	Data not available	
Households with at least one ITN (%)	56.0	53.7	
De facto population with access to an ITN (%)	43.1	40.0	
Children under 5 who slept under an ITN, households with ≥1 ITN (%)	64.3	72.4	
ANC from a skilled provider, most recent live birth in past 2 years (%)	63[a]	66.3	
IPTp: 3+ doses of SP/Fansidar (%)	31.0	33.1	
Febrile children diagnosed with malaria by a healthcare provider (%)	Data not available	34.6	
Febrile children who took an antimalarial and received an ACT (%)	73.9	65.7	
Routine Measure (Facility-based)			
Suspected malaria cases receiving a parasitological test (number)	35,958,729	30,997,421*	

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Confirmed malaria cases receiving first-line antimalarial treatment (number)	24,544,878	20,2589,261 (about 96% of positives given ACT)*	
Persons testing positive for malaria on parasitological test (%)	70.3%	68% (20,998,151 positive of 30,997,421 tested, derived)*	
Persons testing positive who received antimalarial treatment (%)	97–98% of positives	96%*	
Patients with severe malaria receiving injectable artesunate (%)	91.6%	90% treated with artesunate injection*	
Pregnant women receiving 3 doses of SP-IPT (%)	51.3%	41.4%*	
Pregnant women attending ANC who received 3+ doses of IPTp (number)	3,364,257	2,170,409*	
Long-lasting insecticidal nets distributed to target groups (number)	3,163,772	2,423,343*	
Children 3–59 months receiving a full course of SMC (number)	11,711,462 (2024 campaign)	28,748,917	2026 SMC report
Children under 2 receiving the complete 4-dose malaria vaccine schedule (%)	11%	18%	Malaria Vaccine Implementation Review Meeting presentation 14 - 15th September 2026 - NPHCDA
Eligible children under 2 receiving at least 3 doses of malaria vaccine (%)	48%	31%	Malaria Vaccine Implementation Review Meeting presentation 14 - 15th September 2026 - NPHCDA
Persons with confirmed uncomplicated malaria (number)	29,581,068	20,998,151*	

*DHIS2,(FASTR Adjusted, Jan to Sept 2026)

Nigeria Malaria indicator survey shows a consistent decline in all three malaria-related indicators between 2021 and 2025. Malaria prevalence declined by both microscopy and RDT, while the proportion of children under five experiencing fever also decreased, suggesting an overall improvement in malaria-related outcome (Figure 106)

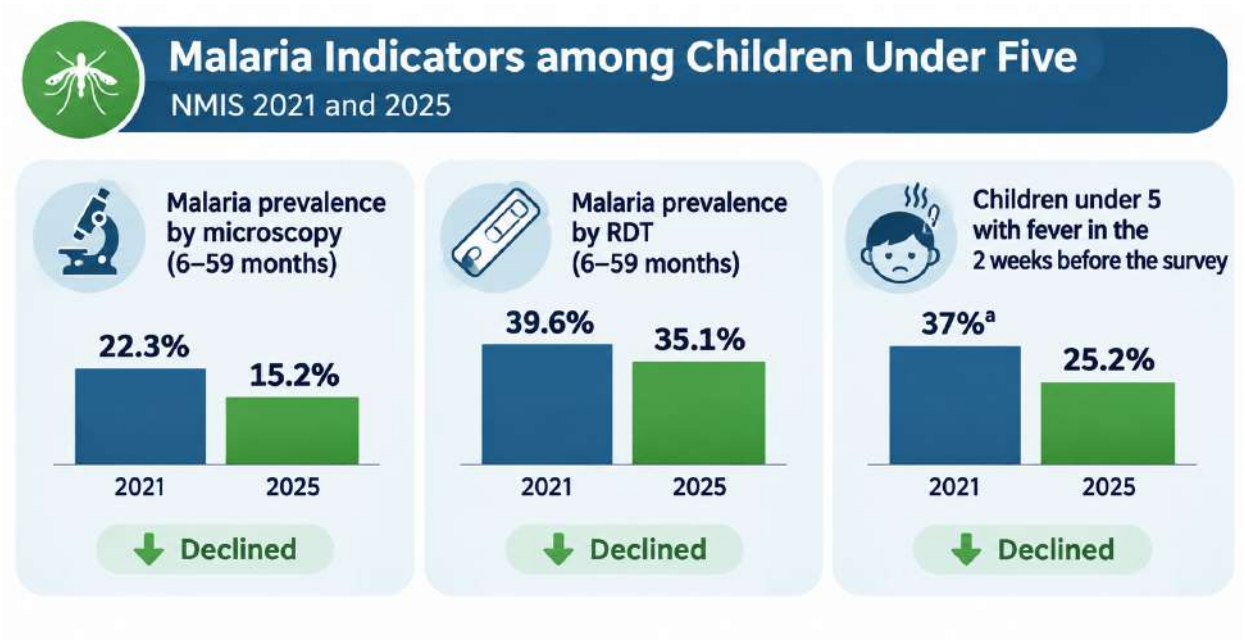


Figure 106: Malaria indicators among children under five, NMIS 2021 and 2025

Malaria testing declined in 2026 compared with 2025, with a slight reduction in test positivity. Most confirmed cases received ACT treatment, while injectable artesunate coverage among patients with severe malaria remained high. Testing peaked in the second quarter, with the North West accounting for the largest share, driven by Katsina, Kano and Kaduna (Figures 107–110).

Malaria testing, positive cases and ACT treatment rose from 2024 to 2025 but declined in 2026, with January–September about 6–9% below 2025. The seasonal pattern persisted, and ACT treatment continued to cover 97–98% of positive cases.

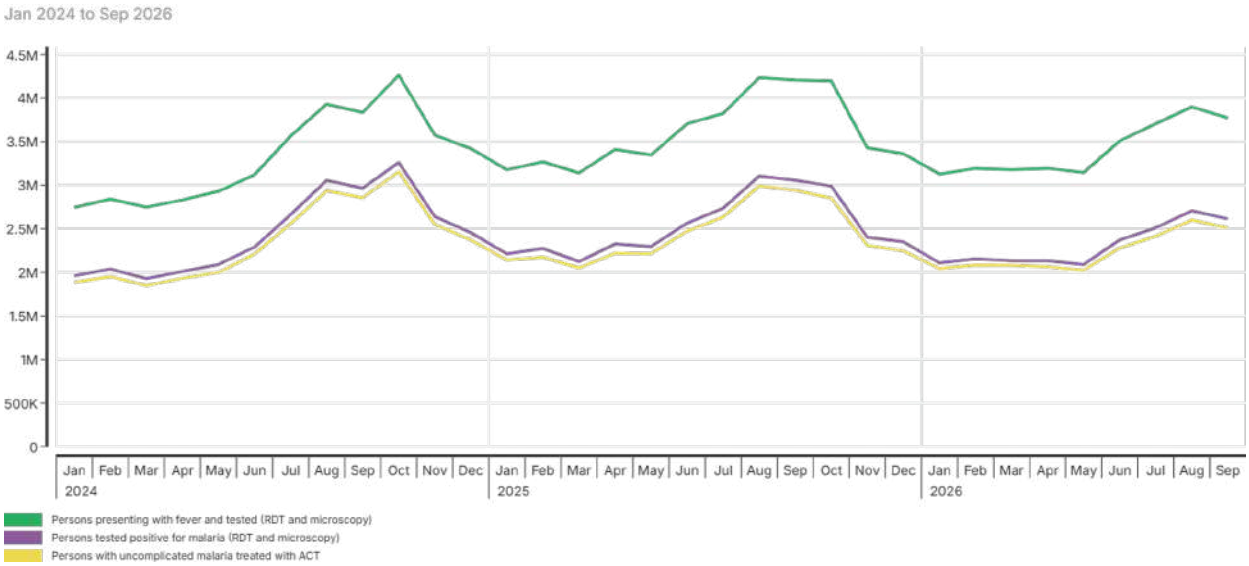


Figure 107: Persons with fever tested, tested positive and treated with ACT, Jan 2024–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Testing increased slightly from Q1 to Q2 2026, with positivity stable at about 67%. ACT treatment remained high, at around 98% of positive cases.

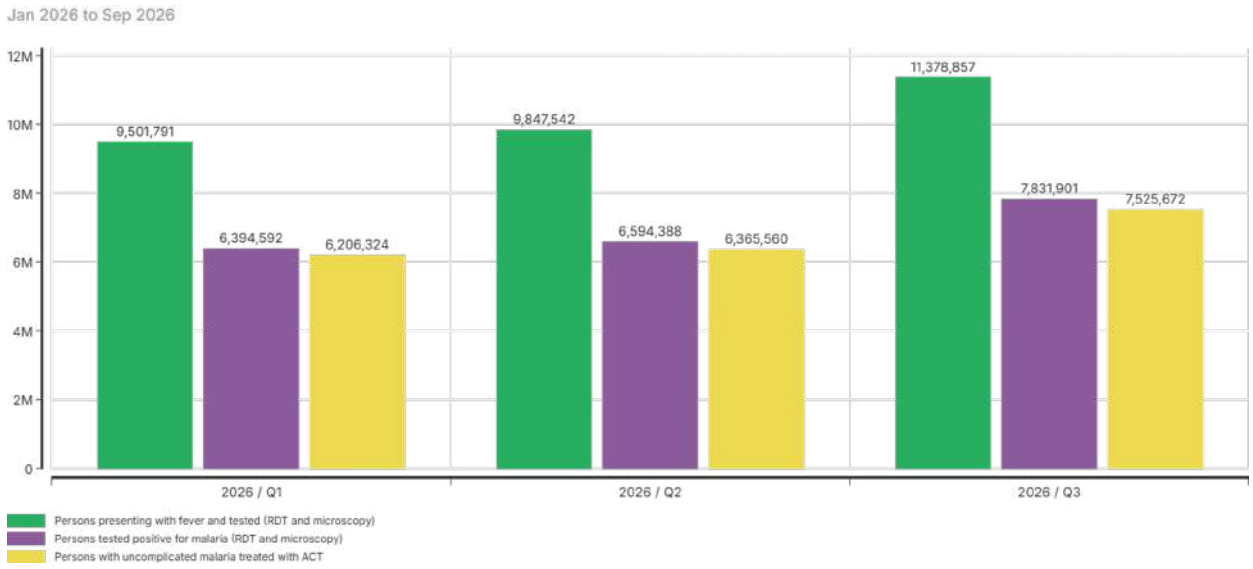


Figure 108: Malaria testing, positivity and ACT treatment by quarter, 2026

Source: DHIS2 (FASTR Adjusted)

The North West accounted for nearly half of malaria testing and recorded the highest positivity (about 70%). Positivity was lowest in the South West (about 50%).

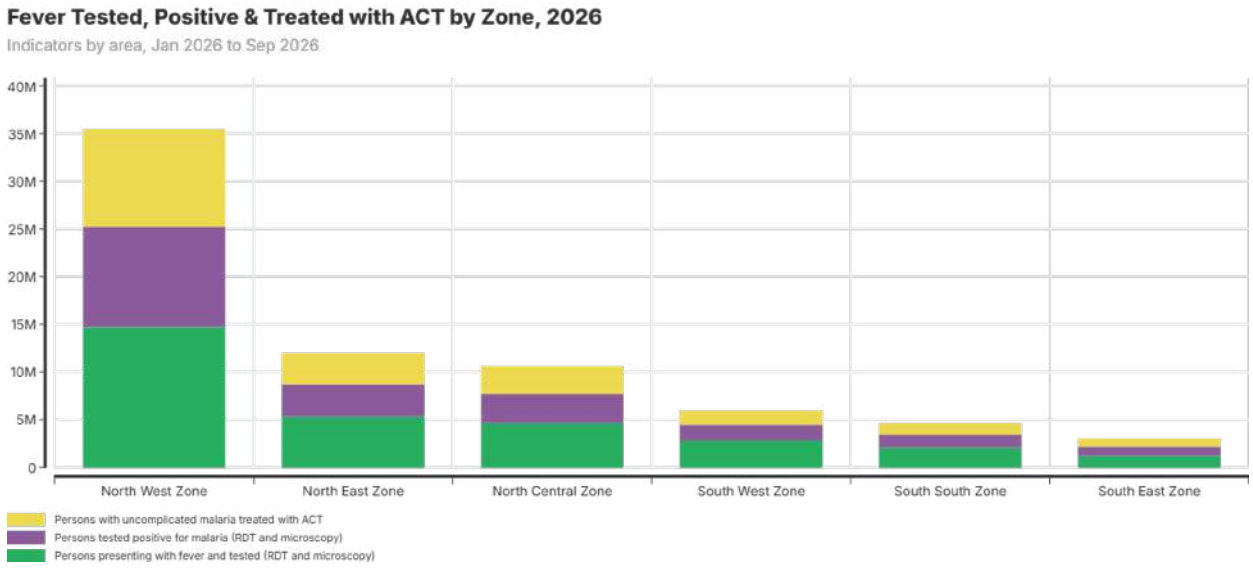


Figure 109: Persons with fever tested, tested positive and treated with ACT by geopolitical zone, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Katsina, Kano and Jigawa recorded the highest malaria testing and treatment volumes. Most southern states reported much lower volumes (Figure 110). Confirmed uncomplicated malaria cases peaked in the third quarter of 2024 and 2025, with lower volumes recorded in the first half of 2026. ACT treatment among clinically diagnosed cases also declined, alongside a decreasing proportion relative to confirmed cases.

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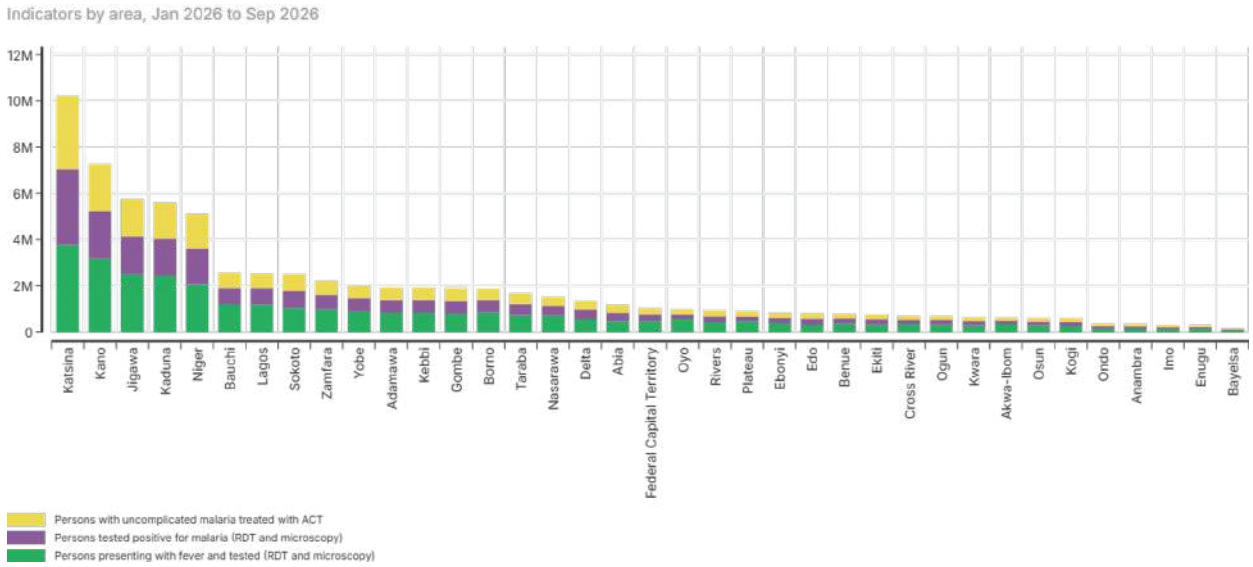


Figure 110: Persons with fever tested, tested positive and treated with ACT by state, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Coverage of three-dose SP-IPTp declined in 2026 compared with 2025, despite relatively stable monthly uptake (Figure 111). Distribution of long-lasting insecticidal nets also decreased, while seasonal malaria chemoprevention expanded its reach. IPTp3 delivery remained relatively steady across the first two quarters of 2026, with the North West accounting for the largest share of recipients, driven by Kano, Kaduna and Jigawa (Figures 112–113).

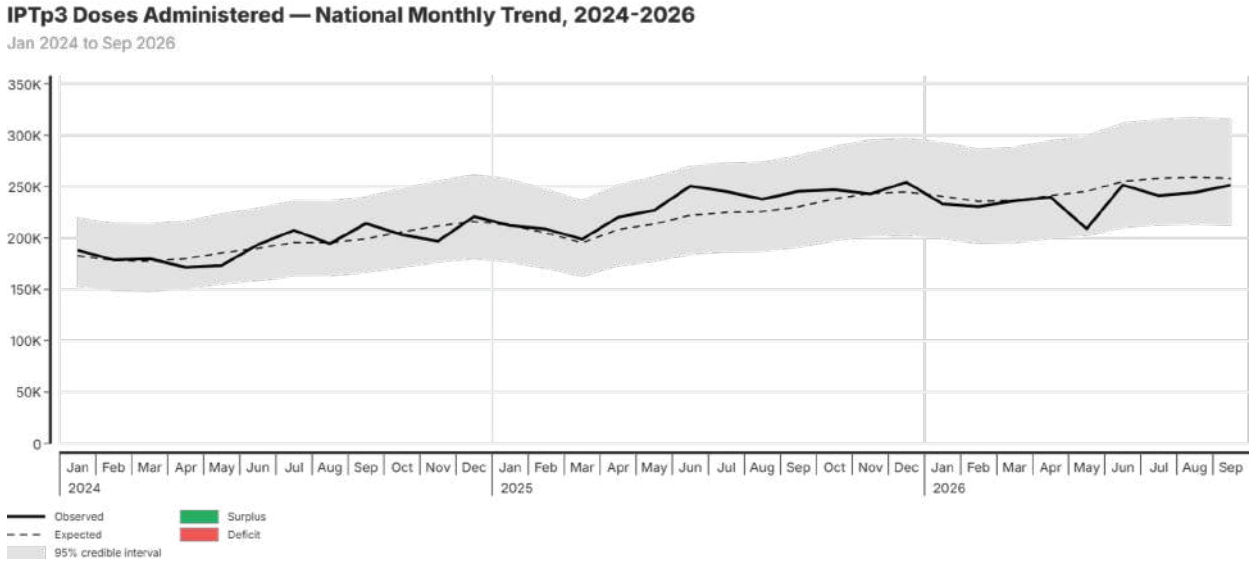


Figure 111: Pregnant women attending ANC who received 3+ doses of IPTp, Jan 2024–Sept 2026

Source:*DHIS2 (FASTR Adjusted)*

The North West accounted for 41% of IPTp3 recipients, followed by the North East and North Central. The South East recorded the fewest.

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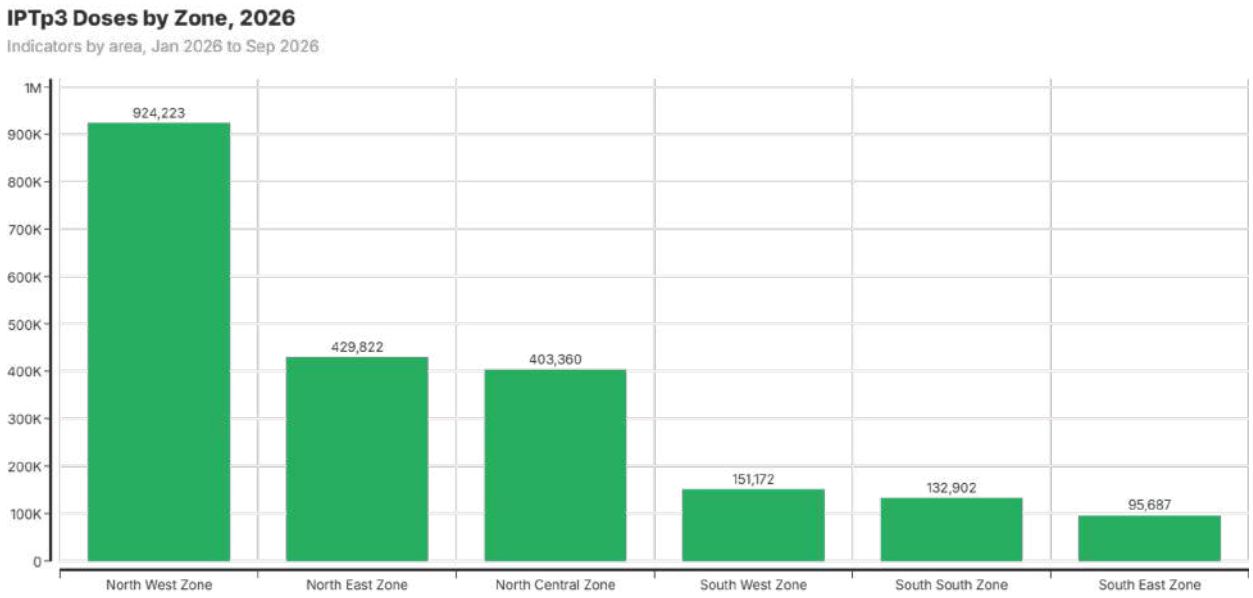


Figure 112: IPTp3 recipients by geopolitical zone, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

Kano, Kaduna and Jigawa recorded the highest IPTp3 uptake, while Ekiti and Bayelsa recorded the lowest.

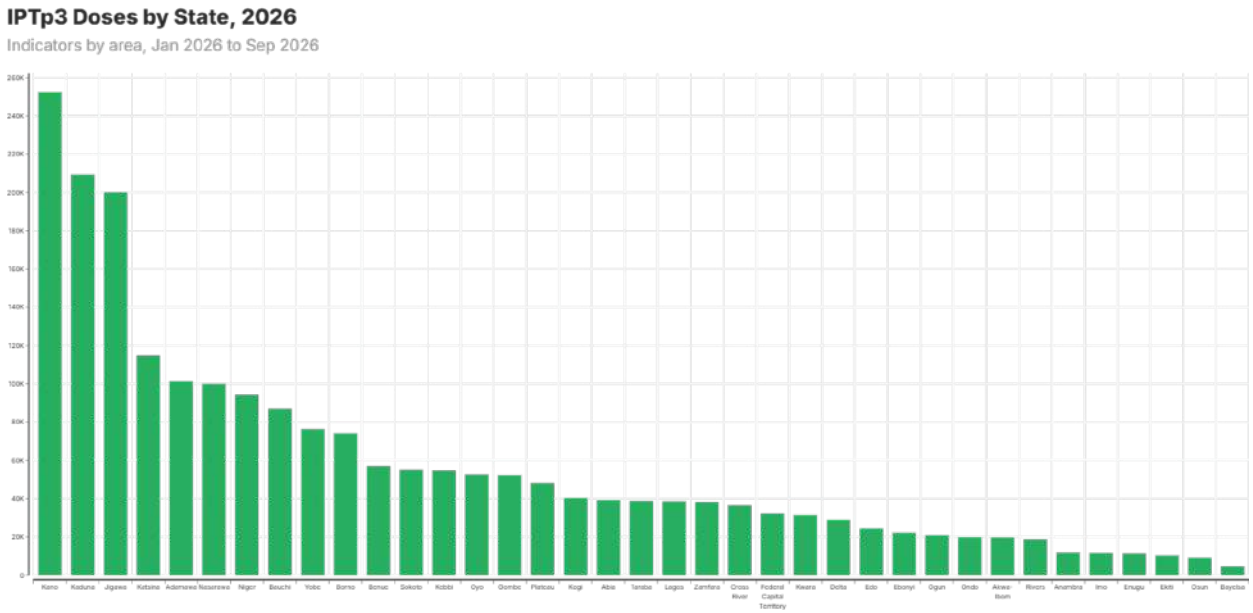


Figure 113: IPTp3 recipients by state, Jan–Sept 2026

Source: DHIS2 (FASTR Adjusted)

The population-based survey estimates show gradual improvement in IPTp coverage between 2018 and 2025–26, particularly among women receiving at least one and two doses. However, progress in completing three or more doses remained very minimal. Regional disparities persist, with the South East recording the highest IPTp3 coverage and the North West the lowest (Figures 114 and 115).

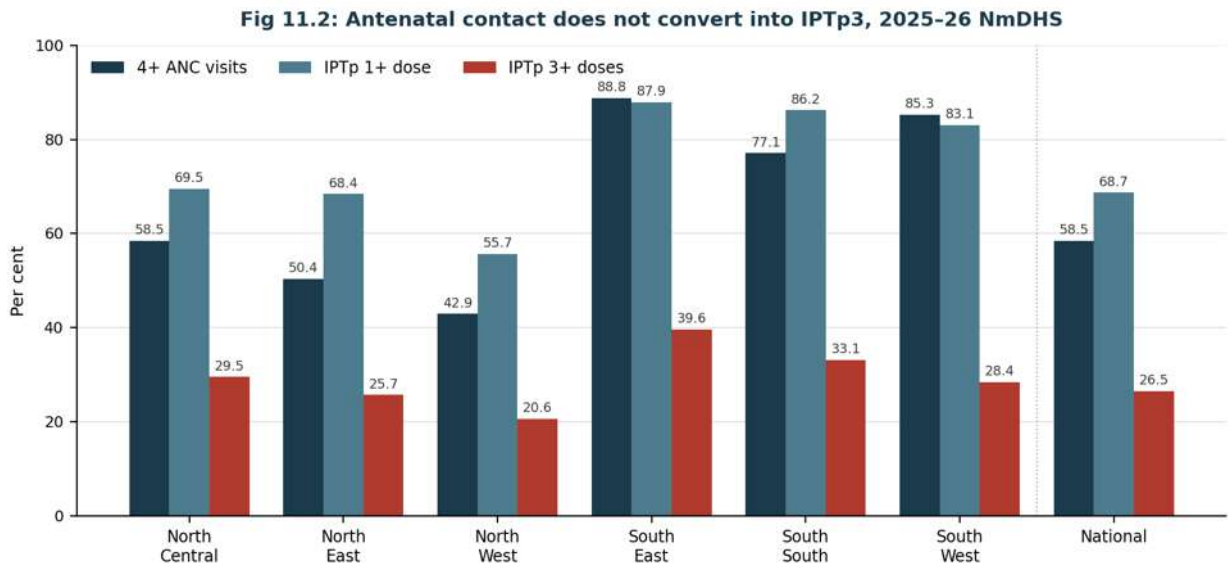


Figure 114: IPTp3 Uptake Trend in pregnant women

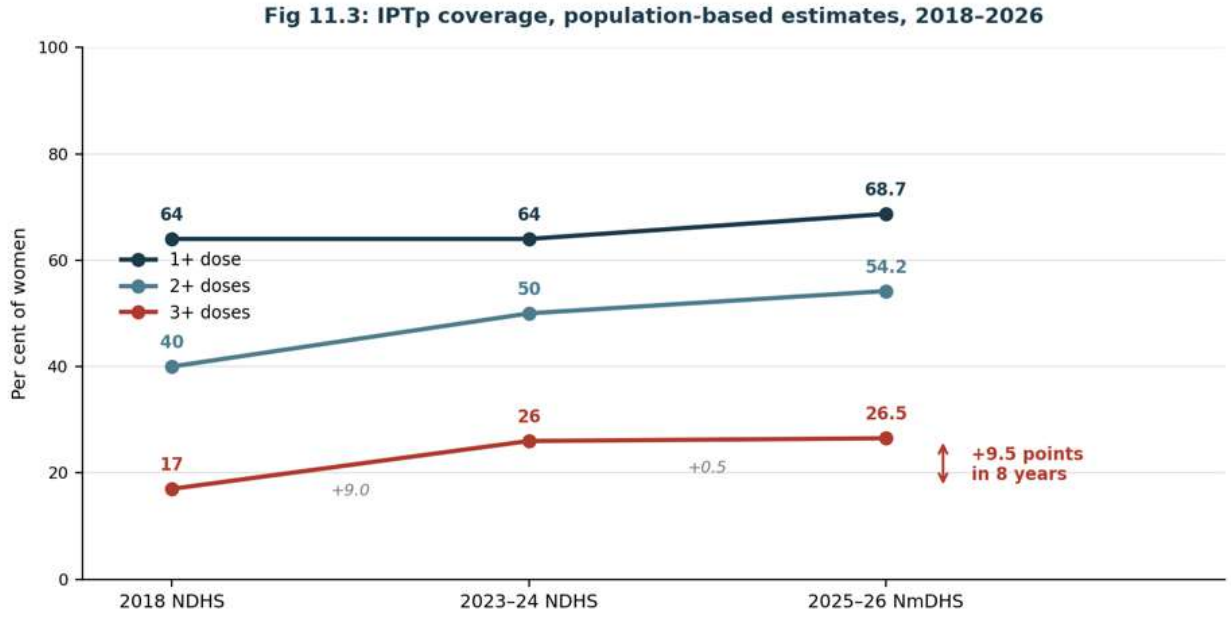


Figure 115: IPTp coverage, population-based estimates, 2018–2026

Malaria testing and treatment remained substantial, with approximately 36 million suspected cases receiving parasitological testing and 24.5 million confirmed cases receiving first-line treatment. The average test positivity rate was 70.3%, indicating that about seven in every ten suspected cases tested positive, with the highest positivity recorded in August (Figure 116).

Malaria vaccine uptake among eligible children under two years showed that children receiving at least three doses of malaria vaccine decreased from 48% in 2025 to 31% in 2026, while children completing the four-dose malaria vaccine schedule increased from 11% in 2025 to 18% in 2026 (NPHCDA, 2026).

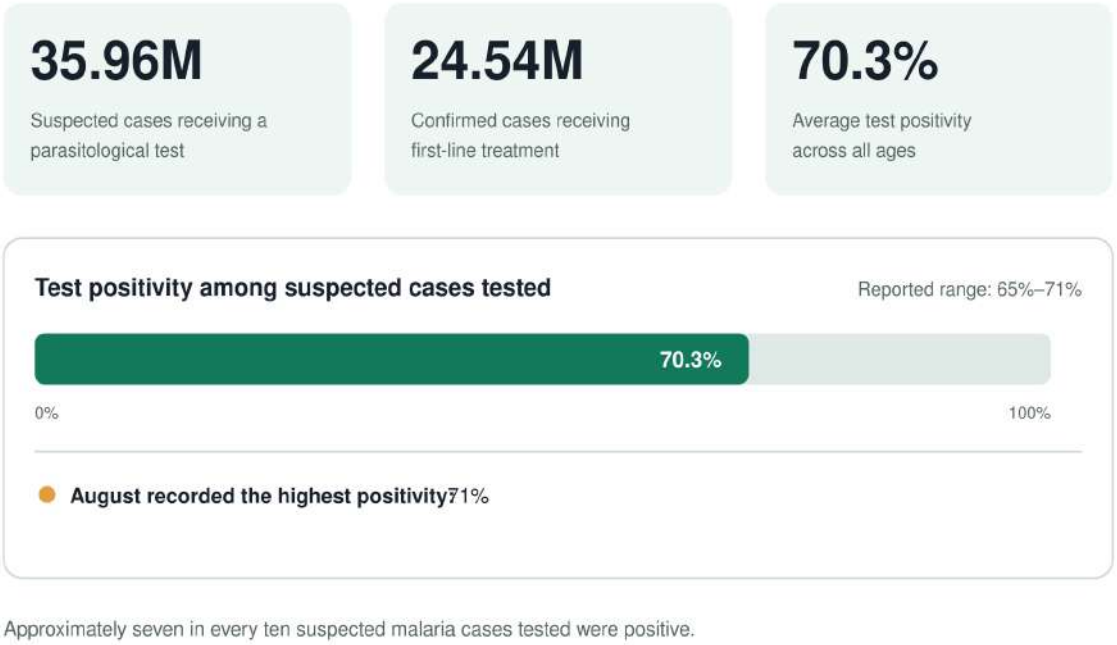


Figure 116: Malaria Testing and Treatment

11.2 HIV/AIDS — Treatment Coverage and Viral Suppression

Nigeria has a substantial HIV burden, with its national response guided by the UNAIDS 95-95-95 targets for diagnosis, treatment and viral suppression. Prevention of mother-to-child transmission (PMTCT) services aim to prevent HIV transmission from mothers to infants through testing, treatment and viral suppression. This section presents progress across the HIV treatment and PMTCT cascades (Figures 117–120).

Table 11.2: HIV/AIDS treatment and PMTCT indicators

Core Indicator	Baseline	2025 Achievement	2026 Achievement	Data Source
New HIV cases detected (number)	124,324	108,230	70,356	NDARS/NDR
New cases of advanced HIV disease (number)	22,699	19,747	20,162	NDARS/NDR
ART coverage (%)	86%	78%	82%	NDARS/NDR
Viral suppression among PLHIV on ART (%)	96%	94%%	95%	NDARS/NDR
HIV testing coverage among pregnant women (%)	80%	83%	93%	NDARS/NDR
ART coverage among pregnant women (%) by Population i.e estimated Pregnant women needing PMTCT	45%	61%%	40%	NDARS/NDR
ART coverage among pregnant women (%) by programme i.e HiV positive Pregnant Women identify.	76%	98%	83%	NDARS/NDR
Pregnant and breastfeeding women living with HIV with suppressed viral load (%)	95%	95%	79%	NDARS/NDR

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Core Indicator	Baseline	2025 Achievement	2026 Achievement	Data Source
HIV-exposed infants with negative final outcome status (%)	1.4%	1.1%	1.2%	NDARS/NDR
HIV prevalence, total population (%)	1.30%	1.3%	1.30%	NAIIS 2018
HIV prevalence, female / male (%)	1.30%	1.7% / 1.3%	1.30%	NAIIS 2018

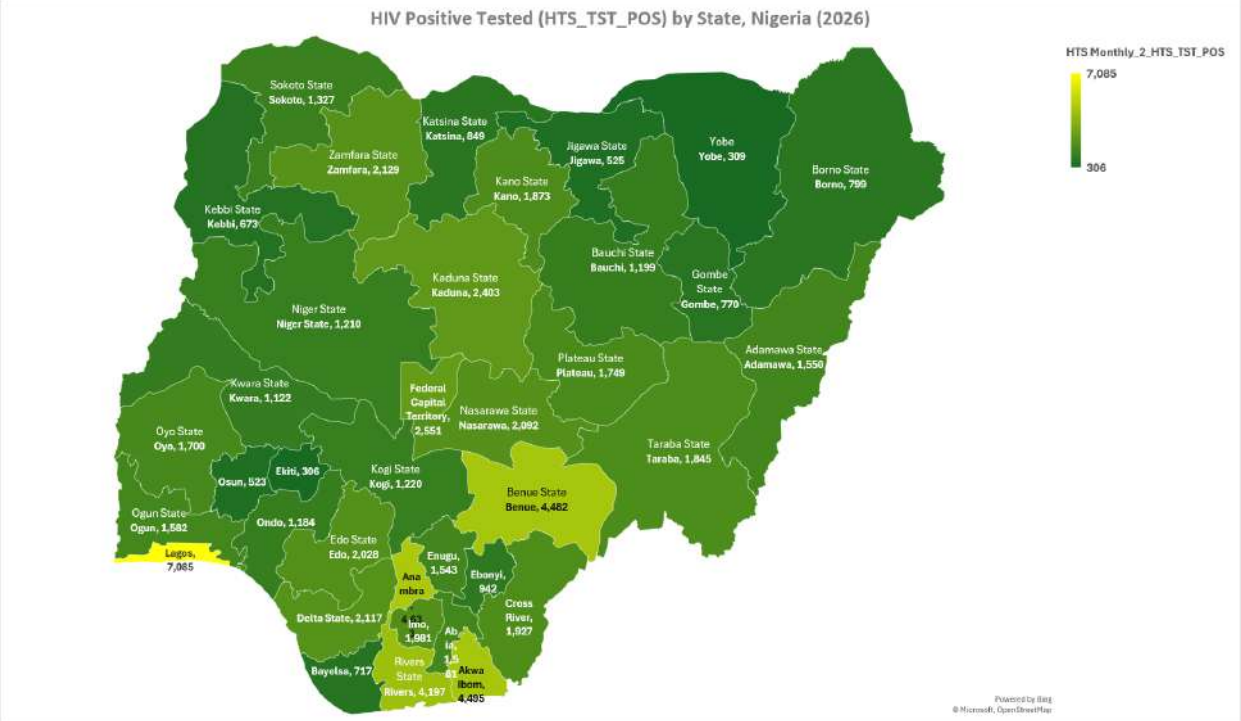


Figure 117: HIV-positive tests by state, 2026. Source: NDARS, 2026

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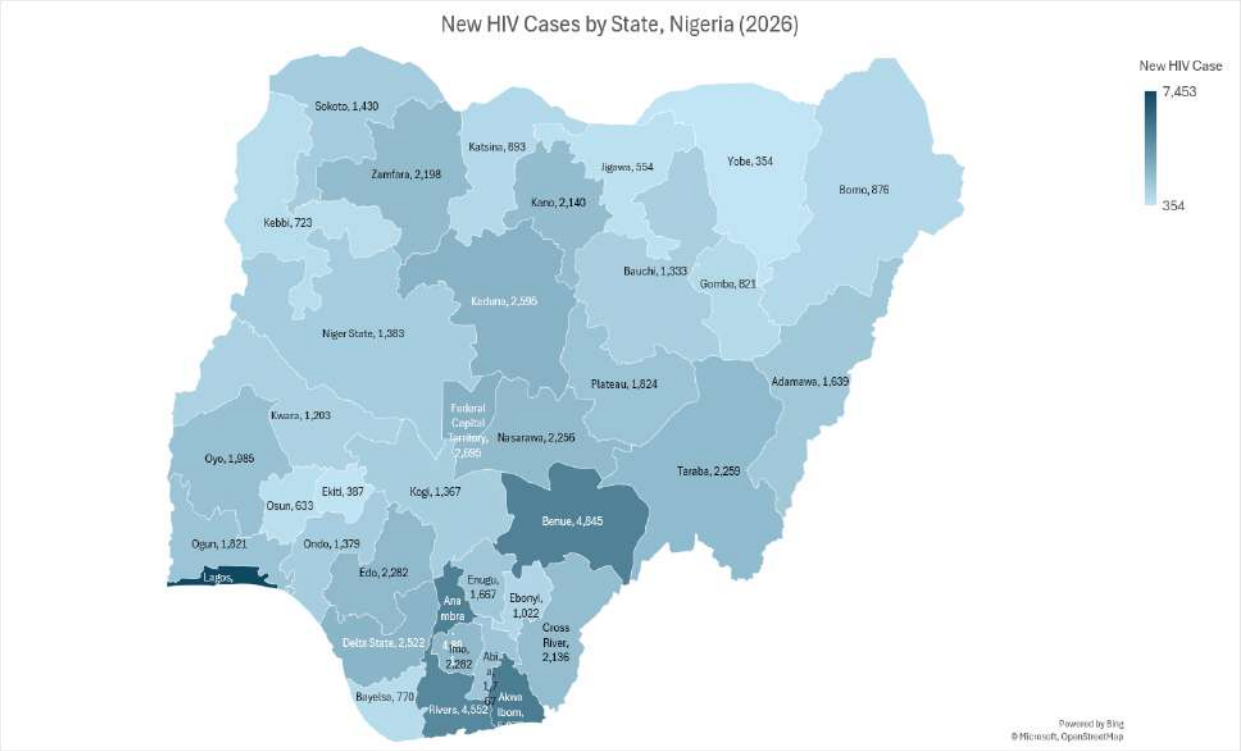


Figure 118: New HIV cases by state, 2026. Source: NDARS, 2026



Figure 119: Newly initiated on ART by state. Source: NDARS, 2026

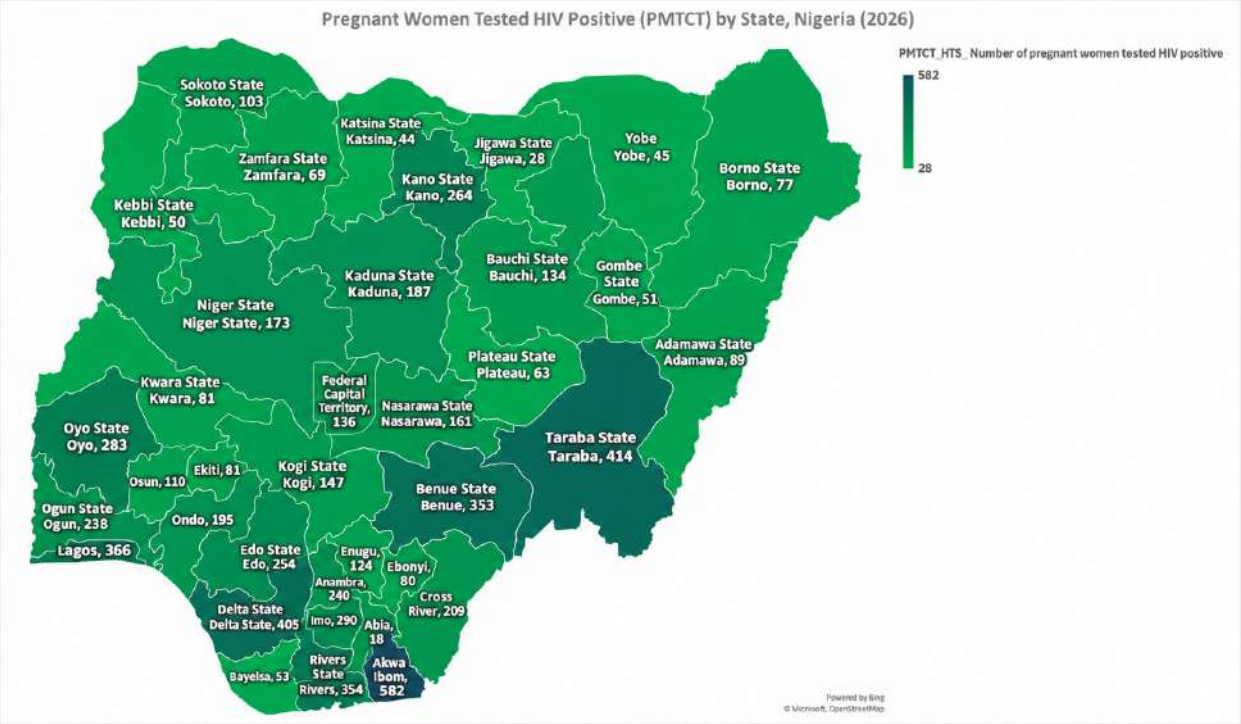


Figure 120: Pregnant women tested HIV positive (PMTCT) by state, 2026. Source: NDARS, 2026

11.3 Tuberculosis and Leprosy — Case Detection, Treatment Success, Trends

Nigeria remains one of the countries with the highest tuberculosis (TB) burden in Africa and remains among the highest-burden countries globally. The National Tuberculosis, Leprosy and Buruli Ulcer Control Programme (NTBLCP) coordinates case detection, treatment, TB preventive therapy and TB/HIV collaborative services, alongside leprosy and Buruli ulcer control. This section presents progress in case detection, treatment outcomes and disease trends.

Table 11.3: Tuberculosis and leprosy indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
TB incidence (per 100,000 population)	219	Data not available	WHO Global TB Report 2025 estimate
TB treatment coverage (%)	79%	Data not available	
TB cases notified (number)	332,466	213,700 (45.8% of target)	
TB treatment success rate (%)	92%	95% in Q2	
TB patients who know their HIV status (number and %)	324,320 (98%)	97% in Q2[2]	
ART coverage for TB/HIV co-infection (%)	92%	93% in Q2	
Contacts of TB patients who began preventive therapy (number)	356,371	263,249 (51.4% of target)	
TPT coverage, child contacts under 5 years (number)	70,452	33,006 (34.8% of target)	
DR-TB patients successfully treated among those notified (%)	81%	87% in Q2	

Core Indicator	2025 Achievement	2026 Achievement	Data Source
LGAs with functional WHO-recommended molecular rapid diagnostic platforms (number and %)	651 (84%)	774 (100%)	
Leprosy cases notified (number)	1,412	505 (20.2% of target)	
Buruli ulcer cases notified (number)	302	170 (48.6% of target)	
Leprosy grade 2 disability cases reported (%)	6%	9%	

11.4 Viral Hepatitis B and C — Screening, and Treatment

Viral hepatitis B and C are major causes of chronic liver disease, cirrhosis and liver cancer. Nigeria faces a substantial hepatitis burden, making early detection, hepatitis B vaccination and access to treatment essential to achieving the 2030 elimination targets. This section presents progress in screening, test positivity and treatment for hepatitis B and C across reporting states (Figure 121).

Table 11.4: Viral hepatitis B and C screening and treatment

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Hepatitis B positivity rate (%)	8.3%	7.8%	NDARS
Hepatitis C positivity rate (%)	3.6%	4.0%	
Persons reactive to hepatitis B virus (number)	14930	20,794	
Persons newly started on hepatitis B treatment (number)	653	845	
Hepatitis B patients who missed treatment (%)	Data not available	Data not available	
Jurisdictions reporting viral hepatitis data (number of 37)	25	27	
Highest state HBV positivity rate (%)	Data not available	Data not available	
Persons screened for hepatitis B (number)	179,299	264,976	
Persons newly started on hepatitis C treatment (number)	Data not available	Data not available	

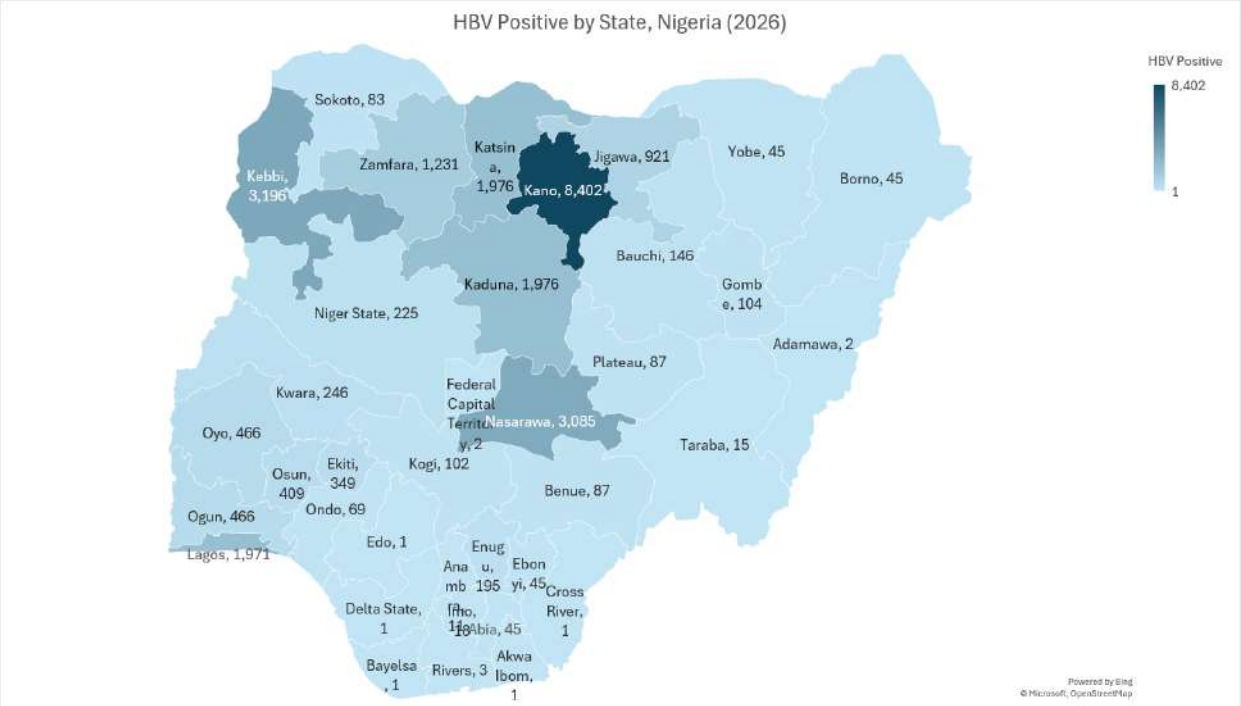


Figure 121: Hepatitis B Virus positive by state. Source: NDARS, 2026

11.5 Neglected Tropical Diseases (NTDs)

Neglected tropical diseases (NTDs) are a group of preventable infections that mainly affect poor and rural communities, and Nigeria carries one of the largest NTD burdens in Africa. Diseases such as lymphatic filariasis, onchocerciasis, trachoma, schistosomiasis and soil-transmitted helminthiasis are controlled largely through mass drug administration until transmission is interrupted. Programmes also provide care for people living with complications such as hydrocele and lymphoedema.

Table 11.5: Neglected tropical diseases indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Hydrocele cases operated (%)	79%	78%	Programme report
Lymphoedema cases cared for (%)	75%	79.3%	
LGAs no longer in need of lymphatic filariasis treatment (%)	65%	74.8	WHO Joint Application Package (JAP)
LGAs no longer in need of trachoma treatment (%)	84%	87%	JAP
States no longer in need of onchocerciasis treatment (%)	34%	52%	
States no longer in need of schistosomiasis treatment (%)	0%	0%	
States no longer in need of soil-transmitted helminth treatment (%)	0%	0%	

Chapter 12

NON-COMMUNICABLE DISEASES AND MENTAL HEALTH



12.1 Cardiovascular Disease, Hypertension and Diabetes

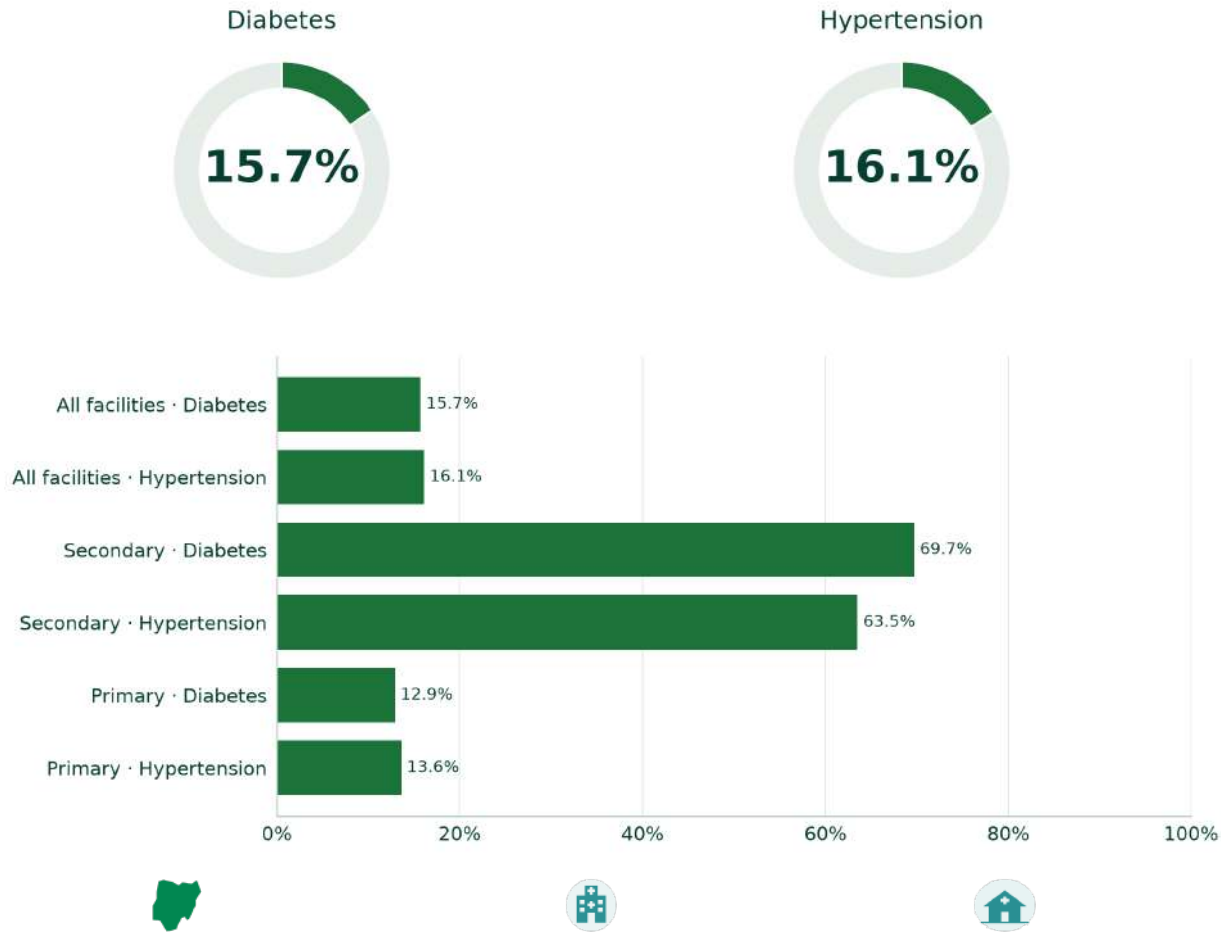
Non-communicable diseases (NCDs), including cardiovascular disease, hypertension and diabetes, are a growing cause of illness and death in Nigeria. Many people with these conditions remain undiagnosed until complications such as stroke, heart failure or kidney disease develop. Early detection, routine screening and continuous treatment at primary and secondary levels of care are key to reducing their burden.

Table 12.1: Cardiovascular, hypertension and diabetes indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
New cases of hypertension (number)	995,318	796,779*	
New cases of diabetes (number)	274,587	211,563*	
New hypertension cases, highest-burden zone (number)	~459,000 (Northwest; 2020: ~367,000)	390,505 (North West)*	
Facilities screening adults for raised blood pressure (%)	15.7%	15.7%	NHFS, 2025
Patients on treatment for hypertension with controlled blood pressure (%)	Data not available	Data not available	

*DHIS2 (FASTR Adjusted, Jan-Sep)

The availability of cardiovascular and diabetes services in public health facilities remains limited nationally. Only 15.7% of public health facilities provided diabetes services, while 16.1% offered hypertension services. Service availability was substantially higher in secondary facilities than in primary health facilities (NHFS, 2025; Figure 122).



Health facilities providing hypertension and diabetes services

Figure 122: Percentage of public health facilities that provide diabetes and hypertension services, national. Source: NHFS, 2025

Service availability varied across geopolitical zones, with hypertension services more available in the North Central and Southwest, while diabetes services were more available in the Southwest and North Central (Figure 123)

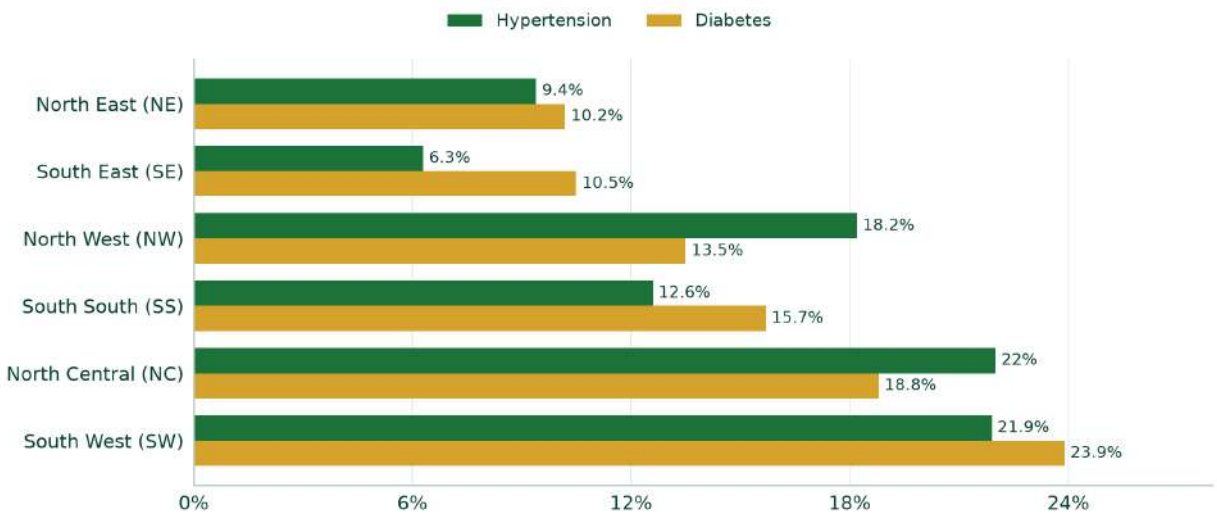


Figure 123: Percentage of Public Health Facilities that Provide Diabetes and Hypertension Services by Zones. Source: (NHFS, 2025)

At the state level, Benue recorded the highest proportion of health facilities providing hypertension services (53.3%), while Cross River recorded the lowest (2.2%), based on the combined figures for primary and secondary health facilities (Figure 124). For diabetes services, Lagos had the highest proportion (56.1%), while Cross River again recorded the lowest (2.2%), with both figures combining primary and secondary health facilities (Figure 125).

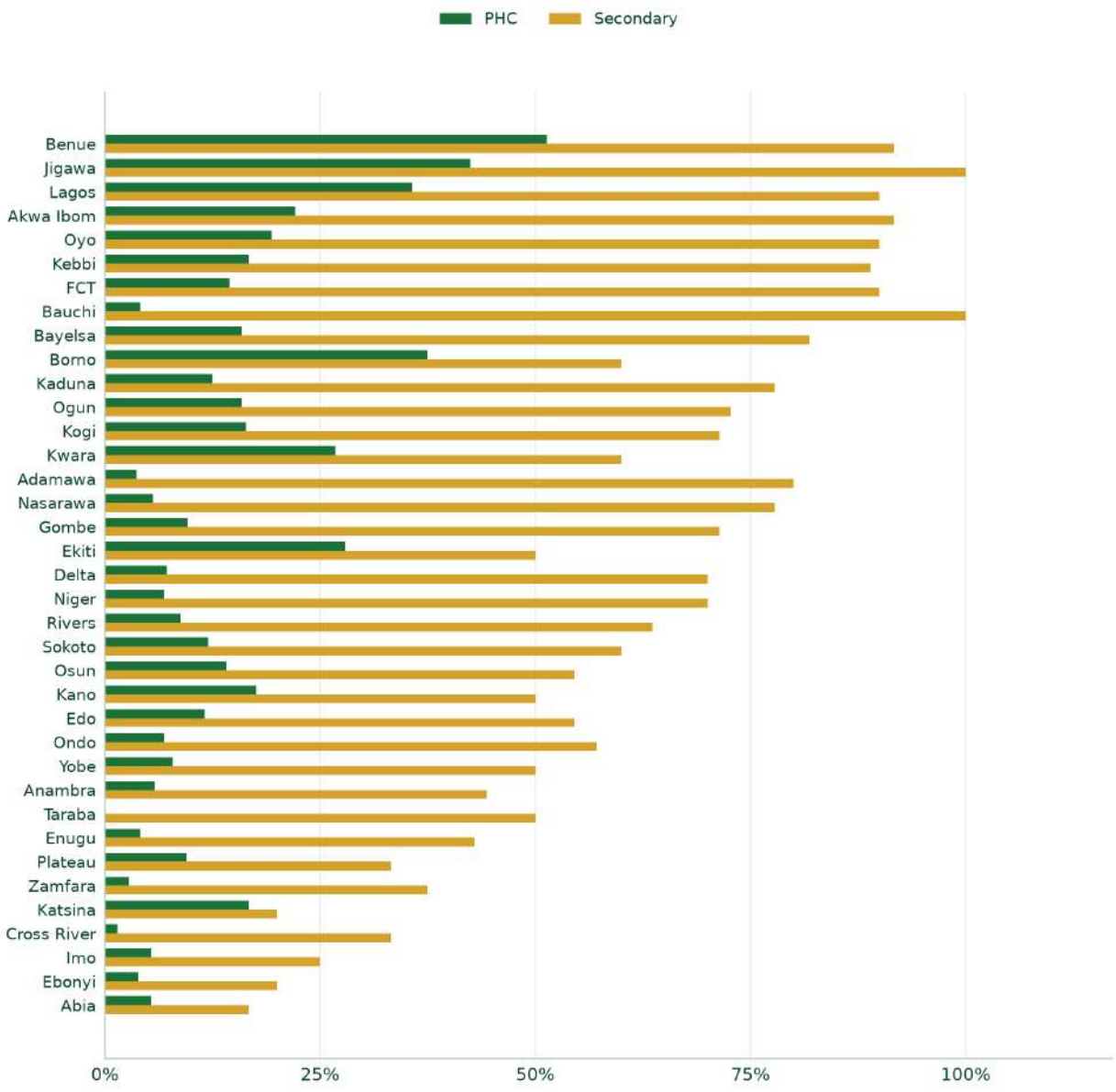


Figure 124: Percentage of Public Health Facilities that Provide Hypertension Services by State, and Facility Type

Source: NHFS, 2025

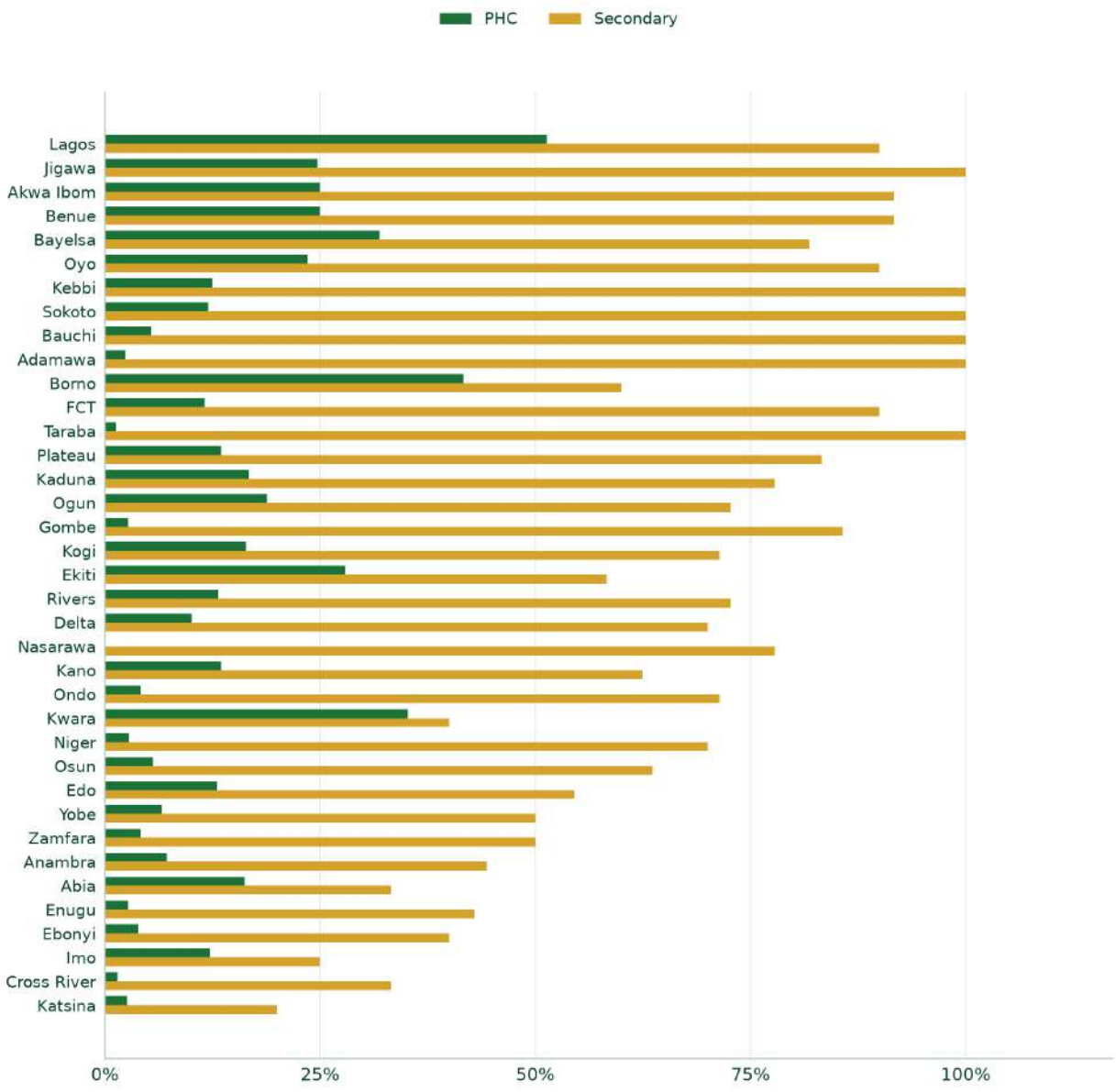


Figure 125: Percentage of Public Health Facilities that Provide Diabetes Services by State, and Facility Type. Source: (NHFS, 2025)

Based on administrative data, health facilities reported about 1.13 million new hypertension cases and about 331,000 new diabetes cases between January and September 2026. Both were slightly lower than in the same period of 2025 (Figure 126).

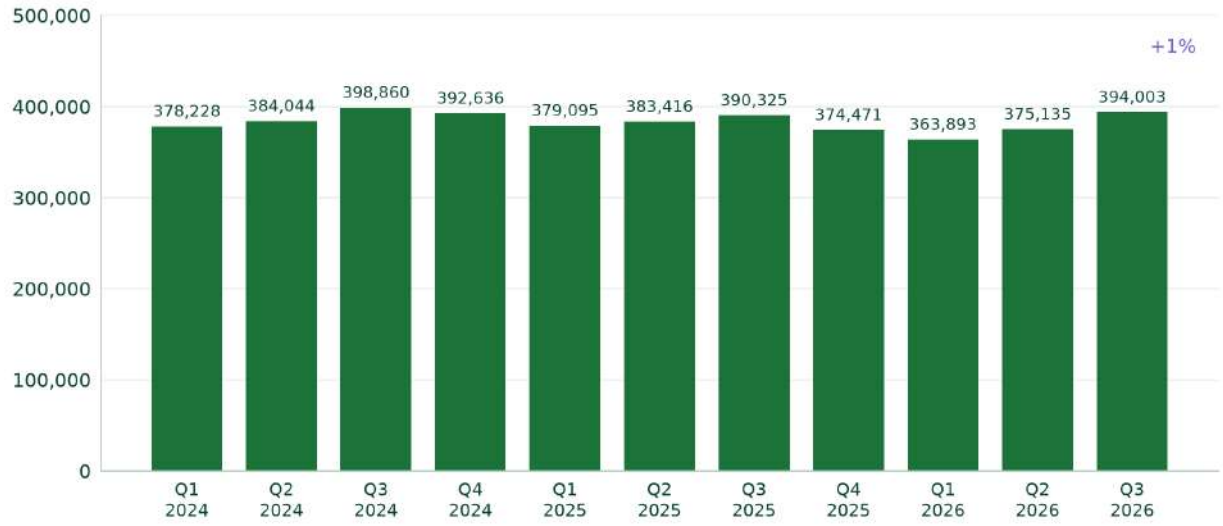


Figure 126: New Hypertension cases by quarter, 2026 (Q3 2026 covers Jul–Sep)

Source: DHIS2 (FASTR Adjusted)

Diabetes cases have declined steadily since 2025, with every quarter below the same quarter of the previous year (Figure 127).

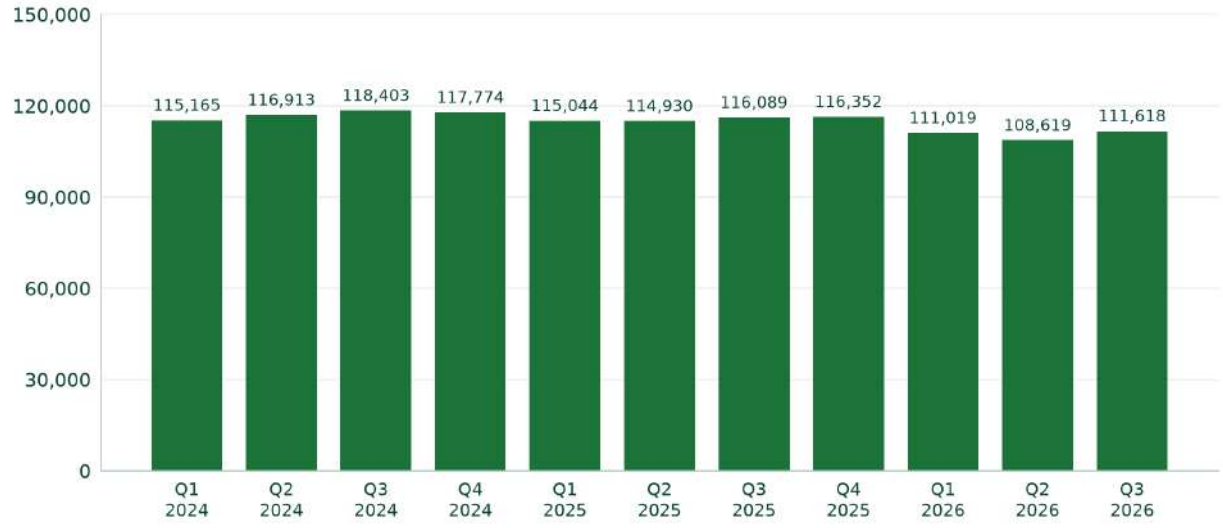


Figure 127: New Diabetes cases by quarter, 2026 (Q3 2026 covers Jul–Sep). Source: DHIS2 (FASTR Adjusted)

However, these figures should be interpreted with caution, as they reflect cases detected and reported through the health system and may not represent the true national burden of these conditions. Gaps in screening, diagnosis, data reporting and completeness may result in underestimation of cases, particularly at the primary healthcare level. This concern is reinforced by the NHFS 2025, which found that only 16.1% of public health facilities offered hypertension services and 15.7% offered diabetes services.

Northwest reported the highest number of new hypertension and diabetes cases in 2025 and 2026 while South-east reported the list numbers in both years (Figures 128–130).

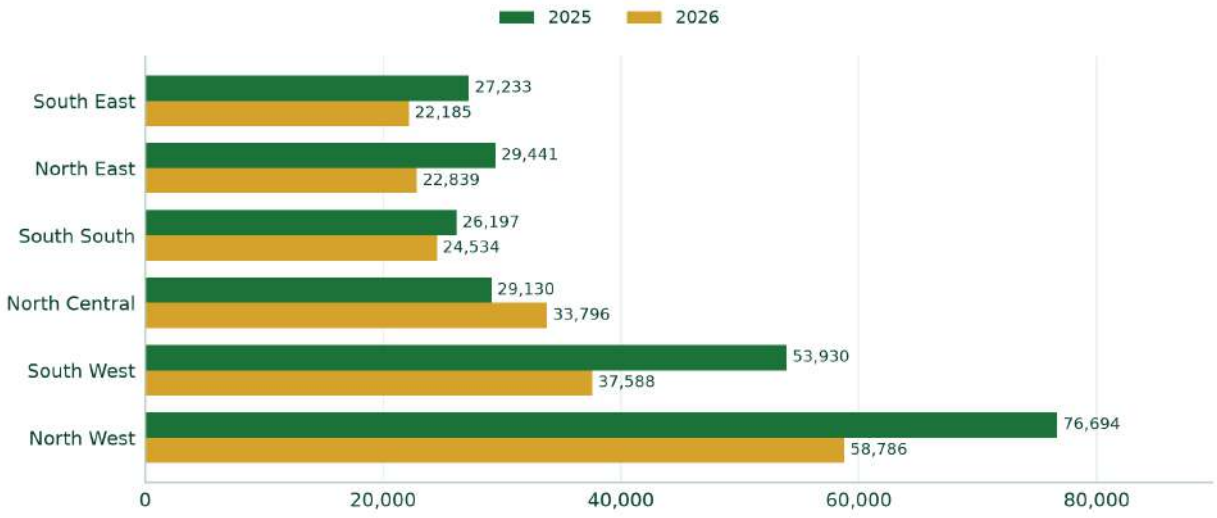


Figure 128: New diabetes cases (2025-2026). Source: DHIS2 (FASTR Adjusted)

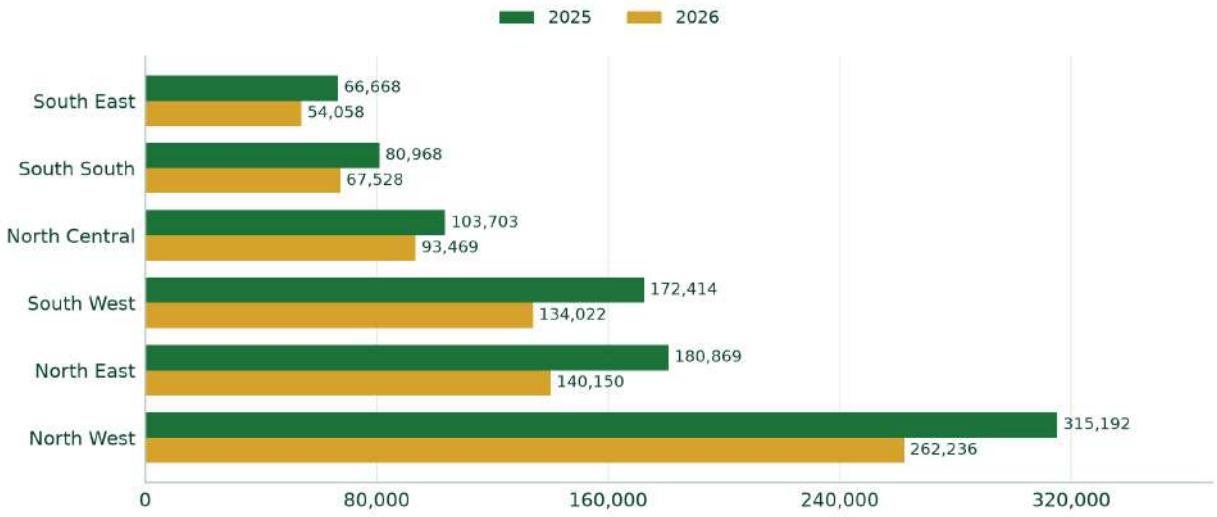


Figure 129: New hypertension cases (2025-2026). Source: DHIS2 (FASTR Adjusted)

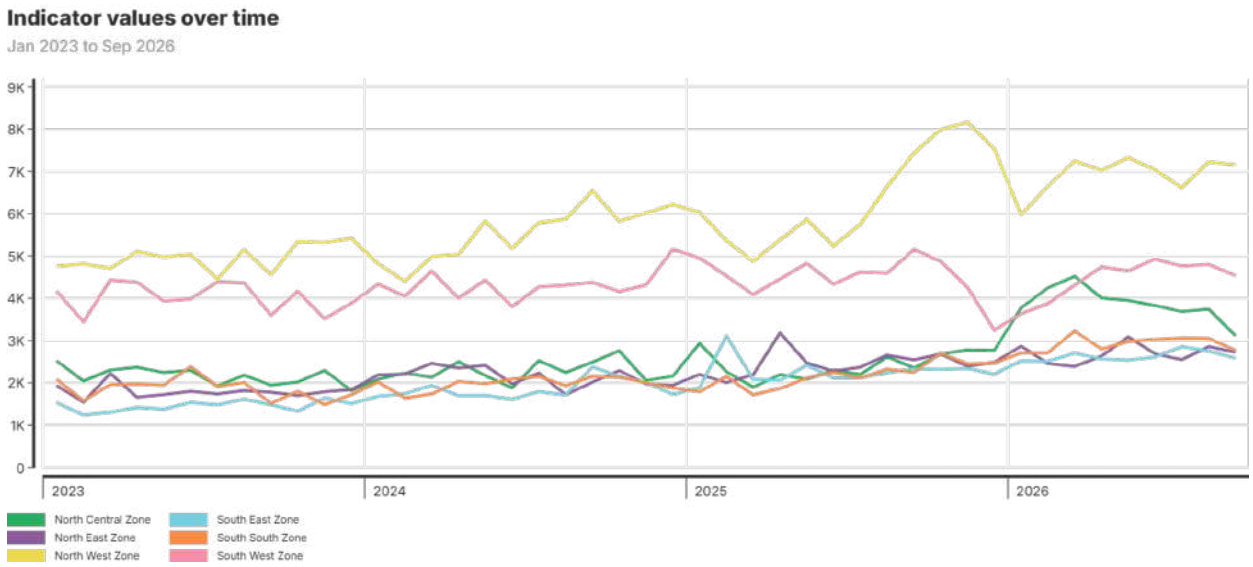


Figure 130: New diabetes cases by geopolitical zone, quarterly, 2020–2026

Source: DHIS2 (FASTR Adjusted)

Self-reported diagnosis and treatment in the 2025 NMDHS complement the administrative case counts. Among women and men aged 15–49, 8.1% and 3.0%, respectively, reported ever being told by a health care provider that they had hypertension; 1.1% of each group reported high blood sugar or diabetes. Among those previously diagnosed with hypertension, 56.7% of women and 54.0% of men were taking medication.

12.2 Cancer — Screening and Treatment

Cancer is a growing cause of illness and death in Nigeria, with breast, cervical and prostate cancers among the most common. The National Institute for Cancer Research and Treatment (NICRAT) leads national cancer control efforts, including cancer registration, while the Cancer Health Fund helps eligible patients cover treatment costs. Expanding screening, treatment capacity and financial protection is key to improving cancer survival (Figure 131).

Table 12.2: Cancer screening and treatment indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Cancer disease burden, registry period (number)	269,109 (2018–2022)	292,934	GLOBOCAN
Fully functioning cancer care facilities (number)	13 (9 government; 4 private)	40	Mapping of oncology resource in Nigeria report,,2025
% Women screened for cervical cancer	Data not available	Data not available	
New cases of cancer diagnosed state returns (number)	>5,000	134,395	NICRAT Cancer Burden Report
Diagnosed cancer patients accessing the Cancer Fund (%)	0%	21%	NCHF Dashboard
Cancer mortality rate	Pending in 2025	90795	GLOBOCAN

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Women screened for cervical cancer (number)	50	136	Preventive Oncology Clinic Programme Progress Report
Distribution of cancer centres of excellence across states (number)	6	7	Federal Ministry of Information and National Orientation

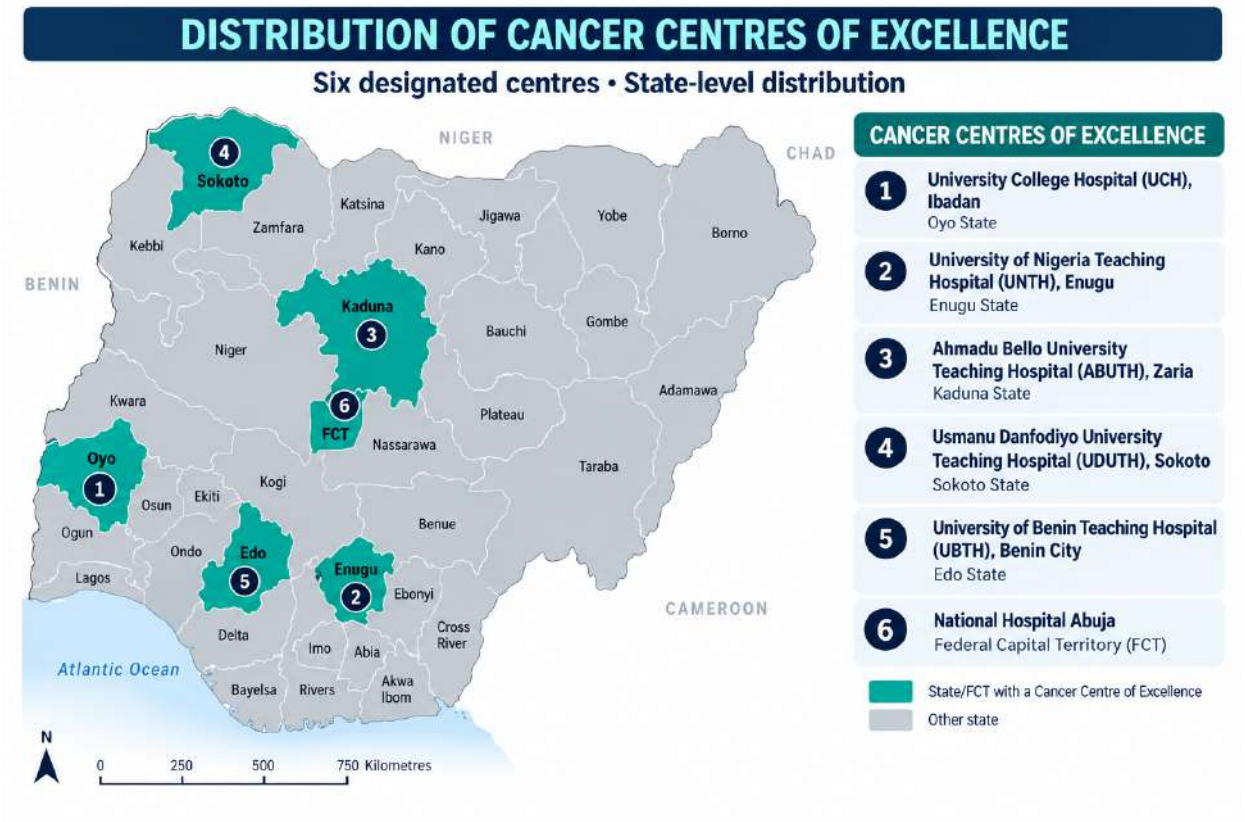


Figure 131: Distribution of cancer centres of excellence

12.3 Mental Health and Substance Use Disorders

Mental health and substance use disorders affect a large number of Nigerians, yet access to care remains limited and is concentrated in specialist neuropsychiatric hospitals. The National Mental Health Act 2021 provides a framework for protecting the rights of people with mental illness and integrating mental health into general health services. The WHO Mental Health Gap Action Programme (mhGAP) supports this integration by training primary health care workers to identify and manage common mental, neurological and substance use conditions.

Table 12.3: Mental health and substance use disorder indicators

Core Indicator	2025 Achievement	2026 Achievement
Percentage of Health facilities offering mental health services	Not Available	575
Percentage of Neuropsychiatric hospitals with a functional Mental Health Assessment Committee	0%	0%

Core Indicator	2025 Achievement	2026 Achievement
Percentage of Cases handled under the decriminalisation of attempted suicide provision	Data not available	0
Number of PHC facilities delivering mental health services under mhGAP	215	362
Number of Persons receiving treatment for substance use disorders	1200	1,989
Number of Health workers trained in basic mental health service delivery	198	254

12.4 Eye Care Services (NESHP)

Uncorrected refractive error and cataract are among the leading causes of visual impairment, yet both can be addressed through simple, cost-effective interventions such as spectacles and surgery. Integrating primary eye care into PHC services allows eye problems to be detected and managed closer to communities. The Effective Spectacle Coverage Initiative (Jigi Bola 2.0) supports this effort by training PHC workers and activating PHCs to deliver primary eye care.

Table 12.4: Eye care services indicators

Core Indicator	2025 Achievement	2026 Achievement
Total number of people screened for presbyopia	1,161,096	171,300 (67% of 2026 Target)
Total number of glasses dispensed	1,134,883	167,343 (68% of 2026 Target)
Total number of people with first pair of glasses	668,562	9,032 (N/A)
Total number of Primary Health Care Workers Trained on Primary Eye Care	2,116	783 (51% of 2026 Target)
Total number of Primary Health Care Centres Activated for Primary Eye Care	770	529 (69% of 2026 Target)

12.5 NCD Integration into Primary Health Care Services

Integrating NCD services into primary health care brings screening, diagnosis and long-term management closer to communities. Primary health care facilities are often the first point of contact with the health system, which makes them well placed to identify people at risk and support them over time. Effective integration depends on trained staff, essential medicines and equipment, and clear referral links to higher levels of care.

Table 12.5: NCD integration into primary health care

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of Health facilities offering NCD and mental health services	20%	Data not available	
Percentage of States with a functional NCD coordination mechanism	72%	100%	Programme report
Number of New hypertension and diabetes diagnoses combined (derived)	1,269,905	1,008,342*	
Percentage of PHC facilities offering NCD screening and management	Not separately reported in 2025	Data not available	
Percentage of PHC facilities with no stockout of essential NCD medicines	Data not available	Data not available	

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of Adults screened for hypertension or diabetes at PHC level	Data not available	Data not available	

*DHIS2 (FASTR Adjusted, Jan to Sep 2026)

Nationally, there still exists gaps in integration of non-communicable disease into Primary healthcare facilities. The NHFS, 2025 demonstrates a critical service readiness gap at PHCs for both hypertension (13.6%) and diabetes (12.9%), heavily suppressing total national health facility capacity below 17% despite higher availability at secondary facilities (63.5% and 69.7%) (Figure 132).

This structural deficit overburdens secondary hospitals with routine chronic management and leaves most communities without accessible, frontline screening and maintenance care.

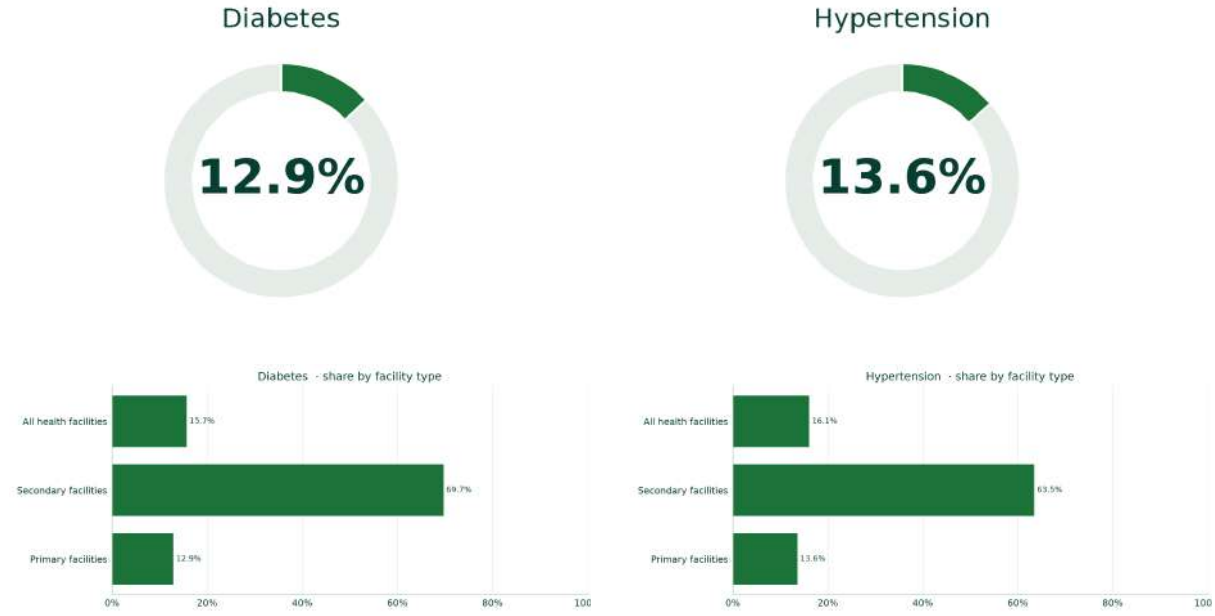


Figure 132: Percentage of PHC facilities that provide hypertension and diabetes services, national. Source: NHFS, 2025

Service availability at PHCs varied across states, with hypertension services more available in Benue, Jigawa, Borno and Lagos States, while diabetes services were more available in Lagos, Borno, Kwara and Bayelsa States (Figures 133 and 134)

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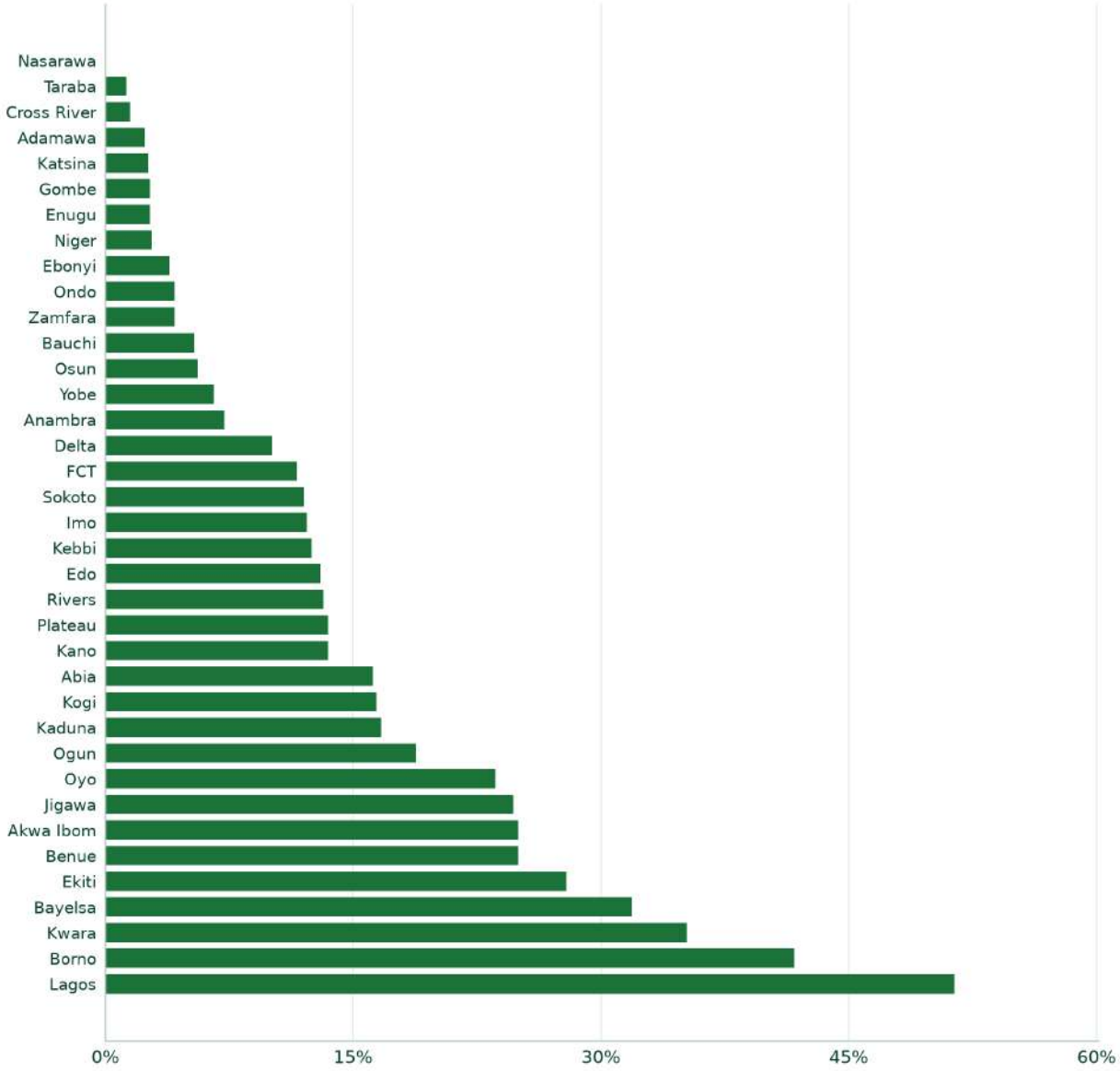


Figure 133: Percentage of Public Health Facilities-PHCS that Provide Diabetes Services by State. Source: (NHFS, 2025)

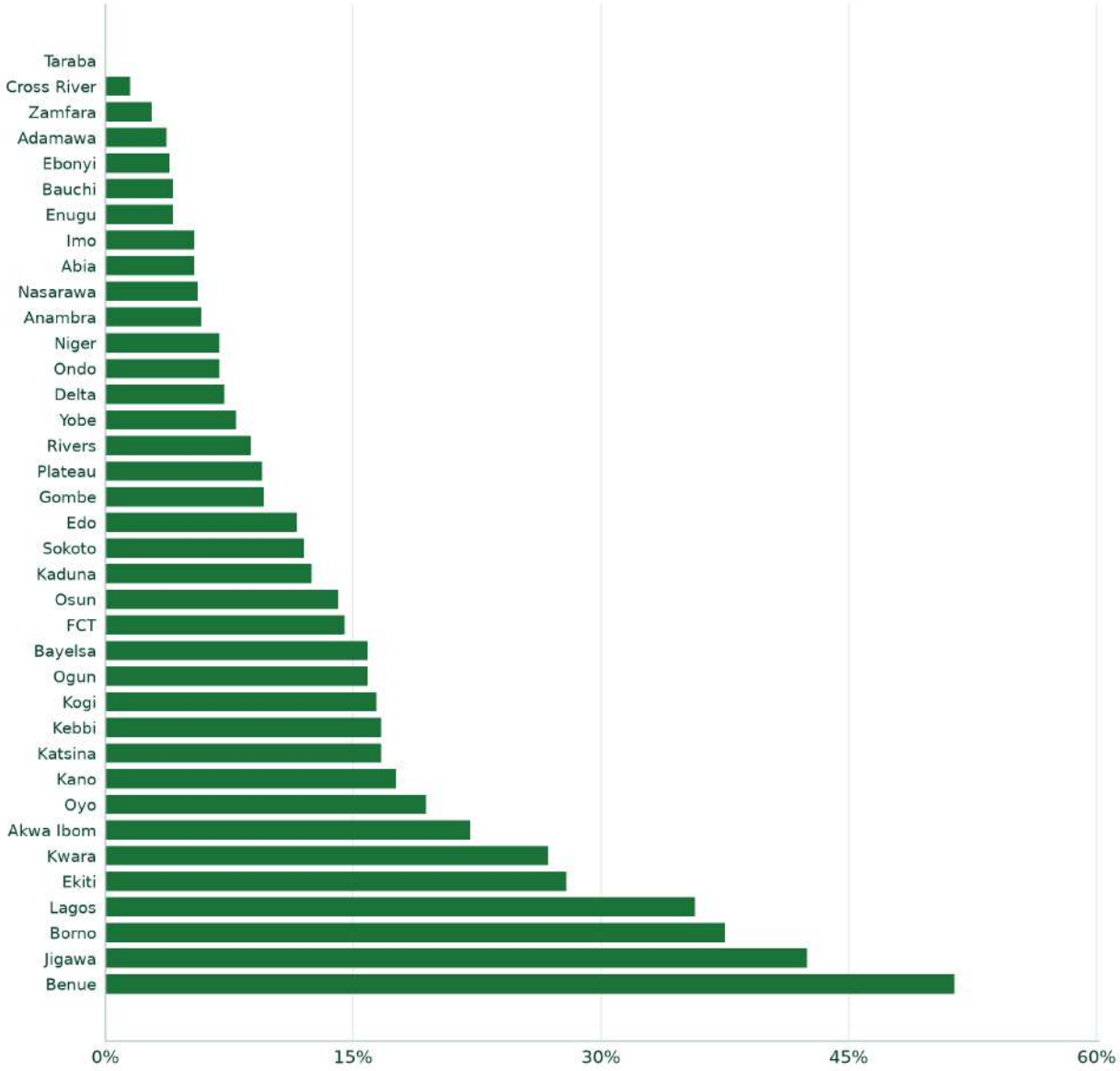


Figure 134: Percentage of Public Health Facilities-PHCS that Provide Hypertension Services by State. Source: (NHFS, 2025)

While Lagos and Borno perform better for diabetes, and Benue, Jigawa and Borno for hypertension, more than half of the states provide these services in fewer than 15% of public health facilities. Cross River, Taraba and Nasarawa record availability below 2% for some services.

12.6 Private Sector Engagement in the Health System Delivery

Private sector engagement contributes to health system capacity, financing, and access by complementing public-sector service delivery across levels of care. Private providers now own 4-in-5 reported secondary facilities. In 2026, private facilities accounted for 82% of reported secondary facilities and private tertiary facilities from 58 to 74. Their place in public financing also grew. The Healthcare Federation of Nigeria (HFN) formally joined the

BHCPF Ministerial Oversight Committee as the private-sector representative, and its September 2026 Town Hall positioned private providers within BHCPF 2.0 strategic purchasing. SafeCare tools supported 8,185 quality assessments under the BHCPF programme. Private partners also anchored the six health-product factories commissioned under PVAC in 2026.

Table 12.6: Private sector engagement in health service delivery

Core Indicator	2025 Achievement	2026 /Achievement	Data Source
Percentage of Private secondary facilities as share of reported secondary facilities	76.8% (3,779 of 4,923)	82%	
Number of Private PHCs	3,460	5,406	
Number of Private tertiary facilities	58	74	
Number of Private facilities empanelled under the BHCPF	Data not available	Data not available	
Private-sector representation on the BHCPF Ministerial Oversight Committee	Data not available	Yes (HFN onboarded, 2026)	Q3 2026 MOC Programmatic Update
Number of BHCPF facility quality assessments conducted with SafeCare	Data not available	8,185	HFN BHCPF MOC Presentation, Oct 2026
Number of Health-product factories commissioned with private-sector partners	Data not available	6 (7 in pipeline)	PVAC, Q3 2026 MOC

Chapter 13

EMERGENCY MEDICAL SERVICES



13.1 Emergency Medical Services and Trauma Care

Emergency medical services and trauma care are critical to reducing preventable deaths and improving survival following accidents, injuries and other medical emergencies in Nigeria. Strengthening pre-hospital care, ambulance coverage and emergency response capacity remains essential to ensuring timely access to life-saving services across the country. The National Emergency Medical Services and Ambulance System (NEMSAS) plays a central coordination role in strengthening emergency response, facilitating access to ambulance services and supporting the integration of emergency medical care across health facilities and other relevant stakeholders.

Table 13.1: Emergency medical services and trauma care indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of Total number of ambulances, public	502	678(Basic life support) 584 & ALS (94) 821(Tricycle Ambulances) 14 (Boat Ambulances)	NEMSAS
Total number of ambulances, private	21	32	
National ambulance fleet per 100,000 population (derived)	0.22	0.29	
Number of functional ambulances	Data not available	678(Basic life support) 584 & ALS (94) 273 (Tricycle Ambulances) 4 (Boat Ambulances	
Percentage of States with an operational emergency medical team	81%	89.19%	
Percentage of Federal teaching hospitals with an operational emergency medical team	15.5%	32.91%	
Percentage of Ambulances meeting minimum standards	***Data not available***	88.8%	
Number of Federal tertiary hospitals maintaining a trauma registry	0	25	Hospital Services Department, FMoHSW

13.2 Blood Bank Adequacy and Transfusion Service Availability

A safe and adequate blood supply is essential for managing obstetric haemorrhage, severe anaemia, trauma, surgery and other life-threatening conditions. The National Blood Service Agency (NBSA) coordinates blood collection, screening and distribution through a network of registered blood banks. Ensuring that all donated blood is screened for transfusion-transmissible infections and that facilities avoid stockouts is central to safe transfusion services.

Table 13.2: Blood transfusion service availability

Core Indicator	2025 Achievement	2026 Achievement
Number of Registered functional blood banks nationwide (number, NBTS)	30	32 in FCT, 1 in Ondo, 3 in Ebonyi
Population per registered functional blood bank (derived)	7,916,667	1,484,000
Number of Units of blood collected nationally	Data not available	3,048
Percentage of Units of blood screened for transfusion-transmissible infections	Data not available	88,2%
Percentage of Facilities reporting a blood stockout in the reporting period	Data not available	2.8%

13.3 Federal Tertiary Health Institutions Performance Review

Federal tertiary health institutions, including teaching hospitals, federal medical centres and specialist hospitals, sit at the top of Nigeria's referral system and provide specialised care, training and research. The performance review assesses how these institutions are meeting their annual service targets, maintaining essential equipment and staff, and responding to operational challenges. Findings are drawn from the quarterly returns submitted by the reporting institutions for January to September 2026 (Figure 135).

Summary of 24 Tertiary facilities that reported combined, January–September 2026



Figure 135: Performance indicators of reporting federal tertiary hospitals, January–September 2026

Box 1

- Report Submission: **25 hospitals** submitted general report. 24 included 2026 figures; 16 cover all three quarters and 8 stopped in June. A further 14 facilities covered mental health, orthopaedics and ENT
- Volume: Attendance reached **74.9% of the level needed** to meet the year's target, and was 4.2% lower than in the same months of 2025.
- Deaths: **7.1 patients died for every 100 admitted**, down from 8.0 in 2025. Maternal deaths fell to 155, about 26.2% fewer than at the same point last year.
- Mental health: new depression cases (**5,909**) were 63% higher than in the same months of 2025, and new drug and alcohol cases (3,314) were 2.6 times higher.
- Workforce: shortage of staff, named by **20 of 24** hospitals, followed by buildings and space (17), funding (15), equipment (15) and power (13). Only 3 of 21 hospitals have a working MRI.
- See Annex for all the list of facilities included

How to interpret the figures. *"Progress vs target" compares what a hospital achieved with what it needed by this point of the year. 100% means on track. Green = on track (90% or more), Yellow = behind (60–89%), Red = far behind (below 60%). Hospitals that reported only two quarters are compared with half of their annual target, not the full year.*

13.3a Service utilisation and quality of care

Between January and September the reporting hospitals recorded 1,358,825 attendances, 1,140,244 outpatient visits and 114,176 admissions. That is a little behind their set target. Attendance reached 74.9% of the level needed to hit the year's target, admissions 82.8% and surgeries 86.9%. Every measure was also slightly lower than in the same months of 2025, by between 2.2% and 6.9%.

Service utilisation reflects the volume of outpatient, inpatient and surgical care that tertiary hospitals deliver to patients. Quality-of-care measures complement these volumes by showing how safely and effectively that care is provided. Together, they indicate whether hospitals are on course to meet the annual targets they set for themselves (Figure 136).

Table 13.3: Service utilisation and quality of care, reporting facilities combined, Q1–Q3 2026

Indicator	Dir.	Hospitals	Q1	Q2	Q3	Jan–Sep 2026	Progress vs target (n)	Change vs 2025
Facility attendance	↑	23	438,802	610,246	309,777	1,358,825	74.9% (17)	−4.2%
Outpatient visits	↑	24	373,835	516,160	250,249	1,140,244	81.8% (17)	−2.5%
Admissions	↑	24	37,754	46,881	29,541	114,176	82.8% (17)	−6.9%
Surgeries performed	↑	23	6,141	9,223	4,777	20,141	86.9% (18)	−2.2%
Hospital deaths	↓	24	3,175	3,794	1,245	8,214	134.2% (14)	−11.3%
Infant deaths	↓	23	404	543	251	1,198	144.4% (14)	−10.5%
Maternal deaths	↓	24	47	82	26	155	127.1% (11)	−26.2%

Indicator	Dir.	Hospitals	Q1	Q2	Q3	Jan–Sep 2026	Progress vs target (n)	Change vs 2025
Deaths per 100 admissions	↓	24				7.1	—	2025: 8.0

(↓) indicators.

Figure 136: Quarterly service volumes Q1–Q3 2026, 16 hospitals that reported all three quarters

13.3B Performance review (2025 vs 2026)

Table 13.4: Federal tertiary health institutions performance review, 2025 vs 2026

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Total number of federal tertiary hospitals that submitted report for JAR	38	32 25 used general reporting template + 7 specialty-only hospitals	JAR 2026 tertiary facility report, Q1–Q3 (Jan–Sep 2026)
Total attendance at federal tertiary hospitals (number)	2,764,089 38 hospitals	1,358,825 23 hospitals	JAR 2026 tertiary facility report, Q1–Q3 (Jan–Sep 2026)
Outpatient visits (number)	1,211,829 38 hospitals	1,140,244 24 hospitals	JAR 2026 tertiary facility report, Q1–Q3 (Jan–Sep 2026)
Total admissions (number)	226,943 38 hospitals	114,176 24 hospitals	JAR 2026 tertiary facility report, Q1–Q3 (Jan–Sep 2026)6)
In-patient deaths (number)	14,857 38 hospitals	8,214 24 hospitals	JAR 2026 tertiary facility report, Q1–Q3 (Jan–Sep 2026)
In-patient mortality rate (%, derived)	6.5%	7.1% Deaths ÷ admissions, same quarters	JAR 2026 tertiary facility report, Q1–Q3 (Jan–Sep 2026)
Bed occupancy rate (%)	59%	55% Average of 24 hospitals	JAR 2026 tertiary facility report, Q1–Q3 (Jan–Sep 2026)
Major surgeries performed (number)	30,516	20,141 All surgeries, 23 hospitals	JAR 2026 tertiary facility report, Q1–Q3 (Jan–Sep 2026)
Minor surgeries performed (number)	12,494	-	—
Birth Registration Coverage			—
Death Registration Coverage			—

8 hospitals reported Q1–Q2 only. "Not collected" = the indicator is not on the 2026 JAR tertiary reporting template. Specialty-only hospitals (4 neuro-psychiatric, 3 orthopaedic) used specialty forms and are not included in the activity totals.

As a population-based CRVS measure, the 2025 NMDHS found that 40.4% of de jure children under five had their births registered with civil authorities: 21.7% had a birth certificate and 18.7% were registered without a certificate. This is childbirth-registration coverage and is not a measure of birth or death registration by tertiary hospitals) (Figure 137).

Chapter 13

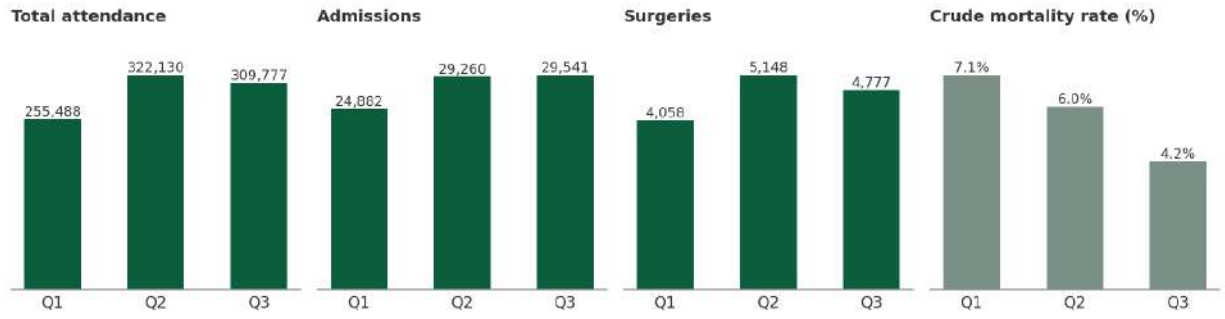


Figure 137: Tertiary hospital service volumes and crude mortality rate by quarter, Q1–Q3 2026

FTH Birnin Kebbi did not report attendance, so that panel covers one hospital fewer.

Table 13.5: Tertiary facility table, Q1–Q3 2026

Rank	Facility	Qtrs	Attendance	Admissions	Surgeries	Deaths	Deaths per 100 admitted (2025)	Beds in use	Progress score
1	FMC Onitsha *	3	34,500	2,100	440	55	2.6 (2.8)	90.0%	138%
2	NOFIC Benin	3	4,267	82	45	0	0.0 (0.0)	40.5%	126%
3	NOFIC Babbarruga	3	14,119	2,726	561	3	0.1 (0.1)	81.2%	105%
4	FMC Abuja	3	194,494	11,928	2,050	273	2.3 (2.5)	97.3%	100%
5	NOH Jalingo	3	2,293	195	199	2	1.0 (0.8)	100.0%	100%
6	FMC Misau	3	19,000	1,394	564	31	2.2 (1.8)	6.3%	100%
7	FMC Epe	3	153,172	2,536	1,168	126	5.0 (5.6)	14.3%	99%
8	NOH Igbobi	3	53,866	4,650	1,563	35	0.8 (1.4)	65.4%	98%
9	MAUTH Yola	3	75,263	9,058	1,867	1,134	12.5 (14.4)	85.7%	97%
10	FMC Hong	3	15,281	3,139	426	207	6.6 (6.0)	82.0%	93%
11	FTH Birnin Kebbi	3	–	11,449	1,562	808	7.1 (12.2)	93.0%	91%
12	FUHSTH Ila-Orangun	3	3,258	191	53	1	0.5	1.0%	83%
13	UBTH	2	126,364	8,695	2,449	1,229	14.1 (14.8)	62.0%	82%
14	FMC Wase	3	7,283	1,362	204	122	9.0 (3.6)	42.7%	79%
15	FUTH Lafia	3	88,799	10,626	1,427	871	8.2 (6.8)	62.4%	79%
16	ISTH Irrua	3	87,132	9,017	276	493	5.5 (5.6)	38.9%	73%
17	FTH Lokoja	2	37,538	1,877	667	227	12.1 (7.8)	73.3%	67%
18	UPTH	2	81,965	3,707	1,165	669	18.0 (12.0)	39.0%	57%
19	UUTH Uyo	2	49,734	3,847	664	355	9.2 (8.4)	49.0%	55%
20	ATBUTH Bauchi	–	–	–	–	–	–	–	–
21	FMC Ikole-Ekiti	2	15,066	847	142	32	3.8	68.5%	–
22	FMC Makurdi	2	44,651	1,961	661	116	2.3	20.5%	–
23	FMC Owo	2	26,639	1,808	410	175	9.7 (11.7)	35.0%	–
24	FTH Katsina	3	134,668	13,230	1,578	599	4.5 (3.6)	49.7%	–
25	UCH Ibadan	2	89,473	7,751	–	651	8.4 (9.2)	27.1%	–

Volume score bands on the same 70/30 rule. Deaths are shown as counts and are not part of the score. Bed occupancy is the mean of reported quarters.

The hospitals recorded **8,214 deaths**, about 11.3% fewer than in the same months of 2025. For every 100 patients admitted, 7.1 died, compared with 8.0 last year. Table 2 still shows deaths in red, because most hospitals set limits far below their 2025 numbers.

Bars show 2026; circles show 2025 where both deaths and admissions were reported. Fistula and orthopaedic centres treat mostly planned, lower-risk cases, so their rates are naturally low.

13.3.1 Availability of essential equipment

Basic life-saving equipment is fairly common. ICU ventilators work at 17 of 24 hospitals, and PCR machines and baby CPAP machines at 16 each. Advanced machines are rare: **only 3 of 21 hospitals** have a working MRI, 3 have radiotherapy, and one has a heart catheter laboratory (Figure 138).

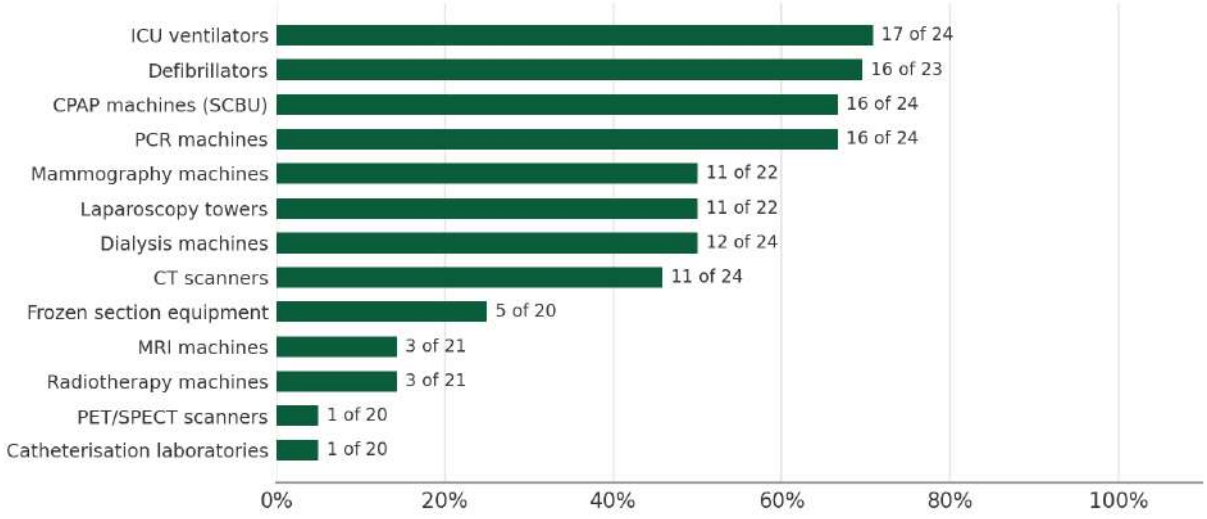


Figure 138: Functional essential equipment with at least one working unit, by type of equipment

13.3.2 Human resources for health

The hospitals report **18,402 staff** in the five groups tracked, including 5,795 doctors and 10,241 nurses and midwives. 15 hospitals set staffing targets. Together they have 81% of the staff they planned for, 2,343 people short. The biggest gap in numbers is nurses and midwives (1,041), then doctors (905). In proportion, laboratory scientists are the shortest, at 71% of target. Hospitals say the same in their own words: 20 of 24 list staff shortage or staff leaving the country as a main problem

Tertiary hospitals depend on an adequate mix of doctors, nurses, midwives, laboratory scientists and other professionals to deliver complex care. Staffing levels are assessed against the targets each hospital set for 2026. This is particularly important as the outward migration of health workers continues to place pressure on staffing in many facilities (Figure 139).

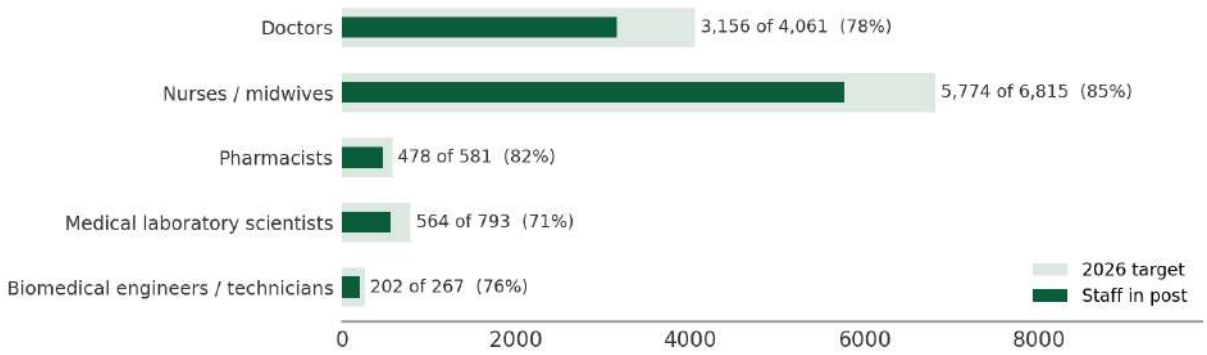


Figure 139: Staff in post compared with 2026 targets — 15 hospitals with staffing targets

13.3.3 Key achievements

The most common achievement was training, accreditation and research, reported by 12 hospitals. Next came new or bigger clinical services (11) and better diagnostic equipment (10). Some are major steps, such as FTH Katsina's new cancer radiotherapy centre and UBTH's IVF service and linear accelerator.

Table 13.6: Key achievements, Q1–Q3 2026

Achievement	No of Hospitals	Highlights reported
Training, accreditation & research	12	Residency accreditation won or renewed (FTH Lokoja, FMC Abuja, FMC Onitsha, UPTH); WACS urogynaecology accreditation (NOFIC Babbar Ruga); four-star national accreditation (FUTH Lafia); colleges of nursing opened (UUTH Uyo, FMC Epe, NOH Igbobi)
New or expanded clinical services	11	Radio-oncology centre opened (FTH Katsina); hip and knee replacement (FMC Epe, UBTH); IVF and embryo cryopreservation (UBTH); ICU, SCBU, dental and physiotherapy units (FMC Hong); urodynamics and ICU (NOFIC Babbar Ruga)
Patient flow & service quality	11	Higher patient flow reported by 10 facilities; shorter waiting times and surgical lists (UPTH); maternal deaths down to 3 from 17 in 2025 (FTH Katsina)
Diagnostic & equipment upgrades	10	120-slice CT and linear accelerator (UBTH); MRI, CT, fluoroscopy and mammography restarted (UPTH); 25 SCBU CPAP machines (FTH Katsina); X-ray and laparoscopy tower installed (FMC Wase); two oxygen plants (FUTH Lafia)
Infrastructure & renovation	9	Staff quarters and patient hostel (NOH Igbobi); A&E and wards renovated (UPTH); permanent-site construction (NOFIC Benin); liquid oxygen infrastructure (UUTH Uyo); theatre and paediatric wards renovated (FMC Hong)
Power & utilities (solar, grid, oxygen)	7	Solar installations (FMC Epe, FMC Wase, NOFIC Babbar Ruga, UPTH via REA/AfDB); Band A grid line extended to UUTH Uyo
Digital health & EMR	6	EMR rolled out or widened (ATBUTH, FMC Hong, FTH Birnin Kebbi, MAUTH Yola); online appointment booking (NOH Igbobi); inventory and personnel apps (FMC Abuja)
Workforce growth	4	More specialists (FMC Onitsha); more nurses, pharmacists and laboratory scientists (FTH Birnin Kebbi); NYSC deployment and nurse internship (FMC Epe)

13.3.4 Challenges and recommendations

Losing staff is the top problem, named by **20 of 24** hospitals, often because doctors and nurses leave the country. Buildings and space (17), funding (15), equipment (15) and power (13) follow. The requests match: 17 hospitals ask for budgets to be released on time and 16 ask for help to recruit and keep staff (Figure 140).

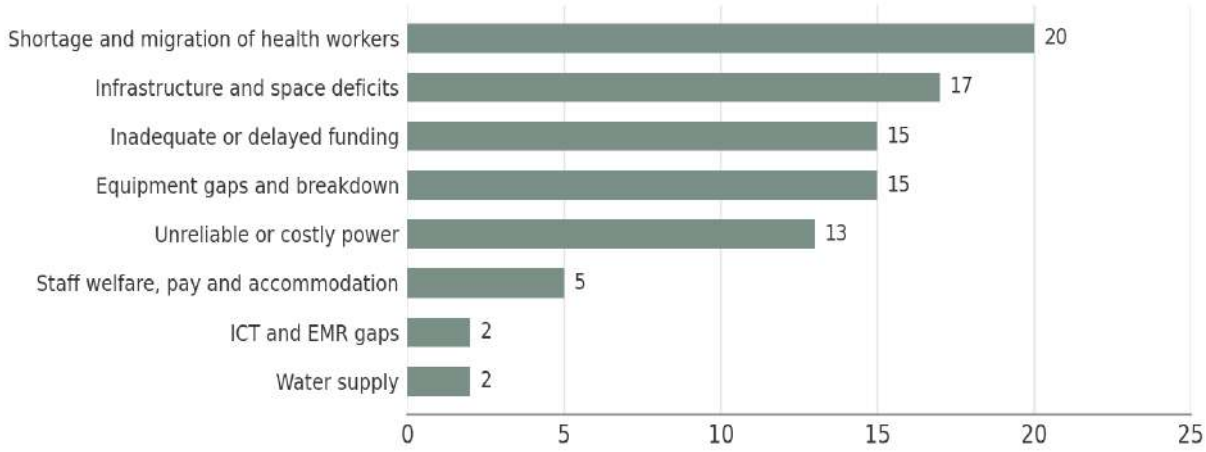


Figure 140: Challenges reported

Table 13.7: Problems reported and recommendations

Problem	Hospitals	What hospitals recommend	Hospitals	Examples of hospitals naming it
Shortage and migration of health workers	20	Recruit, retain and motivate staff	16	FUTH Lafia, ATBUTH Bauchi, FMC Onitsha, FMC Misau …
Infrastructure and space deficits	17	Infrastructure expansion and renovation	8	NOH Jalingo, ATBUTH Bauchi, FMC Onitsha, FMC Misau …
Inadequate or delayed funding	15	Timely and adequate budget releases	17	ATBUTH Bauchi, FMC Onitsha, FMC Owo, FUHSTH Ila-Orangun …
Equipment gaps and breakdown	15	Procure and maintain equipment	9	NOH Jalingo, FUTH Lafia, ATBUTH Bauchi, FMC Misau …
Unreliable or costly power	13	Solar and alternative power; grid restoration	9	ATBUTH Bauchi, FMC Onitsha, FMC Misau, FMC Ikole-Ekiti …
Staff welfare, pay and accommodation	5	Recruit, retain and motivate staff	16	FUTH Lafia, FMC Wase, FMC Epe, UCH Ibadan …
ICT and EMR gaps	2	Digital health and data quality	3	NOFIC Benin, FUHSTH Ila-Orangun
Water supply	2	—		ISTH Irrua, MAUTH Yola

Note:

Flow indicators (attendance, outpatient visits, admissions, surgeries, deaths) are summed across quarters.

Progress vs target = Jan–Sep total ÷ (yearly target × quarters reported ÷ 4). This lets hospitals that sent two or three quarters be compared fairly.

Deaths per 100 admissions calculated as hospital deaths ÷ admissions. It adjusts for volume and is the better guide to quality of care than the raw death count

Table 13.8: Teaching hospital and specialist centre performance

Core Indicator	2025 Achievement	2026 Achievement
Federal tertiary hospitals with a certificate of standards		Data not available
New federal tertiary hospitals established in the reporting year (number)	4	Data not available
Tertiary facility health workers trained on specialised care (number)	5	Data not available
Federal tertiary hospitals that had annual supportive supervisory visits (%)	0%	Data not available
Federal tertiary hospitals reporting average length of stay above 30 days (number)	5	Data not available
Federal tertiary hospitals reporting 100% bed occupancy (number)	4	Data not available

Chapter 13

13.4 State Health Sector Scorecard, Ranking and Trend Analysis

The State Health Sector Scorecard tracks state-level performance across selected health indicators, based on data reported by states. This section presents one summary scorecard for each of the 36 states, including the FCT, that returned the 2026 JAR State-level Reporting Template, using quarterly data reported up to Q3 2026. Each card measures the state against its own annual targets. Each card also records deaths, the workforce in post, and the state's own account of its initiatives, challenges and response.

Abia State summary scorecard, Q1–Q3 2026

Abia State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 10/10/2026 · Validated by All State Programme Officers (08/09/2026)

14 of 30 scored indicators on track (47%) | **14** On track | **7** Close | **9** Not on Track | **9** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	100%	**80%**	● 80%
SCH meetings held	–	**1**	● No target
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	114,107	**26,302**	● 23%
Under-5s given Vitamin A	479,250	**361,430**	● 75%
Skilled birth attendance	100%	**89.8%**	● 89%
Newborn PNC within 48 hrs	100%	**85.8%**	● 85%
Women PNC within 48 hrs	95%	**84%**	● 88%
Under-5 diarrhoea given ORS + zinc	173,444	**4,541**	● 2%
IMMUNISATION			
BCG coverage (live births)	85%	**84.7%**	● 99%
Zero-dose children (12–23 m)	≤50%	**13.7%**	● Met
No routine vaccination (12–23 m)	≤20%	**13.7%**	● Met
All basic antigens (12–23 m)	85%	**36%**	● 42%
Fully vaccinated (12–23 m)	85%	**80%**	● 94%
NCDS			
Hypertension cases on treatment	of 37,368	**65,232**	● 174%
Diabetes cases on treatment	of 4,320	**3,124**	● 72%
New prostate cancer cases	441	**317**	● 71%
New breast cancer cases	809	**582**	● 71%
New cervical cancer cases	225	**162**	● 72%

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	Not reported	● No data
CHEWs trained on integrated care	–	Not reported	● No data
HIV, TB & MALARIA			
New HIV-positive clients	3,100	**1,537**	● 49%
New TB cases diagnosed	10,845	**2,577**	● 23%
PMTCT: HEI final negative	96%	**88%**	● 91%
Uncomplicated malaria diagnosed	146,730	**308,272**	● 210%
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**100%**	● 100%
SHCs certified CEmONC	13.6%	**13.8%**	● 100%
New SSHIA enrolees	500,000	**273,533**	● 54%
Population with health insurance	–	**5%**	● No target
Blood banks registered with NBSA	of 13	**15.4%**	● 15%
2025 health budget released	₦111.0bn	**₦13.8bn**	● 12.5%
HEALTH SECURITY			
IDSR timely reporting (001)	80%	**86.7%**	● 108%
Climate & health milestones met	6	**1**	● 1 of 6
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 749	**1,642**	● Check
SHCs reporting on DHIS2	of 23	**195**	● Check
Tertiary facilities on DHIS2	of 3	**7**	● Check
BHCPF facilities with EMR	of 184	**100**	● 54%
PHCs with EMR	–	Not reported	● No data
Tertiary facilities with EMR	of 3	**1**	● 33%

Deaths reported Q1–Q3: maternal 0 · infant 0 · neonatal 26 · under-5 3 · malaria 38 · HIV 149 · TB 98 · prostate cancer 200 · breast cancer 289 · cervical cancer 100 **Workforce in post:** 264 doctors · 1,871 nurses · 425 midwives · 51 pharmacists · 40 lab scientists · 2,200 CHWs

KEY INITIATIVES
- **242/277 PHCs and 5 GHs rehabilitated; 821 staff recruited**
- **AHCRI in ABSUTH, Abia Specialist Hospital, GH Aba**
- **6 PHCs digitised (MAMII LGAs); monthly epi bulletin**
- **6 emergency referral points; eye care in 3 zones**

MAJOR CHALLENGES
No public health lab, no isolation centre, no sample-shipment logistics, no PHEOC vehicle, no outbreak emergency fund

ACTION TAKEN
- **Public health lab under construction in Aba**
- **IDH Aba being renovated as isolation centre**
- **Sample logistics and PHEOC vehicle in 2027 AOP**
- **Larval source management pilot in 2 LGAs**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

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Adamawa State summary scorecard, Q1–Q3 2026

Adamawa State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 15/10/2026 · Validated by DHPRS SMOH (15/10/2026)

13 of 28 scored indicators on track (46%) | **13** On track | **2** Close | **13** Not on Track | **11** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	5%	**1.3%**	● 26%
SCH meetings held	1	**0**	● 0%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	282,619	**111,224**	● 39%
Under-5s given Vitamin A	1,012,160	**166,993**	● 16%
Skilled birth attendance	80%	**94%**	● 117%
Newborn PNC within 48 hrs	90%	**97.7%**	● 108%
Women PNC within 48 hrs	100%	**99.9%**	● 99%
Under-5 diarrhoea given ORS + zinc	–	**34,629**	● No target
IMMUNISATION			
BCG coverage (live births)	80%	**94%**	● 117%
Zero-dose children (12–23 m)	–	**4%**	● No target
No routine vaccination (12–23 m)	–	**4.7%**	● No target
All basic antigens (12–23 m)	90%	**84.7%**	● 94%
Fully vaccinated (12–23 m)	90%	**114.8%**	● 127%
NCDS			
Hypertension cases on treatment	of 14,341	**12,902**	● 89%
Diabetes cases on treatment	of 4,020	**11,573**	● 287%
New prostate cancer cases	–	**4**	● No target
New breast cancer cases	–	**5**	● No target
New cervical cancer cases	–	**8**	● No target

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	13,732	**4,626**	● 33%
CHEWs trained on integrated care	–	**0**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	–	**1,233**	● No target
New TB cases diagnosed	–	**4,298**	● No target
PMTCT: HEI final negative	100%	**100%**	● 100%
Uncomplicated malaria diagnosed	–	**539,016**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**100%**	● 100%
SHCs certified CEmONC	100%	**25%**	● 25%
New SSHIA enrolees	250,000	**92,381**	● 36%
Population with health insurance	5%	**0.7%**	● 13%
Blood banks registered with NBSA	of 5	**0%**	● 0%
2025 health budget released	₦34.9bn	**₦12.1bn**	● 34.8%
HEALTH SECURITY			
IDSR timely reporting (001)	90%	**75%**	● 83%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 904	**904**	● 100%
SHCs reporting on DHIS2	of 20	**21**	● 105%
Tertiary facilities on DHIS2	of 3	**3**	● 100%
BHCPF facilities with EMR	of 226	**100**	● 44%
PHCs with EMR	of 904	**176**	● 19%
Tertiary facilities with EMR	of 3	**1**	● 33%

Deaths reported Q1–Q3: maternal 76 · infant 128 · neonatal 140 · under-5 212 · malaria 1,083 · HIV 32 · TB 1 · prostate cancer 1 · breast cancer 1 · cervical cancer 2 **Workforce in post:** 73 doctors · 1,586 nurses · 354 midwives · 53 pharmacists · 35 lab scientists · 2,414 CHWs

KEY INITIATIVES
- **MAMII, BEmONC/CEmONC, community MPCDSR and RESMAT**
- **SARMAAN azithromycin for children 1–59 months**
- **Safer Birth Bundle of Care in 9 MAMII LGAs**

MAJOR CHALLENGES
Frequent outbreaks of cholera, diphtheria, Buruli ulcer and Mpox

ACTION TAKEN
- **PHEOC rapid response teams sent to affected LGAs**
- **Daily SORMAS/IDSR reporting from 21 LGAs**
- **Antibiotics and diphtheria antitoxin supplied**
- **IPC strengthened; cases referred for treatment**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

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Akwa Ibom State summary scorecard, Q1–Q3 2026

Akwa Ibom State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 25TH OCTOBER, 2026 · Validated

11 of 31 scored indicators on track (35%) | **11** On track | **9** Close | **11** Not on Track | **8** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	70%	**3%**	● 4%
SCH meetings held	1	**0**	● 0%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	18,000	**13,161**	● 73%
Under-5s given Vitamin A	987,594	**422,678**	● 42%
Skilled birth attendance	87%	**76.5%**	● 87%
Newborn PNC within 48 hrs	100%	**12.3%**	● 12%
Women PNC within 48 hrs	100%	**12.3%**	● 12%
Under-5 diarrhoea given ORS + zinc	4,000	**2,557**	● 63%
IMMUNISATION			
BCG coverage (live births)	90%	**113.3%**	● 125%
Zero-dose children (12–23 m)	–	**3.3%**	● No target
No routine vaccination (12–23 m)	–	**0%**	● No target
All basic antigens (12–23 m)	90%	**57%**	● 63%
Fully vaccinated (12–23 m)	90%	**57%**	● 63%
NCDS			
Hypertension cases on treatment	of 11,246	**3,836**	● 34%
Diabetes cases on treatment	of 3,836	**3,836**	● 100%
New prostate cancer cases	–	**65**	● No target
New breast cancer cases	–	**72**	● No target
New cervical cancer cases	–	**14**	● No target

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	10,000	**1,695**	● 16%
CHEWs trained on integrated care	2,500	**1,983**	● 79%
HIV, TB & MALARIA			
New HIV-positive clients	6,005	**4,725**	● 78%
New TB cases diagnosed	14,188	**6,479**	● 45%
PMTCT: HEI final negative	95%	**80.7%**	● 84%
Uncomplicated malaria diagnosed	200,000	**139,887**	● 69%
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	70%	**36%**	● 51%
SHCs certified CEmONC	100%	**9.3%**	● 9%
New SSHIA enrolees	100,000	**58,639**	● 58%
Population with health insurance	7%	**5.2%**	● 73%
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦182.1bn	**₦153.2bn**	● 84.1%
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**100%**	● 100%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 481	**481**	● 100%
SHCs reporting on DHIS2	of 43	**43**	● 100%
Tertiary facilities on DHIS2	of 1	**1**	● 100%
BHCPF facilities with EMR	of 316	**120**	● 37%
PHCs with EMR	of 481	**120**	● 24%
Tertiary facilities with EMR	of 1	**1**	● 100%

Deaths reported Q1–Q3: maternal 0 · infant 67 · neonatal 67 · under-5 1 · malaria 1 · HIV 0 · TB 60 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 29 doctors · 192 nurses · 111 midwives · 11 pharmacists · 19 lab scientists · 100 CHWs

KEY INITIATIVES
- **350-bed Ibom International Hospital under construction**
- **AKSHIA/Arise Care insurance: 238,766 enrolees**
- **30+ PHCs upgraded to model PHCs**
- **AKISEMSAS; oxygen plant; 2 new general hospitals**

MAJOR CHALLENGES
Too few health workers and continuing staff attrition

ACTION TAKEN
- **Over 3,000 new graduates engaged and deployed**
- **Employment restrictions removed for faster hiring**
- **Capable retired health workers re-engaged**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%, behind <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Anambra State summary scorecard, Q1–Q3 2026

Anambra State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given · Validated ·

2 of 13 scored indicators on track (15%) | **2** On track | **4** Close | **7** Not on Track | **26** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● **50%**
NCH resolutions implemented	–	Not reported	● **No data**
SCH meetings held	–	**0**	● **No target**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**116,612**	● **No target**
Under-5s given Vitamin A	–	**201,355**	● **No target**
Skilled birth attendance	100%	**100%**	● **100%**
Newborn PNC within 48 hrs	89%	**75.3%**	● **84%**
Women PNC within 48 hrs	89%	**75.3%**	● **84%**
Under-5 diarrhoea given ORS + zinc	2,000	**4,057**	● **202%**
IMMUNISATION			
BCG coverage (live births)	–	**6.5%**	● **No target**
Zero-dose children (12–23 m)	–	**73%**	● **No target**
No routine vaccination (12–23 m)	–	**85%**	● **No target**
All basic antigens (12–23 m)	–	**88%**	● **No target**
Fully vaccinated (12–23 m)	–	Not reported	● **No data**
NCDS			
Hypertension cases on treatment	–	Not reported	● **No data**
Diabetes cases on treatment	–	Not reported	● **No data**
New prostate cancer cases	–	Not reported	● **No data**
New breast cancer cases	–	**58**	● **No target**
New cervical cancer cases	–	**13**	● **No target**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	9,000	**7,246**	● **80%**
CHEWs trained on integrated care	–	Not reported	● **No data**
HIV, TB & MALARIA			
New HIV-positive clients	–	**2,960**	● **No target**
New TB cases diagnosed	16,004	**5,059**	● **31%**
PMTCT: HEI final negative	–	Not reported	● **No data**
Uncomplicated malaria diagnosed	60,000	**74,482**	● **124%**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	98%	**28.3%**	● **28%**
SHCs certified CEmONC	100%	**50%**	● **50%**
New SSHIA enrolees	98,573	**32,268**	● **32%**
Population with health insurance	5%	**0.2%**	● **3%**
Blood banks registered with NBSA	–	**5%**	● **No denom.**
2025 health budget released	₦73.3bn	**₦20.6bn**	● **28.1%**
HEALTH SECURITY			
IDSR timely reporting (001)	–	Not reported	● **No data**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	–	**0**	● **No denom.**
SHCs reporting on DHIS2	–	**0**	● **No denom.**
Tertiary facilities on DHIS2	–	**0**	● **No denom.**
BHCPF facilities with EMR	of 329	**110**	● **33%**
PHCs with EMR	–	**110**	● **No denom.**
Tertiary facilities with EMR	–	**3**	● **No denom.**

Deaths reported Q1–Q3: maternal 0 · infant 19 · neonatal 54 · under-5 1 · malaria 15 · HIV 1 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 166 doctors · 838 nurses · 45 midwives · 49 pharmacists · 67 lab scientists · 658 CHWs

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Not provided in the submission

ACTION TAKEN
Not provided in the submission

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Bauchi State summary scorecard, Q1–Q3 2026

Bauchi State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 16/10/2026 · Validated (18/10/2026) ·

15 of 24 scored indicators on track (63%) | **15** On track | **3** Close | **6** Not on Track | **15** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● **50%**
NCH resolutions implemented	100%	**85%**	● **85%**
SCH meetings held	4	**0**	● **0%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**92,336**	● **No target**
Under-5s given Vitamin A	1,936,217	**1,999,800**	● **103%**
Skilled birth attendance	100%	**91%**	● **91%**
Newborn PNC within 48 hrs	100%	**90.3%**	● **90%**
Women PNC within 48 hrs	100%	**90%**	● **90%**
Under-5 diarrhoea given ORS + zinc	60,000	**55,458**	● **92%**
IMMUNISATION			
BCG coverage (live births)	90%	**85.7%**	● **95%**
Zero-dose children (12–23 m)	≤80%	**14.7%**	● **Met**
No routine vaccination (12–23 m)	–	**59.3%**	● **No target**
All basic antigens (12–23 m)	–	**40.7%**	● **No target**
Fully vaccinated (12–23 m)	–	**0.7%**	● **No target**
NCDS			
Hypertension cases on treatment	of 27,774	**27,774**	● **100%**
Diabetes cases on treatment	of 1,985	**1,985**	● **100%**
New prostate cancer cases	–	Not reported	● **No data**
New breast cancer cases	–	**81**	● **No target**
New cervical cancer cases	–	**137**	● **No target**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	Not reported	● **No data**
CHEWs trained on integrated care	–	Not reported	● **No data**
HIV, TB & MALARIA			
New HIV-positive clients	2,000	**668**	● **33%**
New TB cases diagnosed	18,060	**9,672**	● **53%**
PMTCT: HEI final negative	100%	**96.7%**	● **96%**
Uncomplicated malaria diagnosed	810,400	**686,833**	● **84%**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**100%**	● **100%**
SHCs certified CEmONC	–	**42.7%**	● **No target**
New SSHIA enrolees	301,950	**545,657**	● **180%**
Population with health insurance	2%	**0.7%**	● **33%**
Blood banks registered with NBSA	–	Not reported	● **No data**
2025 health budget released	₦70.0bn	**₦0.1bn**	● **0.1%**
HEALTH SECURITY			
IDSR timely reporting (001)	–	**100%**	● **No target**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 713	**1,142**	● **Check**
SHCs reporting on DHIS2	of 28	**27**	● **96%**
Tertiary facilities on DHIS2	of 6	**3**	● **50%**
BHCPF facilities with EMR	of 212	**212**	● **100%**
PHCs with EMR	of 713	**323**	● **45%**
Tertiary facilities with EMR	of 6	**6**	● **100%**

Deaths reported Q1–Q3: maternal 0 · infant 288 · neonatal 166 · under-5 0 · malaria 428 · HIV 54 · TB 81 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 49 doctors · 463 nurses · 866 midwives · 31 pharmacists · 170 lab scientists · 645 CHWs

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Recurrent Lassa fever, diphtheria, cholera, CSM and measles outbreaks; weak surveillance and lab capacity; immunisation, HRH and funding gaps

ACTION TAKEN
- **Rapid response teams, case search, treatment centres**
- **IDSR training; better sample collection and transport**
- **Outbreak-response and routine immunisation intensified**
- **124 PHCs revitalised under the IMPACT Project**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Bayelsa State summary scorecard, Q1–Q3 2026

Bayelsa State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 24TH OCT 2026 · Validated (24TH OCT 2026)

5 of 16 scored indicators on track (31%) | **5** On track | **3** Close | **8** Not on Track | **23** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	–	**2**	● No target
NCH resolutions implemented	20%	**3.3%**	● 16%
SCH meetings held	–	**0**	● No target
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	Not reported	● No data
Under-5s given Vitamin A	500,818	**352,451**	● 70%
Skilled birth attendance	40%	**9%**	● 22%
Newborn PNC within 48 hrs	–	Not reported	● No data
Women PNC within 48 hrs	40%	**20.5%**	● 51%
Under-5 diarrhoea given ORS + zinc	–	Not reported	● No data
IMMUNISATION			
BCG coverage (live births)	100%	**68.3%**	● 68%
Zero-dose children (12–23 m)	–	Not reported	● No data
No routine vaccination (12–23 m)	–	Not reported	● No data
All basic antigens (12–23 m)	–	Not reported	● No data
Fully vaccinated (12–23 m)	–	Not reported	● No data
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	Not reported	● No data
New cervical cancer cases	–	Not reported	● No data

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	Not reported	● No data
CHEWs trained on integrated care	–	Not reported	● No data
HIV, TB & MALARIA			
New HIV-positive clients	2,125	**704**	● 33%
New TB cases diagnosed	–	Not reported	● No data
PMTCT: HEI final negative	100%	**83%**	● 83%
Uncomplicated malaria diagnosed	–	Not reported	● No data
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	98%	**98%**	● 100%
SHCs certified CEmONC	–	Not reported	● No data
New SSHIA enrolees	15,000	**12,215**	● 81%
Population with health insurance	100%	**9%**	● 9%
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦13.6bn	**₦48.5bn**	● Check
HEALTH SECURITY			
IDSR timely reporting (001)	–	Not reported	● No data
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 224	**224**	● 100%
SHCs reporting on DHIS2	of 72	**40**	● 55%
Tertiary facilities on DHIS2	of 3	**3**	● 100%
BHCPF facilities with EMR	of 102	**100**	● 98%
PHCs with EMR	of 224	**100**	● 44%
Tertiary facilities with EMR	of 3	**0**	● 0%

Deaths reported Q1–Q3: maternal 0 · infant 0 · neonatal 0 · under-5 0 · malaria 0 · HIV 53 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 181 doctors · 707 nurses · 120 midwives · 113 pharmacists · 204 lab scientists · 428 CHWs

KEY INITIATIVES
- **HOPE/DLI readiness; RMNCAH-N strengthening**
- **Zero-dose and riverine immunisation outreach**
- **PHC revitalisation; HMIS/DHIS2 and digital health**
- **BHIS/BHCPF enrolment for financial protection**

MAJOR CHALLENGES
Low service use, immunisation and nutrition gaps, HIV/TB diagnostic gaps, riverine access, staff shortages, late fund release

ACTION TAKEN
- **Monthly data harmonisation meetings and DQA**
- **Riverine outreach with marine logistics**
- **SBA training; cold-chain strengthening**
- **HRH needs assessment, recruitment, task shifting**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%, Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Benue State summary scorecard, Q1–Q3 2026

Benue State — **State Summary Scorecard** · 2026 JAR · Q1–Q2
Submitted 23rd September, 2026 · Validated (23rd September, 2026)

3 of 15 scored indicators on track (20%) | **3** On track | **1** Close | **11** Not on Track | **24** Not scored

Indicator	Target	Q1–Q2	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● **50%**
NCH resolutions implemented	–	**31.2%**	● **No target**
SCH meetings held	–	**0**	● **No target**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**7,424**	● **No target**
Under-5s given Vitamin A	–	**302,764**	● **No target**
Skilled birth attendance	–	**88.8%**	● **No target**
Newborn PNC within 48 hrs	–	**15.5%**	● **No target**
Women PNC within 48 hrs	–	**14.5%**	● **No target**
Under-5 diarrhoea given ORS + zinc	–	**10,485**	● **No target**
IMMUNISATION			
BCG coverage (live births)	–	**113.1%**	● **No target**
Zero-dose children (12–23 m)	–	**6.5%**	● **No target**
No routine vaccination (12–23 m)	–	**3.5%**	● **No target**
All basic antigens (12–23 m)	–	**5%**	● **No target**
Fully vaccinated (12–23 m)	–	**5%**	● **No target**
NCDS			
Hypertension cases on treatment	of 8,223	**0**	● **0%**
Diabetes cases on treatment	of 4,635	**0**	● **0%**
New prostate cancer cases	–	**0**	● **No target**
New breast cancer cases	–	**14**	● **No target**
New cervical cancer cases	–	**0**	● **No target**

Indicator	Target	Q1–Q2	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**4,476**	● **No target**
CHEWs trained on integrated care	–	**0**	● **No target**
HIV, TB & MALARIA			
New HIV-positive clients	–	**2,865**	● **No target**
New TB cases diagnosed	16,689	**6,437**	● **38%**
PMTCT: HEI final negative	95%	**99.6%**	● **104%**
Uncomplicated malaria diagnosed	–	**143,467**	● **No target**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	**0%**	● **No target**
SHCs certified CEmONC	–	**7%**	● **No target**
New SSHIA enrolees	60,000	**19,167**	● **31%**
Population with health insurance	–	**1.8%**	● **No target**
Blood banks registered with NBSA	of 11	**0%**	● **0%**
2025 health budget released	~~₦~~47.8bn	**~~₦~~16.8bn**	● **35.1%**
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**100%**	● **100%**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 1,289	**276**	● **21%**
SHCs reporting on DHIS2	of 117	**0**	● **0%**
Tertiary facilities on DHIS2	of 3	**0**	● **0%**
BHCPF facilities with EMR	of 276	**144**	● **52%**
PHCs with EMR	of 1,289	**144**	● **11%**
Tertiary facilities with EMR	of 3	**1**	● **33%**

Deaths reported Q1–Q2: maternal 14 · infant 94 · neonatal 70 · under-5 12 · malaria 25 · HIV 233 · TB 104 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 136 doctors · 905 nurses · 302 midwives · 72 pharmacists · 88 lab scientists · 4,174 CHWs

KEY INITIATIVES
- **2026 Seasonal Malaria Chemoprevention campaign**
- **SEMSAS emergency and ambulance services**
- **MNCH Week 2026; Lassa fever outbreak response**
- **One Health coordination; state health insurance**

MAJOR CHALLENGES
Conflict displacement (about 500,000 IDPs), malaria, Lassa fever, malnutrition, HRH gaps, stock-outs and donor dependence

ACTION TAKEN
- **BENSEMA set up; biometric IDP database**
- **24 IDP camps with 12 camp PHCs; 18 mobile teams**
- **~~₦~~294.5m counterpart funding for 2026 SMC**
- **Free ITNs in IDP camps and ANC clinics**

How scored: counts vs the 50% of annual target due by Q2; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Borno State summary scorecard, Q1–Q3 2026

Borno State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 8TH SEPTEMBER 2026 · Validated (14TH SEPTEMBER 2026)

5 of 16 scored indicators on track (31%)	**5** On track	**3** Close	**8** Not on Track	**23** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	–	Not reported	● No data
NCH resolutions implemented	–	Not reported	● No data
SCH meetings held	–	Not reported	● No data
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	328,469	**116,445**	● 35%
Under-5s given Vitamin A	1,317,868	**401,955**	● 30%
Skilled birth attendance	100%	**38.5%**	● 38%
Newborn PNC within 48 hrs	100%	**97.8%**	● 97%
Women PNC within 48 hrs	100%	**97.8%**	● 97%
Under-5 diarrhoea given ORS + zinc	1,317,867	**97,238**	● 7%
IMMUNISATION			
BCG coverage (live births)	100%	**86.1%**	● 86%
Zero-dose children (12–23 m)	≤100%	**40.8%**	● Met
No routine vaccination (12–23 m)	–	Not reported	● No data
All basic antigens (12–23 m)	100%	**88.5%**	● 88%
Fully vaccinated (12–23 m)	100%	**88.5%**	● 88%
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	Not reported	● No data
New cervical cancer cases	–	Not reported	● No data

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**19,526**	● No target
CHEWs trained on integrated care	–	**2,990**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	–	**663**	● No target
New TB cases diagnosed	–	Not reported	● No data
PMTCT: HEI final negative	–	Not reported	● No data
Uncomplicated malaria diagnosed	–	**402,050**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	**100%**	● No target
SHCs certified CEmONC	–	Not reported	● No data
New SSHIA enrolees	–	**106,303**	● No target
Population with health insurance	–	Not reported	● No data
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦656.1bn	**₦656.0bn**	● 100.0%
HEALTH SECURITY			
IDSR timely reporting (001)	–	Not reported	● No data
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 386	**443**	● Check
SHCs reporting on DHIS2	of 40	**0**	● 0%
Tertiary facilities on DHIS2	of 2	**0**	● 0%
BHCPF facilities with EMR	of 220	**118**	● 53%
PHCs with EMR	of 386	**4**	● 1%
Tertiary facilities with EMR	of 2	**2**	● 100%

Deaths reported Q1–Q3: maternal 0 · infant 122 · neonatal 0 · under-5 0 · malaria 126 · HIV 0 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 222 doctors · 1,222 nurses · 8 pharmacists · 39 lab scientists · 2,990 CHWs

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Not provided in the submission

ACTION TAKEN
Not provided in the submission

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Cross River State summary scorecard, Q1–Q3 2026

Cross River State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 19/10/26 · Validated by DIRECTOR, HPRS

19 of 25 scored indicators on track (76%) | **19** On track | **3** Close | **3** Not on Track | **14** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	–	Not reported	● No data
NCH resolutions implemented	–	Not reported	● No data
SCH meetings held	–	**0**	● No target
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	214,593	**24,803**	● 11%
Under-5s given Vitamin A	92,252	**92,252**	● 100%
Skilled birth attendance	4%	**30%**	● 752%
Newborn PNC within 48 hrs	92%	**76%**	● 82%
Women PNC within 48 hrs	92%	**74.6%**	● 81%
Under-5 diarrhoea given ORS + zinc	80	**11,586**	● 14482%
IMMUNISATION			
BCG coverage (live births)	75%	**106.3%**	● 141%
Zero-dose children (12–23 m)	≤80%	**33.3%**	● Met
No routine vaccination (12–23 m)	≤43%	**2%**	● Met
All basic antigens (12–23 m)	43%	**68.6%**	● 159%
Fully vaccinated (12–23 m)	43%	**40.1%**	● 93%
NCDS			
Hypertension cases on treatment	of 7,899	**300**	● 3%
Diabetes cases on treatment	of 2,896	**2,896**	● 100%
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	55	**15**	● 27%
New cervical cancer cases	65	**49**	● 75%

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	Not reported	● No data
CHEWs trained on integrated care	5	**889**	● 17780%
HIV, TB & MALARIA			
New HIV-positive clients	–	Not reported	● No data
New TB cases diagnosed	60	**120,932**	● 201553 %
PMTCT: HEI final negative	–	Not reported	● No data
Uncomplicated malaria diagnosed	85	**182,431**	● 214624 %
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	98.5%	**99%**	● 100%
SHCs certified CEmONC	19%	**15%**	● 78%
New SSHIA enrolees	–	Not reported	● No data
Population with health insurance	–	Not reported	● No data
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	–	Not reported	● No data
HEALTH SECURITY			
IDSR timely reporting (001)	–	Not reported	● No data
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 196	**196**	● 100%
SHCs reporting on DHIS2	of 15	**15**	● 100%
Tertiary facilities on DHIS2	of 2	**2**	● 100%
BHCPF facilities with EMR	of 196	**196**	● 100%
PHCs with EMR	of 196	**196**	● 100%
Tertiary facilities with EMR	of 2	**2**	● 100%

Deaths reported Q1–Q3: maternal 10 · infant 0 · neonatal 28 · under-5 40 · malaria 0 · HIV 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 390 doctors · 827 nurses · 414 midwives · 161 pharmacists · 148 lab scientists · 2,182 CHWs

KEY INITIATIVES
- **PHC revitalisation and service delivery upgrades**
- **State public health laboratory planned**
- **Dialysis centres upgraded in Calabar and Ogoja**
- **New general hospital in Ikom; school nutrition**

MAJOR CHALLENGES
Low funding, weak infrastructure, too few health workers, gaps in health-security law and disease control

ACTION TAKEN
- **Public health security and animal health bills drafted**
- **Digital surveillance tools; health-worker training**
- **Recruitment and renovation of run-down facilities**
- **More routine immunisation outreaches**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Delta State summary scorecard, Q1–Q3 2026

Delta State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 18/10/2026 · Validated (17/10/2026)

9 of 23 scored indicators on track (39%) | **9** On track | **8** Close | **6** Not on Track | **16** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	–	Not reported	● No data
SCH meetings held	–	Not reported	● No data
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	150,000	**33,541**	● 22%
Under-5s given Vitamin A	1,000,000	**1,081,721**	● 108%
Skilled birth attendance	100%	**83.7%**	● 83%
Newborn PNC within 48 hrs	–	Not reported	● No data
Women PNC within 48 hrs	–	Not reported	● No data
Under-5 diarrhoea given ORS + zinc	–	Not reported	● No data
IMMUNISATION			
BCG coverage (live births)	95%	**91.7%**	● 96%
Zero-dose children (12–23 m)	0%	**16.7%**	● Above
No routine vaccination (12–23 m)	0%	**41%**	● Above
All basic antigens (12–23 m)	95%	**59%**	● 62%
Fully vaccinated (12–23 m)	95%	**33.3%**	● 35%
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	**333**	● No target
New cervical cancer cases	–	Not reported	● No data

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	4,264	**3,608**	● 84%
CHEWs trained on integrated care	787	**680**	● 86%
HIV, TB & MALARIA			
New HIV-positive clients	3,279	**2,447**	● 74%
New TB cases diagnosed	–	Not reported	● No data
PMTCT: HEI final negative	95%	**95.3%**	● 100%
Uncomplicated malaria diagnosed	519,876	**396,085**	● 76%
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	**53%**	● No target
SHCs certified CEmONC	–	Not reported	● No data
New SSHIA enrolees	200,000	**198,385**	● 99%
Population with health insurance	60%	**51.3%**	● 85%
Blood banks registered with NBSA	–	**0%**	● No denom.
2025 health budget released	₦61.8bn	**₦44.2bn**	● 71.5%
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**98%**	● 98%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 470	**458**	● 97%
SHCs reporting on DHIS2	of 64	**64**	● 100%
Tertiary facilities on DHIS2	of 3	**2**	● 66%
BHCPF facilities with EMR	of 268	**140**	● 52%
PHCs with EMR	of 470	**140**	● 29%
Tertiary facilities with EMR	of 3	**2**	● 66%

Deaths reported Q1–Q3: maternal 0 · infant 0 · neonatal 0 · under-5 0 · malaria 0 · HIV 448 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 749 doctors · 1,875 nurses · 205 pharmacists · 99 lab scientists · 680 CHWs

KEY INITIATIVES
- **Helium Doc and Helium Mum: remote, AI-enabled care**
- **Digital access to public health services to cut maternal deaths**

MAJOR CHALLENGES
Low budget provision and release, too few health workers, no public health lab, weak enforcement of health laws

ACTION TAKEN
- **Public health lab being built at Osubi Specialist Hospital**
- **Specimens referred to reference laboratories**
- **Advocacy for quarterly, AOP-based fund release**
- **Advocacy for health-worker recruitment**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Ebonyi State summary scorecard, Q1–Q3 2026

Ebonyi State — **State Summary Scorecard** · 2026 JAR · Q1–Q2
Submission date not given

2 of 3 scored indicators on track (67%) | **2** On track | **0** Close | **1** Not on Track | **36** Not scored

Indicator	Target	Q1–Q2	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● **50%**
NCH resolutions implemented	100%	**20%**	● **20%**
SCH meetings held	1	**1**	● **100%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**24,484**	● **No target**
Under-5s given Vitamin A	–	**81,958**	● **No target**
Skilled birth attendance	–	**93.5%**	● **No target**
Newborn PNC within 48 hrs	–	**64%**	● **No target**
Women PNC within 48 hrs	–	**64%**	● **No target**
Under-5 diarrhoea given ORS + zinc	–	**7,238**	● **No target**
IMMUNISATION			
BCG coverage (live births)	–	**3.3%**	● **No target**
Zero-dose children (12–23 m)	–	Not reported	● **No data**
No routine vaccination (12–23 m)	–	Not reported	● **No data**
All basic antigens (12–23 m)	–	Not reported	● **No data**
Fully vaccinated (12–23 m)	–	Not reported	● **No data**
NCDS			
Hypertension cases on treatment	–	Not reported	● **No data**
Diabetes cases on treatment	–	Not reported	● **No data**
New prostate cancer cases	–	Not reported	● **No data**
New breast cancer cases	–	Not reported	● **No data**
New cervical cancer cases	–	Not reported	● **No data**

Indicator	Target	Q1–Q2	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	Not reported	● **No data**
CHEWs trained on integrated care	–	Not reported	● **No data**
HIV, TB & MALARIA			
New HIV-positive clients	–	Not reported	● **No data**
New TB cases diagnosed	–	Not reported	● **No data**
PMTCT: HEI final negative	–	Not reported	● **No data**
Uncomplicated malaria diagnosed	–	Not reported	● **No data**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	Not reported	● **No data**
SHCs certified CEmONC	–	Not reported	● **No data**
New SSHIA enrolees	–	Not reported	● **No data**
Population with health insurance	–	Not reported	● **No data**
Blood banks registered with NBSA	–	Not reported	● **No data**
2025 health budget released	–	Not reported	● **No data**
HEALTH SECURITY			
IDSR timely reporting (001)	–	Not reported	● **No data**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	–	Not reported	● **No data**
SHCs reporting on DHIS2	–	Not reported	● **No data**
Tertiary facilities on DHIS2	–	Not reported	● **No data**
BHCPF facilities with EMR	–	Not reported	● **No data**
PHCs with EMR	–	Not reported	● **No data**
Tertiary facilities with EMR	–	Not reported	● **No data**

Deaths reported Q1–Q2: maternal 0 · infant 0 · neonatal 97 · under-5 0 · malaria 0 · HIV 0 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** not reported

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Not provided in the submission

ACTION TAKEN
Not provided in the submission

How scored: counts vs the 50% of annual target due by Q2; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Edo State summary scorecard, Q1–Q3 2026

Edo State — **State Summary Scorecard** · 2026 JAR · Q1–Q2
Submission date not given

11 of 18 scored indicators on track (61%) | **11** On track | **2** Close | **5** Not on Track | **21** Not scored

Indicator	Target	Q1–Q2	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● 50%
NCH resolutions implemented	80%	**60.9%**	● 76%
SCH meetings held	4	**2**	● 50%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	49,000	**17,439**	● 35%
Under-5s given Vitamin A	986,989	**1,046,855**	● 106%
Skilled birth attendance	–	**96%**	● No target
Newborn PNC within 48 hrs	–	**20.8%**	● No target
Women PNC within 48 hrs	–	**5.1%**	● No target
Under-5 diarrhoea given ORS + zinc	–	Not reported	● No data
IMMUNISATION			
BCG coverage (live births)	–	**3.7%**	● No target
Zero-dose children (12–23 m)	–	**44.6%**	● No target
No routine vaccination (12–23 m)	–	Not reported	● No data
All basic antigens (12–23 m)	–	Not reported	● No data
Fully vaccinated (12–23 m)	–	Not reported	● No data
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	Not reported	● No data
New cervical cancer cases	–	**25**	● No target

Indicator	Target	Q1–Q2	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**2,605**	● No target
CHEWs trained on integrated care	–	**948**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	2,195	**1,296**	● 59%
New TB cases diagnosed	–	**1,569**	● No target
PMTCT: HEI final negative	98%	**98%**	● 100%
Uncomplicated malaria diagnosed	–	**173,408**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	25%	**8.3%**	● 33%
SHCs certified CEmONC	80%	**8.3%**	● 10%
New SSHIA enrolees	–	**9,741**	● No target
Population with health insurance	–	**11.2%**	● No target
Blood banks registered with NBSA	of 21	**90.5%**	● 90%
2025 health budget released	₦165.7bn	**₦12.9bn**	● 7.8%
HEALTH SECURITY			
IDSR timely reporting (001)	90%	**91.9%**	● 102%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 515	**510**	● 99%
SHCs reporting on DHIS2	of 600	**32**	● 5%
Tertiary facilities on DHIS2	of 5	**5**	● 100%
BHCPF facilities with EMR	of 146	**146**	● 100%
PHCs with EMR	of 515	**146**	● 28%
Tertiary facilities with EMR	of 5	**5**	● 100%

Deaths reported Q1–Q2: maternal 0 · infant 12 · neonatal 9 · under-5 0 · malaria 0 · HIV 134 · TB 36 · prostate cancer 0 · breast cancer 28 · cervical cancer 0 **Workforce in post:** 228 doctors · 778 nurses · 207 midwives · 136 pharmacists · 212 lab scientists · 948 CHWs

KEY INITIATIVES
- **TB and Leprosy Control Programme**
- **Malaria Elimination Programme (NMEP)**
- **Basic Health Care Provision Fund (BHCPF)**
- **National Health Insurance (NHIA)**

MAJOR CHALLENGES
Dengue, Lassa fever, yellow fever, Mpox, diphtheria and cholera outbreaks; maternal and child deaths; malaria

ACTION TAKEN
- **Community sensitisation on rodent control and food storage**
- **Reactive yellow fever vaccination**
- **Private facilities brought into the IDSR network**
- **Diphtheria antitoxin pre-positioned**

How scored: counts vs the 50% of annual target due by Q2; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Ekiti State summary scorecard, Q1–Q3 2026

Ekiti State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given ·

8 of 13 scored indicators on track (62%) | **8** On track | **3** Close | **2** Not on Track | **26** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● 50%
NCH resolutions implemented	100%	**90%**	● 90%
SCH meetings held	–	**0**	● No target
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**11,993**	● No target
Under-5s given Vitamin A	705,946	**533,231**	● 75%
Skilled birth attendance	–	**91.6%**	● No target
Newborn PNC within 48 hrs	–	Not reported	● No data
Women PNC within 48 hrs	–	**59.4%**	● No target
Under-5 diarrhoea given ORS + zinc	–	**3,737**	● No target
IMMUNISATION			
BCG coverage (live births)	80%	**76.8%**	● 96%
Zero-dose children (12–23 m)	≤80%	**17.3%**	● Met
No routine vaccination (12–23 m)	≤80%	**21%**	● Met
All basic antigens (12–23 m)	80%	**79.2%**	● 98%
Fully vaccinated (12–23 m)	80%	**77.5%**	● 96%
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	Not reported	● No data
New cervical cancer cases	–	Not reported	● No data

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	Not reported	● No data
CHEWs trained on integrated care	–	Not reported	● No data
HIV, TB & MALARIA			
New HIV-positive clients	–	Not reported	● No data
New TB cases diagnosed	8,245	**852**	● 10%
PMTCT: HEI final negative	–	Not reported	● No data
Uncomplicated malaria diagnosed	–	**204,690**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	Not reported	● No data
SHCs certified CEmONC	–	Not reported	● No data
New SSHIA enrolees	200,000	**72,991**	● 36%
Population with health insurance	25%	**22%**	● 88%
Blood banks registered with NBSA	–	**0%**	● No denom.
2025 health budget released	–	Not reported	● No data
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**70%**	● 70%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	–	Not reported	● No data
SHCs reporting on DHIS2	of 21	**21**	● 100%
Tertiary facilities on DHIS2	–	Not reported	● No data
BHCPF facilities with EMR	–	Not reported	● No data
PHCs with EMR	–	Not reported	● No data
Tertiary facilities with EMR	–	Not reported	● No data

Deaths reported Q1–Q3: maternal 0 · infant 0 · neonatal 0 · under-5 0 · malaria 0 · hiv 0 · tb 27 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 55 doctors · 444 nurses · 27 pharmacists · 34 lab scientists · 2 CHWs

KEY INITIATIVES
- **Disease surveillance and notification**
- **Outbreak investigation and response**
- **Emergency preparedness and response coordination**
- **IDSR system strengthening**

MAJOR CHALLENGES
Climate effects (heat, flooding, dry spells) driving malaria and food shortage; insecurity limiting access to services

ACTION TAKEN
- **Multisectoral climate and health TWG; policy drafted**
- **Joint climate-health alerts with environment ministry**
- **Vigilante and security support for health campaigns**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%, behind <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, no data, or no N (denominator); Check = value above N.

Chapter 13

Enugu State summary scorecard, Q1–Q3 2026

Enugu State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 25th SEPTEMBER,2026 · Validated (26th SEPTEMBER,2026)

3 of 19 scored indicators on track (16%) | **3** On track | **9** Close | **7** Not on Track | **20** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● **75%**
NCH resolutions implemented	–	**0%**	● **No target**
SCH meetings held	1	**0**	● **0%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**17,989**	● **No target**
Under-5s given Vitamin A	–	Not reported	● **No data**
Skilled birth attendance	80%	**50.7%**	● **63%**
Newborn PNC within 48 hrs	80%	**3%**	● **3%**
Women PNC within 48 hrs	80%	**5%**	● **6%**
Under-5 diarrhoea given ORS + zinc	–	**4,522**	● **No target**
IMMUNISATION			
BCG coverage (live births)	85%	**69%**	● **81%**
Zero-dose children (12–23 m)	≤1.8%	**2%**	● **89%**
No routine vaccination (12–23 m)	≤1.8%	**2%**	● **89%**
All basic antigens (12–23 m)	80%	**12.1%**	● **15%**
Fully vaccinated (12–23 m)	80%	**12.1%**	● **15%**
NCDS			
Hypertension cases on treatment	–	Not reported	● **No data**
Diabetes cases on treatment	–	Not reported	● **No data**
New prostate cancer cases	–	Not reported	● **No data**
New breast cancer cases	–	**49**	● **No target**
New cervical cancer cases	–	**65**	● **No target**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	8,252	**6,752**	● **81%**
CHEWs trained on integrated care	–	Not reported	● **No data**
HIV, TB & MALARIA			
New HIV-positive clients	–	**2**	● **No target**
New TB cases diagnosed	–	Not reported	● **No data**
PMTCT: HEI final negative	–	**104.5%**	● **No target**
Uncomplicated malaria diagnosed	–	**91,882**	● **No target**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	Not reported	● **No data**
SHCs certified CEmONC	–	Not reported	● **No data**
New SSHIA enrolees	–	**15,721**	● **No target**
Population with health insurance	–	Not reported	● **No data**
Blood banks registered with NBSA	–	**0%**	● **No denom.**
2025 health budget released	₦59.1bn	**₦43.3bn**	● **73.3%**
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**75%**	● **75%**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 567	**566**	● **99%**
SHCs reporting on DHIS2	of 53	**40**	● **75%**
Tertiary facilities on DHIS2	of 6	**6**	● **100%**
BHCPF facilities with EMR	of 260	**82**	● **31%**
PHCs with EMR	of 567	**82**	● **14%**
Tertiary facilities with EMR	of 6	**4**	● **66%**

Deaths reported Q1–Q3: maternal 0 · infant 52 · neonatal 73 · under-5 0 · malaria 0 · HIV 0 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 470 doctors · 396 nurses · 587 midwives · 96 pharmacists · 195 lab scientists · 2,252 CHWs

KEY INITIATIVES
- **Active case search for Ebola preparedness and response**

MAJOR CHALLENGES
Moving samples from collection points to the state hub for outbreak confirmation

ACTION TAKEN
- **Advocacy to partners (STRIBES) for sample transport**
- **Surveillance officers collect samples from LGAs**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

FCT summary scorecard, Q1–Q3 2026

FCT — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 17th October, 2026 · Validated by DHPRS (17th October, 2026)

16 of 35 scored indicators on track (46%) | **16** On track | **7** Close | **12** Not on Track | **4** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● 50%
NCH resolutions implemented	100%	**66.7%**	● 66%
SCH meetings held	1	**0**	● 0%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	50,000	**35,988**	● 71%
Under-5s given Vitamin A	648,166	**277,114**	● 42%
Skilled birth attendance	80%	**69.7%**	● 87%
Newborn PNC within 48 hrs	90%	**90.7%**	● 100%
Women PNC within 48 hrs	90%	**90.7%**	● 100%
Under-5 diarrhoea given ORS + zinc	7,600	**5,229**	● 68%
IMMUNISATION			
BCG coverage (live births)	90%	**87.7%**	● 97%
Zero-dose children (12–23 m)	≤90%	**1.3%**	● Met
No routine vaccination (12–23 m)	–	Not reported	● No data
All basic antigens (12–23 m)	90%	**83.3%**	● 92%
Fully vaccinated (12–23 m)	90%	**70.7%**	● 78%
NCDS			
Hypertension cases on treatment	of 797	**1,710**	● 214%
Diabetes cases on treatment	of 153	**480**	● 313%
New prostate cancer cases	66	**7**	● 10%
New breast cancer cases	67	**13**	● 19%
New cervical cancer cases	67	**11**	● 16%

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	3,000	**2,533**	● 84%
CHEWs trained on integrated care	1,000	**665**	● 66%
HIV, TB & MALARIA			
New HIV-positive clients	2,500	**2,023**	● 80%
New TB cases diagnosed	16,731	**2,398**	● 14%
PMTCT: HEI final negative	95%	**97%**	● 102%
Uncomplicated malaria diagnosed	70	**209**	● 298%
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**29%**	● 29%
SHCs certified CEmONC	100%	**64%**	● 64%
New SSHIA enrolees	15,281	**40,325**	● 263%
Population with health insurance	6.5%	**6.4%**	● 99%
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦53.9bn	**₦28.3bn**	● 52.5%
HEALTH SECURITY			
IDSR timely reporting (001)	80%	**100%**	● 125%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 453	**62**	● 13%
SHCs reporting on DHIS2	of 514	**0**	● 0%
Tertiary facilities on DHIS2	of 7	**0**	● 0%
BHCPF facilities with EMR	of 62	**62**	● 100%
PHCs with EMR	of 453	**63**	● 13%
Tertiary facilities with EMR	of 7	**7**	● 100%

Deaths reported Q1–Q3: maternal 0 · infant 0 · neonatal 241 · under-5 0 · malaria 65 · HIV 127 · TB 41 · prostate cancer 7 · breast cancer 6 · cervical cancer 3 **Workforce in post:** 439 doctors · 918 nurses · 128 pharmacists · 176 lab scientists · 634 CHWs

KEY INITIATIVES
- **Triple elimination (HIV/syphilis/HBV) pilot, 2 ART sites**
- **EID point-of-care testing at 8 ART sites**
- **Lenacapavir PrEP pilot at 8 ART sites**
- **Community PMTCT with volunteers and mentor mothers**

MAJOR CHALLENGES
Late fund release, MDR-TB and antimalarial resistance, late data reporting, HIV test-kit stock-outs, donor dependence

ACTION TAKEN
- **IDSR and PHEOC response strengthened**
- **ITN distribution and vector control**
- **NCD screening built into PHC services**
- **Supervision and mentoring to improve data reporting**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Gombe State summary scorecard, Q1–Q3 2026

Gombe State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 14/10/2026

11 of 32 scored indicators on track (34%) | **11** On track | **7** Close | **14** Not on Track | **7** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**5**	● 125%
NCH resolutions implemented	100%	**28.3%**	● 28%
SCH meetings held	1	**0**	● 0%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**65,807**	● No target
Under-5s given Vitamin A	770,852	**346,883**	● 44%
Skilled birth attendance	90%	**92.3%**	● 102%
Newborn PNC within 48 hrs	104%	**73.3%**	● 70%
Women PNC within 48 hrs	107.1%	**75.7%**	● 70%
Under-5 diarrhoea given ORS + zinc	0	**1**	● 271%
IMMUNISATION			
BCG coverage (live births)	72%	**69%**	● 95%
Zero-dose children (12–23 m)	–	**27%**	● No target
No routine vaccination (12–23 m)	–	**19%**	● No target
All basic antigens (12–23 m)	50%	**34.9%**	● 69%
Fully vaccinated (12–23 m)	50%	**34.9%**	● 69%
NCDS			
Hypertension cases on treatment	of 18,244	**17,944**	● 98%
Diabetes cases on treatment	of 3,418	**1,652**	● 48%
New prostate cancer cases	20	**12**	● 60%
New breast cancer cases	25	**15**	● 60%
New cervical cancer cases	30	**23**	● 76%

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	8,790	**6,846**	● 77%
CHEWs trained on integrated care	450	**171**	● 38%
HIV, TB & MALARIA			
New HIV-positive clients	260,000	**114,389**	● 43%
New TB cases diagnosed	6,793	**4,951**	● 72%
PMTCT: HEI final negative	100%	**91.3%**	● 91%
Uncomplicated malaria diagnosed	626,272	**510,247**	● 81%
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	30%	**8.3%**	● 27%
SHCs certified CEmONC	30%	**12%**	● 40%
New SSHIA enrolees	1,150,000	**347,900**	● 30%
Population with health insurance	25%	**10.1%**	● 40%
Blood banks registered with NBSA	of 8	**99%**	● 99%
2025 health budget released	₦320.1bn	**₦14.6bn**	● 4.5%
HEALTH SECURITY			
IDSR timely reporting (001)	90%	**29%**	● 32%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 652	**652**	● 100%
SHCs reporting on DHIS2	of 24	**24**	● 100%
Tertiary facilities on DHIS2	of 1	**2**	● Check
BHCPF facilities with EMR	of 114	**22**	● 19%
PHCs with EMR	of 652	**22**	● 3%
Tertiary facilities with EMR	of 1	**2**	● Check

Deaths reported Q1–Q3: maternal 84 · infant 1,909 · neonatal 264 · under-5 100 · malaria 450 · HIV 66 · prostate cancer 4 · breast cancer 8 · cervical cancer 13 **Workforce in post:** 32 doctors · 487 nurses · 209 midwives · 121 pharmacists · 245 lab scientists · 1,001 CHWs

KEY INITIATIVES
- **228 PHCs revitalised; 114 commissioned**
- **GoHealth insurance: 380,000+ residents covered**
- **1,200+ health workers recruited; 440 ghost workers removed**
- **3,900+ PWID reached with HIV services**

MAJOR CHALLENGES
Declining routine immunisation, TB commodity shortages, low domestic financing, rural HRH gaps, falling donor funds

ACTION TAKEN
- **Mass vaccination; coverage above 85% in several LGAs**
- **GoPharma set up for local drug production**
- **Health budget held at 15%; Health Trust Fund planned**
- **Fathers' Response Team for vaccine confidence**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Imo State summary scorecard, Q1–Q3 2026

Imo State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given

7 of 27 scored indicators on track (26%) | **7** On track | **6** Close | **14** Not on Track | **12** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● **75%**
NCH resolutions implemented	80%	**56.7%**	● **70%**
SCH meetings held	1	**0**	● **0%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**17,182**	● **No target**
Under-5s given Vitamin A	1,431,785	**476,012**	● **33%**
Skilled birth attendance	100%	**76.4%**	● **76%**
Newborn PNC within 48 hrs	100%	**4%**	● **4%**
Women PNC within 48 hrs	100%	**3.5%**	● **3%**
Under-5 diarrhoea given ORS + zinc	–	**7,010**	● **No target**
IMMUNISATION			
BCG coverage (live births)	100%	**99.9%**	● **99%**
Zero-dose children (12–23 m)	≤100%	**11.5%**	● **Met**
No routine vaccination (12–23 m)	≤100%	**11.7%**	● **Met**
All basic antigens (12–23 m)	100%	**80.9%**	● **80%**
Fully vaccinated (12–23 m)	100%	**82.7%**	● **82%**
NCDS			
Hypertension cases on treatment	of 17,752	**453**	● **2%**
Diabetes cases on treatment	of 8,923	**654**	● **7%**
New prostate cancer cases	–	**0**	● **No target**
New breast cancer cases	–	**39**	● **No target**
New cervical cancer cases	–	**5**	● **No target**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	5,454	**3,267**	● **59%**
CHEWs trained on integrated care	391	**285**	● **72%**
HIV, TB & MALARIA			
New HIV-positive clients	–	**1,687**	● **No target**
New TB cases diagnosed	15,058	**6,649**	● **44%**
PMTCT: HEI final negative	–	**92.7%**	● **No target**
Uncomplicated malaria diagnosed	5,910,410	**95,729**	● **1%**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**100%**	● **100%**
SHCs certified CEmONC	80%	**41%**	● **51%**
New SSHIA enrolees	2,500,000	**41,222**	● **1%**
Population with health insurance	46%	**0%**	● **0%**
Blood banks registered with NBSA	–	**0%**	● **No denom.**
2025 health budget released	₦38.3bn	**₦38.3bn**	● **100.0%**
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**98.3%**	● **98%**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 1,109	**548**	● **49%**
SHCs reporting on DHIS2	of 709	**1,109**	● **Check**
Tertiary facilities on DHIS2	of 6	**709**	● **Check**
BHCPF facilities with EMR	of 6	**5**	● **83%**
PHCs with EMR	of 1,109	**548**	● **49%**
Tertiary facilities with EMR	of 6	**2**	● **33%**

Deaths reported Q1–Q3: maternal 15 · infant 87 · neonatal 55 · under-5 0 · malaria 14 · HIV 231 · TB 163 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** not reported

KEY INITIATIVES
- **IMSHIA health insurance expansion and enrolment**
- **Roll Back Malaria: ITNs, IPTp, RDT-based treatment**

MAJOR CHALLENGES
High maternal mortality, diphtheria outbreak, low insurance coverage, no malaria partners since 2017

ACTION TAKEN
- **MAMII project running in 3 LGAs**
- **Multiple micronutrient supplements for pregnant women**
- **Biannual MNCH Week**
- **Insurance enrolment drives; IMSHIA data digitised**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Kaduna State summary scorecard, Q1–Q3 2026

Kaduna State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given

7 of 26 scored indicators on track (27%) | **7** On track | **7** Close | **12** Not on Track | **13** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● **50%**
NCH resolutions implemented	100%	**83.3%**	● **83%**
SCH meetings held	1	**0**	● **0%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	306,926	**258,543**	● **84%**
Under-5s given Vitamin A	946,368	**451,979**	● **47%**
Skilled birth attendance	95%	**95.1%**	● **100%**
Newborn PNC within 48 hrs	60%	**47.2%**	● **78%**
Women PNC within 48 hrs	60%	**47.2%**	● **78%**
Under-5 diarrhoea given ORS + zinc	61,814	**45,112**	● **72%**
IMMUNISATION			
BCG coverage (live births)	90%	**86.9%**	● **96%**
Zero-dose children (12–23 m)	–	Not reported	● **No data**
No routine vaccination (12–23 m)	≤30%	**45.2%**	● **66%**
All basic antigens (12–23 m)	60%	**32.8%**	● **54%**
Fully vaccinated (12–23 m)	45%	**13.9%**	● **30%**
NCDS			
Hypertension cases on treatment	–	Not reported	● **No data**
Diabetes cases on treatment	–	Not reported	● **No data**
New prostate cancer cases	–	Not reported	● **No data**
New breast cancer cases	–	**71**	● **No target**
New cervical cancer cases	–	Not reported	● **No data**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	24,606	**9,953**	● **40%**
CHEWs trained on integrated care	2,159	**774**	● **35%**
HIV, TB & MALARIA			
New HIV-positive clients	–	Not reported	● **No data**
New TB cases diagnosed	–	Not reported	● **No data**
PMTCT: HEI final negative	100%	**99.3%**	● **99%**
Uncomplicated malaria diagnosed	2,000,000	**1,577,000**	● **78%**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	Not reported	● **No data**
SHCs certified CEmONC	–	Not reported	● **No data**
New SSHIA enrolees	1,000,000	**771,960**	● **77%**
Population with health insurance	22%	**11%**	● **50%**
Blood banks registered with NBSA	–	Not reported	● **No data**
2025 health budget released	₦91.4bn	**₦40.6bn**	● **44.5%**
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**96.7%**	● **96%**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 1,087	**254**	● **23%**
SHCs reporting on DHIS2	of 32	**32**	● **100%**
Tertiary facilities on DHIS2	of 7	**0**	● **0%**
BHCPF facilities with EMR	of 255	**142**	● **55%**
PHCs with EMR	of 1,087	**142**	● **13%**
Tertiary facilities with EMR	of 7	**2**	● **28%**

Deaths reported Q1–Q3: maternal 0 · infant 384 · neonatal 122 · under-5 20 · malaria 127 · HIV 248 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 312 doctors · 2,251 nurses · 128 pharmacists · 121 lab scientists · 2,449 CHWs

KEY INITIATIVES
- **SMC and Malaria Elimination Programme**
- **TB, leprosy and Buruli ulcer control**
- **ANRIN nutrition; epidemic preparedness and response**
- **Free VVF surgery; mental health services**

MAJOR CHALLENGES
Malaria, TB, HIV, maternal and child deaths, malnutrition, cholera, diphtheria and Lassa fever, NCDs, VVF, substance abuse

ACTION TAKEN
- **HOPE project, MAMII and SWAp programmes**
- **Infrastructure and equipment upgrades**
- **HRH motivation and recruitment**
- **15% of the budget allocated to health**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%, Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Kano State summary scorecard, Q1–Q3 2026

Kano State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 15/10/2026 · Validated by STATE DHPRS / PROGRAMME SIGN-OFFICERS (15/10/2026)

17 of 37 scored indicators on track (46%) | **17 On track** | **11 Close** | **9 Not on Track** | **2 Not scored**

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	65%	**46%**	● 70%
SCH meetings held	1	**0**	● 0%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	400,590	**269,542**	● 67%
Under-5s given Vitamin A	366,219	**270,449**	● 73%
Skilled birth attendance	35%	**26%**	● 74%
Newborn PNC within 48 hrs	5%	**2.5%**	● 50%
Women PNC within 48 hrs	5%	**2.2%**	● 44%
Under-5 diarrhoea given ORS + zinc	152,449	**100,310**	● 65%
IMMUNISATION			
BCG coverage (live births)	40%	**29.3%**	● 73%
Zero-dose children (12–23 m)	≤17%	**19%**	● 89%
No routine vaccination (12–23 m)	≤12%	**15.3%**	● 78%
All basic antigens (12–23 m)	20%	**13%**	● 65%
Fully vaccinated (12–23 m)	80%	**69%**	● 86%
NCDS			
Hypertension cases on treatment	of 69,400	**177,000**	● 255%
Diabetes cases on treatment	of 20,150	**49,200**	● 244%
New prostate cancer cases	320	**210**	● 65%
New breast cancer cases	500	**345**	● 69%
New cervical cancer cases	400	**270**	● 67%

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	27,000	**27,000**	● 100%
CHEWs trained on integrated care	20,500	**14,500**	● 70%
HIV, TB & MALARIA			
New HIV-positive clients	4,138	**2,934**	● 70%
New TB cases diagnosed	29,028	**19,778**	● 68%
PMTCT: HEI final negative	95%	**89%**	● 93%
Uncomplicated malaria diagnosed	5,279,364	**3,309,722**	● 62%
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	10%	**10.5%**	● 105%
SHCs certified CEmONC	100%	**100%**	● 100%
New SSHIA enrolees	600,000	**454,127**	● 75%
Population with health insurance	100%	**7.3%**	● 7%
Blood banks registered with NBSA	of 55	**75%**	● 75%
2025 health budget released	₦91.4bn	**₦32.3bn**	● 35.4%
HEALTH SECURITY			
IDSR timely reporting (001)	95%	**91%**	● 95%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 1,447	**520**	● 35%
SHCs reporting on DHIS2	of 42	**40**	● 95%
Tertiary facilities on DHIS2	of 7	**7**	● 100%
BHCPF facilities with EMR	of 484	**45**	● 9%
PHCs with EMR	of 1,447	**70**	● 4%
Tertiary facilities with EMR	of 7	**2**	● 28%

Deaths reported Q1–Q3: maternal 61 · infant 645 · neonatal 420 · under-5 335 · malaria 1,230 · HIV 570 · TB 827 · prostate cancer 59 · breast cancer 65 · cervical cancer 47 **Workforce in post:** 499 doctors · 1,315 nurses · 479 midwives · 548 pharmacists · 155 lab scientists · 6,022 CHWs

KEY INITIATIVES
- **PHC supportive supervision redesigned in 44 LGAs**
- **Zero-dose catch-up: IBRA, OBR-0, nomadic vaccination**
- **Diphtheria response: 835,028 doses with MSF**
- **Electronic DHIS2/ODK/Kobo reporting**

MAJOR CHALLENGES
Missed children in nomadic areas, diphtheria, HRH and cold-chain gaps, facility-list mismatch, incomplete 2026 data

ACTION TAKEN
- **Vaccination microplans; missed settlements tracked**
- **Reactive diphtheria vaccination in 5 LGAs**
- **Solar power announced for 484 apex PHCs**
- **Facility registry reconciled (HEFAMS)**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Katsina State summary scorecard, Q1–Q3 2026

Katsina State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 18/10/2026 · Validated (18/10/2026)

20 of 29 scored indicators on track (69%) | **20** On track | **4** Close | **5** Not on Track | **10** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● **50%**
NCH resolutions implemented	–	**75%**	● **No target**
SCH meetings held	4	**3**	● **75%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**92,336**	● **No target**
Under-5s given Vitamin A	1,936,217	**1,999,800**	● **103%**
Skilled birth attendance	100%	**91%**	● **91%**
Newborn PNC within 48 hrs	100%	**90.3%**	● **90%**
Women PNC within 48 hrs	100%	**90%**	● **90%**
Under-5 diarrhoea given ORS + zinc	60,000	**55,458**	● **92%**
IMMUNISATION			
BCG coverage (live births)	90%	**85.7%**	● **95%**
Zero-dose children (12–23 m)	≤80%	**14.7%**	● **Met**
No routine vaccination (12–23 m)	≤100%	**59.3%**	● **Met**
All basic antigens (12–23 m)	100%	**40.7%**	● **40%**
Fully vaccinated (12–23 m)	100%	**0.7%**	● **0%**
NCDS			
Hypertension cases on treatment	of 27,774	**27,774**	● **100%**
Diabetes cases on treatment	of 1,985	**1,985**	● **100%**
New prostate cancer cases	–	Not reported	● **No data**
New breast cancer cases	100	**81**	● **81%**
New cervical cancer cases	100	**137**	● **137%**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**1,628**	● **No target**
CHEWs trained on integrated care	–	Not reported	● **No data**
HIV, TB & MALARIA			
New HIV-positive clients	2,000	**668**	● **33%**
New TB cases diagnosed	18,060	**9,672**	● **53%**
PMTCT: HEI final negative	100%	**96.7%**	● **96%**
Uncomplicated malaria diagnosed	810,400	**686,833**	● **84%**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**100%**	● **100%**
SHCs certified CEmONC	–	**42.7%**	● **No target**
New SSHIA enrolees	301,950	**1,054,302**	● **349%**
Population with health insurance	2%	**0.7%**	● **33%**
Blood banks registered with NBSA	–	Not reported	● **No data**
2025 health budget released	₦4419.9bn	**₦3292.6bn**	● **74.5%**
HEALTH SECURITY			
IDSR timely reporting (001)	–	**100%**	● **No target**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 1,350	**1,142**	● **84%**
SHCs reporting on DHIS2	of 28	**28**	● **100%**
Tertiary facilities on DHIS2	of 4	**4**	● **100%**
BHCPF facilities with EMR	of 212	**212**	● **100%**
PHCs with EMR	of 1,350	**323**	● **23%**
Tertiary facilities with EMR	of 4	**4**	● **100%**

Deaths reported Q1–Q3: maternal 44 · infant 288 · neonatal 166 · under-5 60 · malaria 428 · HIV 54 · TB 81 · prostate cancer 66 · breast cancer 115 · cervical cancer 108 **Workforce in post:** 127 doctors · 2,050 nurses · 1,993 midwives · 139 pharmacists · 36 lab scientists · 1,699 CHWs

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Recurrent Lassa fever, diphtheria, cholera, CSM and measles outbreaks; weak surveillance and lab capacity; immunisation, HRH and funding gaps

ACTION TAKEN
- **Rapid response teams, case search, treatment centres**
- **IDSR training; better sample collection and transport**
- **Outbreak-response and routine immunisation intensified**
- **124 PHCs revitalised under the IMPACT Project**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Kebbi State summary scorecard, Q1–Q3 2026

Kebbi State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given · Validated by BALA ISAH KAMBA

6 of 10 scored indicators on track (60%) | **6** On track | **1** Close | **3** Not on Track | **29** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	–	**2**	● No target
NCH resolutions implemented	–	**0%**	● No target
SCH meetings held	–	**0**	● No target
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**60,258**	● No target
Under-5s given Vitamin A	1,100,317	**983,941**	● 89%
Skilled birth attendance	–	**90.7%**	● No target
Newborn PNC within 48 hrs	–	**30.3%**	● No target
Women PNC within 48 hrs	–	**31.3%**	● No target
Under-5 diarrhoea given ORS + zinc	–	**44,959**	● No target
IMMUNISATION			
BCG coverage (live births)	–	**93.4%**	● No target
Zero-dose children (12–23 m)	–	**81%**	● No target
No routine vaccination (12–23 m)	–	**18.3%**	● No target
All basic antigens (12–23 m)	–	**11.7%**	● No target
Fully vaccinated (12–23 m)	–	**77.3%**	● No target
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	**337**	● No target
New cervical cancer cases	–	**188**	● No target

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**5,630**	● No target
CHEWs trained on integrated care	–	**0**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	–	**28**	● No target
New TB cases diagnosed	–	**10,351**	● No target
PMTCT: HEI final negative	–	Not reported	● No data
Uncomplicated malaria diagnosed	–	**855,933**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	Not reported	● No data
SHCs certified CEmONC	–	Not reported	● No data
New SSHIA enrolees	143,785	**108,625**	● 75%
Population with health insurance	–	**4.1%**	● No target
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦54.0bn	**₦14.8bn**	● 27.5%
HEALTH SECURITY			
IDSR timely reporting (001)	85%	**73.3%**	● 86%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 907	**940**	● 103%
SHCs reporting on DHIS2	of 31	**31**	● 100%
Tertiary facilities on DHIS2	of 2	**2**	● 100%
BHCPF facilities with EMR	of 256	**12**	● 4%
PHCs with EMR	of 907	**13**	● 1%
Tertiary facilities with EMR	of 2	**2**	● 100%

Deaths reported Q1–Q3: maternal 19 · infant 7 · neonatal 13 · under-5 35 · malaria 258 · HIV 0 · TB 96 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 146 doctors · 2,466 nurses · 640 midwives · 67 pharmacists · 78 lab scientists · 4,600 CHWs

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Not provided in the submission

ACTION TAKEN
Not provided in the submission

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Kogi State summary scorecard, Q1–Q3 2026

Kogi State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given

8 of 26 scored indicators on track (31%) | **8** On track | **8** Close | **10** Not on Track | **13** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	100%	**79%**	● 79%
SCH meetings held	–	**0**	● No target
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	62,130	**43,163**	● 69%
Under-5s given Vitamin A	710,894	**392,609**	● 55%
Skilled birth attendance	100%	**76%**	● 76%
Newborn PNC within 48 hrs	100%	**26.1%**	● 26%
Women PNC within 48 hrs	100%	**24.7%**	● 24%
Under-5 diarrhoea given ORS + zinc	9,706	**6,579**	● 67%
IMMUNISATION			
BCG coverage (live births)	100%	**81.5%**	● 81%
Zero-dose children (12–23 m)	–	Not reported	● No data
No routine vaccination (12–23 m)	–	Not reported	● No data
All basic antigens (12–23 m)	–	Not reported	● No data
Fully vaccinated (12–23 m)	–	Not reported	● No data
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	Not reported	● No data
New cervical cancer cases	–	Not reported	● No data

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	3,000	**1,399**	● 46%
CHEWs trained on integrated care	300	**109**	● 36%
HIV, TB & MALARIA			
New HIV-positive clients	–	Not reported	● No data
New TB cases diagnosed	12,968	**7,095**	● 54%
PMTCT: HEI final negative	100%	**99%**	● 99%
Uncomplicated malaria diagnosed	224,466	**160,930**	● 71%
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**100%**	● 100%
SHCs certified CEmONC	14%	**2.6%**	● 18%
New SSHIA enrolees	83,923	**76,560**	● 91%
Population with health insurance	7%	**4.4%**	● 62%
Blood banks registered with NBSA	of 3	**100%**	● 100%
2025 health budget released	₦48.4bn	**₦31.0bn**	● 64.0%
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**100%**	● 100%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 1,080	**233**	● 21%
SHCs reporting on DHIS2	of 151	**43**	● 28%
Tertiary facilities on DHIS2	of 4	**3**	● 75%
BHCPF facilities with EMR	of 233	**100**	● 42%
PHCs with EMR	of 1,080	**100**	● 9%
Tertiary facilities with EMR	of 4	**2**	● 50%

Deaths reported Q1–Q3: maternal 0 · infant 0 · neonatal 31 · under-5 0 · malaria 0 · HIV 55 · TB 32 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 196 doctors · 529 nurses · 225 midwives · 49 pharmacists · 66 lab scientists · 109 CHWs

KEY INITIATIVES
- **MPDSR committee set up**
- **Emergency preparedness and control**
- **Mass drug administration; subsidised cataract surgery**
- **SMC and ITN distribution**

MAJOR CHALLENGES
Underfunding, weak infrastructure, out-of-pocket spending, staff shortages, Lassa fever and measles outbreaks, yearly floods

ACTION TAKEN
- **Bello Care equity fund for vulnerable groups**
- **PHEOC and Lassa fever treatment centre set up**
- **70+ BHCPF facilities upgraded**
- **Health-worker training and retraining**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Kwara State summary scorecard, Q1–Q3 2026

Kwara State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given

3 of 18 scored indicators on track (17%) | **3** On track | **4** Close | **11** Not on Track | **21** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	100%	**89%**	● 89%
SCH meetings held	1	**0**	● 0%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**22,125**	● No target
Under-5s given Vitamin A	–	**291,690**	● No target
Skilled birth attendance	–	**93.1%**	● No target
Newborn PNC within 48 hrs	–	**81.6%**	● No target
Women PNC within 48 hrs	–	**81.8%**	● No target
Under-5 diarrhoea given ORS + zinc	–	**6,217**	● No target
IMMUNISATION			
BCG coverage (live births)	–	**83.4%**	● No target
Zero-dose children (12–23 m)	–	Not reported	● No data
No routine vaccination (12–23 m)	–	Not reported	● No data
All basic antigens (12–23 m)	90%	**77%**	● 85%
Fully vaccinated (12–23 m)	90%	**95.3%**	● 105%
NCDS			
Hypertension cases on treatment	of 10,877	**7,876**	● 72%
Diabetes cases on treatment	of 2,316	**4,869**	● 210%
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	**23**	● No target
New cervical cancer cases	–	Not reported	● No data

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**9,453**	● No target
CHEWs trained on integrated care	–	Not reported	● No data
HIV, TB & MALARIA			
New HIV-positive clients	–	**765**	● No target
New TB cases diagnosed	8,840	**1,990**	● 22%
PMTCT: HEI final negative	–	**100%**	● No target
Uncomplicated malaria diagnosed	–	**182,735**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**88%**	● 88%
SHCs certified CEmONC	–	**14%**	● No target
New SSHIA enrolees	250,000	**24,787**	● 9%
Population with health insurance	7%	**0%**	● 0%
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦72.6bn	**₦35.0bn**	● 48.3%
HEALTH SECURITY			
IDSR timely reporting (001)	–	**70%**	● No target
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 1,039	**590**	● 56%
SHCs reporting on DHIS2	of 333	**154**	● 46%
Tertiary facilities on DHIS2	of 5	**2**	● 40%
BHCPF facilities with EMR	of 193	**100**	● 51%
PHCs with EMR	of 1,039	**100**	● 9%
Tertiary facilities with EMR	of 5	**2**	● 40%

Deaths reported Q1–Q3: maternal 0 · infant 419 · neonatal 130 · under-5 0 · malaria 15 · HIV 0 · TB 16 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 650 doctors · 1,303 nurses · 721 midwives · 239 pharmacists · 190 lab scientists · 5,880 CHWs

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Climate effects (heat, flooding, dry spells) driving malaria and food shortage; insecurity limiting access to services

ACTION TAKEN
- **Multisectoral climate and health TWG; policy drafted**
- **Joint climate-health alerts with environment ministry**
- **Vigilante and security support for health campaigns**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%, Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Lagos State summary scorecard, Q1–Q3 2026

Lagos State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 21/10/2026 · Validated (23/10/2026)

10 of 24 scored indicators on track (42%) | **10** On track | **4** Close | **10** Not on Track | **15** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● 50%
NCH resolutions implemented	100%	**85%**	● 85%
SCH meetings held	1	**0**	● 0%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**83,145**	● No target
Under-5s given Vitamin A	–	**1,726,431**	● No target
Skilled birth attendance	100%	**100%**	● 100%
Newborn PNC within 48 hrs	80%	**42%**	● 52%
Women PNC within 48 hrs	80%	**43%**	● 53%
Under-5 diarrhoea given ORS + zinc	–	**15,328**	● No target
IMMUNISATION			
BCG coverage (live births)	100%	**100%**	● 100%
Zero-dose children (12–23 m)	≤4.5%	**32%**	● 14%
No routine vaccination (12–23 m)	≤5%	**37.7%**	● 13%
All basic antigens (12–23 m)	85%	**37.7%**	● 44%
Fully vaccinated (12–23 m)	85%	**37.7%**	● 44%
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	Not reported	● No data
New cervical cancer cases	–	Not reported	● No data

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**12,386**	● No target
CHEWs trained on integrated care	–	**700**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	–	**322,599**	● No target
New TB cases diagnosed	6,303	**17,802**	● 282%
PMTCT: HEI final negative	98%	**100%**	● 102%
Uncomplicated malaria diagnosed	–	**734,570**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	60%	**27%**	● 45%
SHCs certified CEmONC	80%	**72%**	● 90%
New SSHIA enrolees	608,652	**596,952**	● 98%
Population with health insurance	–	Not reported	● No data
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦216.7bn	**₦119.5bn**	● 55.1%
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**100%**	● 100%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 348	**347**	● 99%
SHCs reporting on DHIS2	of 29	**29**	● 100%
Tertiary facilities on DHIS2	of 6	**6**	● 100%
BHCPF facilities with EMR	of 289	**227**	● 78%
PHCs with EMR	of 348	**257**	● 73%
Tertiary facilities with EMR	of 6	**2**	● 33%

Deaths reported Q1–Q3: maternal 0 · infant 251 · neonatal 975 · under-5 0 · malaria 0 · HIV 349 · TB 388 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 2,698 doctors · 4,445 nurses · 2,155 midwives · 817 pharmacists · 642 lab scientists · 956 CHWs

KEY INITIATIVES
- **Measles–rubella vaccine introduced; PIRI rounds**
- **Digital malaria elimination; End TB Now**
- **Mandatory health insurance (ILERA EKO)**
- **Planned University of Medicine and Health Sciences**

MAJOR CHALLENGES
Low financing and falling donor funds, staff migration, missed TB cases, out-of-pocket costs, crowded facilities, fragmented data

ACTION TAKEN
- **Health insurance enforcement team inaugurated**
- **Molecular TB diagnostics and digital surveillance**
- **PHC performance compact with LGAs**
- **HEFAMAA accreditation of facilities; MAMII task force**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%, Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, no data, or no N (denominator); Check = value above N.

Chapter 13

Nasarawa State summary scorecard, Q1–Q3 2026

Nasarawa State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 15TH OCTOBER, 2025 · Validated (15TH OCTOBER, 2026)

17 of 34 scored indicators on track (50%) | **17 On track** | **7 Close** | **10 Not on Track** | **5 Not scored**

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● **50%**
NCH resolutions implemented	50%	**23.3%**	● **46%**
SCH meetings held	1	**1**	● **100%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	27,573	**69,484**	● **252%**
Under-5s given Vitamin A	1,372,682	**1,178,213**	● **85%**
Skilled birth attendance	79%	**81%**	● **102%**
Newborn PNC within 48 hrs	48%	**47.3%**	● **98%**
Women PNC within 48 hrs	49%	**48.3%**	● **98%**
Under-5 diarrhoea given ORS + zinc	5,894	**16,310**	● **276%**
IMMUNISATION			
BCG coverage (live births)	100%	**100.7%**	● **100%**
Zero-dose children (12–23 m)	≤100%	**110%**	● **90%**
No routine vaccination (12–23 m)	≤100%	**89.3%**	● **Met**
All basic antigens (12–23 m)	100%	**4.3%**	● **4%**
Fully vaccinated (12–23 m)	100%	**69.3%**	● **69%**
NCDS			
Hypertension cases on treatment	–	Not reported	● **No data**
Diabetes cases on treatment	–	Not reported	● **No data**
New prostate cancer cases	–	Not reported	● **No data**
New breast cancer cases	9	**22**	● **244%**
New cervical cancer cases	51	**188**	● **368%**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	15,000	**12,060**	● **80%**
CHEWs trained on integrated care	4,000	**11,203**	● **280%**
HIV, TB & MALARIA			
New HIV-positive clients	4,076	**1,900**	● **46%**
New TB cases diagnosed	13,085	**23,183**	● **177%**
PMTCT: HEI final negative	98%	**98.1%**	● **100%**
Uncomplicated malaria diagnosed	574,094	**393,039**	● **68%**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	30%	**15%**	● **50%**
SHCs certified CEmONC	50%	**25%**	● **50%**
New SSHIA enrolees	265,000	**79,534**	● **30%**
Population with health insurance	9.2%	**9.6%**	● **104%**
Blood banks registered with NBSA	of 11	**15%**	● **15%**
2025 health budget released	~~₦36.0bn~~	**₦23.1bn**	● **64.3%**
HEALTH SECURITY			
IDSR timely reporting (001)	80%	**80%**	● **100%**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 973	**147**	● **15%**
SHCs reporting on DHIS2	of 47	**0**	● **0%**
Tertiary facilities on DHIS2	of 3	**0**	● **0%**
BHCPF facilities with EMR	of 147	**125**	● **85%**
PHCs with EMR	of 973	**125**	● **12%**
Tertiary facilities with EMR	of 3	**2**	● **66%**

Deaths reported Q1–Q3: maternal 41 · infant 0 · neonatal 54 · under-5 3 · malaria 5 · HIV 441 · TB 15 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** not reported

KEY INITIATIVES
- **Sensitisation and awareness creation**

MAJOR CHALLENGES
Late reporting and too little funding for interstate sample transport

ACTION TAKEN
- **Capacity building**
- **Advocacy for release of funds**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Niger State summary scorecard, Q1–Q3 2026

Niger State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given · Validated by Permanent Secretary, SMOH

8 of 25 scored indicators on track (32%) | **8** On track | **3** Close | **14** Not on Track | **14** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	12	**8**	● 66%
NCH resolutions implemented	100%	**90%**	● 90%
SCH meetings held	1	**0**	● 0%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	385,483	**97,814**	● 25%
Under-5s given Vitamin A	1,387,739	**1,325,839**	● 95%
Skilled birth attendance	57%	**46%**	● 80%
Newborn PNC within 48 hrs	37.3%	**3.2%**	● 8%
Women PNC within 48 hrs	40%	**12.4%**	● 31%
Under-5 diarrhoea given ORS + zinc	1,541,932	**38,207**	● 2%
IMMUNISATION			
BCG coverage (live births)	85%	**103.7%**	● 121%
Zero-dose children (12–23 m)	0%	**32.4%**	● Above
No routine vaccination (12–23 m)	0%	**2.5%**	● Above
All basic antigens (12–23 m)	85%	**97.9%**	● 115%
Fully vaccinated (12–23 m)	85%	**97.9%**	● 115%
NCDS			
Hypertension cases on treatment	of 23,615	**19,413**	● 82%
Diabetes cases on treatment	of 9,593	**11,716**	● 122%
New prostate cancer cases	–	**0**	● No target
New breast cancer cases	–	**97**	● No target
New cervical cancer cases	–	**47**	● No target

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	8,000	**7,582**	● 94%
CHEWs trained on integrated care	3,000	**1,450**	● 48%
HIV, TB & MALARIA			
New HIV-positive clients	–	Not reported	● No data
New TB cases diagnosed	–	**10,029**	● No target
PMTCT: HEI final negative	–	Not reported	● No data
Uncomplicated malaria diagnosed	–	**1,571,735**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	**98.9%**	● No target
SHCs certified CEmONC	–	**12.5%**	● No target
New SSHIA enrolees	250,000	**55,863**	● 22%
Population with health insurance	5%	**1.9%**	● 38%
Blood banks registered with NBSA	–	**0%**	● No denom.
2025 health budget released	₦74.3bn	**₦11.1bn**	● 15.0%
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**100%**	● 100%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 1,692	**90**	● 5%
SHCs reporting on DHIS2	of 21	**24**	● Check
Tertiary facilities on DHIS2	of 1	**2**	● Check
BHCPF facilities with EMR	of 274	**100**	● 36%
PHCs with EMR	of 1,692	**100**	● 5%
Tertiary facilities with EMR	of 1	**2**	● Check

Deaths reported Q1–Q3: maternal 12 · infant 472 · neonatal 76 · under-5 102 · malaria 107 · HIV 0 · TB 0 · prostate cancer 0 · breast cancer 9 · cervical cancer 0 **Workforce in post:** 213 doctors · 1,573 nurses · 712 midwives · 256 pharmacists · 140 lab scientists · 4,078 CHWs

KEY INITIATIVES
- **CHIPS agents deployed: iCCM, MUAC screening, Vitamin A**

MAJOR CHALLENGES
Malaria, diarrhoea, cholera, diphtheria, Buruli ulcer, hypertension and TB

ACTION TAKEN
- **Quarterly peer review and commodity distribution**
- **Refresher training for CHIPS agents**
- **LGA-level data validation**
- **Partners engaged for commodity supply**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Ogun State summary scorecard, Q1–Q3 2026

Ogun State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 30/09/2026 · Validated (29/09/2026)

8 of 18 scored indicators on track (44%) | **8** On track | **2** Close | **8** Not on Track | **21** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	–	Not reported	● No data
NCH resolutions implemented	100%	**33%**	● 33%
SCH meetings held	–	**0**	● No target
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**38,875**	● No target
Under-5s given Vitamin A	1,264,062	**1,221,761**	● 96%
Skilled birth attendance	–	**92.8%**	● No target
Newborn PNC within 48 hrs	–	**2.6%**	● No target
Women PNC within 48 hrs	–	**2.6%**	● No target
Under-5 diarrhoea given ORS + zinc	–	**1,742**	● No target
IMMUNISATION			
BCG coverage (live births)	85%	**95.3%**	● 112%
Zero-dose children (12–23 m)	≤85%	**18.7%**	● Met
No routine vaccination (12–23 m)	≤85%	**24.7%**	● Met
All basic antigens (12–23 m)	85%	**45%**	● 52%
Fully vaccinated (12–23 m)	85%	**53.3%**	● 62%
NCDS			
Hypertension cases on treatment	of 11,486	**3,933**	● 34%
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	Not reported	● No data
New cervical cancer cases	–	Not reported	● No data

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**10,582**	● No target
CHEWs trained on integrated care	–	**100**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	–	**1,525**	● No target
New TB cases diagnosed	13,492	**5,061**	● 37%
PMTCT: HEI final negative	–	**99.3%**	● No target
Uncomplicated malaria diagnosed	–	**205,803**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	**100%**	● No target
SHCs certified CEmONC	–	Not reported	● No data
New SSHIA enrolees	278,306	**27,432**	● 9%
Population with health insurance	10%	**6.9%**	● 69%
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦10090.3 bn	**₦2583.8bn**	● 25.6%
HEALTH SECURITY			
IDSR timely reporting (001)	–	**100%**	● No target
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 515	**500**	● 97%
SHCs reporting on DHIS2	of 28	**28**	● 100%
Tertiary facilities on DHIS2	of 3	**3**	● 100%
BHCPF facilities with EMR	of 236	**138**	● 58%
PHCs with EMR	of 515	**186**	● 36%
Tertiary facilities with EMR	of 3	**3**	● 100%

Deaths reported Q1–Q3: maternal 0 · infant 0 · neonatal 166 · under-5 9 · malaria 5 · hiv 0 · tb 244 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 780 doctors · 1,295 nurses · 24 midwives · 230 pharmacists · 276 lab scientists · 1,730 CHWs

KEY INITIATIVES
- **Ibidero: insurance, antenatal and postnatal care for indigent pregnant women**
- **Cash stipend after delivery at the assigned facility**

MAJOR CHALLENGES
Not provided in the submission

ACTION TAKEN
Not provided in the submission

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%, behind <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, no data, or no N (denominator); Check = value above N.

Chapter 13

Ondo State summary scorecard, Q1–Q3 2026

Ondo State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 16th October, 2026 · Validated by DHPRS (16th October 2026)

7 of 20 scored indicators on track (35%) | **7** On track | **3** Close | **10** Not on Track | **19** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● **50%**
NCH resolutions implemented	100%	**35.7%**	● **35%**
SCH meetings held	1	**0**	● **0%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**88,545**	● **No target**
Under-5s given Vitamin A	–	**304,152**	● **No target**
Skilled birth attendance	–	**87.8%**	● **No target**
Newborn PNC within 48 hrs	–	**72%**	● **No target**
Women PNC within 48 hrs	–	**72%**	● **No target**
Under-5 diarrhoea given ORS + zinc	–	**2,710**	● **No target**
IMMUNISATION			
BCG coverage (live births)	–	**99.4%**	● **No target**
Zero-dose children (12–23 m)	–	**24%**	● **No target**
No routine vaccination (12–23 m)	–	**24%**	● **No target**
All basic antigens (12–23 m)	–	**57.3%**	● **No target**
Fully vaccinated (12–23 m)	–	**54.6%**	● **No target**
NCDS			
Hypertension cases on treatment	of 12,133	**12,133**	● **100%**
Diabetes cases on treatment	of 2,450	**2,450**	● **100%**
New prostate cancer cases	–	**22**	● **No target**
New breast cancer cases	–	**116**	● **No target**
New cervical cancer cases	–	**133**	● **No target**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**7,505**	● **No target**
CHEWs trained on integrated care	–	**629**	● **No target**
HIV, TB & MALARIA			
New HIV-positive clients	–	**1,196**	● **No target**
New TB cases diagnosed	12,045	**3,575**	● **29%**
PMTCT: HEI final negative	100%	**100%**	● **100%**
Uncomplicated malaria diagnosed	–	**111,513**	● **No target**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**33.7%**	● **33%**
SHCs certified CEmONC	18%	**75%**	● **416%**
New SSHIA enrolees	100,000	**22,577**	● **22%**
Population with health insurance	100%	**2.1%**	● **2%**
Blood banks registered with NBSA	of 5	**0%**	● **0%**
2025 health budget released	₦47.0bn	**₦38.8bn**	● **82.6%**
HEALTH SECURITY			
IDSR timely reporting (001)	80%	**72.5%**	● **90%**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 604	**203**	● **33%**
SHCs reporting on DHIS2	of 24	**23**	● **95%**
Tertiary facilities on DHIS2	of 3	**3**	● **100%**
BHCPF facilities with EMR	of 203	**133**	● **65%**
PHCs with EMR	of 604	**133**	● **22%**
Tertiary facilities with EMR	of 3	**1**	● **33%**

Deaths reported Q1–Q3: maternal 1 · infant 0 · neonatal 209 · under-5 5 · malaria 0 · HIV 102 · TB 0 · prostate cancer 4 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 350 doctors · 1,342 nurses · 59 midwives · 95 pharmacists · 167 lab scientists · 1,199 CHWs

KEY INITIATIVES
- **ORANGHIS health insurance scheme**

MAJOR CHALLENGES
Outbreaks of Lassa fever and Mpox; methanol poisoning

ACTION TAKEN
- **Community engagement and sensitisation**
- **Stronger surveillance and sample transport**
- **Health-worker training and retraining**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Osun State summary scorecard, Q1–Q2 2026

Osun State — **State Summary Scorecard** · 2026 JAR · Q1–Q2
Submission date not given

1 of 1 scored indicators on track (100%) | **1** On track | **0** Close | **0** Not on Track | **38** Not scored

Indicator	Target	Q1–Q2	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	–	**3**	● No target
NCH resolutions implemented	–	**10%**	● No target
SCH meetings held	–	**0**	● No target
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**14,476**	● No target
Under-5s given Vitamin A	–	Not reported	● No data
Skilled birth attendance	–	Not reported	● No data
Newborn PNC within 48 hrs	–	Not reported	● No data
Women PNC within 48 hrs	–	Not reported	● No data
Under-5 diarrhoea given ORS + zinc	–	**1,648**	● No target
IMMUNISATION			
BCG coverage (live births)	–	Not reported	● No data
Zero-dose children (12–23 m)	–	Not reported	● No data
No routine vaccination (12–23 m)	–	Not reported	● No data
All basic antigens (12–23 m)	–	Not reported	● No data
Fully vaccinated (12–23 m)	–	Not reported	● No data
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	**12**	● No target
New cervical cancer cases	–	**8**	● No target

Indicator	Target	Q1–Q2	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	Not reported	● No data
CHEWs trained on integrated care	–	Not reported	● No data
HIV, TB & MALARIA			
New HIV-positive clients	–	Not reported	● No data
New TB cases diagnosed	–	Not reported	● No data
PMTCT: HEI final negative	–	Not reported	● No data
Uncomplicated malaria diagnosed	–	Not reported	● No data
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	Not reported	● No data
SHCs certified CEmONC	–	Not reported	● No data
New SSHIA enrolees	–	Not reported	● No data
Population with health insurance	–	Not reported	● No data
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	–	Not reported	● No data
HEALTH SECURITY			
IDSR timely reporting (001)	100%	**100%**	● 100%
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	–	Not reported	● No data
SHCs reporting on DHIS2	–	Not reported	● No data
Tertiary facilities on DHIS2	–	Not reported	● No data
BHCPF facilities with EMR	–	Not reported	● No data
PHCs with EMR	–	Not reported	● No data
Tertiary facilities with EMR	–	Not reported	● No data

Deaths reported Q1–Q2: maternal 0 · infant 0 · neonatal 7 · under-5 0 · malaria 0 · HIV 1 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 417 doctors · 48 pharmacists · 131 lab scientists · 1,358 CHWs

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Not provided in the submission

ACTION TAKEN
Not provided in the submission

How scored: counts vs the 50% of annual target due by Q2; rates: average vs target. On track ≥90% of expected, close 60–89%, Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, no data, or no N (denominator); Check = value above N.

Chapter 13

Oyo State summary scorecard, Q1–Q3 2026

Oyo State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given · Validated

12 of 26 scored indicators on track (46%) | **12** On track | **3** Close | **11** Not on Track | **13** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● 50%
NCH resolutions implemented	18%	**4.7%**	● 25%
SCH meetings held	4	**1**	● 25%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	136,413	**46,448**	● 34%
Under-5s given Vitamin A	–	**385,564**	● No target
Skilled birth attendance	100%	**93%**	● 93%
Newborn PNC within 48 hrs	80%	**69.3%**	● 86%
Women PNC within 48 hrs	80%	**69.3%**	● 86%
Under-5 diarrhoea given ORS + zinc	12,000	**11,237**	● 93%
IMMUNISATION			
BCG coverage (live births)	100%	**95.2%**	● 95%
Zero-dose children (12–23 m)	0%	**36%**	● Above
No routine vaccination (12–23 m)	0%	**36%**	● Above
All basic antigens (12–23 m)	80%	**76.3%**	● 95%
Fully vaccinated (12–23 m)	80%	**76.3%**	● 95%
NCDS			
Hypertension cases on treatment	of 26,492	**26,492**	● 100%
Diabetes cases on treatment	of 5,509	**5,509**	● 100%
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	100	**336**	● 336%
New cervical cancer cases	–	**0**	● No target

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**3,470**	● No target
CHEWs trained on integrated care	–	**1,134**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	–	**1,621**	● No target
New TB cases diagnosed	–	**11,065**	● No target
PMTCT: HEI final negative	–	**94.7%**	● No target
Uncomplicated malaria diagnosed	–	**221,856**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	10%	**0%**	● 0%
SHCs certified CEmONC	100%	**13%**	● 13%
New SSHIA enrolees	–	**67,226**	● No target
Population with health insurance	–	**4.6%**	● No target
Blood banks registered with NBSA	of 1	**100%**	● 100%
2025 health budget released	₦17.8bn	**₦0.3bn**	● 1.9%
HEALTH SECURITY			
IDSR timely reporting (001)	–	**0%**	● No target
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 800	**800**	● 100%
SHCs reporting on DHIS2	of 50	**50**	● 100%
Tertiary facilities on DHIS2	of 4	**4**	● 100%
BHCPF facilities with EMR	of 351	**175**	● 49%
PHCs with EMR	of 800	**175**	● 21%
Tertiary facilities with EMR	of 4	**2**	● 50%

Deaths reported Q1–Q3: maternal 0 · infant 346 · neonatal 269 · under-5 5 · malaria 30 · HIV 0 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 347 doctors · 1,476 nurses · 160 midwives · 61 pharmacists · 131 lab scientists · 632 CHWs

KEY INITIATIVES
- **PSA oxygen plants installed in government facilities (UNICEF, Global Fund/NACA)**

MAJOR CHALLENGES
Scarce, costly and delayed medical oxygen for respiratory, obstetric and surgical emergencies

ACTION TAKEN
- **Regular oxygen production at reduced rates**
- **Biomedical engineers trained in plant upkeep**
- **State guide for oxygen plant sustainability**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Plateau State summary scorecard, Q1–Q3 2026

Plateau State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 22ND OCTOBER 2026 · Validated by HON. COMMISSIONER (20TH OCTOBER 2026)

7 of 24 scored indicators on track (29%) | **7** On track | **5** Close | **12** Not on Track | **15** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● **75%**
NCH resolutions implemented	1%	**1%**	● **100%**
SCH meetings held	1	**1**	● **100%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	252,369	**44,299**	● **17%**
Under-5s given Vitamin A	1,009,477	**180,289**	● **17%**
Skilled birth attendance	100%	**19.2%**	● **19%**
Newborn PNC within 48 hrs	100%	**46%**	● **46%**
Women PNC within 48 hrs	75%	**46%**	● **61%**
Under-5 diarrhoea given ORS + zinc	100	**9,637**	● **9637%**
IMMUNISATION			
BCG coverage (live births)	100%	**2.2%**	● **2%**
Zero-dose children (12–23 m)	–	Not reported	● **No data**
No routine vaccination (12–23 m)	–	Not reported	● **No data**
All basic antigens (12–23 m)	–	**18.7%**	● **No target**
Fully vaccinated (12–23 m)	–	**18.6%**	● **No target**
NCDS			
Hypertension cases on treatment	–	Not reported	● **No data**
Diabetes cases on treatment	–	Not reported	● **No data**
New prostate cancer cases	–	Not reported	● **No data**
New breast cancer cases	–	Not reported	● **No data**
New cervical cancer cases	–	Not reported	● **No data**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	10,000	**5,112**	● **51%**
CHEWs trained on integrated care	2,135	**2,135**	● **100%**
HIV, TB & MALARIA			
New HIV-positive clients	–	Not reported	● **No data**
New TB cases diagnosed	–	Not reported	● **No data**
PMTCT: HEI final negative	–	Not reported	● **No data**
Uncomplicated malaria diagnosed	–	Not reported	● **No data**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	2.1%	**100%**	● **4830%**
SHCs certified CEmONC	17%	**17%**	● **100%**
New SSHIA enrolees	40,000	**24,464**	● **61%**
Population with health insurance	10%	**6%**	● **60%**
Blood banks registered with NBSA	of 2	**2%**	● **2%**
2025 health budget released	₦609720.0bn	**₦181.8bn**	● **0.0%**
HEALTH SECURITY			
IDSR timely reporting (001)	–	Not reported	● **No data**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 1,247	**207**	● **16%**
SHCs reporting on DHIS2	of 99	**0**	● **0%**
Tertiary facilities on DHIS2	of 5	**0**	● **0%**
BHCPF facilities with EMR	of 207	**184**	● **88%**
PHCs with EMR	of 1,247	**184**	● **14%**
Tertiary facilities with EMR	of 5	**3**	● **60%**

Deaths reported Q1–Q3: maternal 0 · infant 0 · neonatal 79 · under-5 0 · malaria 0 · HIV 0 · TB 0 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 170 doctors · 652 nurses · 652 midwives · 81 pharmacists · 73 lab scientists · 2,285 CHWs

KEY INITIATIVES
- **BHCPF/PLASCHEMA (Mutfwang Cares)**
- **SWAp, HOPE and AOP 2026**
- **HRH recruitment and PHC upgrades**
- **HIV sustainability; drug revolving fund**

MAJOR CHALLENGES
Diphtheria outbreak and vaccine shortfall, health budget below the 15% Abuja target, staff migration, maternal and child deaths

ACTION TAKEN
- **₦327m ring-fenced for PLASCHEMA; 100% BHCPF counterpart**
- **1,000+ health workers approved for recruitment**
- **Diphtheria incident management system activated**
- **Free insurance for pregnant women and under-5s**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Rivers State summary scorecard, Q1–Q3 2026

Rivers State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given

5 of 14 scored indicators on track (36%) | **5** On track | **4** Close | **5** Not on Track | **25** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	100%	**4.3%**	● 4%
SCH meetings held	–	**0**	● No target
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	–	**23,983**	● No target
Under-5s given Vitamin A	–	**786,263**	● No target
Skilled birth attendance	90%	**93.3%**	● 103%
Newborn PNC within 48 hrs	80%	**55.7%**	● 69%
Women PNC within 48 hrs	80%	**58.5%**	● 73%
Under-5 diarrhoea given ORS + zinc	–	**2,310**	● No target
IMMUNISATION			
BCG coverage (live births)	–	**69.8%**	● No target
Zero-dose children (12–23 m)	–	**89.9%**	● No target
No routine vaccination (12–23 m)	≤6%	**9%**	● 66%
All basic antigens (12–23 m)	6%	**25%**	● 416%
Fully vaccinated (12–23 m)	6%	**24.3%**	● 405%
NCDS			
Hypertension cases on treatment	–	Not reported	● No data
Diabetes cases on treatment	–	Not reported	● No data
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	**407**	● No target
New cervical cancer cases	–	**131**	● No target

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**7,610**	● No target
CHEWs trained on integrated care	–	**1,809**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	–	**3,467**	● No target
New TB cases diagnosed	12,000	**14,386**	● 119%
PMTCT: HEI final negative	–	Not reported	● No data
Uncomplicated malaria diagnosed	–	Not reported	● No data
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	**7.4%**	● No target
SHCs certified CEmONC	100%	**6.7%**	● 6%
New SSHIA enrolees	500,000	**22,318**	● 4%
Population with health insurance	5%	**1.5%**	● 30%
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦97.8bn	**₦72.3bn**	● 74.0%
HEALTH SECURITY			
IDSR timely reporting (001)	–	Not reported	● No data
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	–	**205**	● No denom.
SHCs reporting on DHIS2	–	**23**	● No denom.
Tertiary facilities on DHIS2	–	**3**	● No denom.
BHCPF facilities with EMR	of 205	**50**	● 24%
PHCs with EMR	–	**25**	● No denom.
Tertiary facilities with EMR	–	**4**	● No denom.

Deaths reported Q1–Q3: maternal 17 · infant 0 · neonatal 98 · under-5 126 · malaria 0 · HIV 0 · TB 76 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** not reported

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Not provided in the submission

ACTION TAKEN
Not provided in the submission

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Sokoto State summary scorecard, Q1–Q3 2026

Sokoto State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 16-10-2026

12 of 27 scored indicators on track (44%) | **12** On track | **6** Close | **9** Not on Track | **12** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	100%	**75.7%**	● 75%
SCH meetings held	1	**1**	● 100%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	191,280	**131,281**	● 68%
Under-5s given Vitamin A	1,282,747	**1,074,289**	● 83%
Skilled birth attendance	100%	**83%**	● 83%
Newborn PNC within 48 hrs	100%	**83%**	● 83%
Women PNC within 48 hrs	100%	**83%**	● 83%
Under-5 diarrhoea given ORS + zinc	66,237	**59,538**	● 89%
IMMUNISATION			
BCG coverage (live births)	84%	**64.3%**	● 76%
Zero-dose children (12–23 m)	≤10%	**8.3%**	● Met
No routine vaccination (12–23 m)	≤20%	**7%**	● Met
All basic antigens (12–23 m)	20%	**11%**	● 55%
Fully vaccinated (12–23 m)	100%	**84.3%**	● 84%
NCDS			
Hypertension cases on treatment	of 5,694	**2,791**	● 49%
Diabetes cases on treatment	of 1,528	**883**	● 57%
New prostate cancer cases	–	**0**	● No target
New breast cancer cases	–	**0**	● No target
New cervical cancer cases	–	**0**	● No target

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**21,000**	● No target
CHEWs trained on integrated care	–	**86**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	–	**669**	● No target
New TB cases diagnosed	10,319	**14,416**	● 139%
PMTCT: HEI final negative	–	**95.3%**	● No target
Uncomplicated malaria diagnosed	1,086,300	**986,300**	● 90%
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	Not reported	● No data
SHCs certified CEmONC	–	Not reported	● No data
New SSHIA enrolees	96,097	**43,300**	● 45%
Population with health insurance	23%	**0%**	● 0%
Blood banks registered with NBSA	of 26	**0%**	● 0%
2025 health budget released	₦43.1bn	**₦14.7bn**	● 34.1%
HEALTH SECURITY			
IDSR timely reporting (001)	–	**70%**	● No target
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 802	**826**	● 102%
SHCs reporting on DHIS2	of 23	**23**	● 100%
Tertiary facilities on DHIS2	of 1	**1**	● 100%
BHCPF facilities with EMR	of 267	**151**	● 56%
PHCs with EMR	of 802	**128**	● 15%
Tertiary facilities with EMR	of 1	**1**	● 100%

Deaths reported Q1–Q3: maternal 0 · infant 0 · neonatal 0 · under-5 0 · malaria 0 · HIV 123 · TB 23 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 123 doctors · 3,134 nurses · 827 midwives · 85 pharmacists · 253 lab scientists · 1,811 CHWs

KEY INITIATIVES
- **MAMII and Safe Delivery Initiative**
- **BHCPF 2.0 and NHSRII/SWAp**
- **EU-SARAH programme**
- **Routine immunisation**

MAJOR CHALLENGES
High maternal, newborn and child deaths, malnutrition, outbreaks, zero-dose children, low financing, staff shortages, poor WASH

ACTION TAKEN
- **Free maternal healthcare services**
- **Malnutrition screening in facilities and communities**
- **PHCs and general hospitals renovated**
- **More nurses, midwives and CHWs recruited**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Taraba State summary scorecard, Q1–Q3 2026

Taraba State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 16/10/2026 · Validated (16/10/2026)

4 of 20 scored indicators on track (20%)	**4** On track	**2** Close	**14** Not on Track	**19** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● **75%**
NCH resolutions implemented	100%	**11.7%**	● **11%**
SCH meetings held	1	**0**	● **0%**
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	201,978	**39,856**	● **19%**
Under-5s given Vitamin A	807,913	**167,823**	● **20%**
Skilled birth attendance	100%	**87%**	● **87%**
Newborn PNC within 48 hrs	–	**44.3%**	● **No target**
Women PNC within 48 hrs	–	**41%**	● **No target**
Under-5 diarrhoea given ORS + zinc	807,913	**17,773**	● **2%**
IMMUNISATION			
BCG coverage (live births)	100%	**2%**	● **1%**
Zero-dose children (12–23 m)	–	**9.3%**	● **No target**
No routine vaccination (12–23 m)	–	**9.3%**	● **No target**
All basic antigens (12–23 m)	80%	**25.7%**	● **32%**
Fully vaccinated (12–23 m)	100%	**89%**	● **89%**
NCDS			
Hypertension cases on treatment	of 6,621	**27,145**	● **409%**
Diabetes cases on treatment	of 5,195	**17,828**	● **343%**
New prostate cancer cases	–	Not reported	● **No data**
New breast cancer cases	–	Not reported	● **No data**
New cervical cancer cases	–	Not reported	● **No data**

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**3,743**	● **No target**
CHEWs trained on integrated care	–	**1,765**	● **No target**
HIV, TB & MALARIA			
New HIV-positive clients	–	**1,668**	● **No target**
New TB cases diagnosed	–	**7,037**	● **No target**
PMTCT: HEI final negative	–	**80.7%**	● **No target**
Uncomplicated malaria diagnosed	458,421	**458,421**	● **100%**
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	Not reported	● **No data**
SHCs certified CEmONC	–	**13.8%**	● **No target**
New SSHIA enrolees	111,637	**83,728**	● **75%**
Population with health insurance	4%	**1%**	● **25%**
Blood banks registered with NBSA	–	Not reported	● **No data**
2025 health budget released	₦30.5bn	Not reported	● **No data**
HEALTH SECURITY			
IDSR timely reporting (001)	–	**55%**	● **No target**
Climate & health milestones met	–	Not reported	● **No data**
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 772	**168**	● **21%**
SHCs reporting on DHIS2	of 101	**0**	● **0%**
Tertiary facilities on DHIS2	of 4	**0**	● **0%**
BHCPF facilities with EMR	of 311	**100**	● **32%**
PHCs with EMR	of 772	**100**	● **12%**
Tertiary facilities with EMR	of 4	**2**	● **50%**

Deaths reported Q1–Q3: maternal 25 · infant 1,641 · neonatal 96 · under-5 1,510 · malaria 23 · HIV 594 · TB 51 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** not reported

KEY INITIATIVES
- **State emergency medical and ambulance service**
- **Health digitisation**
- **MAMII interventions**

MAJOR CHALLENGES
Lassa fever outbreak, maternal and child deaths, high malaria burden

ACTION TAKEN
- **Stronger surveillance and MPCDSR**
- **Free emergency medical transport**
- **SMC, ITNs, SP and free malaria treatment**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Yobe State summary scorecard, Q1–Q3 2026

Yobe State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submission date not given · Validated by DPRS

8 of 21 scored indicators on track (38%) | **8** On track | **5** Close | **8** Not on Track | **18** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**3**	● 75%
NCH resolutions implemented	–	Not reported	● No data
SCH meetings held	–	Not reported	● No data
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	140,000	**100,409**	● 71%
Under-5s given Vitamin A	360,000	**209,818**	● 58%
Skilled birth attendance	100%	**96.1%**	● 96%
Newborn PNC within 48 hrs	–	**92.7%**	● No target
Women PNC within 48 hrs	–	**96%**	● No target
Under-5 diarrhoea given ORS + zinc	80,000	**63,717**	● 79%
IMMUNISATION			
BCG coverage (live births)	100%	**127.3%**	● 127%
Zero-dose children (12–23 m)	0%	**0%**	● Met
No routine vaccination (12–23 m)	0%	**0%**	● Met
All basic antigens (12–23 m)	–	**31.3%**	● No target
Fully vaccinated (12–23 m)	–	**125.6%**	● No target
NCDS			
Hypertension cases on treatment	of 12,120	**9,777**	● 80%
Diabetes cases on treatment	of 1,524	**628**	● 41%
New prostate cancer cases	3,500	**1,069**	● 30%
New breast cancer cases	3,000	**879**	● 29%
New cervical cancer cases	1,000	**137**	● 13%

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	–	**11,567**	● No target
CHEWs trained on integrated care	–	**4,096**	● No target
HIV, TB & MALARIA			
New HIV-positive clients	–	**228**	● No target
New TB cases diagnosed	9,400	**4,861**	● 51%
PMTCT: HEI final negative	–	Not reported	● No data
Uncomplicated malaria diagnosed	–	**515,043**	● No target
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	–	**25%**	● No target
SHCs certified CEmONC	–	**14%**	● No target
New SSHIA enrolees	–	Not reported	● No data
Population with health insurance	–	Not reported	● No data
Blood banks registered with NBSA	–	Not reported	● No data
2025 health budget released	₦48.1bn	**₦30.8bn**	● 64.0%
HEALTH SECURITY			
IDSR timely reporting (001)	–	Not reported	● No data
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 482	**169**	● 35%
SHCs reporting on DHIS2	of 21	**0**	● 0%
Tertiary facilities on DHIS2	of 2	**0**	● 0%
BHCPF facilities with EMR	of 161	**125**	● 77%
PHCs with EMR	of 482	**125**	● 25%
Tertiary facilities with EMR	of 2	**2**	● 100%

Deaths reported Q1–Q3: maternal 7 · infant 189 · neonatal 234 · under-5 38 · malaria 251 · HIV 94 · TB 7 · prostate cancer 2 · breast cancer 4 · cervical cancer 1 **Workforce in post:** 424 doctors · 1,422 nurses · 455 midwives · 34 pharmacists · 65 lab scientists · 4,067 CHWs

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Not provided in the submission

ACTION TAKEN
Not provided in the submission

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Chapter 13

Zamfara State summary scorecard, Q1–Q3 2026

Zamfara State — **State Summary Scorecard** · 2026 JAR · Q1–Q3
Submitted 13/10/2026 · Validated by DHPRS (13/10/2026)

6 of 25 scored indicators on track (24%) | **6** On track | **9** Close | **10** Not on Track | **14** Not scored

Indicator	Target	Q1–Q3	Score
LEADERSHIP & GOVERNANCE			
SOC meetings held	4	**2**	● 50%
NCH resolutions implemented	100%	**78%**	● 78%
SCH meetings held	1	**0**	● 0%
MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION			
Pregnant women with ANC4+	164,652	**82,005**	● 49%
Under-5s given Vitamin A	296,374	**77,023**	● 25%
Skilled birth attendance	70%	**91.8%**	● 131%
Newborn PNC within 48 hrs	48%	**51.3%**	● 106%
Women PNC within 48 hrs	70%	**75.7%**	● 108%
Under-5 diarrhoea given ORS + zinc	51,371	**58,651**	● 114%
IMMUNISATION			
BCG coverage (live births)	78%	**54.4%**	● 69%
Zero-dose children (12–23 m)	–	**40.8%**	● No target
No routine vaccination (12–23 m)	–	**40.9%**	● No target
All basic antigens (12–23 m)	–	**45.4%**	● No target
Fully vaccinated (12–23 m)	–	**12.6%**	● No target
NCDS			
Hypertension cases on treatment	of 13,612	**14,429**	● 106%
Diabetes cases on treatment	of 2,394	**1,687**	● 70%
New prostate cancer cases	–	Not reported	● No data
New breast cancer cases	–	**270**	● No target
New cervical cancer cases	–	**57**	● No target

Indicator	Target	Q1–Q3	Score
HUMAN RESOURCES FOR HEALTH			
Frontline HCWs in state employment	12,893	**4,875**	● 37%
CHEWs trained on integrated care	–	Not reported	● No data
HIV, TB & MALARIA			
New HIV-positive clients	–	Not reported	● No data
New TB cases diagnosed	–	**6,901**	● No target
PMTCT: HEI final negative	–	**31%**	● No target
Uncomplicated malaria diagnosed	3,293,036	**375,614**	● 11%
QUALITY OF CARE, FINANCING & SUPPLY			
BHCPF PHCs certified BEmONC	100%	**43%**	● 43%
SHCs certified CEmONC	100%	**46%**	● 46%
New SSHIA enrolees	6,586,071	**251,700**	● 3%
Population with health insurance	100%	**3.7%**	● 3%
Blood banks registered with NBSA	of 18	**75%**	● 75%
2025 health budget released	₦65.4bn	**₦20.5bn**	● 31.4%
HEALTH SECURITY			
IDSR timely reporting (001)	–	Not reported	● No data
Climate & health milestones met	–	Not reported	● No data
HEALTH DATA & DIGITAL			
PHCs reporting on DHIS2	of 697	**637**	● 91%
SHCs reporting on DHIS2	of 27	**23**	● 85%
Tertiary facilities on DHIS2	of 3	**2**	● 66%
BHCPF facilities with EMR	of 147	**100**	● 68%
PHCs with EMR	of 697	**100**	● 14%
Tertiary facilities with EMR	of 3	**1**	● 33%

Deaths reported Q1–Q3: maternal 14 · infant 244 · neonatal 412 · under-5 34 · malaria 227 · HIV 71 · TB 10 · prostate cancer 0 · breast cancer 0 · cervical cancer 0 **Workforce in post:** 69 doctors · 718 nurses · 89 midwives · 15 pharmacists · 88 lab scientists · 3,907 CHWs

KEY INITIATIVES
Not provided in the submission

MAJOR CHALLENGES
Skilled-staff shortage, weak PHC infrastructure and equipment, poor access to skilled birth attendance and EmONC

ACTION TAKEN
- **Recruit and deploy staff by facility need**
- **Facility readiness assessments for equipment gaps**
- **Stronger EmONC, referral and blood transfusion**

How scored: counts vs the 75% of annual target due by Q3; rates: average vs target. On track ≥90% of expected, close 60–89%,Not on Track <60%. Head counts use the latest quarter. 'of N' rows are coverage (value ÷ N). Not scored = no target, denominator or data; Check = value above N.

Pillar II — Key Achievements

- Facility-reported maternal deaths have continued to decline, reflecting progress in expanding access to maternal health interventions. The Maternal Mortality Reduction Innovation Initiative (MAMII) has been adopted in almost all states and has reached over 1.4 million pregnant women
- Routine health facility data indicate a decline in neonatal and under-five deaths, with particularly encouraging reductions in newborn deaths in BHCPF-supported facilities.
- Primary healthcare revitalisation is gaining momentum with more than twice as many facilities revitalised in the current year.

- Emergency transport fleet grew substantially, incorporating conventional ambulances, tricycles and boats, with emergency transport services now operational across all MAMII-supported states

Pillar II — Challenges

- Access to hypertension and diabetes services remains limited across public health facilities. HIV testing and treatment coverage among pregnant women have also deteriorated sharply, raising concerns about the prevention of mother-to-child transmission.
- The health workforce crisis continues to undermine service delivery, compounded by migration and high staff attrition.
- Despite improvements in routine facility data, maternal, neonatal and under-five mortality remain unacceptably high nationally.

Pillar II — Recommendations for 2027

- Expand access to hypertension and diabetes screening and management through PHC facilities, and intensify community-based TB case finding and diagnosis.
- Particular attention should be given to addressing the slowdown in maternal mortality reduction and reversing the increase in stillbirths.

PART IV

PILLAR III: UNLOCKING THE HEALTH VALUE CHAIN



PILLAR III STRATEGIC OBJECTIVES AND ACHIEVEMENTS

Table 13.9: Pillar III strategic objectives and indicators

Strategic Objective	Indicator	Baseline (2023)	Target (2027)	Achievement (2024- 2026)
Promote clinical research and development	Local universities and research institutions' participation in late-stage clinical trials	1	10	Data not available
Stimulate local production of health products	Percentage of health commodities produced in Nigeria through government initiatives	25%	40%	Data not available
	Percent of WHO prequalified health products exported by Nigerian manufacturers annually	9	5%	Data not available
	Percentage increase in local production of Tracer products for Priority health programmes	35%	50%	Data not available
Shape markets to ensure sustainable local demand	Annual growth in demand for health products (pharmaceuticals, medical supplies, diagnostics and LLINs etc.)	5%	20%	Data not available
Strengthen supply chains	Percent reduction in stock-out rates of drugs and essential commodities	60%	30%	Data not available

Chapter 14

LOCAL MANUFACTURING AND PHARMACEUTICAL INDUSTRY DEVELOPMENT



14.1 Domestic Production of Essential Medicines — Volume and Coverage Trends

Nigeria is committed to strengthening domestic production of essential medicines as a pathway to health security, economic growth, and universal health coverage. Through supportive policies, strategic partnerships, regulatory reforms, and investment in local manufacturing, the country aims to reduce reliance on imports and ensure reliable access to quality medicines.

Table 14.1: Domestic production of essential medicines

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of Locally produced medicines and health commodities in public procurement	38%	Data not available	
Percentage of Implementation of the National Roadmap for local production	38% (average)	Data not available	
Number of Local manufacturing plants producing new pharmaceuticals, supplies, diagnostics and LLINs	2	4	
Number of Total local pharmaceutical manufacturing companies (number)	Data not available	190	NAFDAC MIS
Number of Manufacturers benefiting from the import duty and tax waiver order	47	75	PVAC MIS
Percentage increase in local production of Tracer products for Priority health programmes	Data not available	Data not available	

14.2 NAFDAC 5+5 Policy — Transition to Local Manufacturing: Progress Report

The NAFDAC 5+5 policy, introduced in 2019, phases out the importation of selected medicines that can be produced locally by requiring companies to set up local or contract manufacturing in Nigeria within a defined period. It is a key regulatory lever for shifting the

market from importation to domestic production. This section reports on progress in the transition to local manufacturing under the policy

Table 14.2: NAFDAC 5+5 policy implementation progress

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Products transitioned from importation to local production under 5+5 (number)	49	51	NAFDAC Report
Product lines under active 5+5 transition assessment (number)	150	564	NAFDAC MIS
Locally manufactured products holding current NAFDAC registration (number)	17,686	15,682	NAFDAC MIS

14.3 RUTF and Therapeutic Food Local Production Capacity

Ready-to-use therapeutic food (RUTF) is the standard community-based treatment for children with severe acute malnutrition. Nigeria has historically imported much of its supply, leaving treatment programmes exposed to funding and supply disruptions. This section presents progress in building local capacity to produce RUTF and other therapeutic foods.

Table 14.3: RUTF and therapeutic food local production

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Ready-to-use therapeutic food produced locally (metric tonnes)	816	Data not available	Nutrition Dept, FMOH
Locally produced RUTF per SAM admission (kilograms, derived)	26.8	NA (Locally Produced RUTF/Total SAM Admissions)	Nutrition Dept, FMOH
Percentage of National RUTF requirement met from local production	Data not available	Data not available	Nutrition Dept, FMOH
Number of Locally certified RUTF production plants	Data not available	4 (NutriK, DAPs, Ariel Foods, Emzor)	PVAC MIS
Total RUTF procured from international sources	Data not available	Data not available	Nutrition Dept, FMOH

14.4 LLIN / Malaria Net Local Production

Long-lasting insecticidal nets (LLINs) are among the most effective tools for preventing malaria, which remains a leading cause of illness and death in Nigeria. Building local manufacturing capacity helps ensure a reliable, affordable supply for national distribution campaigns.

Table 14.4: LLIN local production

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of Long-lasting insecticidal nets produced locally	0	2,000,000	NMEP NMDR
Number of LLINs distributed to targeted risk groups	3,163,772	1,915,224	NMEP NMDR
Percentage of LLIN requirement met from domestic production (derived)	0%	6%	NMEP MIS NMDR
Number of Local LLIN manufacturing facilities commissioned	0	2	NMEP MIS NMDR

14.5 Vaccine Production — Clinical Trials, Infrastructure and Partnerships

Local vaccine production strengthens Nigeria's ability to respond to outbreaks and reduces reliance on global supply chains, which proved fragile during the COVID-19 pandemic. Developing this capacity requires clinical research, specialised manufacturing infrastructure and strong technical partnerships. This section presents progress across each of these areas.

Table 14.5: Vaccine production indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of Ongoing R&D initiatives for local vaccine production	3	2	NIPRD Annual Report
Number of Clinical trials for vaccine development	0	1	NIPRD Annual Report
Percentage of R&D outputs absorbed by local manufacturers	0%	Data not available	
Number of Listed local herbal medicines and services utilised	168	Data not available	
Number of Herbal medicines listed by NAFDAC on the National Essential Medicines List	240	Data not available	

14.6 Domestic manufacturing of health products and technologies

A stronger domestic manufacturing base is central to improving the availability, resilience and affordability of essential health products in Nigeria. Expanding local production across pharmaceuticals, vaccines, diagnostics, medical devices and consumables can reduce reliance on imports, strengthen supply security and position Nigeria as a competitive regional manufacturing hub. Health sector through PVAC is tracking progress through indicators on local production, factory development, technology transfer and research and development (Figure 141).

Table 14.6: Domestic manufacturing of health products and technologies

Core Indicator	2025 achievement	2026 achievement	Data source
Percentage of the estimated national consumption value of priority health products supplied by domestic manufacturers	Data not available	Data not available	
Number of priority health-product manufacturing facilities commissioned and verified as operational during the reporting year	Data not available	10 factories commissioned cumulatively since inception	MOC Q3 Report
Number of technology-transfer arrangements that reached an agreed implementation milestone during the reporting year, disaggregated by product and local recipient.	Data not available	12 technology transfers reported cumulatively since inception	MOC Q3 Report
Percentage of national active pharmaceutical ingredient (API) consumption supplied by domestic manufacturers.	Data not available	Data not available	

Core Indicator	2025 achievement	2026 achievement	Data source
Number of vaccine manufacturing plants that have completed commissioning and are commercially operational.	Data not available	Data not available	
Number of new medical supplies and diagnostics manufacturing plants that have completed commissioning and are operational.	Data not available	Data not available	
Number of locally manufactured priority products that obtain a defined quality or market-access milestone (e.g., NAFDAC registration, SON certification or WHO prequalification) during the reporting year.	Data not available	12 local manufacturers reportedly received tailored technical assistance for NAFDAC registration; product-level approvals or WHO prequalification outcomes	MOC Q3 Report
Number of clinical research or product-development initiatives supported by PVAC that achieve a defined milestone during the reporting year.	Data not available	2 country-led pilot clinical trials with international partners and a regional clinical-trials hub with CEPI	MOC Q3 Report

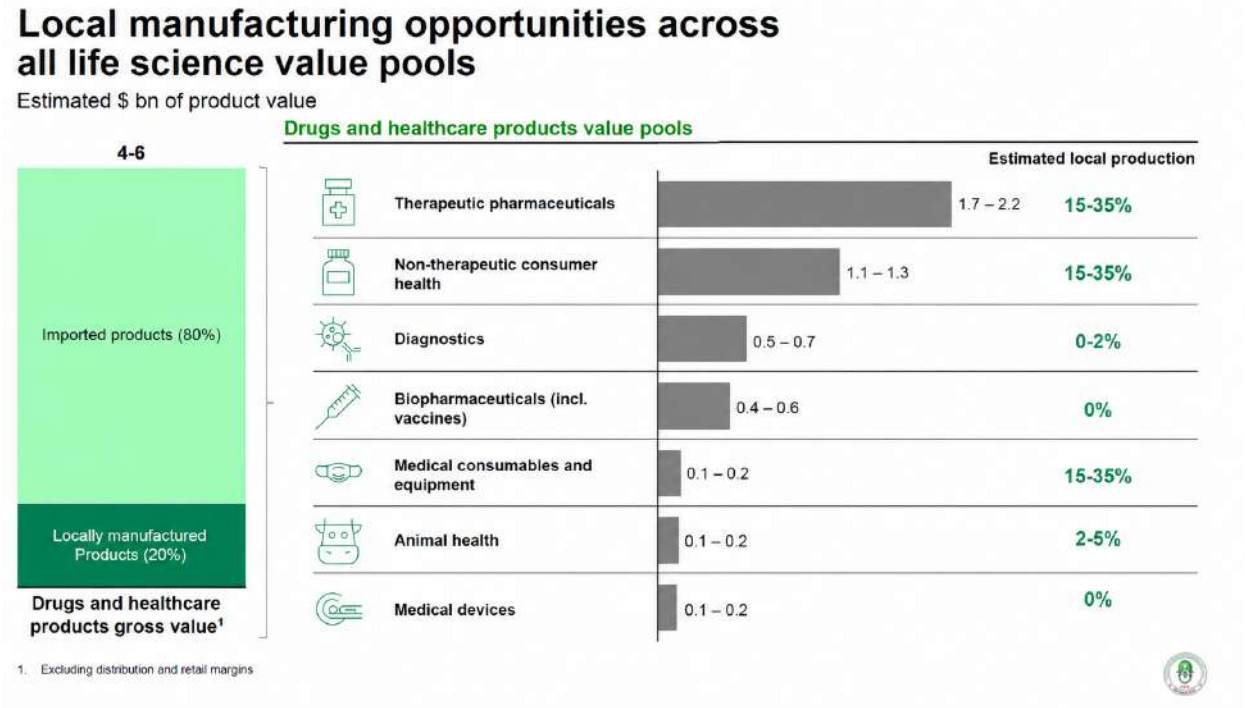


Figure 141: Local manufacturing opportunities across life science value pools

14.7 Quality healthcare services and reduction in outbound medical tourism

Improving the quality and range of healthcare services available within Nigeria is important for strengthening public confidence in the health system and reducing the need to seek treatment abroad. This requires stronger domestic service capacity, investment in specialised care and the development of complementary health ecosystems. PVAC's performance framework therefore includes measures of progress in domestic healthcare service development and the value of outbound medical tourism.

Table 14.7: Quality healthcare services and outbound medical tourism

Core Indicator	2025 achievement	2026 achievement
Percentage reduction in the annual value of outbound medical expenditure by Nigerian residents	Data not available	Data not available
Number of domestic specialised healthcare service or diagnostic-capacity projects supported by PVAC that become operational during the reporting year.	Data not available	Data not available

14.8 Quality jobs and workforce development

The growth of health-product manufacturing and related healthcare value chains is expected to create skilled employment and strengthen the capabilities of the Nigerian workforce. Tracking both direct employment and workforce development is important for assessing whether investment and local production are translating into sustainable jobs and stronger technical capacity. The indicators below distinguish actual employment outcomes from participation in training programmes.

Table 14.8: Quality jobs and workforce development

Core Indicator	2025 achievement	2026 achievement	Data source
Number of direct full-time-equivalent (FTE) jobs in life-sciences manufacturing at supported facilities.	Data not available	Data not available	
Number of participants completing PVAC-supported technical or workforce-development programmes during the reporting year	Data not available	3,805+ enrolees across 40+ Empower Academy courses	MOC Q3 Report

14.9 Investment attraction, market development and ecosystem enablement

Mobilising investment and addressing ecosystem constraints are essential to making domestic manufacturing and service expansion commercially sustainable. PVAC supports this through policy advocacy, fiscal incentives, technical assistance, strategic partnerships, market-shaping arrangements and the development of bankable projects. Monitoring these enabling actions helps show whether the conditions for increased private-sector participation, stronger local firms and improved market access are being put in place (Figure 142).

Table 14.9: Investment attraction, market development and ecosystem enablement

Core Indicator	2025 achievement	2026 achievement / latest MOC evidence	Data source
Value (₦ or US$) of private investment attributable to PVAC-supported projects that reaches financial close during the reporting year.	Data not available	More than US$75 million unlocked for 12+ companies	
Value (₦) of fiscal incentives approved for eligible local health-product manufacturers during the reporting year.	Data not available	Over ₦24 billion in Executive Order tax waivers approved for 75 manufacturers between January 2025 and June 2026	

Core Indicator	2025 achievement	2026 achievement / latest MOC evidence	Data source
Number of local manufacturers receiving completed, documented technical or regulatory assistance from PVAC during the reporting year.	Data not available	12 local manufacturers received tailored technical assistance for NAFDAC registration, including medical devices	MOC Q3 report
Number of national or subnational market-shaping and pooled-procurement mechanisms that are operational and have completed at least one procurement cycle during the reporting year.	Data not available	1 (Medipool)	



Figure 142: PVAC investment achievements since inception

14.10 Supply Chain Management and Procurement

An effective supply chain ensures medicines and health commodities are available in the right place, at the right time, and at an affordable cost. Transparent procurement and reliable distribution systems are essential to avoid stock-outs and waste. This section reports on the performance of supply chain management and procurement for health products.

Table 14.10: Supply chain management and procurement indicators

Core Indicator	Baseline	2025 Achievement	2026 Achievement	Data Source
Number of States with a functional central medical store/warehouses	35	35	37	
Percentage of National aggregated stock-out rate	40%	25.6%	<25%	
Number of warehouses upgraded to Pharma-grade warehouses	22	22	22	

Chapter 14

Core Indicator	Baseline	2025 Achievement	2026 Achievement	Data Source
Facilities stock-out rate for vaccines	*100%*	*NA*	*24%*	NLVSV Dashboard
Number of States with established DMA (check base data with F&D)	23	26	28	

Chapter 15

HEALTH RESEARCH, INNOVATION AND KNOWLEDGE TRANSLATION



15.1 National Health Research Outputs — Publications, Patents and Trials

Health research generates the evidence needed to guide policy, improve services and develop new products. A country's research output is a useful marker of its scientific capacity and innovation potential. This section presents Nigeria's national health research outputs, including publications, patents and clinical trials.

Table 15.1: National health research outputs indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of Health research proposals and protocols approved by NHREC	5	95 (Jan–Jun)	NHREC Portal
Number of Peer-reviewed scientific publications	Data not available	22 (requires validation)	NIPRD MIS
Number of Local universities and research institutions in late-stage clinical trials	Data not available	2	NIPRD MIS
Number of Clinical trials registered on a recognised national or international registry	Data not available	163	NAFDAC Clinical Trials database
Number of Health-related patents filed by Nigerian institutions	Data not available	Data not available	
Number of Operational clinical trial centres	Data not available	Data not available	NHREC

15.2 Research Funding Landscape — Domestic vs. International

Health research in Nigeria has long relied heavily on international funding, which can shape research priorities and limit national ownership. Increasing domestic investment is key to aligning research with national health needs. This section compares domestic and international sources of health research funding.

Table 15.2: Health research funding indicators

Core Indicator	2025 Achievement	2026 Achievement
Funding for R&D on essential medicines and vaccines (US$)	Data not available	Data not available
Number and value of R&D grants provided, utilised and reported	Data not available	Data not available

Core Indicator	2025 Achievement	2026 Achievement
Percentage of Domestic share of total health research funding	Data not available	Data not available
Percentage of International share of total health research funding	Data not available	Data not available
Percentage of Health research funding as a share of total health expenditure	Data not available	Data not available
Number of Institutions receiving competitive national health research grants	Data not available	Data not available

15.3 Evidence-to-Policy Pathways

Evidence-to-policy pathways describe how research findings are translated into policies, plans and programme decisions. Strong links between researchers and decision-makers help ensure that health investments are informed by evidence. This section presents selected studies that illustrate how evidence has shaped health policy in Nigeria.

Table 15.3: Evidence-to-policy pathways indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Availability of national research priorities (yes/no)	Yes	Yes	
Number of Policy documents citing a national research output	Data not available	4	DHPRS Report
Number of Evidence briefs produced for policy decision points	Data not available	2	DHPRS Report
Percentage of NCH memos supported by a documented evidence base	Data not available	Data not available	
Number of Documented evidence-to-policy case studies published	Data not available	Data not available	

Pillar III — Key Achievements

- Local manufacturing is gaining momentum. PVAC has commissioned 10 factories, concluded 12 technology transfers and 30 strategic partnerships, and built a pipeline of more than 90 companies worth over $5 billion.
- Investment and incentives have been mobilised. Financing includes $75 million unlocked for near-term disbursement, $1 billion from Afreximbank and €1 billion from the EIB, alongside over ₦24 billion in tax waivers for 75 manufacturers.
- New domestic production lines. Local LLIN production rose from zero to 2 million nets from two new plants, four RUTF plants are certified, 51 products have transitioned to local production under the NAFDAC 5+5 policy, and the first local vaccine clinical trial has started.
- Supply chains have been strengthened, all 36 states and the FCT have functional central medical stores, and states with additional states establishing Drug Management Agency

PILLAR III — CHALLENGES

- Local production is still below target
- Research funding and evidence use are untracked.
- Clinical research capacity is limited

PILLAR III — RECOMMENDATIONS FOR 2027

- Need to accredit additional trial centres, leverage the CEPI-supported regional clinical-trials hub, and support more local institutions to lead late-stage trials.
- To create a dedicated health research funding line, track domestic and international research funding annually, and require evidence briefs for NCH memos.
- Expand offtake agreements for locally made LLINs, RUTF and NAFDAC 5+5 products to move the locally produced share towards the 40% target.

PART V

PILLAR IV: HEALTH SECURITY



Chapter 16

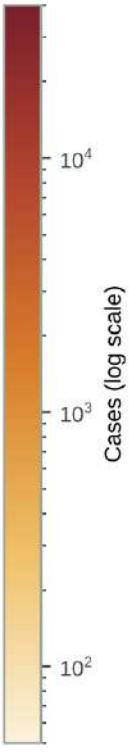
HEALTH SECURITY PLANNING, IHR CAPACITY AND FINANCING



Nigeria faces recurrent outbreaks of epidemic-prone diseases, driven by gaps in immunisation, water and sanitation, and seasonal and environmental factors. Tracking trends in these diseases helps identify emerging threats and guide preparedness. This section presents surveillance trends for the country's priority diseases (Figure 143).

Priority disease burden: suspected cases, 2024 to 2026

	2024	2025	2026 (Jan to Sep)
Cholera	24,349	24,349	34,942
Measles	27,430	27,430	7,466
Diphtheria	20,031	20,031	12,915
CSM	4,628	4,628	1,405
Influenza	3,590	3,590	1,295
Yellow fever	2,297	2,297	902
Mpox	1,778	1,778	441
Lassa fever*	1,148	1,148	1,110
Dengue	735	735	122
Avian influenza	115	115	96
Rabies	103	103	54
COVID-19	NR	NR	1,342



* Lassa fever shows confirmed cases. NR: not reported. 2026 = H1 + Q3.

Figure 143: Table of priority disease burden, 2024 to 2026

Source: NCDC submission to JAR 2026. 2026 = H1 + Q3.

Table 16.1: Disease surveillance summary

Disease Surveillance Summary (2017 – Q3 2026). Source: NCDC, 2026				
Priority Disease	Baseline (2024)	2025 Achievement	2026 Achievement (H1/Q3)	Trend
Lassa Fever	1,148 confirmed	1,148 confirmed; CFR 16.9%	922 confirmed (H1); 188 confirmed (Q3); CFR 24.0% (H1) → 18.6% (Q3)	↑ Endemic
Cholera	24,349 suspected	24,349 suspected; 548 deaths	26,937 suspected (H1); 8,005 suspected (Q3); CFR 0.7%	↑ Endemic
Cerebrospinal Meningitis (CSM)	4,628 suspected	4,628 suspected; 324 deaths (7%)	1,304 suspected (H1); 101 suspected (Q3); CFR 2.5%	↑ Seasonal
Measles	27,430 suspected	27,430 suspected; 153 deaths (0.6%)	5,186 suspected (H1); 2,280 suspected (Q3); 2,001 confirmed	↑ Vaccine-preventable
Yellow Fever	2,297 suspected	2,297 suspected; 5 deaths (0.2%)	719 suspected (H1); 183 suspected (Q3); CFR 5.3% (2026)	↑ Endemic
Diphtheria	20,031 suspected; 1,162 deaths (6%)	20,031 suspected	11,476 suspected (H1); 1,439 suspected (Q3); 9,685 confirmed (H1)	↑ Outbreak
Mpox	1,778 suspected; 6 deaths (1%)	1,778 suspected	364 suspected (H1); 77 suspected (Q3); 79 confirmed (H1)	↑ Endemic
COVID-19	Not reported	Not reported	1,226 suspected (H1); 116 suspected (Q3)	→ Transitioned
Influenza	3,590 suspected	3,590 suspected	1,199 suspected (H1); 96 suspected (Q3)	→ Endemic
Dengue Fever	735 suspected; 9 deaths (1%)	735 suspected	90 suspected (H1); 32 suspected (Q3)	↑ Emerging
Hepatitis E	—	—	—	
Avian Influenza	115 suspected (Q1)	115 suspected	96 suspected (Q3)	→ Sporadic
Rabies	103 suspected	103 suspected	54 suspected (Q3)	→ Endemic
Chemical Events	—	—	Sokoto/Zamfara acute childhood ascites (PA toxicity); Ogun lead exposure; Plateau gas exposure	↑ Emerging
Ebola				

PREPAREDNESS AND RESPONSE

16.1 IHR Capacity and Health Security Planning

The International Health Regulations (IHR, 2005) require countries to build core capacities to prevent, detect, and respond to public health threats. Nigeria implements the International Health Regulations (IHR 2005) at both national and subnational levels, using the IHR Monitoring and Evaluation Framework (IHR MEF) to assess capacities, identify gaps and translate findings into health security priorities.

Table 16.2: International Health Regulations (IHR): Prevent, Detect and Respond Indicators

Core Indicator	2024	2025 Achievement	2026 Achievement	Data Source
PREVENT				
Number of states that completed a subnational Joint External Evaluation (JEE) during the year	2 states: Nasarawa and Ogun (activity record)	3 states: Akwa Ibom, Bauchi and Plateau	18 states cumulatively	NCDC JEE records
Number of states with a developed costed State Action Plan for Health Security (SAPHS)	5 states	5 states	12 states cumulatively	NCDC SAPHS records
Number of simulation exercises (SimEx) conducted to test preparedness and response arrangements	Exercise Keep Pushing reported	Ebola tabletop exercise and chemical-event SimEx	Ebola tabletop exercise (February 2026) and chemical-event SimEx (July 2026 activities)	NCDC
Number of after-action reviews (AARs) or intra-action reviews (IARs) completed following public health events	Lassa fever AAR reported	Lassa fever AAR (October 2025) reported	Lassa fever AAR and diphtheria IAR reported	NCDC
Percentage of IHR core capacity scores achieved in the annual State Party Self-Assessment Annual Reporting (SPAR)	-	64% (2025 SPAR assessment; coordinated in Q1 2026)	2025 SPAR result: 64%; no separate 2026 SPAR score	NCDC 2025 SPAR assessment; supplied narrative
JEE / IHR capacity score (%) Percentage of IHR core capacities achieved in the Joint External Evaluation (JEE)			54% (2023 national JEE); subnational JEEs in 10 states	NCDC
Number of multi-hazard risk assessments (MHRA) conducted and documented during the reporting year.	Jigawa, Niger, Oyo, Borno Yobe, Adamawa	Jigawa, Niger, Oyo, Borno Yobe, Adamawa	Yobe: 22 hazards; Adamawa: 25 hazards	NCDC
DETECT				
Percentage of expected Integrated Disease Surveillance and Response (IDSR) reports submitted completely	94%	94%	94%	NCDC
Percentage of expected IDSR reports submitted within the required reporting timeline	85%	85%	85%	NCDC
Number of states with upgraded Event-Based Surveillance (EBS) systems	EBS upgraded; state count not specified	12 states	12 states	NCDC
Number of laboratories using the Laboratory Information Management System (LIMS)	2 laboratories (pilot)	15 laboratories	25 laboratories across 20 states	NCDC
Percentage of outbreak alerts detected within 7 days under the 7-1-7 framework	-	-	87% (Q3 2026)	NCDC 7-1-7 monitoring data
Percentage of outbreak alerts notified within 1 day under the 7-1-7 framework	-	-	89% (Q3 2026)	NCDC 7-1-7 monitoring data

Core Indicator	2024	2025 Achievement	2026 Achievement	Data Source
Number of residents who completed the Advanced Field Epidemiology Training Programme (NFELTP) during the reporting year	29	29	17 (Cohort 13 selected)	NCDC
RESPOND				
Percentage of states with functional Public Health Emergency Operations Centres (PHEOCs)	86.5%	86.48%	94%	NCDC
Number of functional PHEOCs established at state level	32	32	35	NCDC
Number of states supported through National Rapid Response Team (NRRT) deployments	Not reported	18 states	16+ states (10 in H1 and 6 additional by Q3)	NCDC
Percentage of detected outbreaks for which response is initiated within 7 days under the 7-1-7 framework	Not reported	Not reported separately	22% (Q3 2026)	NCDC 7-1-7 monitoring data

The 2026 column includes year-to-date/Q3 information where available and is not a full-year result.

16.2 Health Security Financing

Sustainable financing is critical for health security, as preparedness and response depend on funds being available before emergencies occur. Reliance on emergency or external funding can delay response and weaken long-term capacity. Through the NCDC BHCPF Gateway, NCDC and State PHEOCs received additional financing to strengthen preparedness and response. In June 2026, amid heightened regional Ebola risk, the Honourable Minister approved over ₦700 million for EVD preparedness, with each state receiving between ₦16 million and ₦25 million based on its assessed risk (Figures 144 and 145).

Table 16.3: Health security financing indicators

Core Indicator	Baseline (2024)	2025 Achievement	2026 Achievement (Q1-Q3)
Value of BHCPF funds received (₦)	Data not available	Data not available	₦3,046.7M received; ₦2,106.8M spent (69%) to Q3
BHCPF NCDC Gateway disbursement (₦)	₦489.9M	₦489.9M	₦973.2M (H1)
Percentage of S-OIRF allocation utilised	Data not available	Data not available	64% (₦1,558.0 million of ₦2,437.4 million)
Percentage of PHEORF allocation utilised	Data not available	Data not available	90% (₦548.8 million of ₦609.3 million

Source: NCDC.

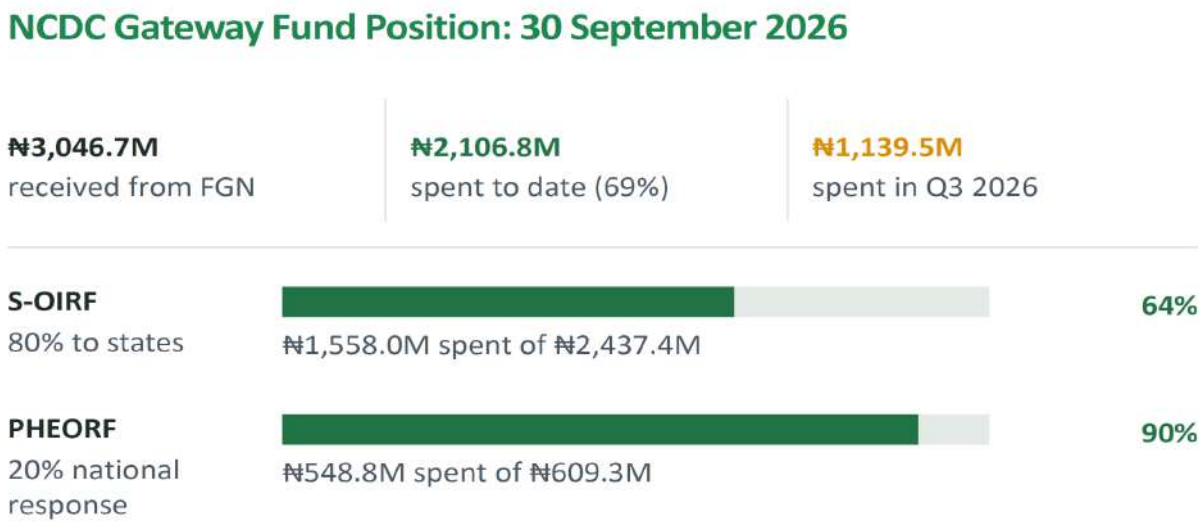


Figure 144: NCDC funding gateway

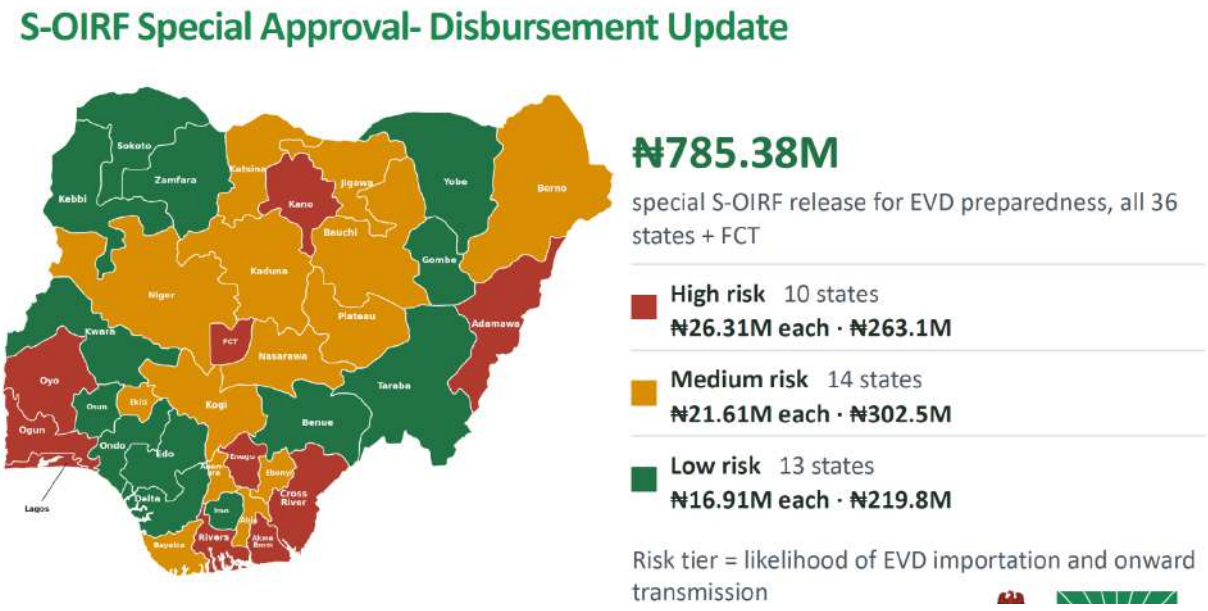


Figure 145: S-OIRF showing Special Approval-Disbursement across states

DISEASE SURVEILLANCE AND EARLY WARNING

16.3 IDSR AND DIGITAL SURVEILLANCE

Integrated Disease Surveillance and Response (IDSR) is the WHO-recommended framework for routine reporting of priority diseases and public health events. Digital tools are increasingly used to make reporting faster and more complete. This section presents IDSR performance in Nigeria and the digital systems that support it (Figure 146).

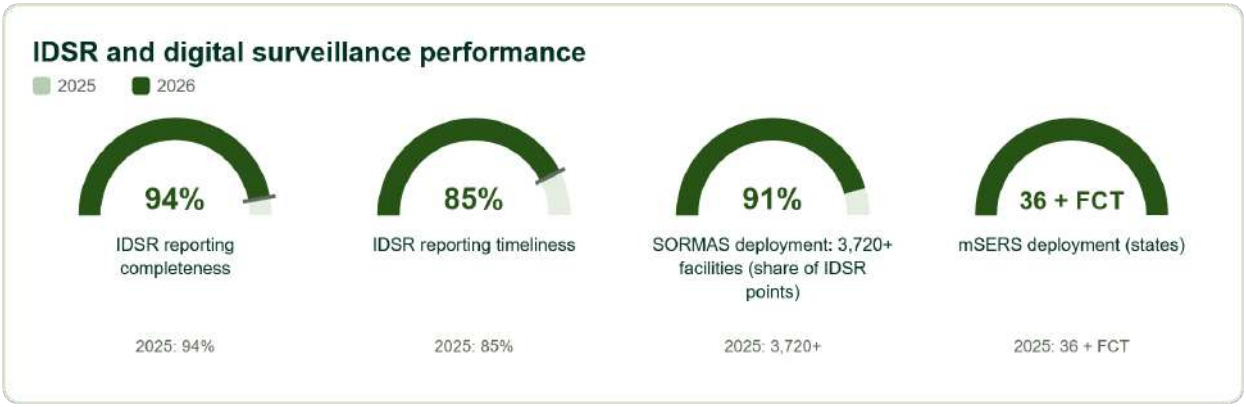


Figure 146: IDSR and digital surveillance performance, 2025 and 2026

Table 16.4: IDSR and digital surveillance indicators

Core Indicator	Baseline (2024)	2025 Achievement	2026 Achievement (Q1-Q3)
IDSR reporting completeness (%)	94%	94%	94%
IDSR reporting timeliness (%)	85%	85%	85%
SORMAS deployment	774 LGAs	3,720+ facilities	3,720+ facilities (91% of IDSR points)
mSERS deployment (states)	36 + FCT	36 + FCT	36 + FCT

Source: NCDC submission to JAR 2026.

16.4 Event-Based, Community and Sentinel Surveillance

Routine facility reporting does not capture every health threat, so complementary approaches are needed to strengthen early warning. Event-based, community and sentinel surveillance extend detection beyond health facilities into communities and selected high-value sites. This section presents the performance of these surveillance approaches.

Table 16.5: Event-based, community and sentinel surveillance indicators

Core Indicator	Baseline (2024)	2025 Achievement	2026 Achievement (H1/Q3)
Public health intelligence signals / incidents (number)	95	Not reported	185+ (H1 122; Q3 63)
Event-based surveillance (EBS)	EBS upgraded	12 states trained	12 states trained
Community-based surveillance (CBS)	SOPs developed; pilot in Kano, Oyo, Enugu	660 informants active	660 informants active
National Influenza Sentinel Surveillance (NISS)	10 sentinel sites	10 sentinel sites	3,538 samples collected

Source: NCDC

16.5 National Outbreak Situation

Outbreak surveillance and response are essential to protecting population health, limiting disease transmission and reducing preventable deaths. Timely detection, effective case management, vaccination and coordinated public health interventions help contain outbreaks and minimise their impact on communities. The health sector tracks the status of

major outbreaks through NCDC situation reports to monitor disease trends and response priorities. In 2026, Lassa fever mortality remains high, cholera transmission is declining, while diphtheria continues to require sustained vaccination and treatment support (Figures 147–153).

Table 16.6: National outbreak situation by disease, 2026

Disease	Suspected	Confirmed	Case Fatality Ratio (CFR)	Geographic Reach
Lassa fever	8,379	1,134	23.6%	24 states / 119 LGAs
Cholera	70,947	Pending	0.6%	35 states / 204 LGAs
Diphtheria	22,085	16,556	3.5%	26 states / 309 LGAs
Mpox	760	76	0%	24 states / 55 LGAs

Source: NCDC

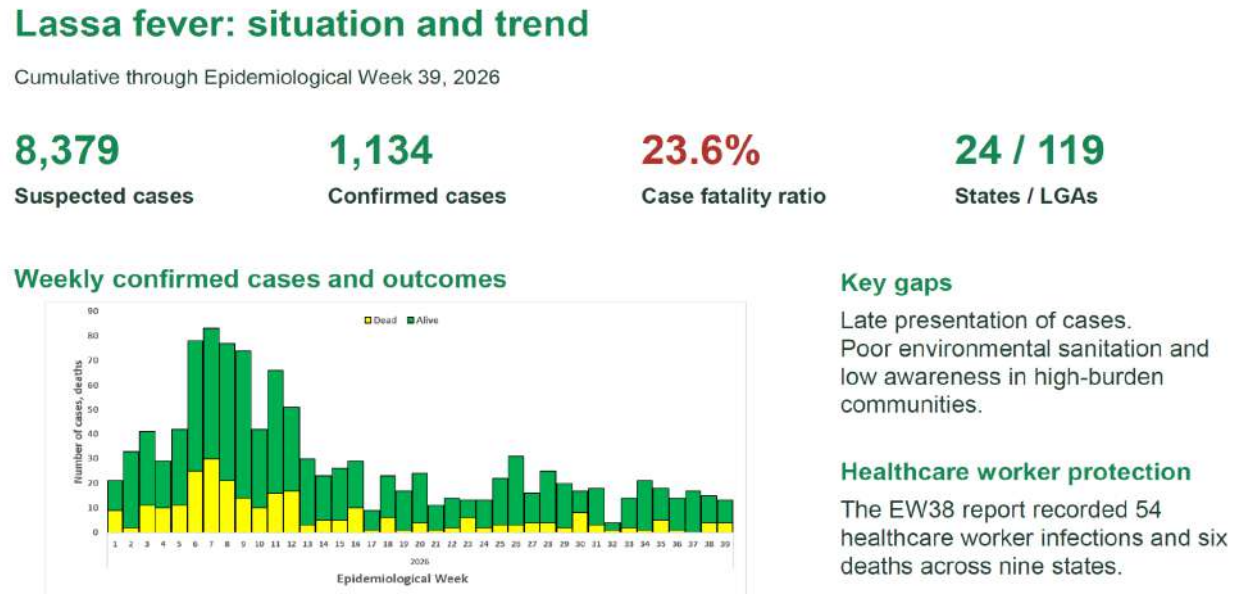


Figure 147: Lasser fever weekly trend, 2026

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CHOLERA SITUATION REPORT, WEEK 39 OF 2026

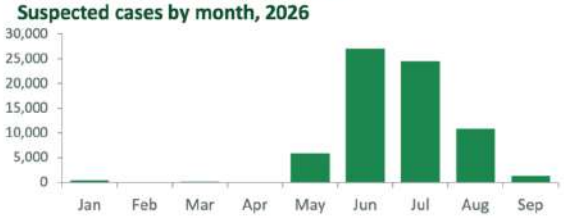
Cases are declining, but priority response gaps remain.

70,947	461	154	96%
Suspected cases	**Deaths**	**Cases in Week 39**	**Borno cumulative share**
35 states, 204 LGAs	CFR 0.6%	Down 70% from previous week	68,152 of 70,947 cases

Week 39: 154 cases and one death across five states and seven LGAs.
Weekly cases decreased by 70% compared with the preceding week.

Trend and response progress

Suspected cases by month, 2026



June peak: 27,065 cases. September: 1,345 cases.
7 LGAs affected in Week 39. Nine-pillar multisectoral EOC, OCV in Borno and WASH interventions in four states.

Priority response gaps

WASH: inadequate state funding for interventions.

Commodities: shortages of Ringer's lactate, ORS and cholera RDT kits.

Laboratory: limited testing coverage and inconsistent reported confirmation totals.

Sample transport: no funding within states.

Case management: CFR above 1% in some states.

Figure 148: Cholera monthly trend, 2026

Diphtheria update

Epi Week 1 (29 December 2025) to Week 38 (20 September 2026)

22,085	16,556	4,834	695	581
Suspected cases	**Confirmed cases**	**Discarded**	**Pending**	**Deaths**
26 states, 309 LGAs	LC 154, EL 3,135, CC 13,267			CFR 3.5%

Top eight states by suspected cases

State	Suspected	Confirmed
Kano	8,968	8,006
Katsina	4,361	2,486
Bauchi	2,872	1,991
Borno	1,918	1,856
Sokoto	1,009	817
Yobe	580	193
Zamfara	538	430
Plateau	474	399

Top eight states: 94% of suspected and 98% of confirmed cases.

Epidemic curve by final classification

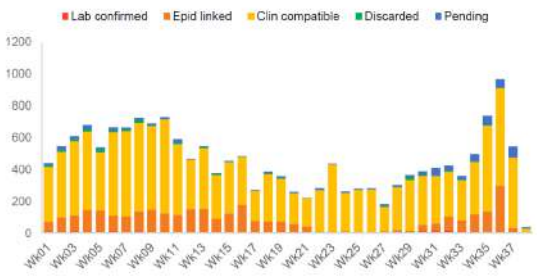


Figure 149: Diphtheria epidemic across states, 2026

Chapter 16

Diphtheria: response and support needs

Response progress

Weekly EOC meetings and NRRT deployment to Katsina, Zamfara, Plateau, Sokoto, Niger and Kano. Round one vaccination completed in Kaduna, Plateau, Gombe and Kano States.

Laboratory and supply planning

Subnational and national testing, isolate sequencing and a surveillance/laboratory review meeting. Quantification of clinical consumables and reagents is ongoing.

Vaccination status among reported confirmed cases in 2026

Vaccination status	Share
Unvaccinated	67.1%
Partially vaccinated	2.0%
Fully vaccinated	8.6%
Unknown	22.3%

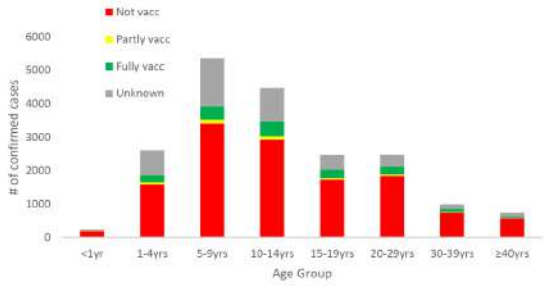


Figure 150: Diphtheria epidemic response and progress, 2026

Mpox: situation and epidemic curve

Cumulative through Epidemiological Week 40, 2026. Confirmation totals are provisional pending reconciliation.

760	76	0	24 / 55
Suspected cases	Confirmed cases	Reported deaths	States / LGAs with confirmed cases

Weekly laboratory results

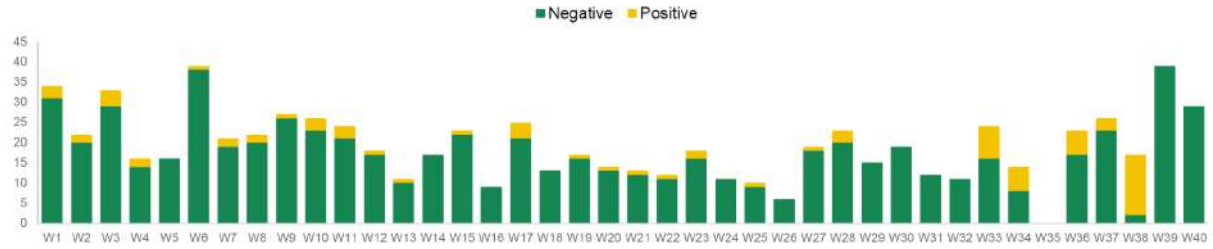


Figure 151: Mpox epidemic curve, 2026

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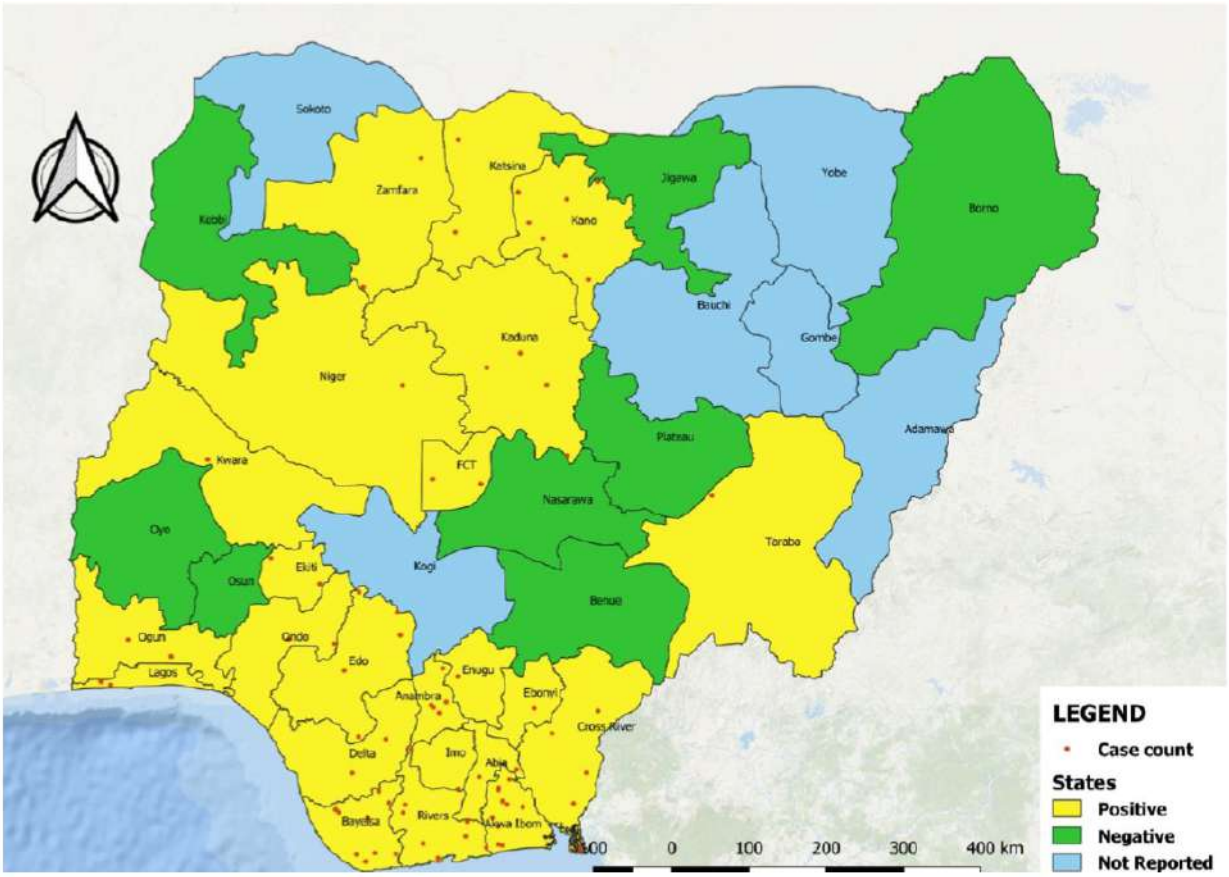


Figure 152: Mpox epidemic situation across the States

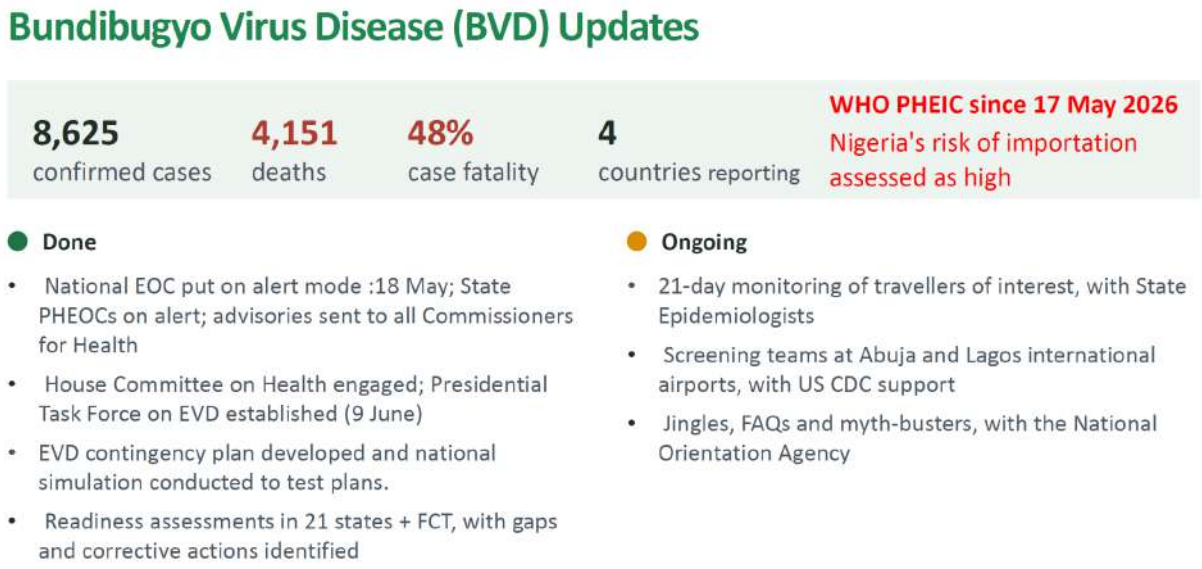


Figure 153: Bundibugyo Virus disease response and progress, 2026

LABORATORY, GENOMIC AND AMR SURVEILLANCE

16.6 Laboratory Network and Genomic Surveillance

Laboratories confirm suspected cases, guide treatment, and provide the data needed to track outbreaks. Genomic sequencing adds a further layer by showing how pathogens spread and change over time. This section presents the capacity of Nigeria's laboratory network and genomic surveillance.

Table 16.7: Laboratory network and genomic surveillance indicators

Core Indicator	Baseline (2024)	2025 Achievement	2026 Achievement (H1/Q3)
Laboratories with expanded diagnostic capacity (number)	100+	100	100+
Laboratories using LIMS (number)	Pilot in 2 labs	15	25 labs across 20 states
Pathogens sequenced (genomic surveillance)	310	310	310+ (2025 annualised)
Case confirmation rate (%)	Data not available	14.2% (Q1); 12.7% (Q2)	Not reported

Source: NCDC , 2026.

16.7 Antimicrobial Resistance Surveillance

Antimicrobial resistance (AMR) occurs when bacteria, viruses, fungi, and parasites no longer respond to the medicines used to treat them, making infections harder to manage. Surveillance is essential to understand the scale of the problem and guide appropriate antimicrobial use. This section presents progress in Nigeria's AMR surveillance and related actions (Figure 154).



Figure 154: Antimicrobial resistance surveillance, 2025 and 2026

Table 16.8: Antimicrobial resistance surveillance

Core Indicator	Baseline (2024)	2025 Achievement	2026 Achievement (Q1-/Q3)
AMR sentinel sites (number)	18	18	18
AMR surveillance reporting rate (%)	78%	78%	78%
AMR data submission to WHO GLASS (%)	100%	100%	100%

Source: NCDC, 2026.

EMERGENCY RESPONSE

16.8 Response Timeliness and Rapid Response Capacity - 7-1-7 Performance

Timely outbreak detection and response are essential to containing disease transmission, preventing avoidable deaths and limiting the impact of public health emergencies. The 7-1-7 target is an internationally used benchmark for timely outbreak response: detection within 7 days of emergence, notification within 1 day of detection, and early response actions completed within 7 days of notification. Achieving these targets depends on effective surveillance systems, adequate resources, rapid response teams and a skilled field epidemiology workforce. The health sector tracks performance against the 7-1-7 milestones to identify delays and strengthen national and subnational outbreak preparedness and response capacity (Figures 155 and 156).

Table 16.9: Response timeliness and 7-1-7 performance

Core Indicator	2025 Achievement	2026 Achievement (H1/Q3)
7-1-7: detection within 7 days (%)	Data not available	78% (Q1) → 87% (Q3)
7-1-7: notification within 1 day (%)	Data not available	85% (Q1) → 89% (Q3)
7-1-7: response within 7 days (%)	Data not available	15% (Q1) → 22% (Q3)
7-1-7: all three targets met (%)	Data not available	15% (Q1) → 19% (Q3)
National RRT deployments (states supported)	18 states (8 PHEs)	16 states (H1 10; Q3 6)
NFELTP advanced residents (number)	29	17 (Cohort 13)

Source: NCDC, 2026.

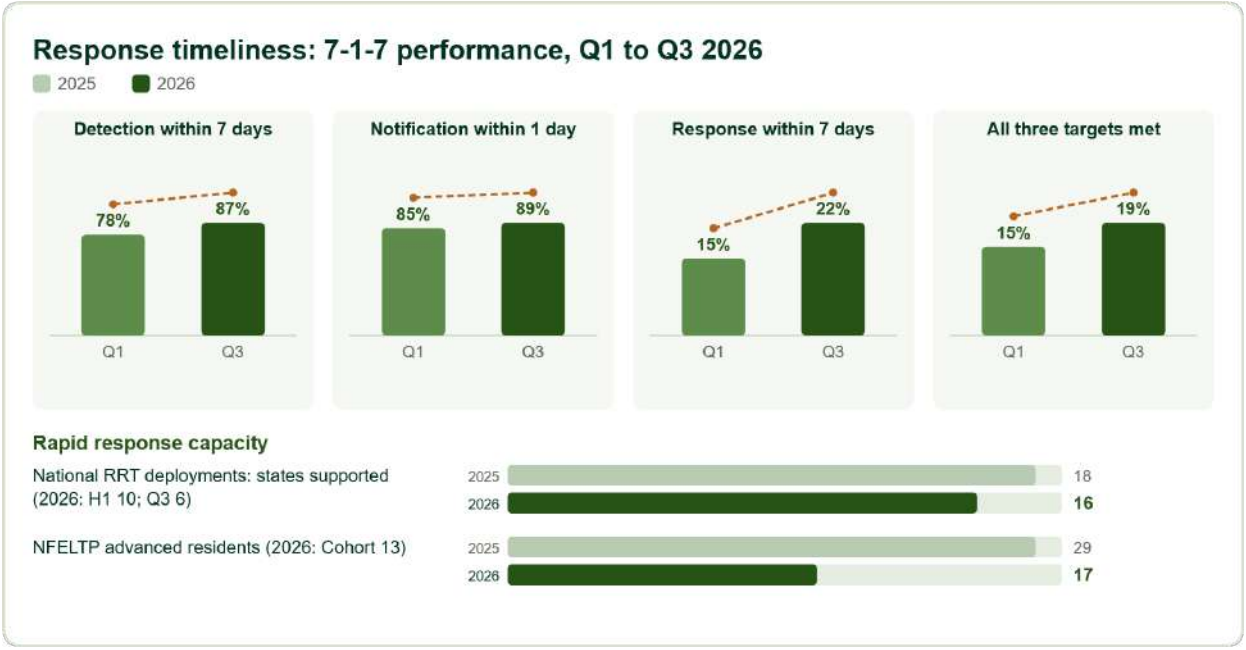


Figure 155: Response timeliness: 7-1-7 performance, Q1 to Q3 2026

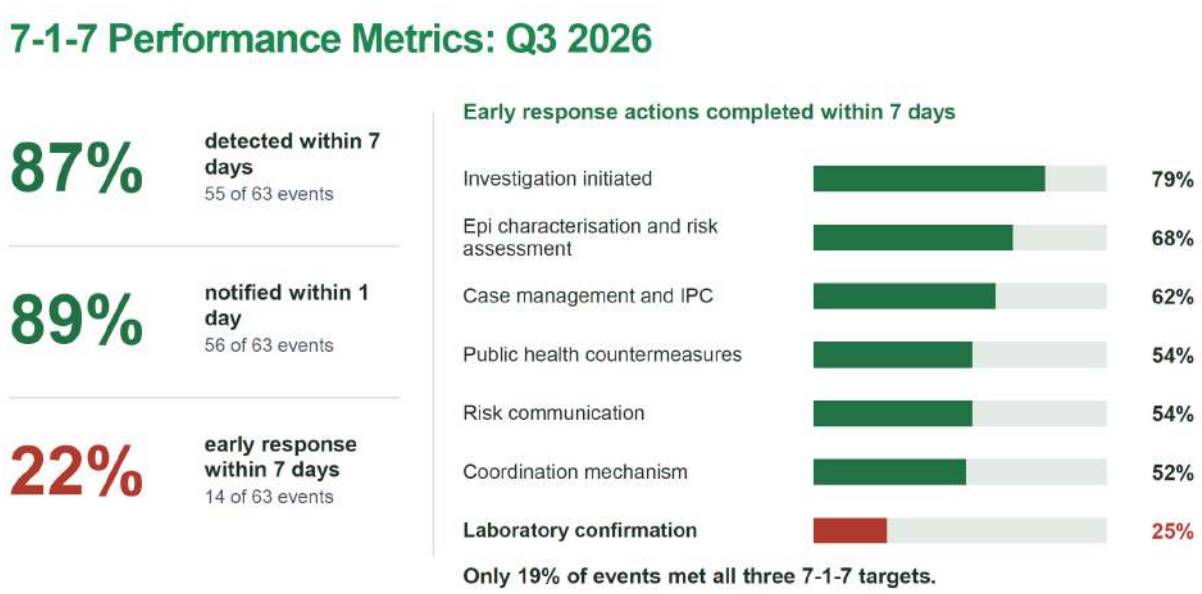


Figure 156: 7-1-7 performance metrics as at Q3 2026

16.9 Medical Countermeasures and Logistics

Medical countermeasures are the medicines, vaccines, diagnostics, and other supplies needed to respond to outbreaks. Their impact depends on adequate stockpiles and logistics systems that can deliver them quickly to affected areas. This section presents the availability of countermeasures and the logistics that support their distribution (Figure 157).



Figure 157: Medical countermeasures and logistics

Table 16.10: Medical countermeasures and logistics indicators

Core Indicator	Baseline (2024)	2025 Achievement	2026 Achievement (Q1-Q3)
Number of medical countermeasures distributed	Not reported	100,000+ antibiotics; 75,000+ cholera RDTs	100,000+ antibiotics; 75,000+ cholera RDTs
Delivery time, requisition to arrival	6 to 8 days	6 to 8 days	6 to 8 days
Number of states with Infectious disease treatment centres	16	16	16

Source: NCDC,2026.

16.10 One Health Coordination — Human-Animal-Environment Interface

One Health recognises that the health of people, animals and the environment are closely linked and cannot be managed in isolation; with most emerging infectious diseases originating in animals. Effective prevention and response therefore require coordination across the human, animal and environmental health sectors. This section presents progress in One Health coordination in Nigeria (Figure 158).



Figure 158: One Health coordination, 2026

Table 16.11: One Health coordination indicators

Core Indicator	2025 Achievement	2026 Achievement (Q1-Q3)
Percentage number of states with One Health committees	Data not available	88.9%
Percentage number of states with One Health strategic plans	Data not available	88.9%
Number of National One Health Technical Committee meetings hel	Data not available	1
Number of National Joint Risk Assessments conducted	Data not available	7
Percentage number of states with Joint Risk Assessment capacity	Data not available	75%

Source: NCDC, 2026

Chapter 17

CLIMATE CHANGE, ENVIRONMENTAL HEALTH AND RESILIENCE



17.1 Climate Change and Health

Climate change affects health through flooding, extreme heat, drought, and shifting disease patterns. These effects strain the health system and hit vulnerable communities hardest.

Nigeria is making encouraging progress in integrating health into climate action, ranking second globally in the 2026 Healthy NDC Scorecards for commitments to health, clean air, and climate action, a global assessment of how comprehensively health is integrated into national climate plans, highlighting an opportunity to build on this progress through stronger implementation and climate-resilient health interventions. Building on its Climate and Health Vulnerability and Adaptation Assessment, in 2025 Nigeria developed its first Health National Adaptation Plan (HNAP), providing a roadmap for integrating climate adaptation into health planning and strengthening health system and population resilience (Figures 159 and 160).

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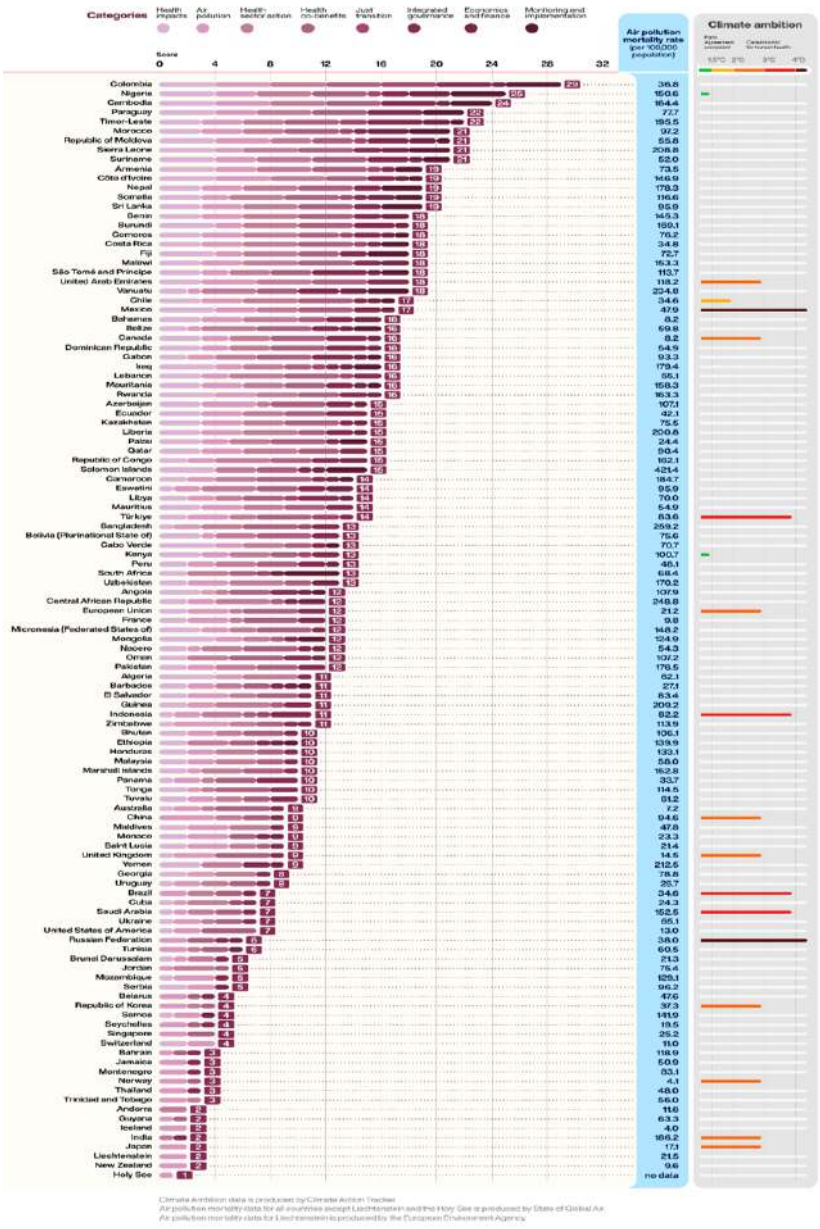


Figure 159: 2026 Healthy NDC Scorecard. The ranking of who is leading on health, clean air and climate action.

More information: Bit.ly/healthyNDCs3-0

Table 17.1: Indicators on Climate-attributable disease burden

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of climate-sensitive disease outbreaks recorded e.g (confirmed outbreaks: cholera, Lassa fever, CSM, dengue, yellow fever)	Data not available	Data not available	NCDC outbreak register (IDSR/SORMAS), annual

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Cholera: suspected cases, deaths and case fatality rate (%) -climate-sensitive tracer	NCDC cholera sitrep, Epi Week 52 2025	70,947 suspected; 461 deaths; CFR 0.6% 35 states, 204 LGAs (EW1–39, 2026)	NCDC cholera situation report EW39 2026 (Q3 2026 MOC); national
Number of states reporting heat-related illness presentations	Data not available	Data not available	
Number of health facilities damaged or made non-functional by climate events	Data not available	Data not available	
Number of flood-affected LGAs reporting a disease outbreak	128 LGAs flood-affected	Data not available	NEMA (LGA list) linked to NCDC outbreak register
Number of persons displaced by flood	58,000 (NEMA approximation, 2025)	Data not available	NEMA flood review; IOM DTM; national
Percentage of flood-displaced persons reached with health services	Data not available	Data not available	
Number of deaths attributed to flood disasters	241 deaths 27 states, 128 LGAs (Jan–Dec 2025)	Data not available	NEMA 2025 flood review, reported Apr 2026; national
Mortality attributed to household and ambient air pollution (deaths per 100,000)	Data not available	150.6 per 100,000	Healthy NDC Scorecard 2026 citing State of Global Air

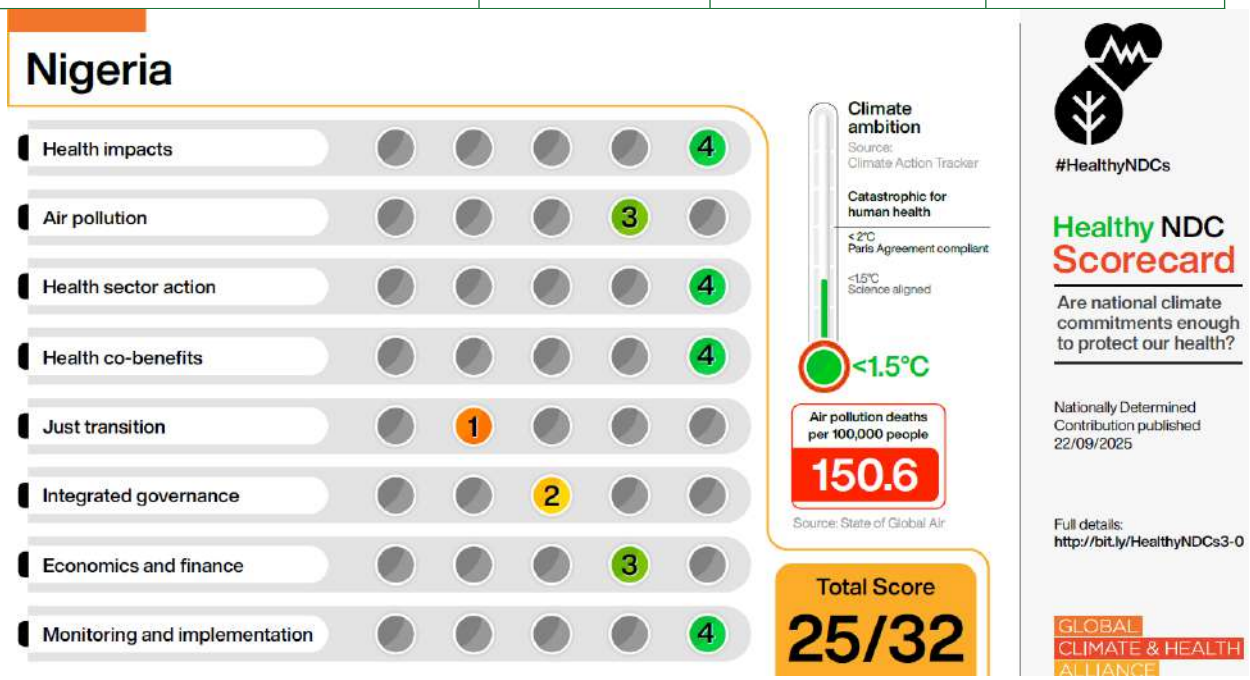


Figure 160: Nigeria's Healthy NDC Scorecard, 2026

17.2 Health System Climate Adaptation

Adapting the health system to climate change means building facilities, supply chains and services that can withstand climate shocks. Facility resilience assessments help identify

where health infrastructure is most at risk. This section presents the results of the health facility climate resilience assessment.

Table 17.2: Health system climate adaptation indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of states that have domesticated the HNAP	15 out of 36 states	21 out of 36 states	
Percentage of States implementing HNAP-related green procurement strategies	0%	Data not available	
Percentage of States/FCT with integrated EWARS for climate-linked health emergencies	0	Data not available	
Costed national climate change and health adaptation plan developed (Yes/No)	Yes- HNAP 2025–2030 issued	Yes- result confirmed at HOPE PHC interim verification	Climate Change Laws of the World; HOPE PHC verification (Q3 2026 MOC)
Percentage of Health facilities, EOCs and treatment centres complying with low-carbon building standards	0	Data not available	
Healthy NDC Scorecard total score (points out of 32)	Data not available	25/32; ranked 2nd of 117 NDCs NDC published 22/09/2025	Global Climate and Health Alliance, Healthy NDC Scorecards 2026 (launched 14 Oct 2026)
Number of climate-resilient health infrastructure models and blueprints available	99	Data not available	
BHCPF 2.0 guidelines revised to reflect climate resilience (Yes/No)	Data not available	Yes- revised and approved (HOPE PHC interim verification)	Q3 2026 MOC (HOPE PHC PfR update)
Percentage of public health events meeting 7-1-7 timeliness targets	Data not available	Detected ≤7 days: 87% (55/63) Notified ≤1 day: 89% (56/63) Early response ≤7 days: 22% (14/63) All three targets: 19% (Q3 2026)	NCDC Q3 2026 performance report (MOC); national
Guidelines for facilities developed from the Smart Hospitals Toolkit (availability)	Data not available	Data not available	
Percentage of health care facilities with basic services	55% (limited 32%; none 13%)	Data not available	WHO/UNICEF JMP, WASH in health care facilities 2015–2025 report; national
Number of health facilities with a completed climate vulnerability assessment	Data not available	Data not available	
Number of health workers trained on climate change and health	Data not available	Data not available	

17.3 WASH Infrastructure and Environmental Health Indicators

Water, sanitation and hygiene (WASH) services and environmental health practices are basic requirements for safe care and for preventing disease in communities. Gaps in

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WASH contribute to outbreaks of cholera and other water-borne diseases. This section presents the status of WASH infrastructure and environmental health in Nigeria

Table 17.3: WASH infrastructure and environmental health indicators

Core Indicator	2025 Achievement	2026 Achievement
Percentage of health facilities with basic water supply services	55%*	55%*
Percentage of health facilities with basic sanitation services	10%*	10%*
Percentage of health facilities with basic hand hygiene services	20%*	20%*
Percentage of health facilities with basic hand hygiene facilities at points of care	74.1%**	74.1%**
Percentage of health facilities with a basic healthcare waste management service	51.%**	51.%**
Percentage of Health facilities with a basic health care waste management service	Data not available	Data not available
Percentage of Health facilities with functional environmental cleaning protocols	Data not available	Data not available
Number of Healthcare workers trained in infection prevention and control	Data not available	Data not available

Source: *2025 NHFS

**2019 National WASH NORM II Report

Pillar IV — Key Achievements

- Emergency coordination has been strengthened with functional Public Health Emergency Operations Centres on the increase
- Faster detection and notification outbreak under the 7-1-7 framework
- Surveillance and laboratory capacity expanded.

Pillar IV — Challenges

- Heavy and persistent outbreak burden
- Outbreak response is too slow
- Weak core IHR capacities. SPAR scores are lowest for human resources, food safety and chemical events and for infection prevention and control and risk communication

Pillar IV — Recommendations for 2027

- Strengthen and pre-fund state rapid response teams, expand the field epidemiology workforce, and use routine 7-1-7 bottleneck reviews to fix delays
- Scale climate-resilient health action.
- To close the weakest IHR capacity gaps, prioritising IPC, risk communication, food safety and chemical events, alongside diphtheria catch-up vaccination and WASH interventions in cholera hotspots.

PART VI

PERFORMANCE OF THE THREE ENABLERS



ENABLER I STRATEGIC OBJECTIVE AND ACHIEVEMENT

Table 17.4: Enabler I strategic objectives and indicators

Strategic Objective	Indicator	Baseline (2023)	Target (2027)	Achievement (2024-2026)
Digitise the health system & have data-backed decision-making	Health Information Exchange (HIE) maturity assessment score for Nigeria (This is a maturity assessment to evaluate health information governance, generation, and use)	1	4	Data not available

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ENABLER I: DATA, DIGITISATION AND HEALTH INFORMATION SYSTEMS



18.1 Data and Digital Health Strategy Implementation and Innovation

Data and digital health transformation have witnessed tremendous progress at Federal, State, LGA and facility levels in 2026. The National Health Technology and Data Analytics Office (NHTDAO) has been set up to address the issue of coordination of digital health agenda and data systems. While efforts at the deployment of digital tools such as electronic medical records (EMRs), telemedicine, mobile health (mHealth) applications, and AI-enabled diagnostics have received significant boost through government, partners and the private sector (Figures 161–164).

Table 18.1: Data and digital health indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of tertiary facilities (public & private) that operate EMR	74.5% of 79 federal tertiary hospitals	Not available 59.3% (2026 JAR state submission)	National EMR Assessment Report 2025
Percentage of secondary facilities (public & private that operate EMR	Data not available	8.4%	2026 JAR state submission
Percentage of primary facilities (public & private that operate EMR	Data not available	18.6%	2026 JAR state submission
Percentage of tertiary hospitals with robotic surgery capability	Data not available	Data not available	
Percentage of tertiary hospitals with telemedicine capability	Data not available	Data not available	

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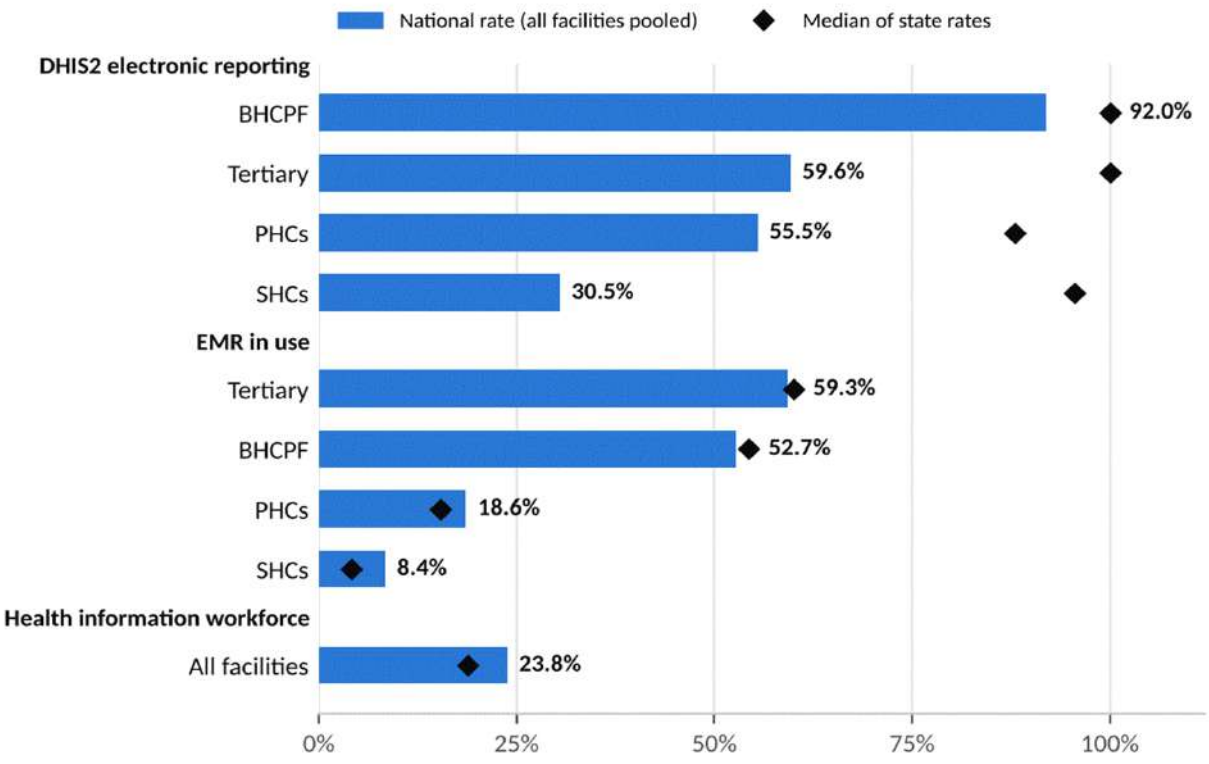


Figure 161: National coverage of electronic reporting, EMR and HIS staffing as at Q3, 2026. Source:2026 JAR state submissions

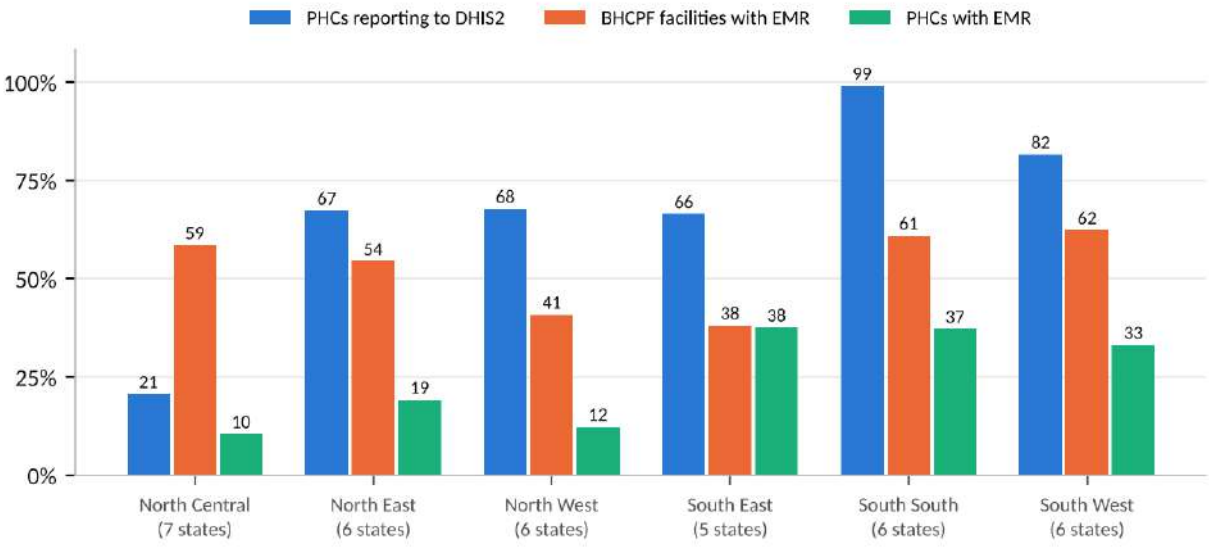


Figure 162: Percentage PHC electronic reporting and EMR coverage by geopolitical zone as at Q3 2026

The count under each zone is the number of states that submitted. Source: 2026 JAR state submissions.

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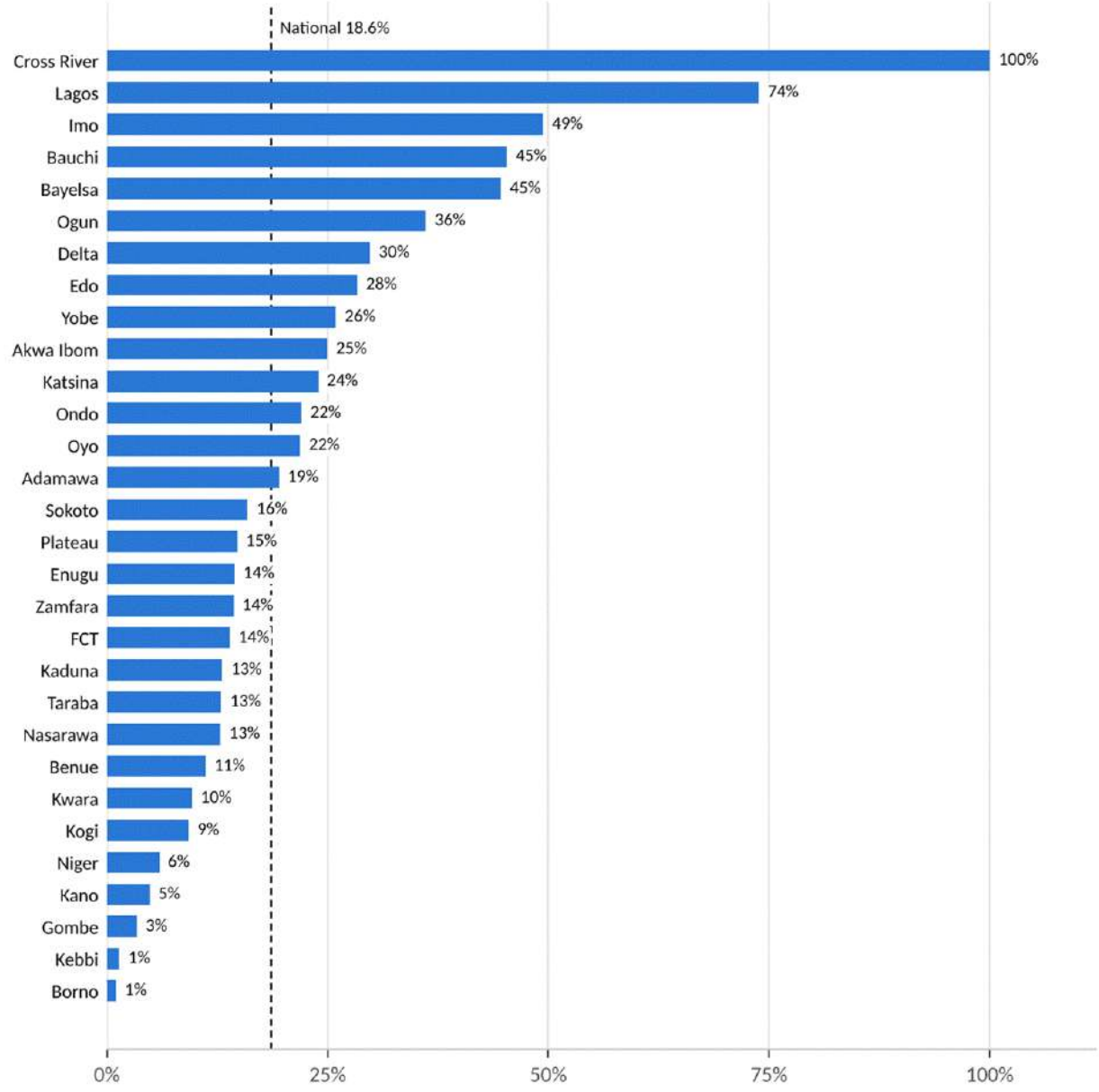


Figure 163: PHCs with an EMR system by state as at Q3 2026

Dashed line: national rate 18.6%. States with no valid value are not shown. Source: 2026 JAR state submission

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	DHIS2: PHCs	DHIS2: SHCs	DHIS2: Tertiary	DHIS2: BHCPF	EMR: PHCs	EMR: SHCs	EMR: Tertiary	EMR: BHCPF	HIM officer
Abia	>N	>N	>N	100	-	0	33	54	-
Adamawa	100	100	100	100	19	0	33	44	27
Akwa Ibom	100	100	100	>N	25	0	100	38	22
Anambra	-	-	-	0	-	-	-	33	-
Bauchi	>N	96	50	100	45	96	100	100	4
Bayelsa	100	56	100	100	45	51	0	98	-
Benue (Q2)	21	0	0	100	11	3	33	52	2
Borno	>N	0	0	100	1	0	100	54	-
Cross River	100	100	100	100	100	100	100	100	16
Delta	97	100	67	100	30	5	67	52	53
Ebonyi (Q2)	-	-	-	-	-	-	-	-	-
Edo (Q2)	99	5	100	100	28	2	100	100	2
Ekiti	-	100	-	-	-	14	-	-	-
Enugu	100	75	100	100	14	32	67	32	-
FCT	14	0	0	100	14	10	100	100	7
Gombe	100	100	>N	100	3	4	>N	19	4
Imo	49	>N	>N	>N	49	0	33	83	0
Kaduna	23	100	0	100	13	0	29	56	-
Kano	36	95	100	99	5	12	29	9	29
Katsina	85	100	100	>N	24	>N	100	100	3
Kebbi	100	100	100	88	1	3	100	5	-
Kogi	22	28	75	100	9	0	50	43	19
Kwara	57	46	40	-	10	-	40	52	47
Lagos	100	100	100	100	74	79	33	79	95
Nasarawa	15	0	0	85	13	0	67	85	14
Niger	5	>N	>N	100	6	>N	>N	36	-
Ogun	97	100	100	100	36	18	100	58	9
Ondo	34	96	100	100	22	4	33	66	75
Osun (Q2)	-	-	-	-	-	-	-	-	-
Oyo	100	100	100	100	22	0	50	50	44
Plateau	17	0	0	100	15	4	60	89	8
Rivers	-	-	-	100	-	-	-	24	-
Sokoto	100	100	100	100	16	100	100	57	100
Taraba	22	0	0	54	13	20	50	32	-
Yobe	35	0	0	100	26	14	100	78	20
Zamfara	91	85	67	100	14	7	33	68	67

Figure 164: Percentage Health Information system coverage by state as at Q3, 2026. Source: 2026 JAR state submissions

Note: Darker cells show higher coverage. ">N" = value above the number of facilities, excluded from totals. "–" = not reported. (Q2) = state reported only to Q2. Source: 2026 JAR state submissions

Status of State Health Information system coverage as at Q3, 2026

Table 18.2: Health facility DHIS2 reporting and EMR coverage by state

State	Qtr	PHCs	PHCs on DHIS2	PHCs with EMR	SHCs	SHCs on DHIS2	SHCs with EMR	BHCPF	BHCPF on DHIS2	BHCPF with EMR	All facilities	HIM officer
Abia	Q3	749	1,642 (>N)	–	23	195 (>N)	0 (0%)	184	184 (100%)	100 (54%)	1,003	–
Adamawa	Q3	904	904 (100%)	176 (19%)	20	20 (100%)	0 (0%)	226	226 (100%)	100 (44%)	927	250 (27%)
Akwa Ibom	Q3	481	481 (100%)	120 (25%)	43	43 (100%)	0 (0%)	316	408 (>N)	120 (38%)	592	130 (22%)
Anambra	Q3	–	–	–	–	–	–	329	0 (0%)	110 (33%)	–	–
Bauchi	Q3	713	1,142 (>N)	323 (45%)	28	27 (96%)	27 (96%)	212	212 (100%)	212 (100%)	1,202	48 (4%)
Bayelsa	Q3	224	224 (100%)	100 (45%)	72	40 (56%)	37 (51%)	102	102 (100%)	100 (98%)	299	–
Benue	Q2	1,289	276 (21%)	144 (11%)	117	0 (0%)	3 (3%)	276	276 (100%)	144 (52%)	1,408	28 (2%)
Borno	Q3	386	443 (>N)	4 (1%)	40	0 (0%)	0 (0%)	220	220 (100%)	118 (54%)	443	–
Cross River	Q3	196	196 (100%)	196 (100%)	15	15 (100%)	15 (100%)	196	196 (100%)	196 (100%)	1,175	186 (16%)
Delta	Q3	470	458 (97%)	140 (30%)	64	64 (100%)	3 (5%)	268	268 (100%)	140 (52%)	831	442 (53%)
Ebonyi	Q2	–	–	–	–	–	–	–	–	–	–	–
Edo	Q2	515	510 (99%)	146 (28%)	600	32 (5%)	9 (2%)	146	146 (100%)	146 (100%)	7,000	114 (2%)
Ekiti	Q3	–	–	–	21	21 (100%)	3 (14%)	–	–	–	–	–
Enugu	Q3	567	566 (100%)	82 (14%)	53	40 (75%)	17 (32%)	260	260 (100%)	82 (32%)	1,112	–
FCT	Q3	453	62 (14%)	63 (14%)	514	0 (0%)	53 (10%)	62	62 (100%)	62 (100%)	974	67 (7%)
Gombe	Q3	652	652 (100%)	22 (3%)	24	24 (100%)	1 (4%)	114	114 (100%)	22 (19%)	678	26 (4%)
Imo	Q3	1,109	548 (49%)	548 (49%)	709	1,109 (>N)	2 (0%)	6	1,852 (>N)	5 (83%)	1,852	5 (0%)
Kaduna	Q3	1,087	254 (23%)	142 (13%)	32	32 (100%)	0 (0%)	255	254 (100%)	142 (56%)	1,491	–
Kano	Q3	1,447	520 (36%)	70 (5%)	42	40 (95%)	5 (12%)	484	480 (99%)	45 (9%)	1,601	470 (29%)
Katsina	Q3	1,350	1,142 (85%)	323 (24%)	28	28 (100%)	120 (>N)	212	361 (>N)	212 (100%)	1,998	60 (3%)
Kebbi	Q3	907	907 (100%)	13 (1%)	31	31 (100%)	1 (3%)	256	225 (88%)	12 (5%)	–	–

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State	Qtr	PHCs	PHCs on DHIS2	PHCs with EMR	SHCs	SHCs on DHIS2	SHCs with EMR	BHCPF	BHCPF on DHIS2	BHCPF with EMR	All facilities	HIM officer
Kogi	Q3	1,080	233 (22%)	100 (9%)	151	43 (28%)	0 (0%)	233	233 (100%)	100 (43%)	1,235	233 (19%)
Kwara	Q3	1,039	590 (57%)	100 (10%)	333	154 (46%)	–	193	–	100 (52%)	1,377	650 (47%)
Lagos	Q3	348	347 (100%)	257 (74%)	29	29 (100%)	23 (79%)	289	289 (100%)	227 (79%)	2,263	2,150 (95%)
Nasarawa	Q3	973	147 (15%)	125 (13%)	47	0 (0%)	0 (0%)	147	125 (85%)	125 (85%)	1,048	147 (14%)
Niger	Q3	1,692	90 (5%)	100 (6%)	21	24 (>N)	24 (>N)	274	274 (100%)	100 (36%)	–	–
Ogun	Q3	515	500 (97%)	186 (36%)	28	28 (100%)	5 (18%)	236	235 (100%)	138 (58%)	1,391	121 (9%)
Ondo	Q3	604	203 (34%)	133 (22%)	24	23 (96%)	1 (4%)	203	203 (100%)	133 (66%)	833	628 (75%)
Osun	Q2	–	–	–	–	–	–	–	–	–	–	–
Oyo	Q3	800	800 (100%)	175 (22%)	50	50 (100%)	0 (0%)	351	351 (100%)	175 (50%)	1,455	638 (44%)
Plateau	Q3	1,247	207 (17%)	184 (15%)	99	0 (0%)	4 (4%)	207	207 (100%)	184 (89%)	1,351	102 (8%)
Rivers	Q3	–	–	–	–	–	–	205	205 (100%)	50 (24%)	–	–
Sokoto	Q3	802	802 (100%)	128 (16%)	23	23 (100%)	23 (100%)	267	267 (100%)	151 (57%)	826	826 (100%)
Taraba	Q3	772	168 (22%)	100 (13%)	101	0 (0%)	20 (20%)	311	168 (54%)	100 (32%)	875	–
Yobe	Q3	482	169 (35%)	125 (26%)	21	0 (0%)	3 (14%)	161	161 (100%)	125 (78%)	522	107 (20%)
Zamfara	Q3	697	637 (91%)	100 (14%)	27	23 (85%)	2 (7%)	147	147 (100%)	100 (68%)	727	486 (67%)

Note: ">N" = value above number of facilities. "–" = not reported. Source: 2026 JAR state submissions.

Figures 165–169 show the share of BHCPF facilities in each state and the coverage of electronic medical record (EMR) systems in primary, secondary and tertiary facilities in 2025 and 2026.

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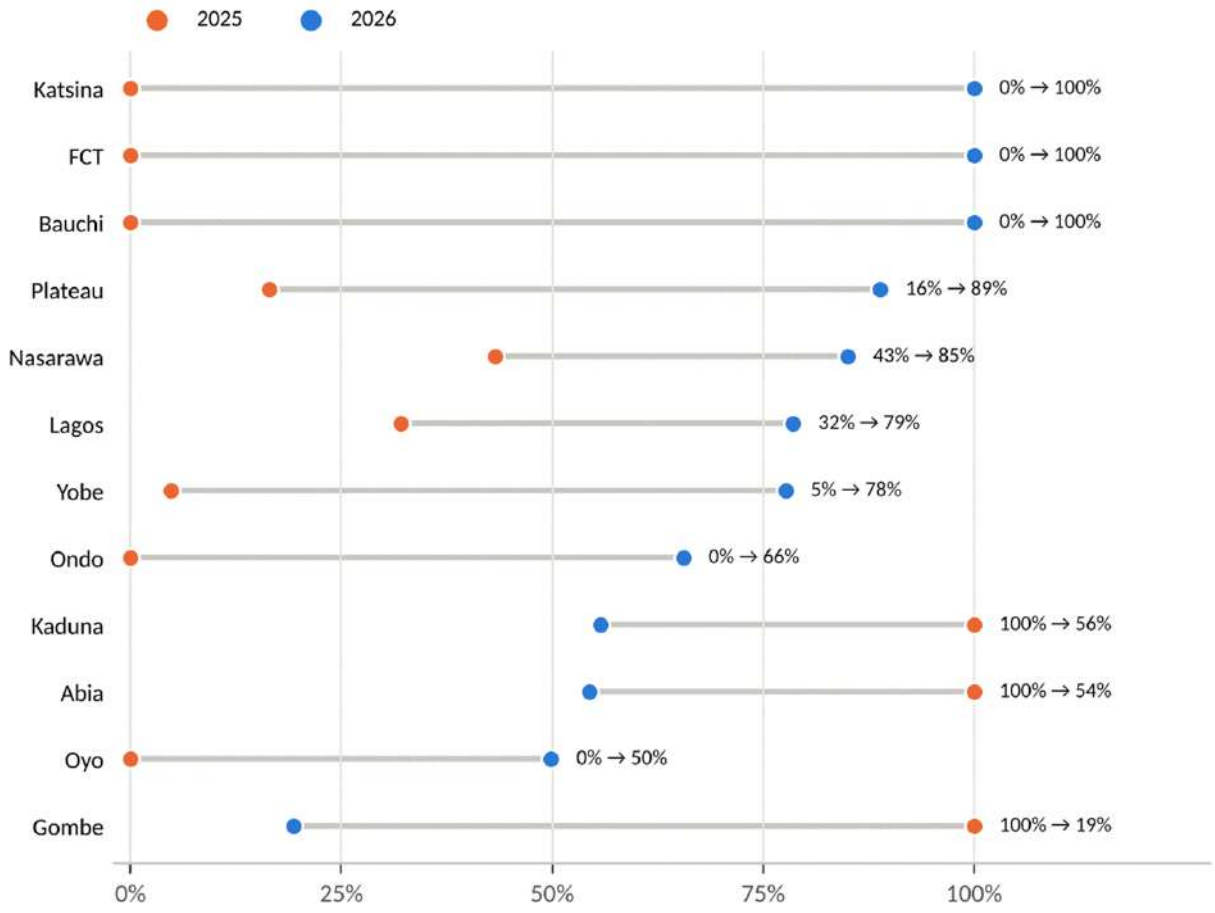


Figure 165: BHCPF facilities with an EMR system, 2025 and 2026, states reporting in both years Sources: 2025 and 2026 JAR state submissions

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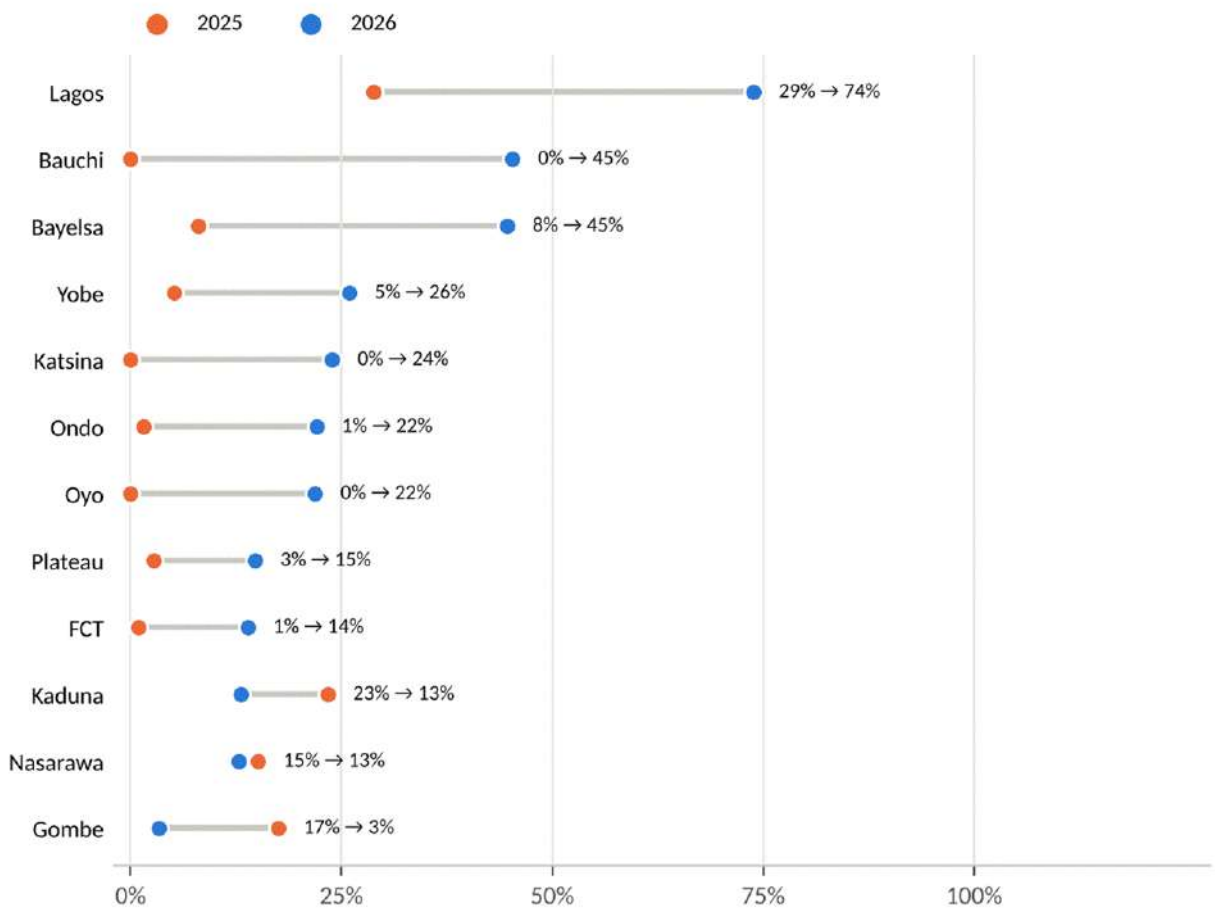


Figure 166: PHCs with an EMR system, 2025 and 2026, states reporting in both years. Sources: 2025 and 2026 JAR state submissions

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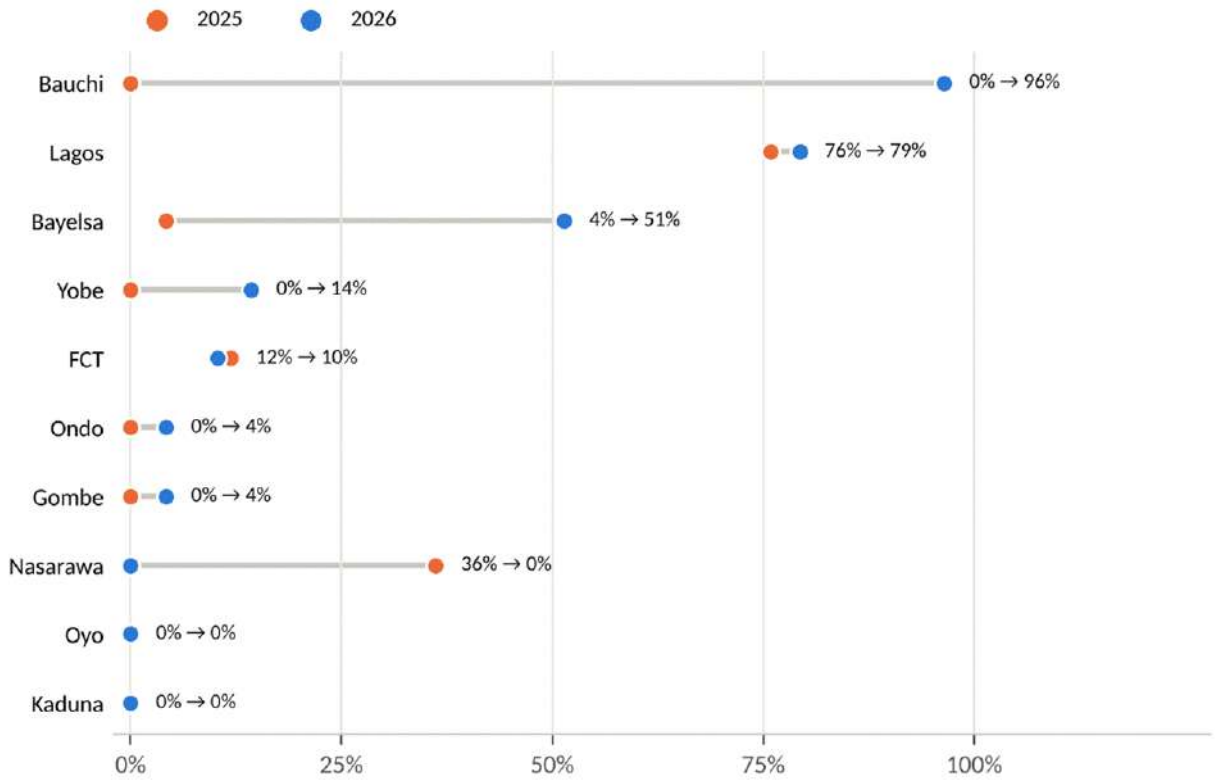


Figure 167: SHCs with an EMR system, 2025 and 2026, states reporting in both years

Sources: 2025 and 2026 JAR state submissions.

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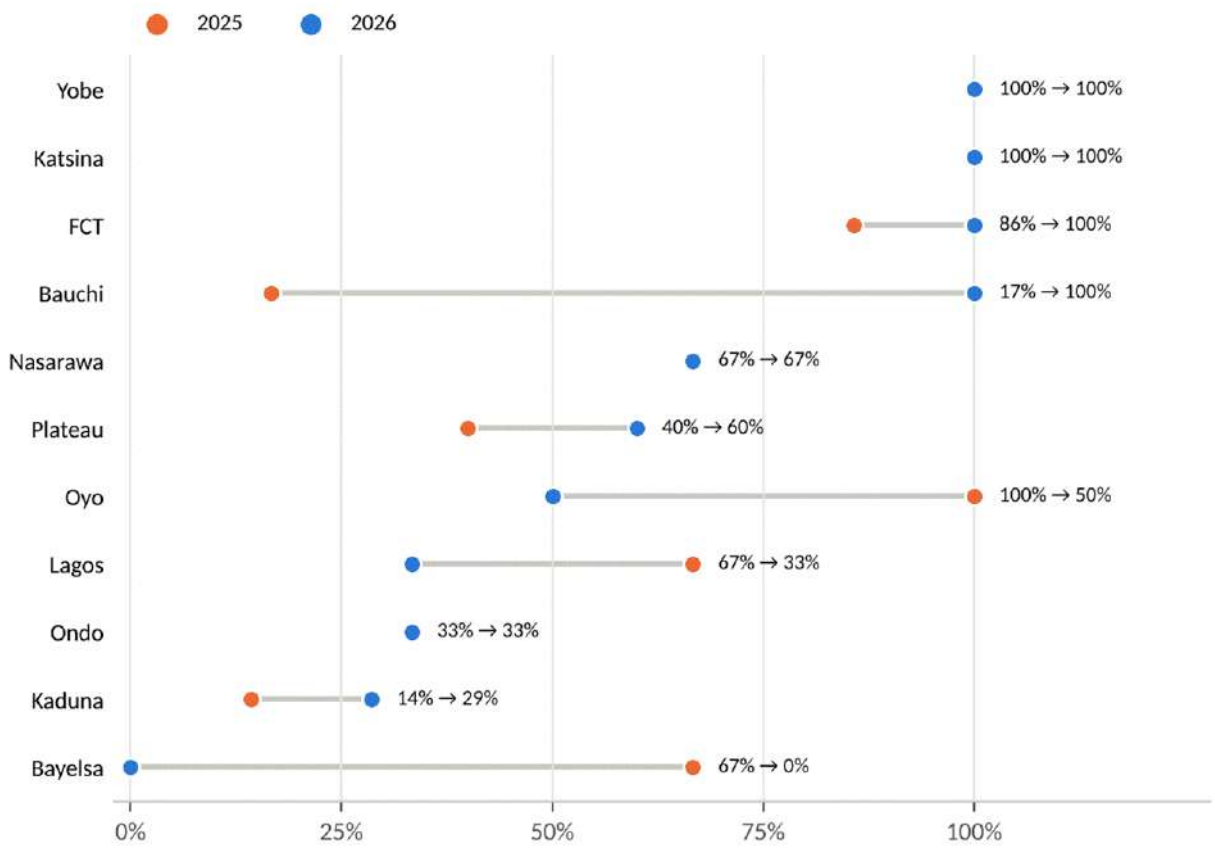


Figure 168: Tertiary facilities with an EMR system, 2025 and 2026, states reporting in both years

Sources: 2025 and 2026 JAR state submissions.

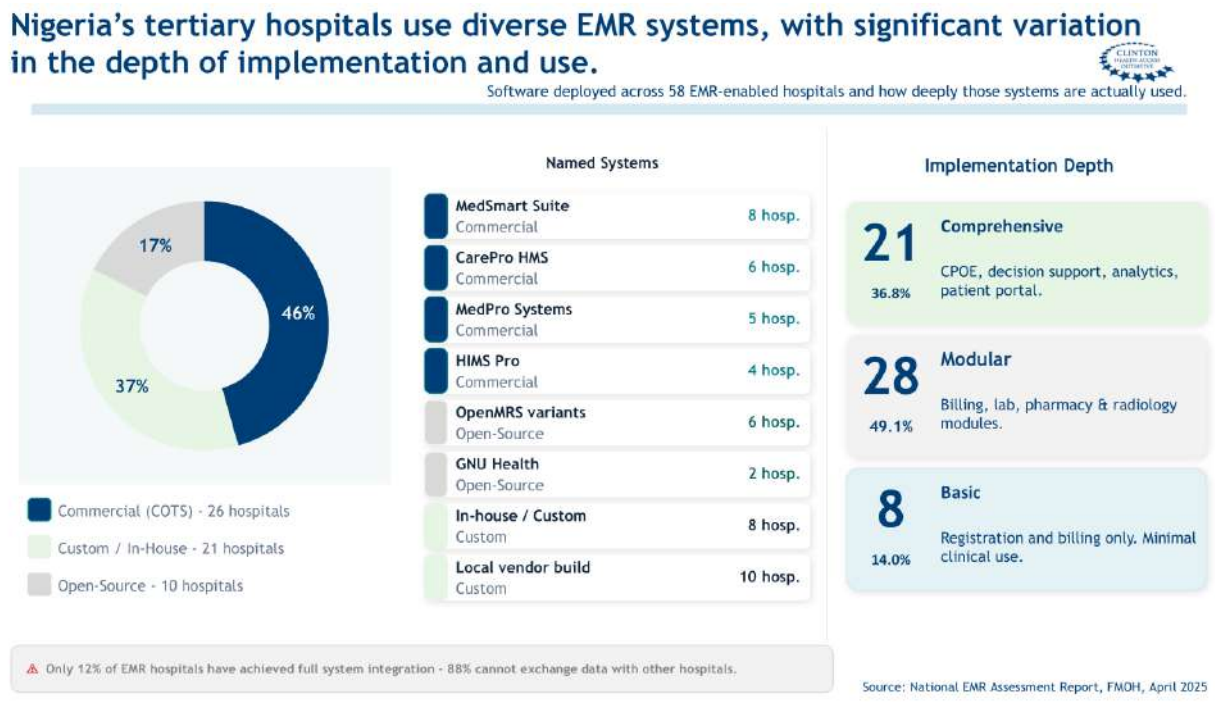


Figure 169: EMR systems in tertiary hospitals and depth of implementation

18.2 Health Data Governance Framework

Health data governance sets the rules for how health data are collected, stored, shared and protected. Clear governance builds trust in health information systems and protects patient privacy. To ensure a harmonised approach to information sharing, Nigeria has adopted the Fast Healthcare Interoperability Resources (FHIR) standard for implementation of EMRs across the country.

Table 18.3: Health data governance indicators

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of EMRs deployed that meet minimum national (FHIR) Standards	Data not available	Data not available	
Percentage of routine data systems that meet minimum national (FHIR) Standards	Data not available	Data not available	

18.3 Interoperability of Health Information Systems

Interoperability is the ability of different health information systems to exchange and use one another's data. It allows information to flow across programmes and levels of care and reduces duplicate reporting. Despite resolutions by the National Council on Health for the use of the DHIS-2 as the only data aggregation systems, there continues to be proliferation of data systems which impedes the single source of truth principle. This section presents progress in connecting Nigeria's health information systems.

Table 18.4: Interoperability of health information systems

Core Indicator	2025 Achievement	2026 Achievement
Percentage of EMRs linked to the DHIS-2 national instance	Data not available	Data not available
Percentage of routine data systems (non-EMR) linked to the DHIS-2 national instance	Data not available	Data not available
Percentage of health system registries linked to the DHIS-2 national instance	Data not available	Data not available

18.4 DHIS-2 Performance — Completeness, Timeliness and Data Quality

The DHIS2 National Instance is Nigeria's main source of routine health service data. The usefulness of this data for planning depends on its completeness, timeliness and quality. This section presents NHMIS performance across these three dimensions (Figure 170).

Table 18.5: DHIS2 completeness, timeliness and data quality

Core Indicator	2025 Achievement	2026 Achievement
Percentage of DHIS2 National Instance reporting rate	93%	70%*
Percentage of Facilities reporting on the DHIS2 National Instance electronically	15%	22%*
Percentage of Facilities reporting timely on the DHIS2 National Instance	88%	66%*
Percentage of Facilities reporting complete data on the DHIS2 National Instance	93%	70%*

Core Indicator	2025 Achievement	2026 Achievement
Percentage of BHCPF facilities reporting on the DHIS2 National Instance	99%	99%*
Number of NHMIS reports received vs expected	419,633	315,013*

Table 18.6: Health facilities reporting to DHIS2

Core Indicator	2025 Achievement	2026 Achievement
Number of Primary health centres reporting to DHIS2	Data not available	22,000*
Number of Secondary health facilities reporting to DHIS2	Largely nil across state returns	4,906*
Number of Tertiary health facilities reporting to DHIS2	Largely nil across state returns	186*
Number of Quaternary hospitals reporting to DHIS2	0	Data not available
Number of BHCPF facilities reporting electronically to DHIS2	8,254	8,254*
Number of Private health facilities reporting in the DHIS2 national instance	Data not available	12,137*
Number of Facilities with licensed health information management officers	40%	23.8%*

*DHIS2 (Jan-Sep)

Table 18.7: National NHMIS reporting coverage by indicator, as at Q3 2026

Indicator	Numerator	Denominator (facilities)	National rate	No States included	Median state	State range	Excluded (value > denominator)	Submitted but did not report on this indicator
PHCs reporting electronically to DHIS2	12,593	22,702 PHCs in the state	55.5%	28	88.0%	5–100%	3	4
SHCs reporting electronically to DHIS2	830	2,677 SHCs in the state	31.0%	29	95.8%	0–100%	3	3
Tertiary facilities reporting electronically to DHIS2	62	104 tertiary facilities	59.6%	27	100.0%	0–100%	4	4
BHCPF facilities reporting electronically to DHIS2	6,090	6,621 BHCPF facilities	92.0%	29	100.0%	0–100%	3	3
PHCs with an EMR system	4,425	23,801 PHCs in the state	18.6%	30	15.4%	1–100%	0	5
SHCs with an EMR system	257	3,048 SHCs in the state	8.4%	29	4.2%	0–100%	2	4
Tertiary facilities with an EMR system	67	113 tertiary facilities	59.3%	29	60.0%	0–100%	2	4
BHCPF facilities with an EMR system	3,876	7,348 BHCPF facilities	52.7%	33	54.3%	5–100%	0	2

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Indicator	Numerator	Denominator (facilities)	National rate	No States included	Median state	State range	Excluded (value > denominator)	Submitted but did not report on this indicator
Facilities with a licensed HIM officer	7,914	33,266 all health facilities	23.8%	23	18.9%	0–100%	0	12

Source: 2026 JAR state submissions, Q3 2026 (Q2 for Benue, Ebonyi and Edo).

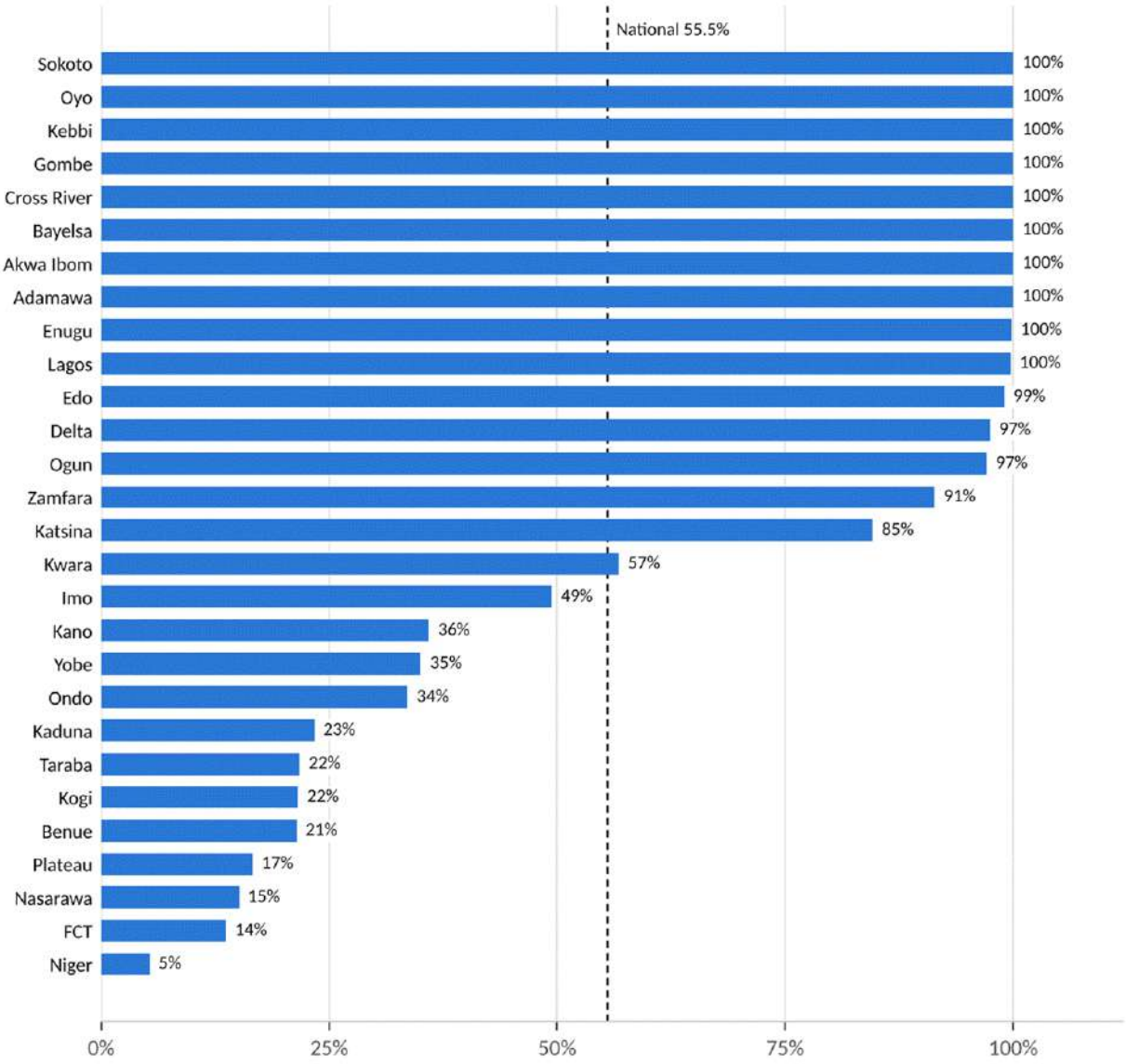


Figure 170: PHCs reporting electronically to DHIS2 by state as at Q3 2026

Note: Dashed line is the national rate 55.5%. Abia, Bauchi and Borno reported more PHCs on DHIS2 than PHCs in the state and are not shown. Source: 2026 JAR state submissions.

18.5 Data Quality Audit — Reconciliation Between DHIS2, NDHS and Administrative Data

Data quality audits test the reliability of routine data by comparing DHIS2 figures with survey sources such as the Nigeria Demographic and Health Survey (NDHS) and with administrative data. Large differences between sources point to areas where data quality needs attention. This section presents the results of this reconciliation.

Table 18.8: Data quality audit indicators

Core Indicator	2025 Achievement	2026 Achievement
Percentage of National mean data quality assessment score	90.4% (2024: 89.4%)	90.9%*
Percentage of Highest zonal data quality assessment score	92.1% (South East)	93.2% (South South)*
Percentage of Lowest zonal data quality assessment score	86.5% (South West; 2024: 81.3%)	87.5% (South West)*
Percentage of Highest single jurisdiction score	96.16% (Akwa Ibom)	98.5% (Jigawa State)*
Percentage of Lowest single jurisdiction score	71.75% (FCT)	94.4% (Akwa Ibom State)*
Percentage of Key performance indicator completeness by geopolitical zone	Immunisation >85%; maternal <60%	Data not available
Percentage of Mean data quality (DQA) score by geopolitical zone	Data not available	Q1 87.5% to 93.1%; Q2 87.5% to 93.1%; Q3 78.0% to 85.0% (range across zones)*

*DHIS2 (FASTR Adjusted, Jan to Sep 2026)

18.6 Periodic Assessments and Surveys

Assessment such as facility Service Availability and Readiness Data (SARA), BEmONC and CEmONC facility evaluation, as well as population surveys, provide quality progress measures for planning health sector interventions. The health sector is implementing an innovative approach to facility assessment using the FASTR approach with focus on BHCPF facilities, while also harmonising surveys to reduce duplication and in pursuant of harmonised survey information (Figure 171).

Table 18.9: Progress on assessment and survey implementation

Core Indicator	2023	2024	2025	2026	Data Source
Number of national health surveys conducted	6	3	8	3	DHPRS Survey Division

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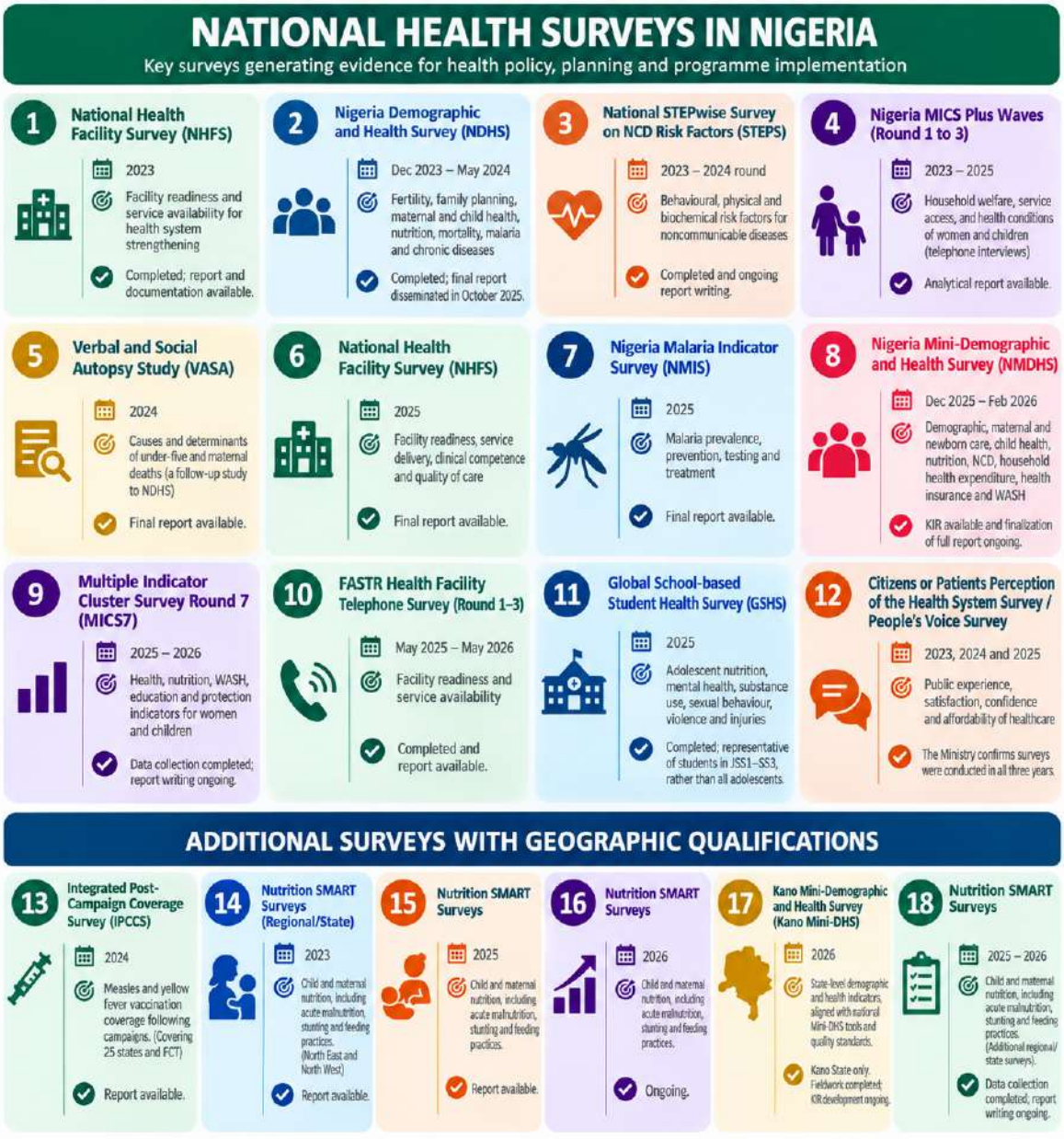


Figure 171: National health surveys in Nigeria

Table 18.10: Progress on facility assessment

Core Indicator	2025 Achievement	2026 Achievement
Percentage of tertiary facilities assessed for minimum standards	Data not available	Data not available
Percentage of secondary facilities assessed for minimum standards	Data not available	Data not available
Percentage of PHCs assessed for minimum standards	Data not available	Data not available
Percentage of BHCPF facilities assessment using the FASTR approach	Data not available	Data not available

18.7 Data Use

The health sector continues to strengthen the use of data to inform planning, resource allocation and accountability at federal, state and facility levels. All states conducted their

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Joint Annual Review in line with national guidelines in both 2025 and 2026 (Table 18.11), giving every state a structured, evidence-based platform to review performance against targets, agree priorities and feed findings into annual operational planning.

At the federal level, quarterly Ministerial Oversight Committee reviews and Annual Operational Plan quarterly review submissions use routine DHIS2, programme and survey data to track delivery of HSSB interventions and redirect resources where performance lags.

Table 18.11: Progress on assessment and survey implementation

Core Indicator	2025 Achievement	2026 Achievement
Percentage of ministerial performance bond reports developed and submitted to the presidency	Data not available	Data not available
Percentage of planned quarterly ministerial dialogues held with State Commissioners of health	Data not available	Data not available
Percentage of States that conducted JAR in line with national guidelines	100%	100%

Enablers I — Key Achievements

Enabler I: Data, Digitisation and Health Information Systems

- The National Health Technology and Data Analytics Office (NHTDAO) has been set up to coordinate the digital health agenda and data systems.
- Interoperability standards have been adopted (FHIR) standard for EMR implementation across the country.
- Tablet deployment to states to improve service delivery

Enablers I — Challenges

- Parallel data systems persist despite the NCH resolution adopting DHIS2 as the sole aggregation platform, undermining the one-source-of-truth principle.
- Foundational registries such as the National Health Facility and Health Workforce and key disease registries (Cancer, Hypertension, Diabetes, HIV, TB etc) remain fragmented and managed separately.

Enablers I — Recommendations for 2027

- Link EMRs and registries to DHIS2 using the FHIR standard, and report EMR and interoperability indicators.
- Aggressively pursue the integration of health registries, facility assessments and population surveys and their coordination to ensure national representation

ENABLER II STRATEGIC OBJECTIVES AND ACHIEVEMENTS

Table 18.12: Enabler II strategic objectives and indicators

Strategic Objective	Indicator	Baseline (2023)	Achievement 2024
Increase effectiveness and efficiency of healthcare spending	Out-Of-Pocket (OOP) Expenditure as share of Current Health Expenditures (CHE) (%)	65.7% (2023)	62.2% (2024)
	Government General Health Expenditures (GGHE) – THE per capita (₦)	₦9,388.1	₦ 12,810.3
	GGHE (THE) as a share of GDP (%)	0.7%	0.8%
	Preventive spending as share of CHE	15.1%	19.8%
	Preventive spending as share of CHE	65.5%	61.6%

Chapter 19

ENABLER II: HEALTH FINANCING AND FINANCIAL PROTECTION



19.1 HEALTH SECTOR FINANCING ARCHITECTURE

Nigeria's mixed health financing landscape is dominated by out-of-pocket expenditure (>70% of Total Health Expenditure [THE]), substantially above the WHO target (<30%) required for Universal Health Coverage[2]. Public spending accounts for 14.3% of THE, while external donor contributions represent 7.5% [1]. At the federal level, budgetary allocation to health averaged ~4% between 2019 and 2020[3], falling well short of the 15% Abuja Declaration commitment. This shortfall is compounded by a constrained fiscal environment, with government revenue at 9.4% of GDP—significantly trailing the Sub-Saharan African average of 23% (Figure 172).

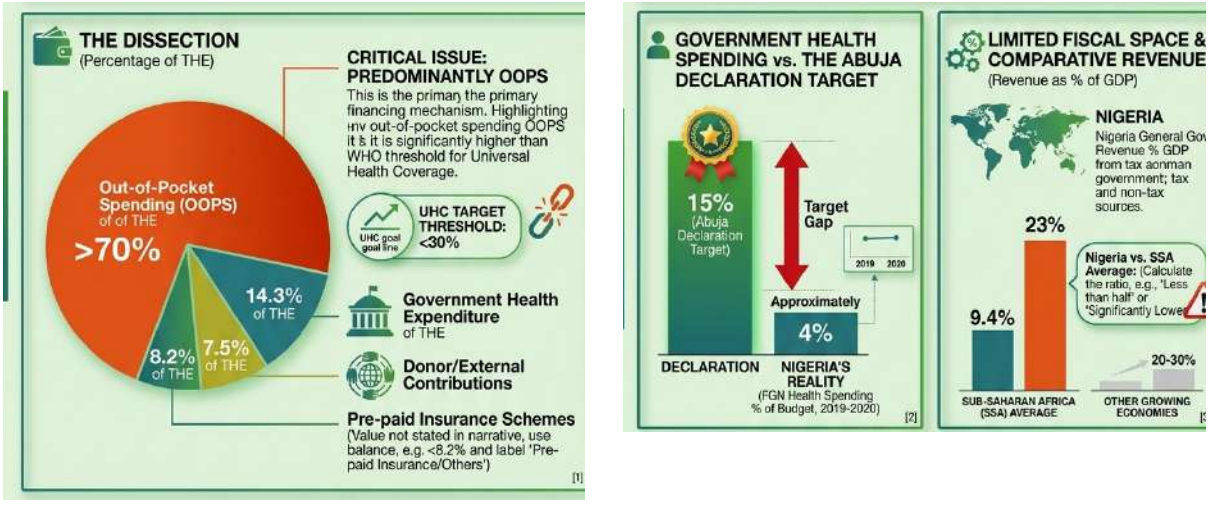


Figure 172: The Nigerian health financing system: Analysis of the total health expenditure (THE) & fiscal constraints

[2] https://hfr.fmohconnect.gov.ng/

[3] Federal Ministry of Health. *National Health Accounts 2017*. Abuja; 2017.

Chapter 19

KEY TAKEAWAYS FOR UHC

Reduce OOPS (<30% WHO goal) to achieve UHC

Increase government health allocation towards 15% (Abuja target)

Address limited fiscal space by expanding the revenue base (e.g., tax reform)

Despite federal health allocations climbing from ₦635.53bn in 2021 to a peak of ₦2.83tn in 2025, momentum is set to reverse with a proposed decline to ₦2.46tn for 2026. Compounding this challenge, state governments continue to deprioritise and underutilise healthcare funds, dedicating just 6.98% of actual spending to the sector and achieving a low-budget implementation rate of 61.74% in 2025 (Figure 173).



Figure 173: Federal and state health budget allocation, expenditure and prioritisation, 2021–2026

19.2 Federal and State Health Budget Allocation vs. Execution

Federal health budget allocation increased from ₦2.48 trillion in 2025 to ₦3.55 trillion in 2026, while aggregate state health budget allocations rose from ₦1.86 trillion to ₦3.44 trillion over the same period. This represents a substantial increase in planned public

investment in health at both federal and state levels, indicating a stronger budgetary commitment to domestic financing of the health sector.

Table 19.1: Federal and state health budget allocation and execution

Core Indicator	2025	2026	Data Source
Total federal health budget allocation (₦)	₦2.48 trillion	3.55 trillion	Federal Budget Appropriation
Total state health budget allocations (₦)	₦1.86 trillion	3.44 trillion	Aggregate of State Budgets
Total amount raised by PVAC (US$)	Not reported in 2025	**$75m** investment unlocked for 12+ companies; $5bn+ project pipeline; ₦24bn+ tax waivers (Jan 2025 to June 2026); $200m Lafiya Fund in progress	
Percentage of development partner funding tracked through RMET	87%	95%	
Percentage of development partners providing all required RMET information	Data not available	75%	

19.3 Abuja Declaration Commitments — Progress Tracking

Under the 2001 Abuja Declaration, African heads of state committed to allocate at least 15% of their annual budgets to health. The commitment remains a widely used benchmark of government priority for health. This section tracks Nigeria's progress towards this target.

Table 19.2: Abuja Declaration commitments progress

Core Indicator	2025 (Latest available data)	2026 (Latest Available data)	Data Source
General Government Health Expenditure (THE) as a share of Total Government Expenditure (%)	6.0% (2023)	5.6% (2024)	2023/2024 NHA
Total health expenditure as a share of GDP (%)	2.7%	3.0%	2023/2024 NHA
Government General Health Expenditures (GGHE) – THE per capita (₦)	₦9,388.1 (2023)	₦ 12,810.3	2023/2024 NHA
Household out-of-pocket spending as a share of current health expenditure (%)	65.7% (2023)	62.2% (2024)	2023/2024 NHA

19.4 Basic Health Care Provision Fund (BHCPF) — Disbursement, Utilisation and Impact

The Basic Health Care Provision Fund (BHCPF), established under the National Health Act 2014, finances a basic minimum package of health services for Nigerians. The Fund flows through several gateways to support primary health care facilities and health insurance for vulnerable groups. This section presents the disbursement and use of the Fund and its contribution to service delivery.

Table 19.3: BHCPF disbursement, utilisation and impact

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Total BHCPF budget appropriation (₦)	₦298 billion	298 billion	MOC Secretariat
Total BHCPF disbursements (₦)	98.6 billion (Q1 –Q2)	98.6 billion (Q1&Q2)	MOC Secretariat
BHCPF disbursement as a share of allocation (%, derived)	100%	75%	MOC Secretariat
Total partner contributions to the BHCPF basket (₦)	0	0	
Total private sector contributions to the BHCPF (₦)	0	0	
Percentage of Donors fulfilling funding commitments to BHCPF implementation	100%	100%	
Percentage of Donor funding commitments made to the BHCPF	0% (conflicting value, pending reconciliation)	0	
Number of Participating states receiving funds in compliance with the allocation formula	37	37	
Number of Facilities where NHIA and NPHCDA payment gateways converge	Data not available	Data not available	
Facilities receiving direct financing from the NPHCDA gateway	8,309	8,309	

19.5 Health Insurance Coverage

Health insurance protects households from the financial risk of illness and is a key pathway to universal health coverage. Expanding enrolment, especially among informal sector workers and vulnerable groups, remains a national priority. This section presents progress in health insurance coverage in Nigeria (Figures 174 and 175).

Chapter 19

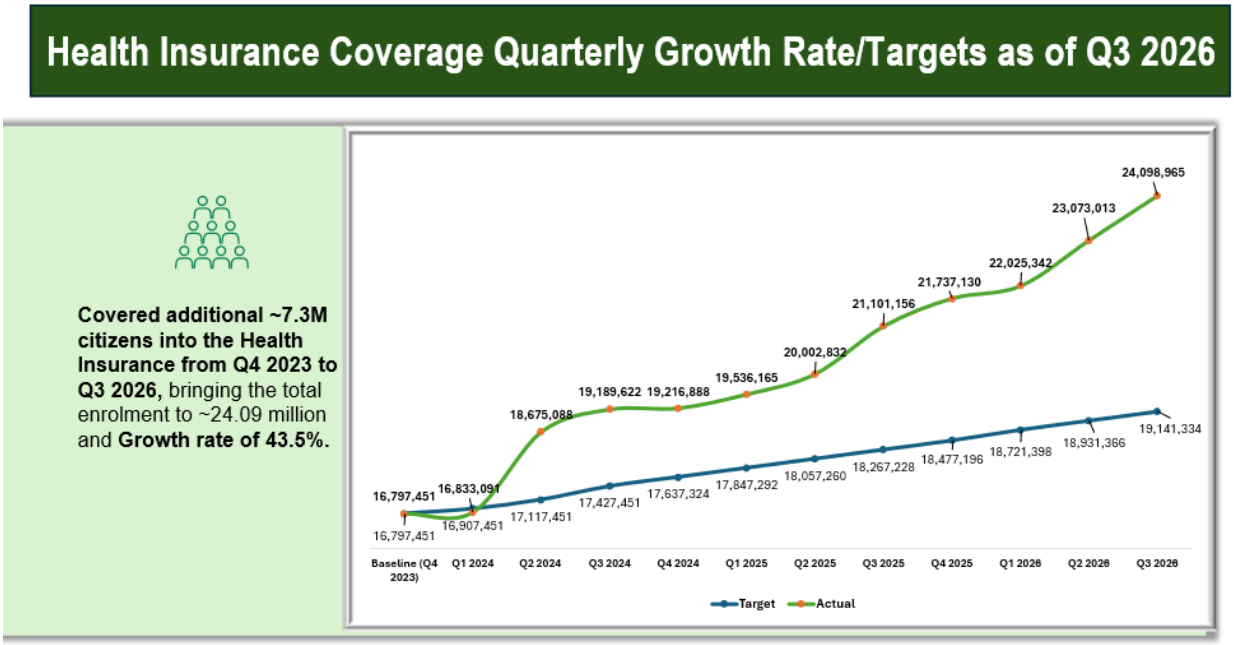


Figure 174: Health Insurance coverage status by states and programmes (Jan-Jun 2026)

Health Insurance Coverage Status by State by Program as of Q3 2026

S/N	State	SSHIA Programmes	BHCPF Program with NIN	Federal Formal Sector	Self-Paying Agencies	Organized Private Sector	GIFSHIP General	GIFSHIP NYSC	GIFSHIP Constituency	GIFSHIP Retirees (Police & DSS)	TISHIP	Global Fund RSSH Grant	NHIA CBHI/MHA	HMO's Private Plan	Total Per State
1	Abia	148,411	58,566	72,744	1,559	96	1,129	6,617	300	582	26,388	0	293	12,749	**329,434**
2	Adamawa	123,000	121,690	83,940	3,996	58	496	5,920	0	1,480	25,709	0	0	7,242	**373,531**
3	Akwa-Ibom	9,260	70,150	75,850	1,809	6	1,147	6,270	1	1,815	29,085	0	1,293	12,460	**209,146**
4	Anambra	291,500	59,924	83,371	2,081	27	1,492	6,157	10	806	80,716	14,636	15,137	6,850	**562,707**
5	Bauchi	57,215	149,527	109,668	4,360	75	139	5,214	1	1,345	2,078	0	10,097	3,766	**343,485**
6	Bayelsa	262,349	26,542	60,035	1,151	2	477	5,611	0	507	38,170	0	0	3,788	**398,632**
7	Benue	31,689	88,657	98,595	3,358	59	1,412	4,006	789	2,688	49,241	0	4,082	15,224	**299,800**
8	Borno	12,353	135,449	109,138	3,493	135	200	3,817	0	761	48,407	0	0	3,879	**317,632**
9	Cross River	19,786	80,358	97,432	2,592	54	466	3,824	502	1,817	46,300	0	3,746	25,143	**282,020**
10	Delta	2,910,043	55,494	91,021	3,001	93	870	5,040	5	1,359	38,346	0	0	27,323	**3,136,595**
11	Ebonyi	37,375	99,758	75,158	1,643	0	785	4,642	393	752	10,677	11,164	10,210	16,811	**269,368**
12	Edo	141,486	60,116	138,494	3,024	362	2,548	5,442	0	1,414	40,798	0	8,515	58,160	**460,359**
13	Ekiti	871,787	66,975	69,849	1,751	8	660	3,985	0	386	96,676	0	46,648	7,787	**1,166,512**
14	Enugu	133,685	29,545	123,707	4,158	563	1,818	5,730	6	1,717	71,727	0	15,669	12,129	**400,454**
15	FCT	177,713	72,229	377,975	63,723	2,321	5,841	27,845	9	1,743	1,292	0	0	230,245	**960,936**
16	Gombe	427,804	75,124	86,042	3,075	33	313	4,683	1	1,473	26,170	24,777	7,801	3,477	**660,773**
17	Imo	128,618	70,031	102,867	2,999	19	2,561	4,660	5	1,220	23,500	0	6,684	6,573	**349,737**
18	Jigawa	477,402	177,438	63,211	1,719	8	53	4,336	0	330	14,290	0	18,392	5,745	**762,924**
19	Kaduna	590,745	126,280	261,767	15,965	643	1,974	7,761	517	2,840	64,882	0	9,294	48,151	**1,130,819**
20	Kano	881,567	213,018	168,492	14,787	453	1,082	6,976	1	1,280	145,963	0	0	19,560	**1,455,179**
21	Katsina	242,447	131,975	93,352	5,692	95	166	4,508	0	599	42,567	0	93,986	7,928	**623,315**
22	Kebbi	115,597	103,888	61,760	1,807	29	79	2,045	0	525	8,025	0	1,866	1,878	**297,499**
23	Kogi	161,705	73,923	88,300	3,162	47	398	4,439	0	1,384	22,040	0	10,379	34,587	**400,364**
24	Kwara	12,146	58,144	116,049	5,111	63	1,638	4,622	2	1,150	44,423	7,870	0	40,912	**292,330**
127	Lagos	1,743,240	41,964	249,512	23,298	766	4,565	38,658	29	2,682	101,595	12,782	0	1,180,285	**3,399,376**
26	Nasarawa	210,470	81,427	127,241	6,503	240	736	6,759	1	1,461	10,403	0	90	13,609	**458,940**
27	Niger	50,519	135,852	130,792	8,077	136	389	3,901	3	1,336	48,812	0	41,191	51,175	**472,183**
28	Ogun	187,832	60,396	108,186	3,221	29	2,357	12,618	2	1,371	26,423	0	0	55,261	**457,696**
29	Ondo	184,511	61,928	81,154	3,604	6	1,017	4,613	3	1,211	33,253	0	0	34,827	**406,127**
30	Osun	230,857	35,724	95,739	2,602	136	5,240	7,920	0	699	105,906	0	0	30,962	**515,785**
31	Oyo	239,274	54,405	154,241	5,907	35	3,294	15,356	5	2,435	117,746	0	0	30,521	**623,219**
32	Plateau	191,554	94,367	141,574	5,792	450	783	5,452	1	2,715	50,671	0	1,121	19,599	**514,079**
33	Rivers	56,113	84,054	108,557	4,612	83	1,692	14,623	6,801	1,354	104,695	0	0	149,783	**532,367**
34	Sokoto	77,007	94,368	77,365	3,305	18	183	3,700	1	418	58,645	0	33,188	1,594	**349,792**
35	Taraba	16,877	102,701	71,140	1,739	17	219	3,707	1	1,083	15,385	0	674	2,703	**216,246**
36	Yobe	222,395	100,816	58,249	1,437	27	49	3,404	0	262	8,566	0	0	712	**395,917**
37	Zamfara	147,813	30,140	65,320	1,730	44	50	1,704	0	325	23,304	0	2,541	716	**273,687**
	Total	**11,824,145**	**3,182,943**	**4,177,887**	**227,843**	**7,236**	**48,318**	**272,765**	**9,389**	**47,325**	**1,702,874**	**71,229**	**342,897**	**2,184,114**	**24,098,965**

Figure 175: Health insurance coverage by state and programme, Q3 2026

Table 19.4: Health insurance coverage indicators

Core Indicator	Baseline	2025 Achievement	2026 Achievement
Number of Total population covered by any approved health insurance	19,216,888 (P2.8.14)	21,100,000	24,098,965 (Q3 2026)

Core Indicator	Baseline	2025 Achievement	2026 Achievement
Percentage of Population covered by any approved health insurance	Data not available	~10%	10.1%
Number of Population in vulnerable groups covered through the BHCPF	2,401,776 (P2.8.14)	2,400,000	3,182,943 (Q3 2026)
Number of Indigent Nigerians covered by the VGF and other special funds	Data not available	6,600,000	8,195,537 (Q2 2026)
Percentage of Rate of utilisation of any approved health insurance	17.5% (P2.8.14)	16.5%	Data not available
Number of Private health insurance enrolment)(HMO plan)	1,710,639 (P2.8.14.5)	Data not available	2,184,114 (Q2 2026)
Number of High-impact interventions covered under health insurance and BHCPF	13,351 TB and HIV patients (P2.8.14.3)	Data not available	57,336(Q3 2026)

Source: NHIA report

19.6 Development Partner Health Financing — Portfolio Analysis

Development partners, including multilateral agencies, bilateral donors and philanthropic foundations, provide a significant share of health financing in Nigeria. Aligning this support with national priorities is essential to use resources effectively. The development partner financing portfolio grew substantially between 2025 and 2026, with mapped resources increasing by more than USD 200 million from $1.34 billion to $1.50 billion.

Table 19.5: Development partner health financing

Core Indicator	2025 Baseline Achievement	2026 Target / Reported Achievement	COMMENT
Resources mapped from development partners (US$)	$1.34 billion	$1.50 billion	RMET Data
Proportion of mapped health sector financing aligned with national health priorities (%)	98%	93%	
Proportion of mapped development partner financing pooled or channelled through coordinated financing arrangements (%)	*Data not available*	*Data not available*	SWAP Office Data
Share of resources channelled through government systems (%)	23%	27%	RMET Data
TA concentration and coordination (%)	11%	9%	
Proportion of development partner financing commitments allocated to direct service delivery (%)	65%	48%	

19.7 Private Sector Health Investment and PPP Frameworks

Private sector investment and public-private partnerships (PPPs) can mobilise capital, expertise and innovation beyond what public funding alone can provide. Clear frameworks are needed to guide these partnerships and protect the public interest. This section presents private sector investment in health and the frameworks that guide PPPs.

Table 19.6: Private sector health investment and PPP indicators

Core Indicator	2025 Achievement	2026 Achievement
Number of Health value chain projects in the curated investment pipeline	85	91+ (cumulative)
Total value of the curated investment pipeline (US$)	>$5 billion	>$5 billion (cumulative)
Development finance facilities committed to the health value chain (US$)	$1 billion Afreximbank; €1 billion EIB	$1 billion Afreximbank; €1 billion EIB (cumulative)
Number of Health PPP agreements executed in the reporting year	1 (Medipool)	1 (same as 2025)
Number of Private facilities empanelled under the BHCPF	Data not available	Data not available

Source: MOC Q3 Report

Enabler II: Health Financing and Financial Protection

- Faster BHCPF releases. The share of the BHCPF appropriation disbursed rose from 11% to 33.1% by mid-year.
- Wider insurance coverage. Health insurance enrolment rose from 21.1 million to 24.1 million, with 3.1 million vulnerable people covered through the BHCPF, and FP and BEmONC are now in the NHIA benefit package.

Enablers II — Challenges

- Health remains under-prioritised in public budgets. Government health expenditure is 7.4% of total government spending against the Abuja target of 15%, and states devoted only 6.98% of actual spending to health in 2025.
- Weak budget execution and releases.
- Out-of-pocket spending remains about 71% of current health expenditure, limiting financial protection.

Enablers II — Recommendations for 2027

- Release BHCPF funds on time and publish quarterly disbursement and utilisation reports by gateway.
- Accelerate insurance enrolment by enforcing the mandatory coverage provisions of the NHIA Act 2022 and expanding coverage for informal-sector workers and vulnerable groups.

ENABLER III STRATEGIC OBJECTIVE AND ACHIEVEMENTS

Table 19.7: Enabler III strategic objectives and indicators

Strategic Objective	Indicator	Baseline (2023)	Target (2027)	Achievement (2024-2026)
Strengthen skills, capabilities & values and drive a performance-based culture within the FMoHSW	Skill/capacity gap as percent of total requirements based on MoH organisational chart	35%	20%	Data not available
	Distribution of skill sets among departments of MoH (Goodness-of-fit Score)	60%	80%	Data not available

Chapter 20

ENABLER III: CULTURE, TALENT MANAGEMENT AND INSTITUTIONAL CAPACITY



20.1 FMoHSW Staff Training, Skills Development and Capacity Building

The implementation of the NHSRII continues to have at its core the identification and development of talent within the ministry, agencies and parastatals at all levels. High flyers within MDAs have been placed at the forefront of ongoing reforms supported by local and global industry experts. The Nigeria health fellows programme to identify future health managers have the second set of talent deployed in 774 LGAs across the country (Figure 176).

Table 20.1: FMoHSW staff training and capacity building

Core Indicator	2025 Achievement	2026 Achievement
FMoHSW staff trained on the Performance Management System (%)	*79.93%*	90% (as of Q3)
Health DAPs trained on the Performance Monitoring System (%)	90%	92% (as of Q3)

Source: Training Report



Figure 176: National Health Fellows 2.0 in Nigeria's health sector transformation

20.2 Performance Management Systems — Adoption and Implementation Rate

A Performance Management System (PMS) links individual staff objectives to institutional goals through target-setting, regular review and appraisal. Consistent use of the system strengthens accountability and rewards good performance. This section presents the adoption and implementation of performance management across the Ministry and its agencies.

Table 20.2: Performance management system adoption and implementation

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Percentage of State health MDAs that have adopted PMS	0%	0%	
Percentage of Ministry staff with a satisfactory performance rating under the PMS	82%	80% (as of Q3)	Data Collations from performance ranking template
Number of Staff with improved performance metrics	1,850 of 2,252 staff	1,875 of 2,252 staff	Data Collations from departments
Percentage of Staff improved-performance target achievement (derived)	82.1%	71% (as of Q3)	Quarterly performance review by HRM
Proportion of staff with improved performance metrics tracked by quarterly review	**28.8%**	37.3% (as of Q3)	Submissions made by different departments
Performance Management System operating on a digital platform (yes/no)	No	No	Developed but not operational due to non-release of funds
Average performance appraisal score of top health sector leadership (score)	**73%**	85%	Appraisal Rating by OHCSF
Number of Top-level leaders assessed using a structured performance appraisal protocol	18 (Directors/HoDs)	18 (Directors/HoDs)	TMC Meeting report

20.3 Staff Satisfaction, Welfare and Retention within FMoHSW

Staff satisfaction, welfare and retention influence productivity, service quality and the Ministry's ability to keep skilled personnel. Understanding staff experience helps the Ministry address the factors that drive attrition. This section presents the state of staff welfare and retention within the FMoHSW.

Table 20.3: FMoHSW staff satisfaction, welfare and retention

Core Indicator	2025 Achievement	2026 Achievement	Data Source
FMoHSW staff satisfaction survey conducted (yes/no)	Data not available	Data not available	
Percentage of Staff reporting satisfaction with working conditions	Data not available	Data not available	PMS Training report
Service processing time, yellow card issuance (minutes)	15min (from 25 min operating time)	13 mins (from 15 min standard time)	Mystery shopping report
Number of Top-level leaders enrolled in and completing leadership development programmes	4	2	List of nominated officers to NIMSS
Number of Identified capacity gaps from leadership evaluation addressed	2 (46)	Data not available	

20.4 Organisational Culture Change Initiatives and Change Management

Organisational culture shapes how an institution works, makes decisions and serves the public. Change management helps embed new ways of working as reforms are introduced. This section presents the culture change initiatives under way within the Ministry.

Table 20.4: Organisational culture change initiatives

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Structured policy document on culture change and talent management in place (yes/no)	No	No	
Number of Departments, agencies and parastatals with functional feedback platforms	90	92 (as of Q3)	Quarterly Collations of NODAL officers report from FHIs
Percentage of Feedback items responded to within 24 hours	Data not available	Data not available	
Number of Interactive workshops or peer-learning sessions held	4	3 (as of Q3)	Report of the peer-learning sessions (across Federal DAPs)
Knowledge repository available in all departments and units (yes/no)	Data not available	Data not available	
Percentage of Change management activities implemented against the annual plan (within tertiary not with ministry)	Data not available	Data not available	

Enablers — Key Achievements

- National Health Fellows 2.0 deployed across all 774 LGAs to support coordination, PHC delivery, data management and accountability.
- Widened institutional reach with 125 of 136 institutions trained on the Performance Monitoring Plan, up from 120.

Enablers — Challenges

- The digital Performance Management System has been developed but is not operational because funds have not been released.
- Culture and welfare are not measured. No staff satisfaction survey has been conducted, no culture change and talent management policy is in place, and response time to feedback is not tracked.

Enablers — Recommendations for 2027

- Release funds to operationalise the digital PMS and extend quarterly performance tracking to all staff.
- Measure culture and welfare. Conduct the first FMoHSW staff satisfaction survey and adopt a culture change and talent management policy.
- Invest in leadership and digital ways of working by expanding leadership development enrolment and ECM licences for officers below directorate level.

PART VII

SPECIAL FOCUS INTERVENTIONS



Chapter 21

MAMII (MATERNAL AND MORTALITY INNOVATIONS INITIATIVE) - 2026 REVIEW



21.1 MAMII Design, Implementation Architecture and Coverage

Nigeria accounts for a significant proportion of global maternal deaths, with the burden concentrated in selected states and local government areas. The Maternal and Neonatal Mortality Reduction Innovation Initiative (MAMII) was designed to accelerate reductions in maternal and newborn mortality through targeted interventions in 172 high-burden LGAs. This section presents the initiative's design, implementation architecture and geographical coverage (Figure 177).

Table 21.1: MAMII design, implementation and coverage

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of LGAs implementing MAMII	172	172	
Number of BHCPF facilities in the 172 MAMII LGAs	Data not available	1,799 of the 8,309 (22%)	
Number of facilities revitalised in the 172 LGAs	435	(52.4%) i.e 943 of the 1799 BHCPF HFs in the 172 LGAs	Consolidated BHCPF Report
Number of LGAs with a context-specific costed workplan	166	172	
Percentage of LGAs with at least two Level 2 facilities in the 172 LGAs	52%	90% of the 172 LGAs	Consolidated BHCPF report
Percentage of LGAs with one BHCPF-supported PHC per ward in the 172 LGAs	78%	(162 of the 172 LGAs (94%)	
Number of women line-listed across the 172 LGAs	3,195,041	586,401	MAMII Dashboard
Number of CEmONC referral facilities in the intervention LGAs	231 (from 66)	Data not available	
Number of free caesarean sections performed under the initiative	>4,000	Data not available	
Number of facilities receiving lifesaving MNCH commodities	>500	779	MAMII Dashboard

Core Indicator	2025 Achievement	2026 Achievement	Data Source
Number of states with activated emergency transport systems in MAMII LGAs	12	All 33 states, 171/172 LGAs (Borgu not implementing in Niger State)	NEMSAS

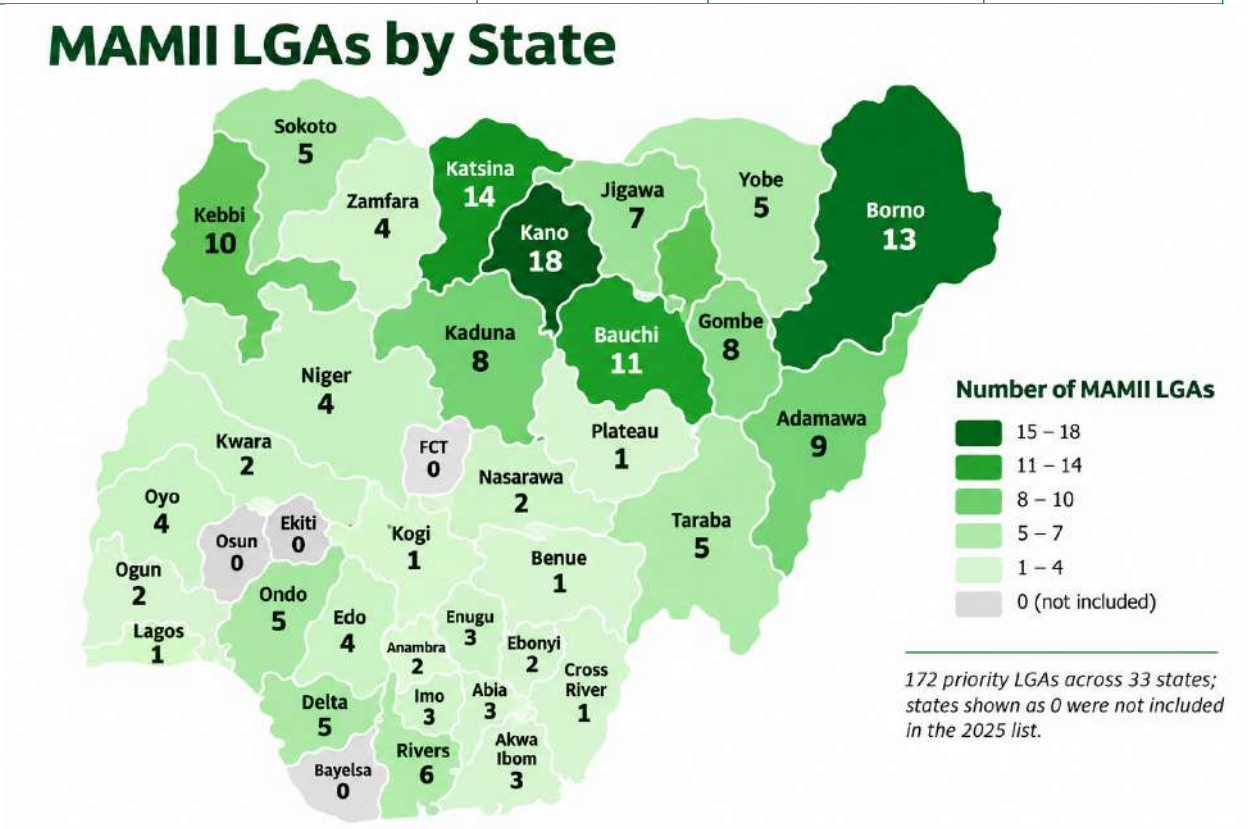


Figure 177: Number of MAMII LGAs by state. Source: HOPE-PHC Programme Operations Manual – Annex 11

21.2 MAMII Impact on Maternal and Neonatal Mortality in Target States

Assessing MAMII's impact requires tracking maternal and newborn outcomes in the target areas over time. Comparing outcomes before and during implementation shows whether the initiative is making a difference. This section presents changes in maternal and neonatal mortality in the states covered by the initiative

Table 21.2: MAMII maternal and newborn outcome indicators

Core Indicator	2025 Status	2026 Status	Data Source
Percentage of Reduction in maternal deaths in the 172 LGAs	20%	-	
Percentage of Reduction in newborn deaths in the 172 LGAs	12%	-	
Number of Total deliveries in the 172 LGAs	669,866	844,687 *	
Number of ANC first booking before 20 weeks in the 172 LGAs	1,951,193	940,263*	
Number of Fourth ANC visits in the 172 LGAs	1,109,290	848,995*	

Core Indicator	2025 Status	2026 Status	Data Source
Percentage of BHCPF facilities in the 172 LGAs linked to SEMSAS or NEMSAS	25%	99% (171/172)	NEMSAS
Number of Referrals in the 172 LGAs completed on the NEMSAS system	7,451	168,571 referrals paid for	NEMSAS
Percentage of BHCPF facilities in the 172 LGAs with at least 2 midwives or CHEWs	12%	1,640 of the 1,799 PHCs in the 172 MAMII LGAs (91%)	
Percentage of LGAs equipped with heat-stable carbetocin	47%	Data not available	
Number of Live births in the 172 LGAs	900,251	768,089 (Q1 246,917; Q2 258,563; Q3 262,609)	
Number of ANC attendance in the 172 LGAs, by quarter	5,671,681	4,269,738	

*DHIS2 (FASTR Adjusted, Jan-Sep 2026)

Table 21.3: MAMII impact on maternal and neonatal mortality indicators

Core Indicator	2025 Achievement	2026 Achievement
Percentage of MAMII LGA facilities reporting an obstetric team	Data not available	55% (95 of 172)
Percentage of MAMII LGA facilities empanelled	Data not available	22% (38 of 172)
Number of Women reached through the NHIA CEmONC (maternal) programme	Data not available	80,906 (263 facilities; cumulative to Oct 2026)
Number of Newborns reached through the NHIA CEmONC (neonatal) programme	Data not available	9,103 (cumulative to Oct 2026)
Number of CEmONC claims under HOPE-PHC	Data not available	42,664 (>85% of Year 1 target)

Data Source: MOC Q3 2026 report

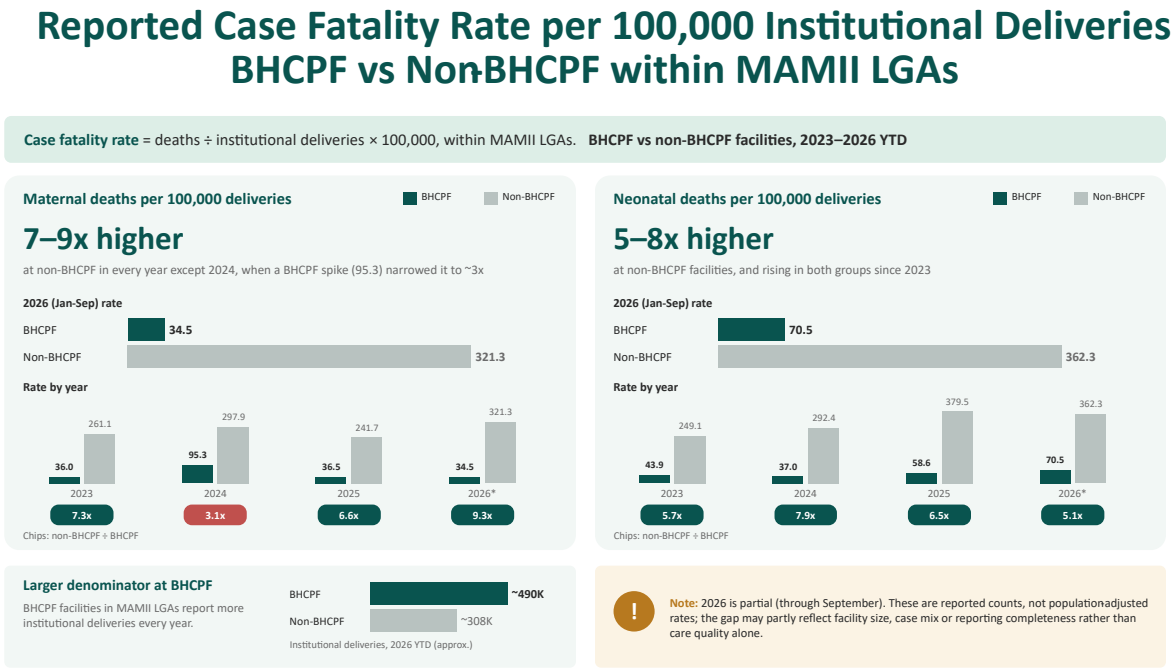
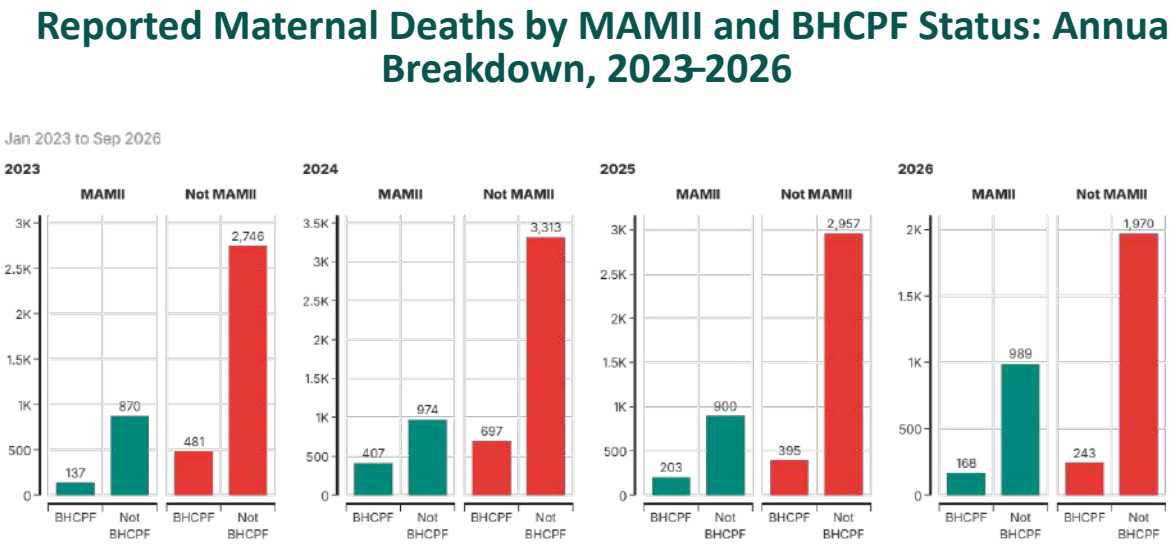


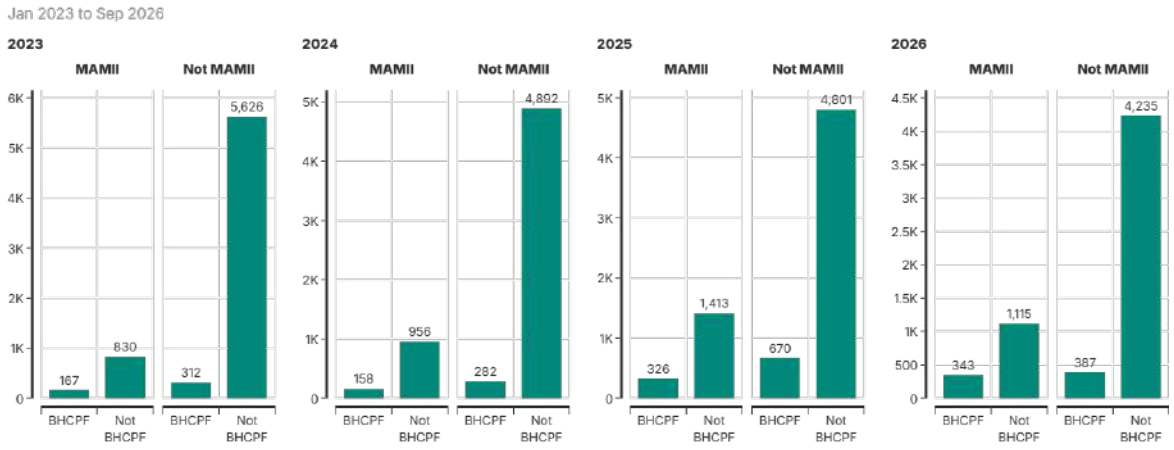
Figure 178: Reported case fatality rates per 100,000 institutional deliveries in MAMII LGAs by BHCPF status, 2023–2026



Non-MAMII, non-BHCPF facilities account for the largest share of maternal deaths each year (59–65%), reflecting their share of the network. MAMII, BHCPF facilities account for the smallest share (3–8%). BHCPF facilities report a smaller share than non-BHCPF facilities within both MAMII and non-MAMII groups. 2026 is partial (through September).

Figure 179: Reported maternal deaths by MAMII and BHCPF status, 2023–2026

Reported Neonatal Deaths by MAMII and BHCPF Status: Annual Breakdown, 2023–2026



Non-MAMII, non-BHCPF facilities account for the largest share of neonatal deaths each year (67–81%). MAMII, BHCPF facilities account for the smallest share (2–6%), a share that has grown each year. 2026 is partial (through September).

Figure 180: Reported neonatal deaths by MAMII and BHCPF status, 2023–2026

Chapter 22

PRIMARY HEALTH CARE REVITALISATION



22.1 PHC Revitalisation Status

Primary Health Care (PHC) revitalisation is central to improving access to essential health services, strengthening community-level healthcare delivery and advancing Universal Health Coverage. The health sector is implementing targeted interventions to strengthen PHC facilities, improve service readiness, equip and support the health workforce, and enhance the availability of essential medicines and other resources. Progress is tracked through key indicators that assess the implementation and results of PHC revitalisation efforts across the country.

Table 22.1: PHC Revitalisation Indicators

Core Indicator	2025 Achievement	2026 Achievement
Public primary health centres (number)	27,442	27,442
Number of PHCs revitalised in the reporting year	1,610	3,504
Percentage of wards with at least one functional Level 2 PHC facility	Data not available	Data not available
Percentage of revitalised PHCs meeting minimum functionality standards	Data not available	Data not available
Percentage of functional Level 2 PHCs with adequate skilled health workers to provide 24-hour services	Data not available	Data not available
Percentage of revitalised PHCs with availability of essential medicines and tracer commodities	Data not available	Data not available
Percentage of revitalised PHCs with functional basic amenities (water, electricity and sanitation)	Data not available	Data not available
Percentage of pregnant women receiving at least four ANC visits in revitalised PHC catchment populations	Data not available	Data not available
Percentage of functional Level 2 PHCs with functional referral systems	Data not available	Data not available
Percentage of PHCs with access to functional emergency transport/ambulance services	Data not available	Data not available
Percentage of revitalised PHCs with functional Ward Development Committees (WDCs)	Data not available	Data not available

22.2 BHCPF 2026 Facility Service Delivery Performance

The BHCPF facility scorecard tracks how primary health care facilities funded through the Fund perform in delivering services. It gives a common basis for comparing facility performance and targeting support. This section presents the 2026 scorecard for BHCPF-supported facilities (Figures 181 and 182).

Table 22.2: BHCPF operational performance

Core Indicator	2025 Achievement	2026 Achievement
Value of BHCPF funds approved and released by the	Data not available	Data not available
Percentage of approved BHCPF funds disbursed to implementing gateway	Data not available	Data not available
Percentage of BHCPF funds received by states and facilities	Data not available	Data not available
Percentage of states that provided the required BHCPF counterpart funding	Data not available	Data not available
Number of PHC facilities receiving BHCPF facility financing (DFF)	Data not available	Data not available
Number of people enrolled in the BHCPF-supported Basic Minimum Package of Health Services (BMPHS)	Data not available	Data not available
Percentage of validated BHCPF PHCs meeting PHC standards Level 2 (%)	21%	38%*
Number of New FP acceptors in BHCPF facilities	Data not available	Data not available
Number of First ANC before 20 weeks in BHCPF facilities	1,050,105	1,280,000*
Number of fourth ANC visits in BHCPF facilities	1,218,855	1,180,000*
Percentage of deliveries attended by a skilled birth attendant in BHCPF facilities	87.7%	96.3% (SBA/delivery ratio); ≈97.2%*
Number of facility maternal deaths in BHCPF facilities	698	409*
Percentage of BHCPF facilities reporting electronically on DHIS2 (%)	75%	Completeness: BHCPF digitised 74.7%, not digitised 67.6%; non-BHCPF digitised 56.9%, not digitised 67.0%*

*DHIS2 (FASTR Adjusted, Jan-Sep 2026)

22.2.1 Family Planning Services in BHCPF Facilities

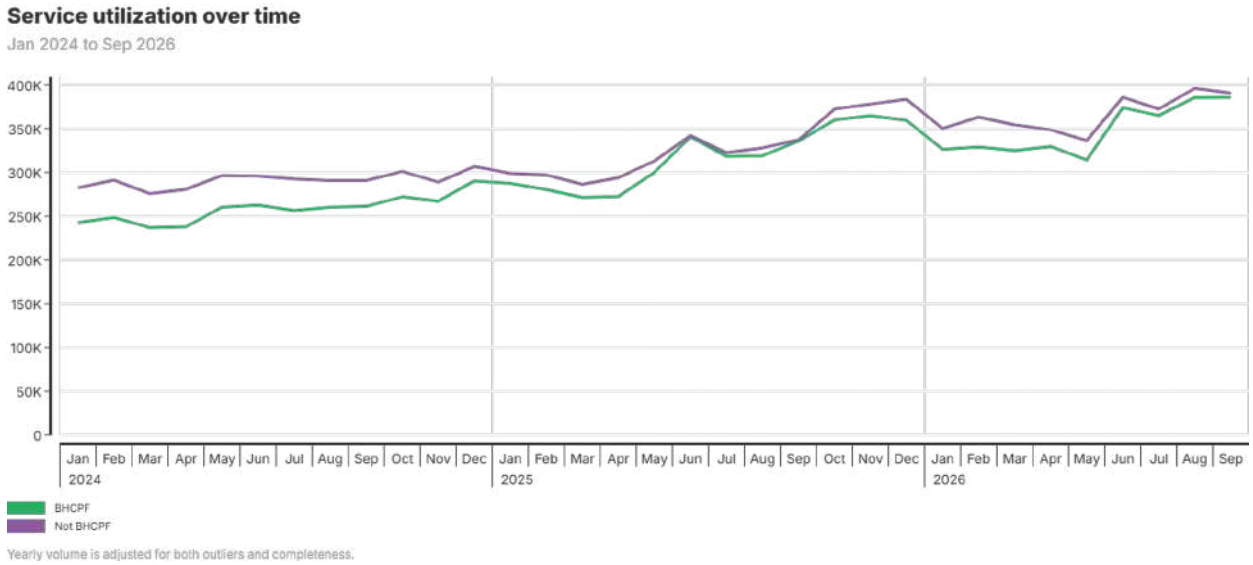


Figure 181: New family planning acceptors and females using modern contraception by BHCPF status, Jan 2024–Sept 2026

Source: DHIS2 (FASTR Adjusted)

New family planning acceptors increased in both BHCPF and non-BHCPF facilities, with a stronger rise in BHCPF-supported facilities, narrowing the gap between the two groups. Modern contraceptive use also recorded sustained growth, particularly in BHCPF facilities,

22.2.2 Ante Natal Care Services in BHCPF Facilities

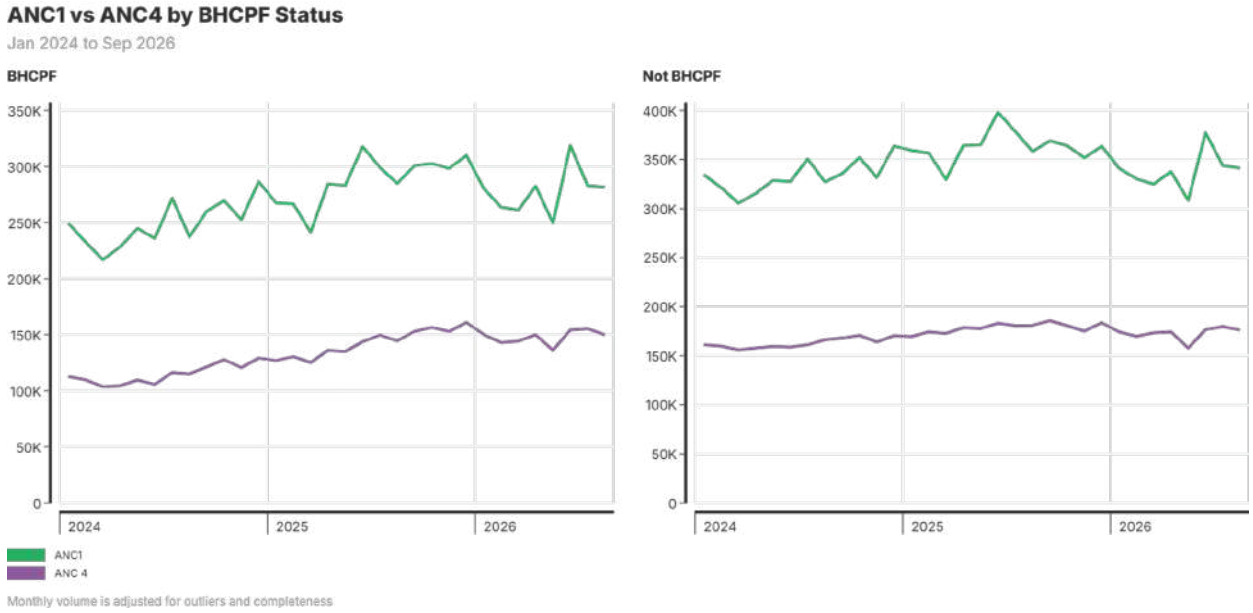


Figure 182: ANC1 vs ANC4 by BHCPF and NON-BHCPF facilities

Source: DHIS2 (FASTR Adjusted analysis)

ANC1 attendance is significantly higher than ANC4 completion both at BHCPF and non-BHCPF facilities with roughly about 50% drop-off in women returning for all four antenatal visits. Both BHCPF and NON-BHCPF facilities followed the national pattern (Figure 183).

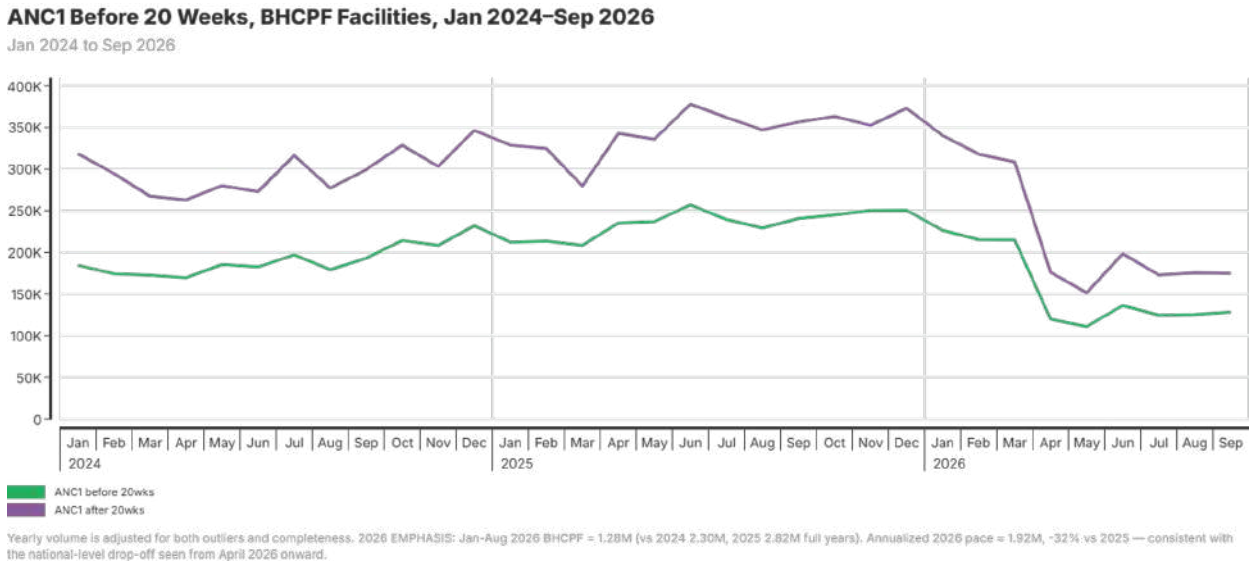


Figure 183: 1st ANC Before 20 Weeks — BHCPF Facilities, Trend 2024–2026

BHCPF-supported facilities recorded an increase in first ANC visits before 20 weeks of gestation between January 2024 and December 2025. However, both indicators experienced a sharp decline from April 2026, with only modest recovery through September (Figure 184).

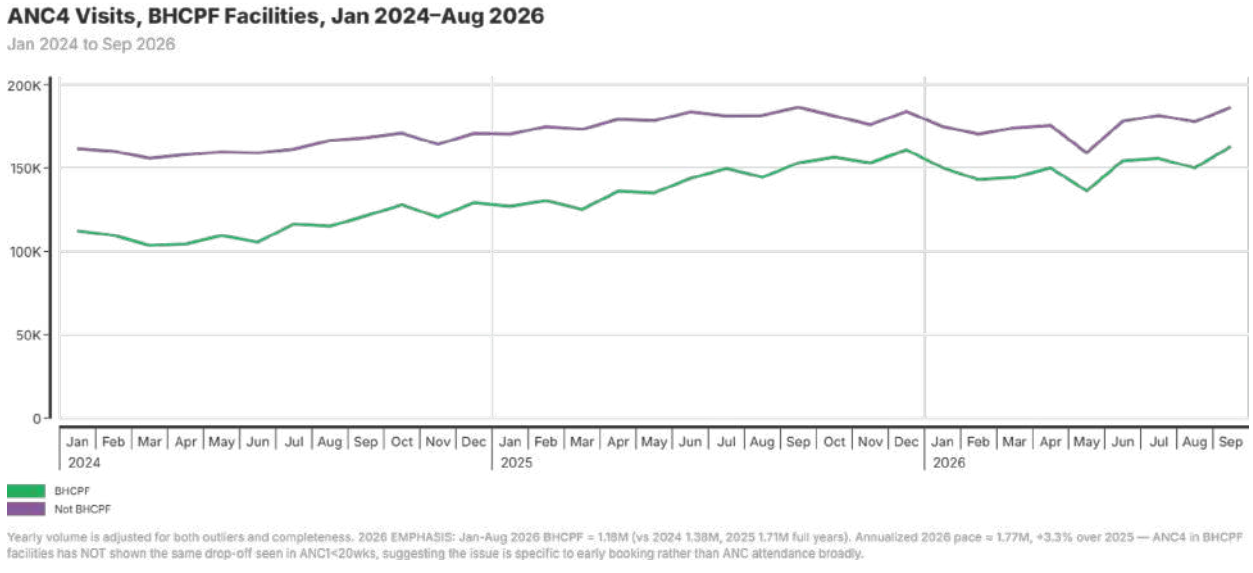


Figure 184: Antenatal Care ANC1 before and after 20 Weeks (2024–2026)

Source: DHIS2 (FASTR Adjusted analysis)

Notably, BHCPF facilities recorded steady upward growth across all indicators particularly in uterotonic administration during labour from early 2024 through 2026, whereas non-

BHCPF facilities maintained higher total volumes but remained largely flat throughout the period (Figure 185).

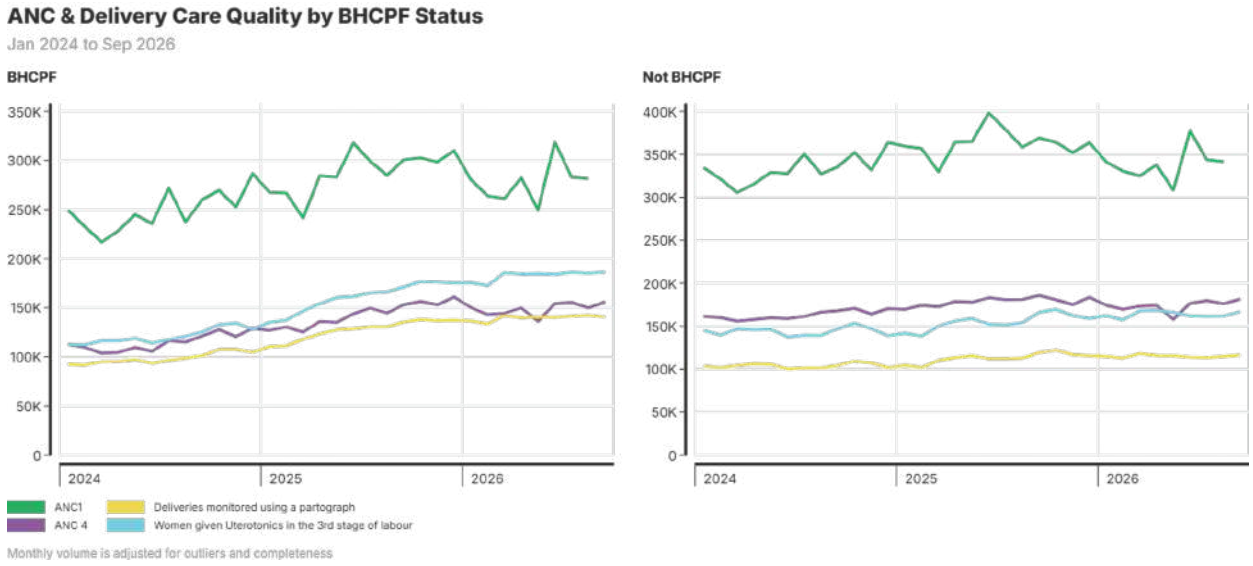


Figure 185: ANC and delivery care quality indicators by BHCPF status, Jan 2024–Aug 2026

Source: DHIS2, FASTR Adjusted

BHCPF facilities demonstrated generally improving trends in antenatal care and delivery-related service indicators than Non-BHCPF facilities

22.2.3 Skilled Birth Attendance and Facility Delivery Trend

Institutional deliveries in BHCPF facilities increased steadily, overtaking non-BHCPF facilities from early 2025 and sustaining higher volumes thereafter. This trend suggests growing utilisation of BHCPF-supported facilities for childbirth and a potentially positive contribution of the programme to access to facility-based delivery services (Figure 186).

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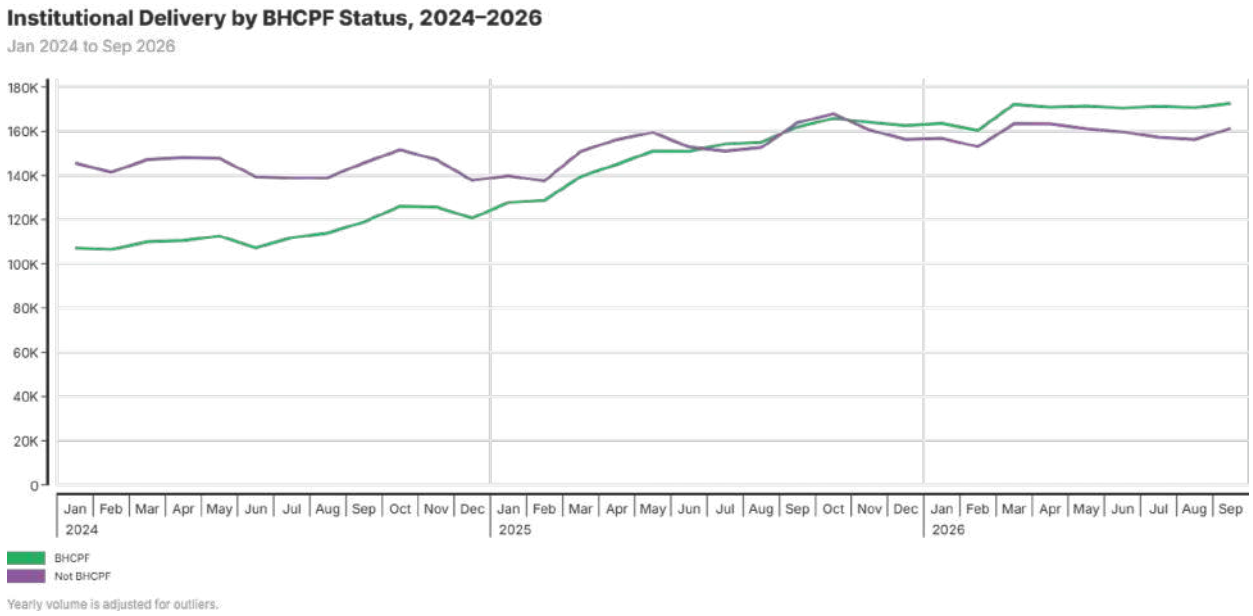


Figure 186: Institutional Deliveries by BHCPF Status, 2024–2026

Source: DHIS2, FASTR Adjusted

BHCPF facilities recorded higher delivery volumes than non-BHCPF facilities in the North-West and North-East, while non-BHCPF facilities maintained higher volumes across the southern zones and North-Central, highlighting persistent regional differences in the utilisation of BHCPF-supported delivery services (Figures 187 and 188).

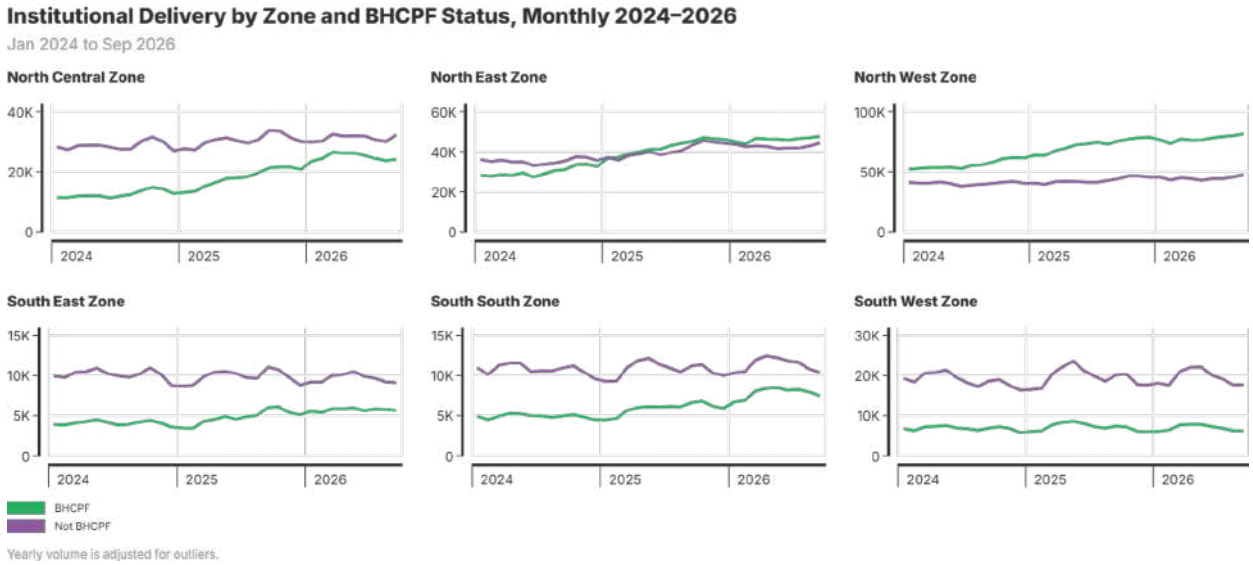


Figure 187: Institutional Delivery by Zone and BHCPF Status, Monthly 2024–2026

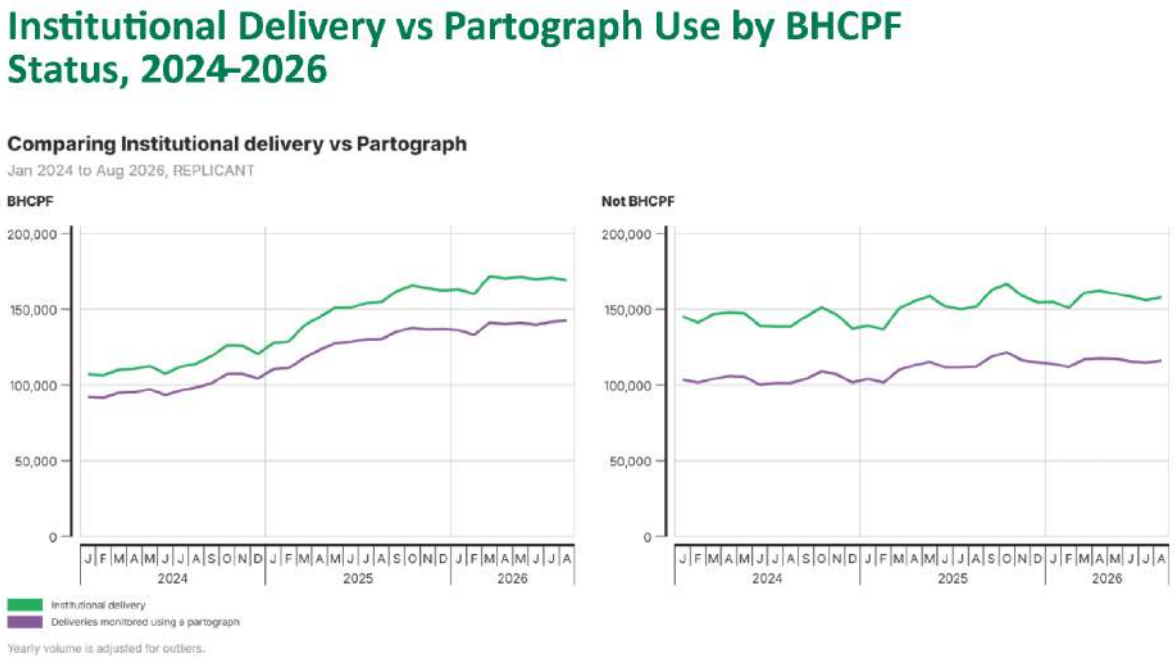


Figure 188: Institutional delivery vs partograph use by BHCPF status, 2024–2026

Source: DHIS2, FASTR Adjusted

When disaggregated by Basic Health Care Provision Fund (BHCPF) status, the upward trend appears to be driven primarily by BHCPF facilities, where institutional deliveries increased alongside a corresponding rise in partograph monitoring. In contrast, non-BHCPF facilities showed relatively stable trends over the same period with a widening gap between institutional deliveries and deliveries monitored using partographs.

22.2.4 Maternal Death in BHCPF and Non-BHCPF Facilities

Most reported maternal deaths occurred in non-BHCPF which remained consistently higher than in BHCPF facilities throughout the three years. The maternal death however appears to be rising in BHCPF facilities towards the Q3 2026 (Figures 189 and 190).

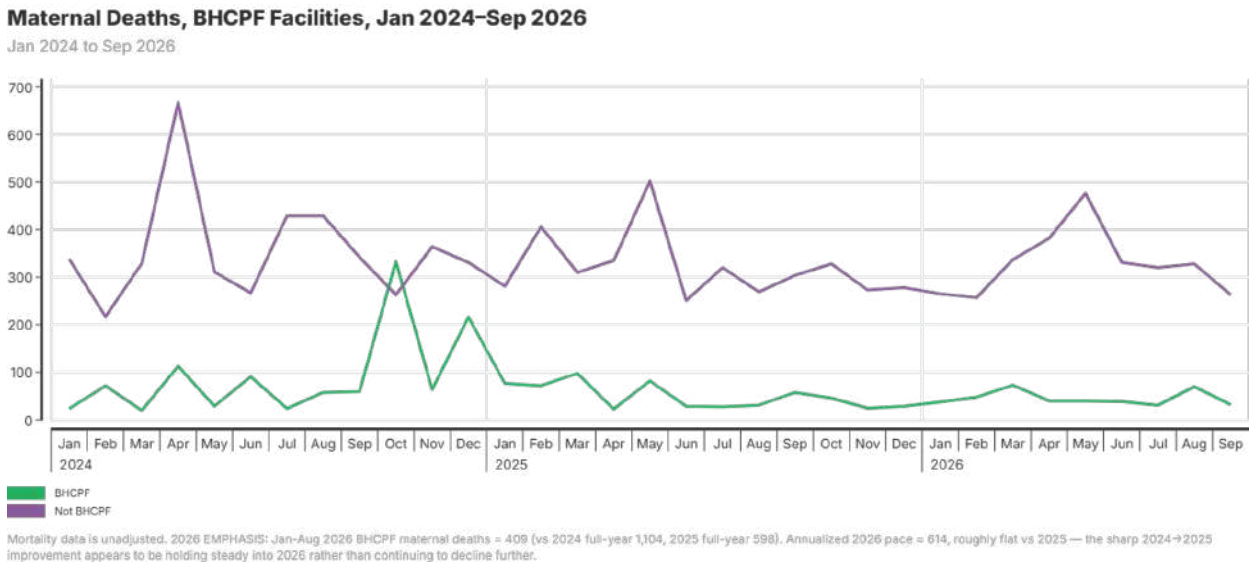


Figure 189: Facility Maternal Deaths — BHCPF Facilities, Trend 2024–2026

Source: DHIS2, FASTR Adjusted

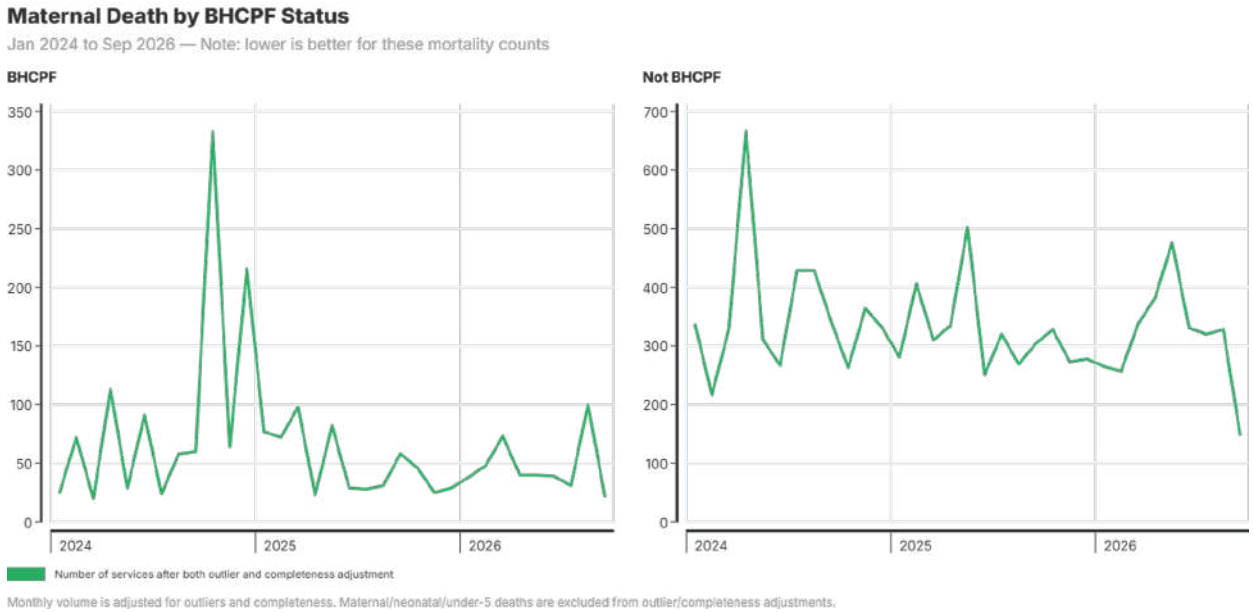


Figure 190: Maternal deaths by BHCPF Status (2024-2026)

Source: DHIS2, FASTR Adjusted

22.3 BHCPF Immunisation Coverage and Trends

Antigen volumes were stable in 2024–2025 and increased in 2026 in both BHCPF and non-BHCPF facilities. Growth was stronger in BHCPF facilities (about 7–10% against 3–5%), and both groups peaked in June 2026 (Figure 191).

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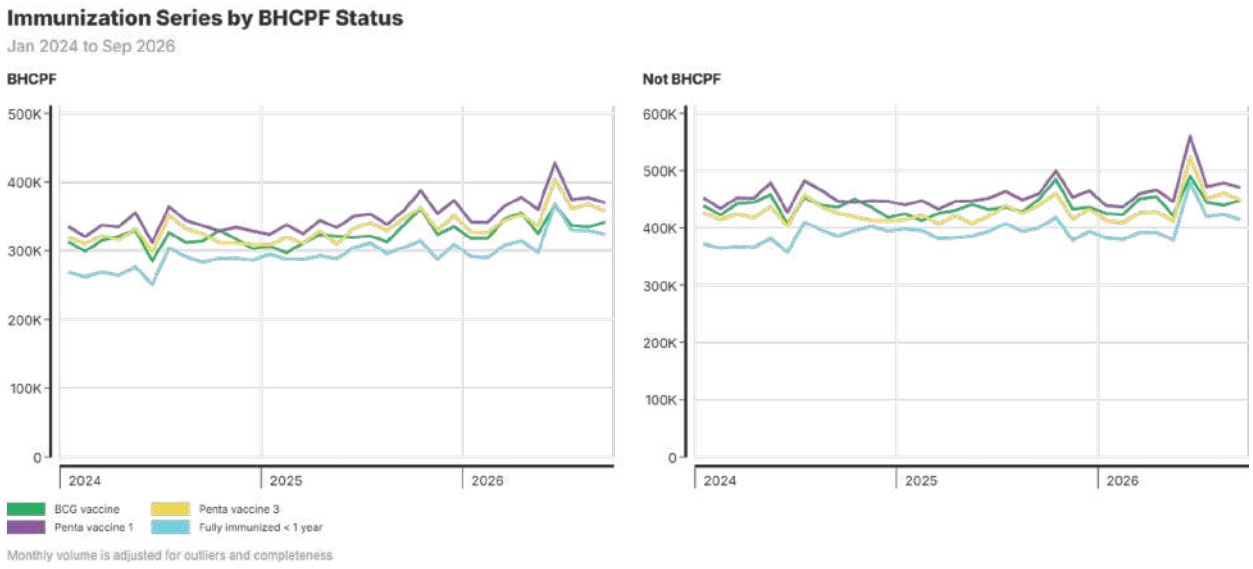


Figure 191: BCG, Penta 1, Penta 3 and full immunisation by BHCPF status, Jan 2024–Sept 2026

Source: DHIS2, FASTR Adjusted

Neonatal deaths accounted for almost 50% of all reported under-five deaths in both 2025 and 2026. Reported stillbirths (48,860 in 2025; 36,185 in 2026) means that roughly 1 reported stillbirth for every 62 live births in 2025, and about 1 for every 68 live births in 2026. This points to significant loss of life occurring around the time of birth, before a live birth is even achieved (Figure 192).

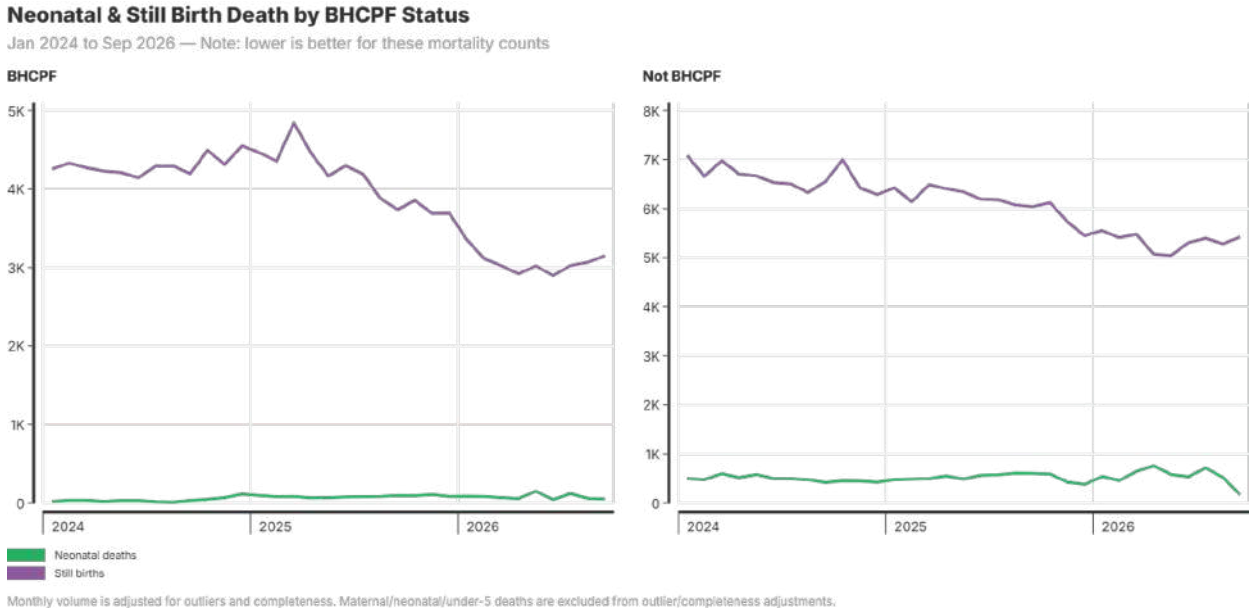


Figure 192: Neonatal deaths and stillbirths by BHCPF status, Jan 2024–Sept 2026

Source: DHIS2, FASTR Adjusted

Reported Under-5 deaths in non-BHCPF facilities were consistently high, ranging approximately between 700 and 1,300 monthly, with an observed upward trend in 2026. In

contrast, BHCPF facilities recorded much fewer deaths but more concerning spikes, with one in late 2024, early 2025 and May 2026 (Figure 193).

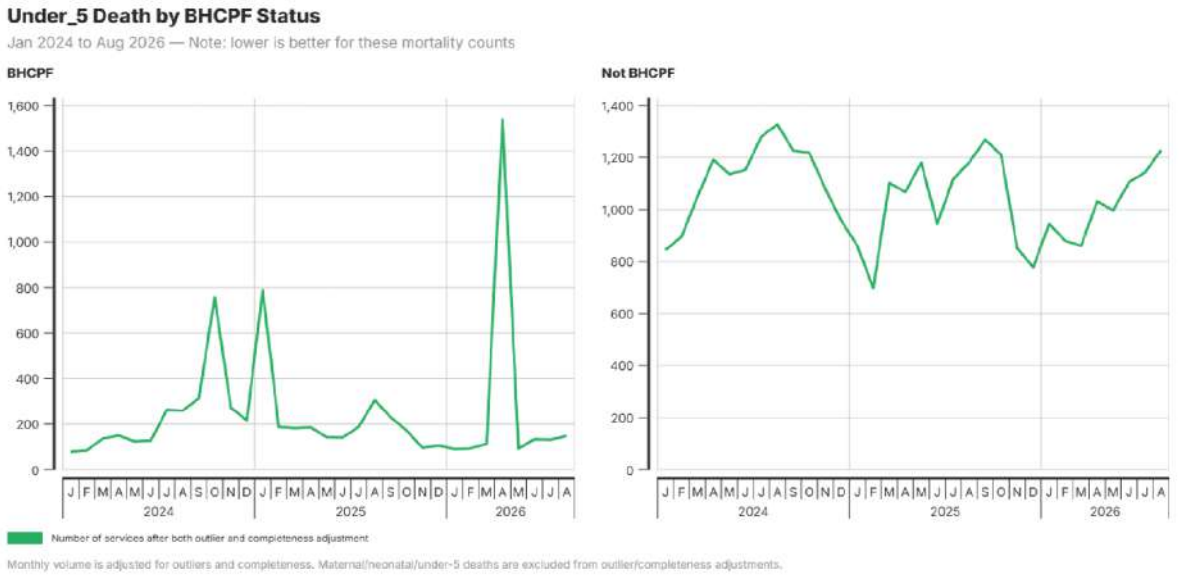


Figure 193: Under-5 Deaths by BHCPF Status (2024 – 2026)

Source: DHIS2, FASTR Adjusted

22.4 NUTRITION

Growth monitoring and promotion reached more children in BHCPF facilities, about 1.25–1.6 million a month in 2026, against 1.1–1.4 million in non-BHCPF facilities (Figure 194). Vitamin A volumes in both groups fell. Growth monitoring rose steadily in BHCPF facilities (+6% in 2026) but declined slightly in non-BHCPF facilities. Vitamin A supplementation fell in both groups in 2025 and declined further in 2026, by about a quarter.

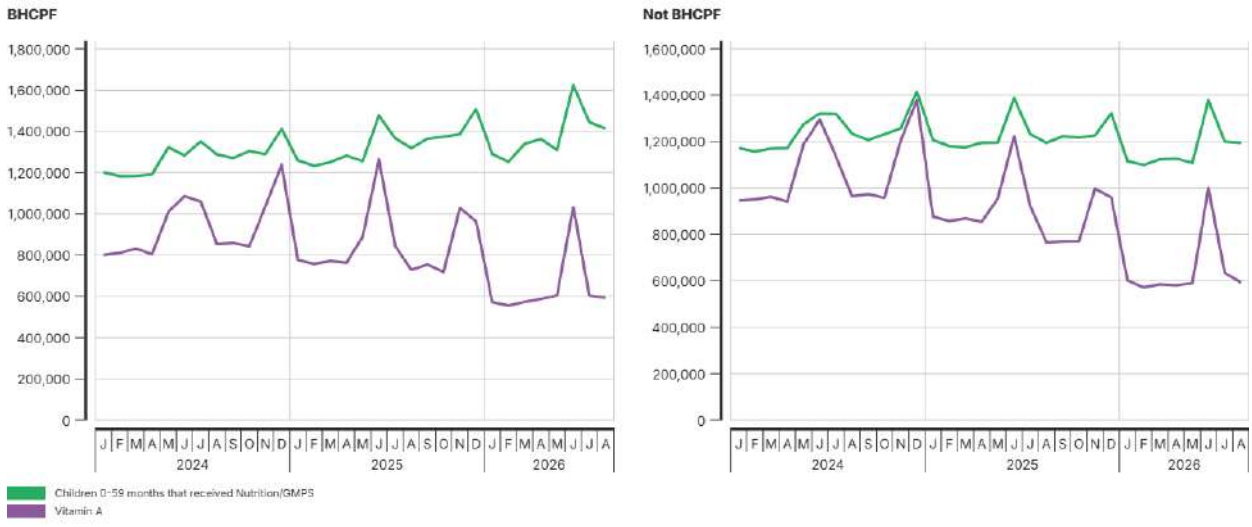


Figure 194: Growth monitoring and promotion and vitamin A supplementation by BHCPF status, Jan 2024–Aug 2026

Source: DHIS2, FASTR Adjusted

22.5 NCDs

Between 2020 and 2024, reporting remained relatively steady across most geopolitical zones, with the Northwest and Southwest consistently recording the highest volumes of new diabetes cases (Figure 195).

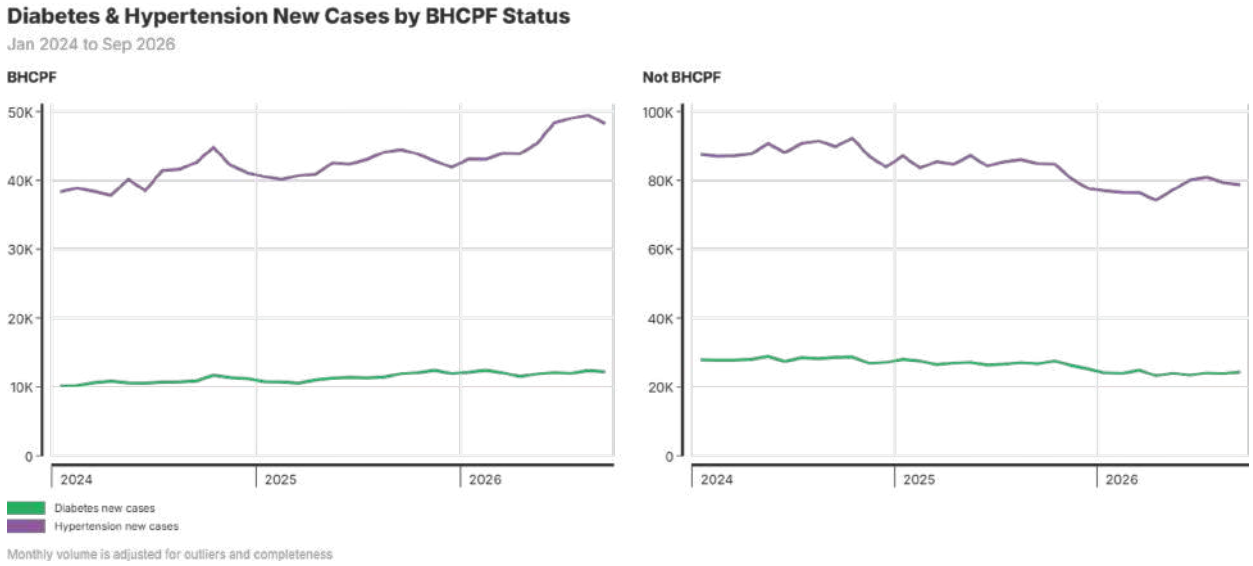


Figure 195: New diabetes and hypertension cases by BHCPF status, Jan 2024–Sept 2026

Source: DHIS2, FASTR Adjusted

New hypertension and diabetes cases increased steadily in BHCPF facilities from 2024 to 2026 (about 10–12% in 2026), while non-BHCPF facilities recorded a gradual decline (about 8–10%).

22.6 BHCPF Performance on Rapid Phone Survey

The survey aims to provide up-to-date snapshots of primary health care (PHC) facility performance, and also supports continuous monitoring of Basic Health Care Provision Fund (BHCPF) facility performance. Three quarterly survey rounds have been conducted since May 2025. The most recent round was conducted from May to August 2026 on a representative panel sample of 3,852 public PHC facilities.

Key findings

BHCPF facilities generally performed better than non-BHCPF facilities in medical supplies, service availability and community engagement. However, provider training remains a major gap, alongside declining vaccine availability in non-BHCPF facilities. Service delivery challenges remain widespread, particularly in infrastructure and human resources. Non-BHCPF facilities face greater difficulties, especially with financing and medical supplies, while the South East reports the highest level of service delivery challenges (Figures 196–201).

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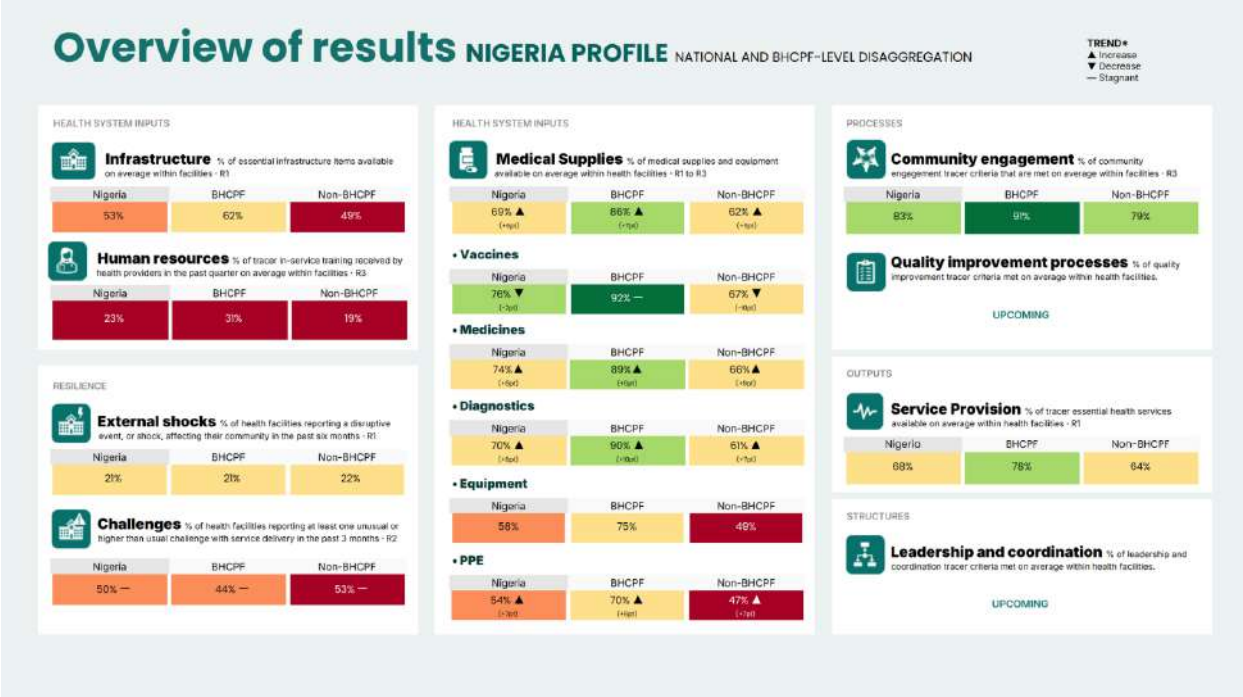


Figure 196: Overview of PHC survey results: national and BHCPF-level disaggregation

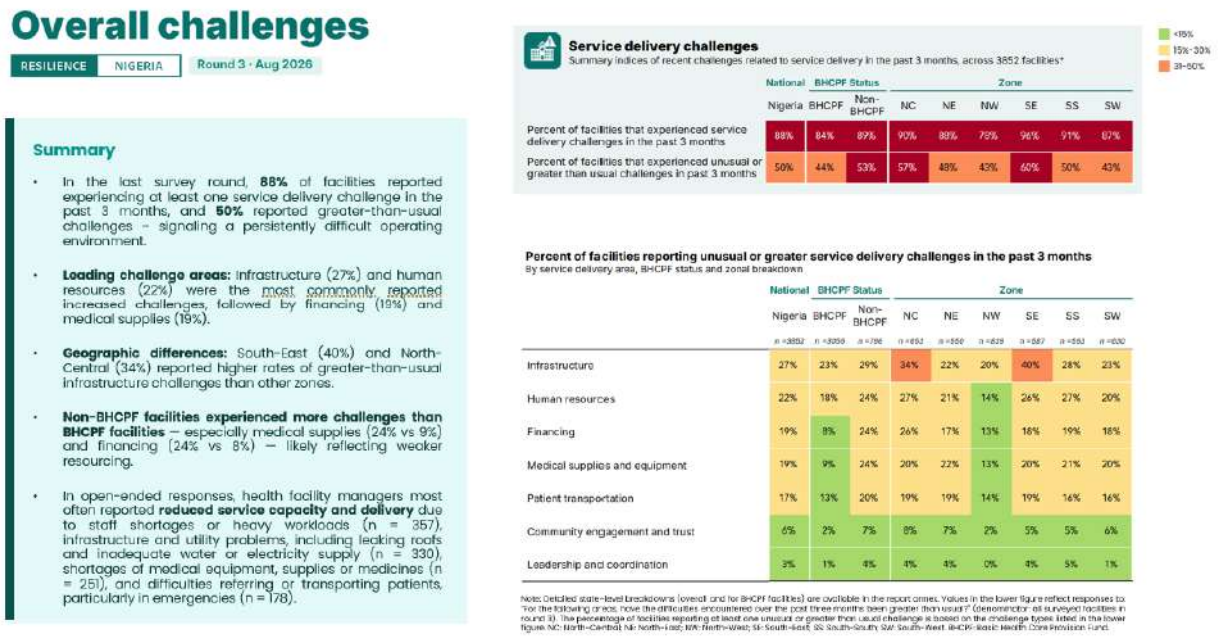


Figure 197: PHC service delivery challenges, Round 3, Aug 2026

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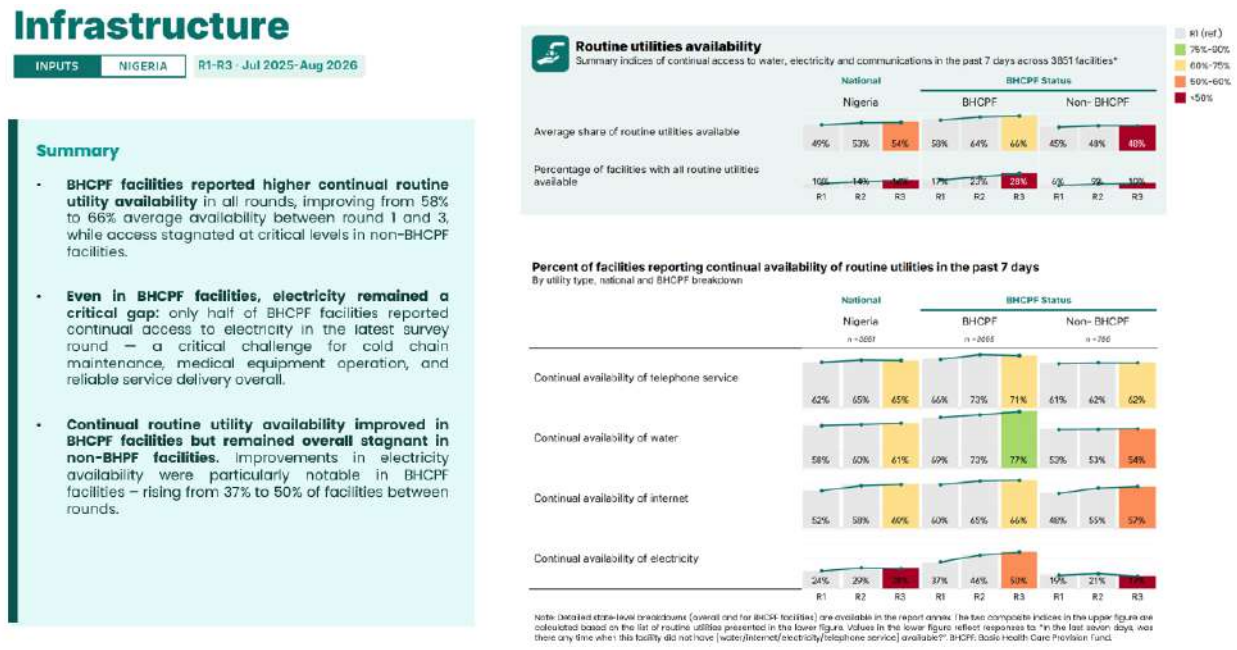


Figure 198: Routine utilities availability by BHCPF status, Jul 2025–Aug 2026

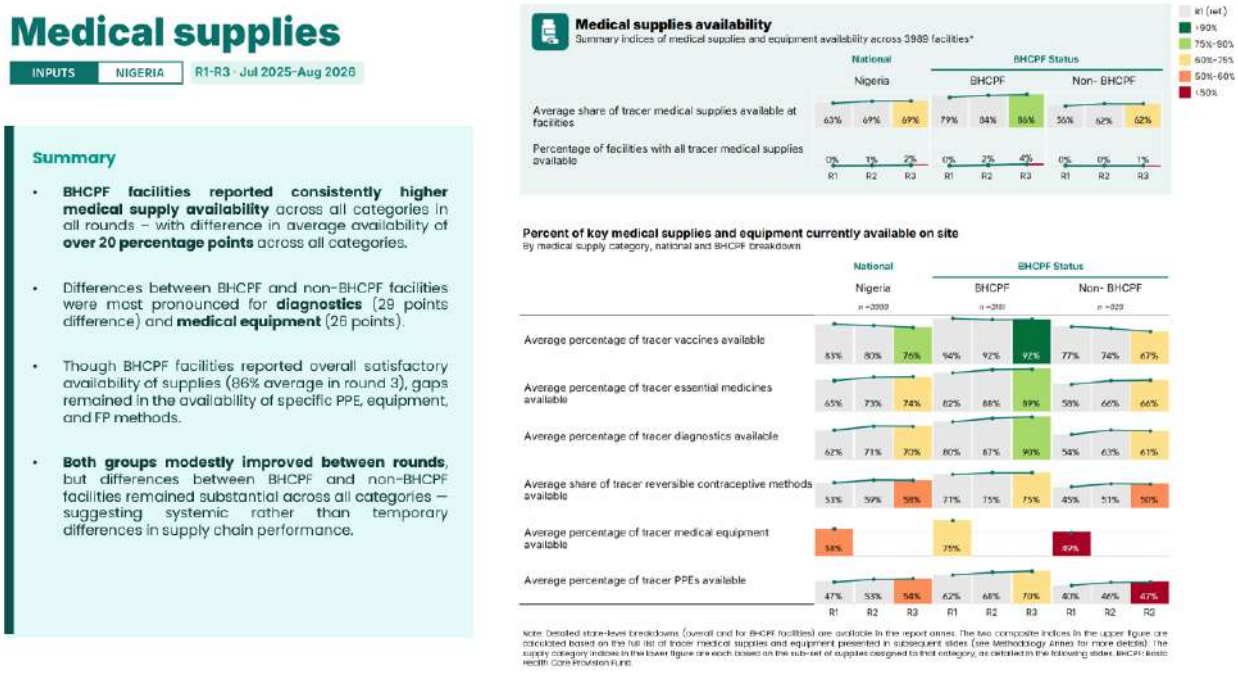


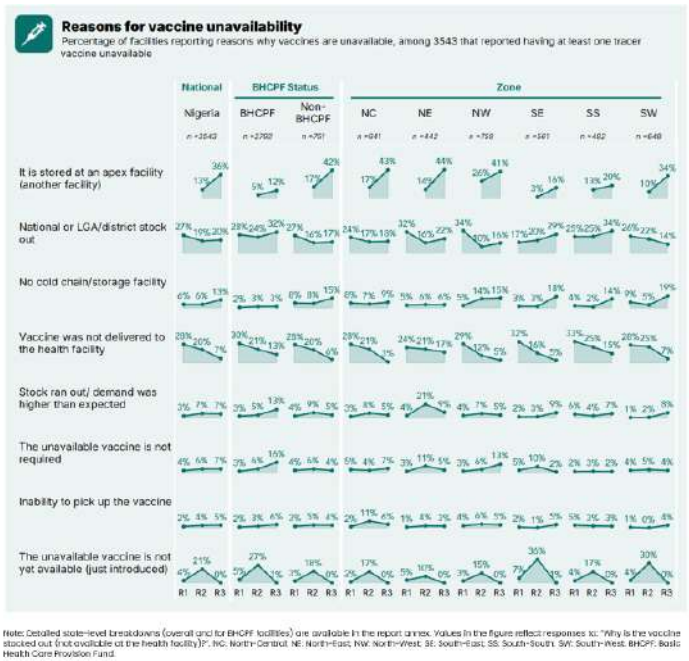
Figure 199: Medical supplies and equipment availability by BHCPF status, Jul 2025–Aug 2026

Medical supplies

INPUTS | NIGERIA | R1-R3 · Jul 2025-Aug 2026

Summary

- In the latest survey round, the most commonly reported reason for vaccine unavailability was that **vaccines were stored at another facility**, cited by **36%** of facilities with at least one unavailable tracer vaccine.
- **Supply chain and storage gaps:** stockouts at the national, LGA, or district level were reported by **20%** of these facilities, and **13%** cited a lack of cold chain or storage capacity, double the share reported in the first survey round(6%).
- **Failure to deliver vaccines** to the facility was the most common reason in round 1 (28%) but **declined sharply** to 7% in round 3. Higher-level stockouts also declined slightly (-7 percentage points), suggesting that both last-mile delivery and system-level supply gaps became less common over time.
- **Reasons for vaccine unavailability differed between BHCPF and non-BHCPF facilities.** In non-BHCPF facilities, unavailability was mainly linked to storage, with vaccines stored at another facility (42% vs. 12%) and lack of cold chain or storage capacity (15% vs. 3%) cited far more often. In BHCPF facilities, supply-related reasons were more common, including higher-level stockouts (32% vs. 17%), non-delivery of vaccines (13% vs. 6%), and stock running out due to higher-than-expected demand (13% vs. 5%).



Note: Detailed state-level breakdowns (overall and for BHCPF facilities) are available in the report annex. Values in the figure reflect responses to: "Why is the vaccine stocked out (not available at the health facility)?". NC: North-Central; NE: North-East; NW: North-West; SE: South-East; SS: South-South; SW: South-West; BHCPF: Basic Health Care Provision Fund.

Figure 200: Reasons for vaccine unavailability, Jul 2025–Aug 2026

Medical supplies

INPUTS | NIGERIA | R1-R3 · Jul 2025-Aug 2026

Summary

- **BHCPF facilities reported consistently higher essential medicine availability in both rounds**, with an overall high average of **89%** in the latest round.
- **Differences most pronounced for key maternal and chronic disease medicines**: chlorhexidine (84% vs. 48%), magnesium sulphate (79% vs. 45%), anti-asthmatics, and first-line antihypertensives showed the largest gaps in round 3.
- **Oxytocin gap warrants attention:** 94% of BHCPF facilities had oxytocin available compared to 65% of non-BHCPF — a **29-percentage point gap** with direct implications for maternal safety in delivery facilities.
- **Availability improved across rounds in both groups for most items,** with gaps remaining broadly similar between rounds — suggesting that non-BHCPF facilities are improving at a comparable pace but from a considerably lower base.



Percent of facilities reporting essential medicines currently available on site
By medicine type, national and BHCPF breakdown

	National	BHCPF Status						
	Nigeria	BHCPF			Non- BHCPF			
	n =3952	n =3059			n =799			
Iron folic acid	88% 89% 89% —	97% 98% 95% —			83% 85% 85% —			
ACTs	80% 85% 87% ▲	93% 96% 95% —			72% 79% 83% ▲			
First-line analgesics	77% 86% 88% ▲	90% 96% 97% ▲			70% 81% 81% ▲			
Oral rehydration salts	83% 84% 85% ▲	93% 95% 95% —			74% 79% 80% ▲			
Amoxicillin or gentamicin	77% 83% 85% ▲	92% 95% 97% —			71% 77% 79% ▲			
Short-acting RCM	57% 75% 84% ▲	77% 91% 97% ▲			47% 67% 78% ▲			
Zinc sulphate	72% 79% 81% ▲	88% 92% 94% ▲			64% 72% 75% ▲			
Oxytocin	69% 73% 74% ▲	87% 91% 94% ▲			60% 65% 65% —			
Vitamin A	79% 73% 71% ▼	88% 83% 81% ▼			75% 68% 66% ▼			
Antihelminthics	58% 69% 68% ▲	76% 86% 85% ▲			49% 61% 59% ▲			
MMS	57% 71% 66% ▲	72% 85% 81% ▲			50% 65% 60% ▲			
Long-acting RCM	56% 66% 65% ▲	78% 87% 85% ▲			44% 56% 54% ▲			
First-line anti-hypertensives	58% 66% 65% ▲	82% 89% 89% ▲			47% 55% 54% ▲			
Chlorhexidine gel for cord care	51% 57% 58% ▲	73% 80% 84% ▲			40% 46% 46% ▲			
Antiasthmatics	40% 54% 58% ▲	54% 72% 77% ▲			33% 45% 49% ▲			
Magnesium sulphate	49% 57% 56% ▲	66% 76% 79% ▲			40% 48% 45% —			
	R1	R2	R3	R1	R2	R3	R1	R2	R3

Note: Detailed state-level breakdowns (overall and for BHCPF facilities) are available in the report annex. The two composite indices in the upper figure are calculated based on the list of tracer supplies presented in the lower figure. BHCPF: Basic Health Care Provision Fund; ACT: Artemisinin-based Combination Therapy; RCM: Reversible Contraceptive Methods; MMS: Multiple Micronutrient Supplementation. **TREND:** Percentage point (pt) difference between round 1 and round 3 estimates, where longitudinal data are available. Changes of ≥5 pt are flagged as an increase (▲) or decrease (▼); changes within ±5 pt are considered stagnant (—).

Figure 201: Essential medicine availability by BHCPF status, Jul 2025–Aug 2026

Chapter 23

HOPE PHC



23.1 HOPE PHC Implementation

The HOPE-PHC Programme aims to improve the utilisation of quality essential healthcare services and strengthen health-system resilience in Nigeria. Its results framework tracks progress across three interrelated areas: improving the quality of services; improving utilisation of essential services; and improving the resilience of the health system. Financing is released against agreed results, linking investment directly to improvements in services.

Table 23.1: HOPE-PHC implementation indicators

Core Indicator	Baseline	2025 Achievement	2026 Achievement
Number of States participating in HOPE PHC	Data not available	Data not available	23
Number of health facilities supported under HOPE PHC	Data not available	Data not available	Data not available
Number of poor and vulnerable people enrolled by SSHIAs in the NHIA gateway of the BHCPF	1,800,000	Data not available	Data not available
Number of tracer essential health service contacts delivered by community health workers and recorded in DHIS2	Data not available	Data not available	Data not available
Number of patients with obstetric or neonatal complications transported through the digitised Emergency Medical Transport dispatch system	Data not available	Data not available	Data not available
Number of women and neonates receiving CEmONC and neonatal services and/or VVF surgery, with VVF surgeries not exceeding 30% of reimbursed services	Data not available	Data not available	Data not available
Percentage of deliveries attended by a skilled birth attendant	46%*	Data not available	Data not available
Percentage of pregnant women receiving multiple micronutrient supplementation during antenatal care for at least 180 days	25%	Data not available	Data not available
Percentage of children receiving the third dose of the pentavalent vaccine (Penta 3 coverage)	53%	Data not available	Data not available
Number of people receiving quality health and nutrition services, including adolescents	0	Data not available	Data not available

Chapter 23

Core Indicator	Baseline	2025 Achievement	2026 Achievement
Percentage of complaints from all users, including adolescents, resolved within established timelines through recognised feedback channels	0%	Data not available	Data not available
Number of states receiving BHCPF funds in compliance with the allocation formula in the revised guidelines	0	Data not available	Data not available
Number of states implementing their emergency preparedness and response (EPR) programme plans, meeting the specified implementation threshold	0	Data not available	Data not available
Number of states implementing their climate and health adaptation plans, meeting the specified implementation threshold	0	Data not available	Data not available
Number of people benefiting from climate-resilient infrastructure, disaggregated by female and youth beneficiaries	0	Data not available	Data not available
Disbursement-linked results verified	Data not available	Data not available	9
Independent verification exercises completed	Data not available	Data not available	IVA recruitment process is ongoing.
Programme financing released against verified results (US$)	Data not available	Data not available	About $18 million unlocked ($18.233M)

ANNEXES



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ANNEX II INSTITUTIONAL REFERENCE TABLES

Table A.2: Agencies and parastatals of the FMoHSW

Agency	Acronym	Core mandate
National Primary Health Care Development Agency	NPHCDA	Primary health care development, immunisation; BHCPF gateway (45%)
National Health Insurance Authority	NHIA	Health insurance and financial risk protection; BHCPF gateway (48.75%)
Nigeria Centre for Disease Control and Prevention	NCDC	Disease surveillance, outbreak preparedness and response; BHCPF gateway (1.25%)
National Agency for Food and Drug Administration and Control	NAFDAC	Regulation of food, drugs, cosmetics, medical devices, chemicals and packaged water
Nigerian Institute of Medical Research	NIMR	Biomedical and public health research
National Institute for Pharmaceutical Research and Development	NIPRD	Pharmaceutical, phytomedicine and diagnostics research and development
National Agency for the Control of AIDS	NACA	Coordination of the national HIV/AIDS response and the National Strategic Plan
National Blood Service Agency	NBSA	Safe blood collection, screening and supply
National Postgraduate Medical College of Nigeria	NPMCN	Postgraduate specialist training of doctors and dentists; accreditation of residency programmes

FEDERAL TEACHING HOSPITALS

Table A.3: Federal teaching hospitals

Teaching hospital	Location	State	Zone
Abubakar Tafawa Balewa University Teaching Hospital	Bauchi	Bauchi	NE
Ahmadu Bello University Teaching Hospital	Zaria	Kaduna	NW
Alex Ekwueme Federal University Teaching Hospital	Abakaliki	Ebonyi	SE
Aminu Kano Teaching Hospital	Kano	Kano	NW
David Umahi University of Health Sciences Teaching Hospital	Uburu	Ebonyi	SE
Federal Teaching Hospital, Birnin Kebbi	Birnin Kebbi	Kebbi	NW
Federal Teaching Hospital, Gombe	Gombe	Gombe	NE
Federal Teaching Hospital, Ido-Ekiti	Ido-Ekiti	Ekiti	SW
Federal Teaching Hospital, Katsina	Katsina	Katsina	NW
Federal Teaching Hospital, Lokoja	Lokoja	Kogi	NC
Federal University of Health Sciences Teaching Hospital, Ila-Orangun	Ila-Orangun	Osun	SW
Federal University of Health Sciences Teaching Hospital, Otukpo	Otukpo	Benue	NC
Federal University Teaching Hospital, Lafia	Lafia	Nasarawa	NC
Federal University Teaching Hospital, Owerri	Owerri	Imo	SE
Federal University Teaching Hospital, Wukari	Wukari	Taraba	NE
Irrua Specialist Teaching Hospital	Irrua	Edo	SS
Jos University Teaching Hospital	Jos	Plateau	NC
Lagos University Teaching Hospital	Idi-Araba	Lagos	SW
Modibbo Adama University Teaching Hospital	Yola	Adamawa	NE
National Hospital, Abuja	Abuja	FCT	NC
Nnamdi Azikiwe University Teaching Hospital	Nnewi	Anambra	SE
Obafemi Awolowo University Teaching Hospitals Complex	Ile-Ife	Osun	SW
Rasheed Shekoni Federal University Teaching Hospital	Dutse	Jigawa	NW
University College Hospital	Ibadan	Oyo	SW

Teaching hospital	Location	State	Zone
University of Abuja Teaching Hospital	Gwagwalada	FCT	NC
University of Benin Teaching Hospital	Benin City	Edo	SS
University of Calabar Teaching Hospital	Calabar	Cross River	SS
University of Ilorin Teaching Hospital	Ilorin	Kwara	NC
University of Maiduguri Teaching Hospital	Maiduguri	Borno	NE
University of Nigeria Teaching Hospital	Ituku-Ozalla	Enugu	SE
University of Port Harcourt Teaching Hospital	Port Harcourt	Rivers	SS
University of Uyo Teaching Hospital	Uyo	Akwa Ibom	SS
Usmanu Danfodiyo University Teaching Hospital	Sokoto	Sokoto	NW

FEDERAL MEDICAL CENTRES

Table A.4: Federal medical centres

Federal medical centre	State	Zone
FMC Abeokuta	Ogun	SW
FMC Asaba	Delta	SS
FMC Azare	Bauchi	NE
FMC Bida	Niger	NC
FMC Birnin Kudu	Jigawa	NW
FMC Daura	Katsina	NW
FMC Ebute Metta	Lagos	SW
FMC Epe	Lagos	SW
FMC Gusau	Zamfara	NW
FMC Hong	Adamawa	NE
FMC Ikole-Ekiti	Ekiti	SW
FMC Jabi, Abuja	FCT	NC
FMC Jalingo	Taraba	NE
FMC Keffi	Nasarawa	NC
FMC Makurdi	Benue	NC
FMC Misau	Bauchi	NE
FMC Mubi	Adamawa	NE
FMC New Bussa	Niger	NC
FMC Nguru	Yobe	NE
FMC Onitsha	Anambra	SE
FMC Owo	Ondo	SW
FMC Umuahia	Abia	SE
FMC Wase	Plateau	NC
FMC Yenagoa	Bayelsa	SS

FEDERAL SPECIALTY HOSPITALS

Table A.5: Federal specialty hospitals

Specialty hospital	Specialty	State	Zone
Federal Neuro-Psychiatric Hospital, Aro, Abeokuta	Mental health	Ogun	SW
Federal Neuro-Psychiatric Hospital, Budo-Egba	Mental health	Kwara	NC
Federal Neuro-Psychiatric Hospital, Calabar	Mental health	Cross River	SS
Federal Neuro-Psychiatric Hospital, Dawanau	Mental health	Kano	NW
Federal Neuro-Psychiatric Hospital, Enugu	Mental health	Enugu	SE
Federal Neuro-Psychiatric Hospital, Kaduna	Mental health	Kaduna	NW
Federal Neuro-Psychiatric Hospital, Kware	Mental health	Sokoto	NW

Specialty hospital	Specialty	State	Zone
Federal Neuro-Psychiatric Hospital, Maiduguri	Mental health	Borno	NE
Federal Neuro-Psychiatric Hospital, Uselu, Benin City	Mental health	Edo	SS
Federal Neuro-Psychiatric Hospital, Yaba	Mental health	Lagos	SW
National Orthopaedic Hospital, Benin City	Orthopaedics and trauma	Edo	SS
National Orthopaedic Hospital, Dala	Orthopaedics and trauma	Kano	NW
National Orthopaedic Hospital, Enugu	Orthopaedics and trauma	Enugu	SE
National Orthopaedic Hospital, Igbobi	Orthopaedics and trauma	Lagos	SW
National Orthopaedic Hospital, Jalingo	Orthopaedics and trauma	Taraba	NE
National Orthopaedic Hospital, Jos	Orthopaedics and trauma	Plateau	NC
National Obstetric Fistula Centre, Abakaliki	Obstetric fistula	Ebonyi	SE
National Obstetric Fistula Centre, Benin City	Obstetric fistula	Edo	SS
National Obstetric Fistula Centre, Katsina	Obstetric fistula	Katsina	NW
National Obstetric Fistula Centre, Ningi	Obstetric fistula	Bauchi	NE
National Eye Centre, Kaduna	Ophthalmology	Kaduna	NW
National Ear Care Centre, Kaduna	Otorhinolaryngology	Kaduna	NW

PROFESSIONAL REGULATORY COUNCILS AND BOARDS

Table A.6: Professional regulatory councils and boards

Regulatory body	Acronym	Professions regulated
Medical and Dental Council of Nigeria	MDCN	Medical and dental practitioners; alternative medicine
Pharmacy Council of Nigeria	PCN	Pharmacists, pharmacy technicians and pharmaceutical premises
Nursing and Midwifery Council of Nigeria	NMCN	Nurses and midwives
Medical Laboratory Science Council of Nigeria	MLSCN	Medical laboratory scientists, technicians and assistants
Radiographers Registration Board of Nigeria	RRBN	Radiographers and radiography practice
Community Health Practitioners Registration Board of Nigeria	CHPRBN	Community health officers and extension workers
Dental Therapists Registration Board of Nigeria	DThRBN	Dental therapists and dental surgery technicians and assistants
Optometrists and Dispensing Opticians Registration Board of Nigeria	ODORBN	Optometrists and dispensing opticians
Medical Rehabilitation Therapists (Registration) Board of Nigeria	MRTB	Physiotherapists, occupational therapists and allied rehabilitation professions
Health Records Officers Registration Board of Nigeria	HRORBN	Health records and health information officers
Institute of Public Analysts of Nigeria	IPAN	Public analysts (food, drug and water analysis)
Dental Technologists Registration Board of Nigeria	DTRBN	Dental technologists

GOVERNANCE BODIES AND STATUTORY COMMITTEES UNDER THE NATIONAL HEALTH ACT 2014

GOVERNANCE BODIES: MEMBERS, STATUTORY FUNCTIONS AND STATUS IN 2026

Table A.7: Governance bodies: members, statutory functions and status in 2026

Body	Members	Statutory functions	Status
National Council on	Chair: Minister of Health Members: Minister of State	As the highest policy-making body on health in Nigeria, the Council is responsible for protecting,	

Body	Members	Statutory functions	Status
Health (NCH) & the Technical Committee of the NCH	for Health (if any); Commissioners for Health of all States; Secretary for Health, FCT Secretary: Permanent Secretary, FMoH Meetings: at least once a year (s.4(3)) TECHNICAL COMMITTEE Chair: Permanent Secretary, FMoH Members: all FMoH Directors and the Legal Adviser; Permanent Secretary and two Directors of every State Ministry and the FCT; one rep each of the Army, Air Force and Navy Medical Corps; one rep of Prisons Medical Services; one rep of each FMoH parastatal; one rep of all statutory health regulatory agencies; Chair of the Committee of CEOs of Teaching and Specialist Hospitals and FMCs; one rep of each registered health professional association, including traditional and alternative practitioners; one rep of private providers Secretariat: FMoH	promoting, improving and maintaining the health of citizens and for formulating the policies and measures needed to achieve this. It advises the Federal Government, through the Minister, on national health guidelines, implementing the National Health Policy, and how health services are organised, delivered, and distributed. It ensures the delivery of basic health services and prioritises other services within available resources; issues norms, standards, and guidelines and promotes adherence to them; and identifies national health goals and priorities and monitors their implementation. The Council also promotes healthy lifestyles, facilitates the prevention and control of communicable and non-communicable diseases, and ensures that children aged 0 to 5 years and pregnant women are immunised. It coordinates the services of the Federal Ministry, States, Local Governments, wards, and private providers; integrates federal and state health plans annually; and performs other duties the Minister assigns (s.5(1)). Beyond section 5, it sets the timeframes, guidelines and format for National and State Health Plans (s.5(2)), appoints the committee that administers the BHCPF emergency treatment portion (s.11(3)(e)), ensures the widest possible coverage of health insurance (s.40), and develops policy and plans for human resources for health (s.41, s.44). The Committee advises the National Council on Health on all of the Council's functions under section 5(1) and on any other matter the Council refers to (s.7). It aims to reach decisions by consensus, falling back on a majority vote where consensus cannot be reached, and may set up ad hoc committees of experts to advise it on any matter within its remit. It determines its own proceedings, with a quorum of one-third of its members including the person presiding (s.8).	
National Tertiary Health Institutions Standards Committee (NTHISC)	Chair: health professional with vast experience, appointed by the Minister Members: reps of the Ministries of Finance and Education and the Office of the Head of Service; reps of tertiary hospital CEOs; Registrars of all health regulatory councils; six public-interest members, one per geopolitical zone, at least two of them women; one organised private sector rep Secretary: Director, Hospital Services, FMoH	The Committee advises the Minister on establishing tertiary hospitals and prepares periodic master plans for their balanced and coordinated development. It sets minimum standards for tertiary health facilities, inspects and accredits them, and investigates and makes recommendations to Federal and State Governments on tertiary care in the national interest. It advises the Federal Government on the recurrent and capital financing needs of tertiary health services, including training and research, sets the criteria for allocating federal funds to tertiary institutions, and monitors how those funds are used. Each year it collates, analyses and publishes information on tertiary health care. It lays down operational guidelines for the Tertiary Hospitals	

Body	Members	Statutory functions	Status
	Terms: four years, single term; meets at least four times a year; two-thirds quorum	Management Board, monitors and evaluates tertiary hospitals, receives their annual reports and supervises annual peer reviews (s.10(1)). Elsewhere in the Act, it issues Certificates of Standards for tertiary institutions (s.13(3)), enforces quality standards in tertiary hospitals (s.19(3)) and prescribes the criteria for approving organ transplant facilities (s.54(3)).	
Emergency Medical Treatment Committee of the BHCPF	Fund: no board; NPHCDA disburses through State and FCT PHC Boards Committee: appointed by the NCH; composition not specified	The Fund is financed by an annual Federal Government grant of not less than 1% of the Consolidated Revenue Fund, together with donor grants and funds from other sources (s.11(2)). Half of the Fund pays for the basic minimum package of health services through the NHIS; 20% buys essential drugs, vaccines and consumables for primary health care facilities; 15% provides and maintains facilities, equipment and transport; 10% develops human resources for primary health care; and 5% pays for emergency medical treatment through a committee appointed by the National Council on Health (s.11(3)). States and Local Governments must contribute at least 25% of project costs to qualify (s.11(5)). NPHCDA withholds funds where earlier disbursements were misapplied, where counterpart funds are unpaid, or where national norms are not implemented (s.11(6)), and it develops guidelines for administering, disbursing and monitoring the Fund with the Minister's approval (s.11(7)).	
National Health Research Committee (NHRC)	Members: not more than 13, appointed by the Minister on recommendation of health research institutions and related bodies; must reflect federal character Chair: acknowledged, renowned health researcher; 3 years, renewable once Secretary: Director of Health Planning and Research, FMoH (now DHPRS)	The Committee promotes health research by public and private health authorities and ensures that the national research agenda and research resources focus on priority health problems. It develops, and advises the Minister on, an integrated national strategy for health research, and it collates and documents information on the research activities of public and private health establishments (s.31(6)).	
National Health Research Ethics Committee (NHREC)	Members: not more than 15, to include a chair; medical doctor; legal practitioner; pharmacist; nurse; one Christian and one Islamic representative; community health worker; medical researcher; pharmaceutical researcher; medical laboratory scientist; health records officer; radiographer; physiotherapist; medical laboratory science	The Committee determines the guidelines under which institutional health research ethics committees operate. It sets norms and standards for research on humans and animals, including clinical trials, and determines the extent of health research to be carried out by public and private health authorities. It registers and audits institutional committees, adjudicates complaints about how they function, and hears complaints from researchers who believe they have faced discrimination. The Committee refers ethical or professional violations by health care providers to the relevant regulatory body, recommends disciplinary action	

Body	Members	Statutory functions	Status
	researcher; and three persons of unquestionable integrity, at least one a woman Terms: 3 years, renewable once; removable by the Minister in the public interest	against anyone who breaches research norms, and advises federal and state ministries on ethical issues in health research (s.33(6)). It also prescribes the conditions under which research may be conducted on minors (s.32(2), (3)).	
Institutional Health Research Ethics Committees (HRECs)	Members: set by each institution, agency or establishment conducting health research; must be registered with the NHREC	Each committee reviews research proposals and protocols to ensure that research by its institution will promote health, contribute to preventing communicable or non-communicable diseases or disability, or lead to cures. It approves research that meets its ethical standards and performs any other functions the Minister refers to it (s.34(2)). Its authorisation is also required before a health care provider may use a user's identifiable health records for study, teaching or research (s.28(1)(b)).	
FCT Health Information Committee	Members: established by the FCT Secretary for Health; composition not specified	The committee maintains, facilitates and implements the health information system at FCT and Area Council levels, as part of the National Health Management Information System coordinated by the Federal Ministry of Health (s.35(1), s.36).	
National Drugs Formulary and Essential Drugs List Review Committee	Members: not specified	The Committee periodically reviews the Essential Drugs List, the compendium of drugs approved for use in health facilities throughout the Federation, within the National Drugs Formulary. The Act also directs that local manufacture of as many listed items as practicable be encouraged (s.39).	
	Members: left to regulations made by the Minister	The Service provides blood transfusion services for the Federation under regulations the Minister makes for its establishment and maintenance. States remain free to set up their own blood transfusion services within their jurisdictions (s.47).	
Independent Tissue Transplantation Committees	Members: independent committee within each health establishment that carries out transplantation; composition "as prescribed"	Each committee provides independent oversight of tissue transplantation within its health establishment, alongside the written authorisation of the medical practitioner in charge of clinical services (s.51(1), (3)). The practitioner who authorises a transplant may not be the lead participant in it (s.51(2)).	
	Members: composition set by the Minister by notice or circular	These committees perform whatever advisory or technical functions the Minister assigns to help achieve the objects of the Act. The Minister sets their functions, working procedure and any incidental matters by notice or circular (s.60).	
	Members: representatives of the FMoH, national organisations identified by the Minister, and state organisations	The Forum promotes and facilitates interaction, communication and information sharing on national health issues between representatives of the Federal Ministry of Health, national organisations identified by the Minister, and state organisations (s.61(2)).	


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