

Assessment of Primary Health Centres in selected States of Nigeria

Summary report of findings from Christian Aid Supported Communities in Anambra, Benue, Kaduna, Plateau States and the Federal Capital Territory (FCT)

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List of Acronyms

ANC	Antenatal Care
AOS	Available on Site
BEmOC	Basic Emergency Obstetric Care
CAID	Christian Aid
CBHIS	Community Based Health Insurance Scheme
CDC	Centre for Disease Control
CHEW	Community Health Extension Workers
CHIS	Community Health Insurance Scheme
CHO	Community Health Officer
DRF	Drug revolving fund
EPI	Expanded programme on immunization
FP	Family Planning
HMIS	Health Management Information System
HTN	Hypertension
IMCI	Integrated management of childhood illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IPT	Intermittent Preventive Treatment
IUCD	Intrauterine Contraceptive Device
JCHEW	Junior Community Health Extension Workers
LGA	Local Government Area
MCH	Maternal and Child Health
MDA	Ministries Department Agencies
MoH	Ministry of Health
MSS	Midwives Service Scheme
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
OIC	Officer in Charge
PHC	Primary Health Centre
PMTCT	Prevention of mother to child transmission
RDT	Rapid Diagnostic Test
RPR	Rapid Plasma Reagin
SAM	Service Availability Mapping
SARA	Service Availability Readiness Assessment
SCHH	Strengthening Community health and HIV
V2P	Voice to the People
VDRL	Venereal Disease Research Laboratory
WASH	Water Sanitation and Hygiene

Christian Aid's Community Health and HIV Programme

Christian Aid believes that it is the responsibility of government to guarantee quality health services for its population. Our role is to work with individuals and communities to create an environment in which every member of society can enjoy the right to health services, and hold governments and health systems to account. This is our community health framework/approach. It is hinged on a development approach to health services delivery, building of equitable institutions and ensuring equitable social norms.

We work in Nigeria to improve the health of poor and marginalised people, particularly women, children and people with compromised immunity. With our partners, we seek to strengthen community-based health systems to increase the accessibility, affordability and quality of public and private health care. We enable community members to understand and adopt health-seeking behaviour and mobilise them to demand their rights to health.

We work to increase the accountability of duty bearers and the involvement of rights holders in health policy formulation, budget allocation and oversight of primary healthcare facilities in line with national policy. We put pressure on government to increase its spending on healthcare and regulate the private health sector. We also promote formalised community health insurance cover for all.

Executive summary

The Alma-Ata Declaration of 1978 evolved as a result of the challenges health care was facing, particularly at the primary health care level which if not addressed will hamper the realization of the goal of 'Health for All'. It aims at addressing the main health problems in the communities by promoting and providing preventive, curative and rehabilitative services. This triggered the restructuring of the Nigerian health system to align with the Alma Ata declaration, with Nigeria being one of the 134 signatory to the idea. The implementation of primary health care in Nigeria however varies based on the PHC type¹.

Taking cognizance of these facts, the Nigerian government is strongly committed to strengthening the delivery of primary health care services to ensure universal coverage and access. This commitment is articulated in several frameworks such as the National Strategic Health Development Plan (NSHDP), the National Primary Health Care Development Agency Minimum Package of Care, the Integrated Maternal, New-born and Child Health Strategy, the National Health Insurance Policy and the National Health Bill to mention a few².

The PHC system currently faces a number of challenges including funding constraints and ineffective management. Although management of PHCs constitutionally falls within the purview of the 3rd tier of government (Local Government Area), poor funding due to the skewed federal allocation system in the country and lack of prioritization of healthcare by the local government administrators has rendered most of the PHCs ineffective.

Realizing the importance of Primary Health Care centres to meeting the health needs of rural dwellers and also to help advocate for improved health care services across its project states, LGAs and communities, Christian Aid decided to conduct an assessment of selected Primary Health Centres across communities where its partners work in four States and the FCT.

The methodology employed and utilized both quantitative and qualitative data collection techniques using WHO developed Service Availability Mapping (SAM) tools (adapted for policymakers at the LGA and State levels), Service Availability and Readiness Assessment (SARA) and IHC developed Clients' Satisfaction tool. This assessment covered primary health care facilities located within Christian Aid partners' communities of intervention across 20 Local Government Areas within the FCT (10), and States like: Anambra (9), Benue (19), Kaduna (22) and Plateau (13)³. Furthermore, two⁴ interviews were conducted at the State level and 17⁵ interviews with the HODs (Health) across the concerned LGAs and Area Councils. Also, clients were interviewed based on their use of the various facilities within the last one month. Clients were identified and then interviewed both at the facility level (exit interview) and in the community. In total, 294 clients (Anambra – 36, Benue – 76, Kaduna – 87, Plateau – 55, and FCT – 40) were interviewed across the communities where the 73⁶ facilities are located.

Findings from this assessment show that:

- According to the minimum requirements for PHCs set by the National Primary Healthcare development agency, of the 73⁷ facilities visited, population-wise, only 16 facilities met NPHCDA stipulated between 10,000 and 20,000 catchment population that a facility in the category of PHCs must reach-out to.
- Of all the facilities assessed, more than half (47) appear to be in good conditions although up to 36 have their walls in bad shape.

The PHC system currently faces a number of challenges, including funding constraints and ineffective management. Although management of PHCs constitutionally falls within the purview of the 3rd tier of government (Local Government Area), poor funding due to the skewed federal allocation system in the country and lack of prioritization of healthcare by the local government administrators has rendered most of the PHCs ineffective.

- Regarding the availability of accommodation for staff, only 22 of the 73 facilities assessed have some form of accommodation for some selected staff.
- Across all the facilities, more than half (60) have functional stethoscope while less than this (57) have functional pressure machine /cuff available for use. Furthermore, functional thermometers were found to be scarce as only a little above half the population of the assessed facilities (49) have them. However, functional pulse oximeter for measuring oxygen saturation is virtually non-existent across the assessed facilities as only a few (2) have it.
- Inadequate human resource is a critical and cross-cutting challenge. Overall medical official ratio to catchment area population (per 20,000) across the states is 0.430 – a very low figure compared to the NPHCDA minimum standards, which requires that a PHC serving a population of between 10,000 and 20,000 must have at least one doctor in its employ. CHEWs and JCHEWs are the most available cadre of staff overall except in one state (Anambra). However, there is a limit to the range of services that this cadre is authorized to provide.
- With respect to training and capacity building needs, of all the facilities assessed, only 13 of the visited facilities have staff who have received training on some important health issues. Furthermore, it was also found that none of the facilities have guidelines for the various areas of services they provide to their catchment communities. This however raises some questions on their capacity to provide the right skilled services.
- Regarding available services across the facilities, malaria (67), child services like nutrition, diarrhoea, upper respiratory tract infections etc. (64), and new born care (57) appeared the most provided services. While less than a third of all the facilities provide youth friendly (26) and TB (17) services respectively. Also, only less than half (32) of the assessed facilities provide simple laboratory services.
- Across all the CAID supported states, only facilities in three of the four States and the FCT offer outreach services especially to hard-to-reach communities within their catchment area.
- Regarding programmes supporting service provision, Drug revolving fund (DRF) is only operational in 47 of the 73 facilities, while Free MCH programme is only functional in 38 of the facilities assessed.
- Regarding service utilization, it was found that service uptake has generally improved across all the States from 2011-2014.
- Across all facilities, responses received about the health workers were quite encouraging. Of the 294 clients interviewed, 280 agreed that health workers were courteous and respectful, while 279 were of the opinion that they were accorded sufficient length of time during consultation and care. However, most of the respondents (161) did not agree that respectful health workers could also be friendly.

Based on these findings, it is recommended that:

- Based on infrastructure and staff availability, certain facilities should be designated for basic out-patient services while others are designated, staffed and supported to provide 24 hour MCH services. This will ensure compliance to NPHCDA and other clinical standards governing service delivery.
- Highly motivated staff should be employed with effective retention plan in place to forestall shortages. This could be done through provision of accommodation, power supply and other incentives like the 'bush allowance'.

According to the minimum requirements for PHCs set by the National Primary Healthcare development agency, of the 73 facilities visited, population-wise, only 16 facilities met NPHCDA stipulated between 10,000 and 20,000 catchment population that a facility in the category of PHCs must reach-out to.

- Government could also enter into agreement with training institutions and the National Youth service Corps for deployment of relevant students and youth corps members to areas with workforce challenges during industrial attachments and youth service respectively.
- Appropriate task-shifting should be encouraged for health workers in line with the new task-shifting policy guidelines to expand the scope of services the lower level of staff can safely and appropriately deliver.
- Capacity to conduct basic investigations should be strengthened and the use of rapid test kits explored as necessary so as to circumvent the challenges faced with laboratory services.
- New innovative approaches and technologies such as blood grouping test kits and MCH combo test kits which combine multiple tests (hepatitis, syphilis and blood group required for ANC) should be explored.
- Training (clinical and non-clinical issues) should be provided for all cadres of staff in all health facilities (especially at the PHC level) across rural-urban divide, as it appears PHC staff are often left out when planning for staff trainings especially those in rural communities.
- Appropriate national and state-level structures and agencies like the SURE-P, MSS, NHIS and other initiatives should be engaged to improve programme coverage.
- Commodity logistics need to be strengthened. Appropriate government structures, private sectors and NGOs should be engaged in this regard for synergy. This will help forestall stock-outs of essential commodities like drugs (and other consumables like cotton wool, iodine, needles and syringes etc.).
- Adequate monitoring and supervision will help ensure efficiency of health workers in addition to motivating staff especially those in hard-to-reach rural communities.
- Community structures need to be strengthened to implement structured supervision and feedback mechanisms for health in their various wards and also to be able to hold the government accountable.

Across all the Christian Aid supported states, only facilities in three of the four States and the FCT offer outreach services especially to hard-to-reach communities within their catchment area.

Background

With less than 12 months⁸ to the deadline for meeting up with achieving the health-related MDGs, Nigeria still faces several challenges that make the realization of these goals bleak as national health indices still remain poor. In addition, poverty indices reveal that over half of the population lives below the poverty line especially amongst the rural dwellers. This is important for the poor because health risks are often identified as the greatest among all other risks faced by this group of people. Health problems not only impact expenditure of the household but also reduce productivity and opportunity for growth.

Household out-of-pocket expenditure remains by far the largest source of health expenditure in Nigeria (about 69%) and in absolute terms increased from N489.79 billion in 2003 to N656.55 billion in 2005. The estimated health expenditure of private firms grew from N20.32 billion in 2003 to N29.67 billion in 2005. The contributions from the development partners to health sector in Nigeria are estimated to have increased from N48.02 billion in 2003 to N78.78 billion in 2005.

In terms of contribution from different levels of Government, the NHA 2003-05 estimates that the Federal Government contributes above a tenth of the total sum (12.1%), State Governments about 7.6%, and LGAs about 4.5%. The Household Out-Of-Pocket Expenditure (OOPE), by far remains the largest source contributing over two thirds (68.6%) while Private Firms contribute (3.1%) and Development Partners (4.1%)⁹.

Regardless of government's poor spending on health, Primary Health Care has been identified as the most basic and probably most important aspect of healthcare because it touches the largest segment of the population-the poor, especially the rural dwellers.

*'Primary Health Care (PHC) is an essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination'*¹⁰.

The Alma-Ata Declaration of 1978 evolved as a result of the challenges facing health care particularly at the primary health care level which if not addressed will hamper the realization of the goal of 'Health for All'. It aims at addressing the main health problems in the communities by providing promotional, preventive, curative and rehabilitative services. This triggered the restructuring of the Nigerian health system to align with the Alma Ata declaration-being one of the 134 signatory to the idea. The implementation of primary health care in Nigeria however varies based on the PHC type¹¹.

Taking cognizance of the aforementioned facts, the Nigerian government is strongly committed to strengthening the delivery of primary health care services to ensure universal coverage and access. This commitment is articulated in several frameworks such as the National Strategic Health Development Plan (NSHDP), the National Primary Health Care Development Agency Minimum Package of Care, the Integrated Maternal, New-born and Child Health Strategy, the National Health Insurance Policy and the National Health Bill to mention a few¹². Implementing these frameworks however, requires a collaborative effort of several ministries, departments and agencies (MDAs), development partners and private sector in an integrated approach to meeting the needs of the Nigerian people, particularly those in (poor) rural areas where the health indices are relatively worse.

Currently, the PHC system faces many challenges including funding constraints and ineffective management. PHC constitutionally is a responsibility of the 3rd tier of government (Local Government Area). However,

due to the skewed federal allocation system in the country, poor funding of the LGAs in addition to the fact that successive local government administrators have not been prioritizing healthcare, the PHCs have been left unattended to.

The identified problems notwithstanding, the provision of quality healthcare is a social responsibility of the Government and any inadequacy at the PHC level will automatically translate to a fracture of secondary and tertiary healthcare, which impacts negatively on both State and Federal tiers of Government. In order to circumvent these, the Federal Government set up the National Primary Health Care Development Agency and consequently the States versions to ameliorate this problem.

Christian Aid in collaboration with its partners support poor and marginalized people to make informed and empowered decisions about their lives, take action which challenges the systems and structures that perpetuate poverty, inequality and injustice whilst proffering home-grown solutions to home-grown problems. Currently CAID is implementing several projects using a rights based approach to programming for more sustainable interventions in Nigeria and these include: Strengthening Community Health and HIV Response in Nigeria (SCHH)¹³, NetsforLife¹⁴, Voice to the People (V2P)¹⁵, Improving Community Response to Management of Malaria (ICRAM)¹⁶ and 'People Living Positively' – South to South Learning¹⁷

Realizing the importance of primary healthcare centres to meeting the health needs of the rural dwellers and to help in advocating for improved health care services across project states, LGAs and communities (including the FCT), Christian Aid decided to conduct an assessment of selected Primary Health Centres across communities where its partners work in the country.

To this end, CAID Nigeria engaged InSiGHt Health Consulting Limited to supervise the assessment while various state partners were trained and used as data collectors.

Presented in this report is the summary of important findings from the PHC assessment carried out across CAID project implementation States.

Purpose and Objectives

Purpose of the Assessment

The purpose of this assessment is to provide information on the status of selected health facilities in the supported states; Anambra, Benue, Kaduna and Plateau States and the FCT in relation to national standards regarding the minimum health care package that should be available to Nigerians irrespective of who they are and the capabilities of the identified facilities to provide this minimum service.

The findings of the assessment will be used to engage relevant government ministries, departments and agencies at local and state levels for health care planning, resourcing, improved participation, etc. and ultimately provision of adequate and sustainable healthcare to Nigerians.

Objectives of the Assessment

The objectives of this assessment are to:

- Assess the status of types and levels of services available in the selected health facilities.
- Assess infrastructure and the human resource capacity of the selected health facilities.
- Identify the nature and types of problems associated with accessibility, utilization and service delivery of health care in the selected health facilities in relation to the minimum care package.

- Identify gaps, strength and weaknesses in health care in the selected health facilities and offer recommendations.

Research Methodology

Summary of Approach

This assessment was conducted through a series of key informant interviews at both the LGA and State levels, clients' interviews using questionnaire and facility audits. Purposeful sampling method was used to select the facilities while a snowball approach was used to select the clients. The methodology also included the review of documents.

Below is the summary of steps that were followed:

Table 1: Summary of Approach

S/N	Objectives	Information Sources	Approach
1	To assess the status of types and levels of services available in the selected health facilities.	Facility audits to assess the service quality of the facilities including records etc. Service providers which include doctors, nurses, CHEWS, pharmacists and laboratory personnel.	Service Availability Readiness Assessment (SARA) Key Informant interviews (SAM)
2	To assess infrastructure and the human resource capacity of the selected health facilities.	Facility audits to assess the service quality of the facility including records etc.	Service Availability Readiness Assessment (SARA)
3	To identify the nature and types of problems associated with accessibility, utilization and service delivery of health care in the selected health facilities in relation to the minimum care package.	Facility audits to assess the service quality of the facility including records etc. Service providers which include doctors, nurses, CHEWS, pharmacists and laboratory personnel.at the facility level and key local government officials in the health department (MOH and Apex nurse)	Service Availability Readiness Assessment (SARA) Key Informant interviews for both facility and LGA level (SAM)
4	To identify gaps, strength and weaknesses in health care in the selected health facilities and offer recommendations.	Facility audits to assess the service quality of the facility Service providers which include doctors, nurses, CHEWS, pharmacists and laboratory personnel.at the facility level and key local government officials in the health department (MOH and Apex nurse) Client satisfaction survey was also conducted amongst respondents who had used the PHC within the last 1 month & live within the catchment communities and those met in the facility during visitation.	Service Availability Readiness Assessment (SARA) Key Informant interviews (SAM). Client satisfaction assessment tool. Client satisfaction survey tool.

Facility Selection and Coverage

The assessment covered primary health care facilities located within Christian Aid partners' communities of intervention in Anambra, Benue, Kaduna and Plateau States including the FCT. Within these communities spread across 20 Local Government Areas supported by Christian Aid partners are 73 PHCs serving 71 communities¹⁸.

Presented below is the summary of the facilities visited by State and number of facilities: (See the full list of facilities visited by state, LGA in appendix table 1)

Table 2: Breakdown of assessed facilities (by State, LGA)

State	Number of PHCs assessed
Anambra	9
Benue	19
FCT	10
Kaduna	22
Plateau	13

See Appendix for list of facilities assessed

Respondent Selection

Two¹⁹ interviews were conducted at the State level with directors of PHCs, while 17²⁰ others were conducted with HODs of Health across the supported LGAs. Also, clients were interviewed based on their use of the various facilities within the last one month. They were identified both at the facility (exit interview) and in the community. In total, 294 clients were interviewed across the communities where the 73²¹ facilities are located.

Table 3: Number of clients interviewed by State

State	Number of clients
Anambra	36
Benue	76
Kaduna	87
Plateau	55
FCT	40
Total	294

Tools

Four tools were used to collect data across the supported sites. Two tools were adapted while the other two were developed in collaboration with the CAID team.

1. SARA-Service Availability and Readiness Assessment (WHO).
2. SAM- Service Availability Mapping (WHO) further split into LGA SAM and States SAM.
3. Client satisfaction tool

Data Collection Team

The data collection was carried out by five teams of data collectors (11 in total: Anambra – 2, Benue – 3, FCT – 2, Kaduna – 2 and Plateau State – 2) drafted from CAID partners across the supported states. Data collection commenced immediately after the training under the supervision of 2 IHC Limited’s consultants. Data collection lasted for 19 days (5 extra days inclusive) while supervision was carried out for 15 days (three days per State spread between two supervisors).

The selected data collectors were centrally trained at the same location for a period of two days. This training included pre-testing and post-testing.

Privacy and Confidentiality

While the subject matter of this assessment was not unduly sensitive still, participants were assured that under no circumstances will confidential information about them be shared with third parties.

Informed Consent

Informed consent was obtained from the clients and respondents before interview.

Language

Though the tools used for this assessment were developed in English language, field teams did some on-the-spot translation of some words in Igbo and Hausa languages as required.

Limitations on the Field

There were some challenges faced during the data collection period. Some of these challenges include:

- The distant locations of the supported facilities from the nearest towns, most of which are not accessible and more time than anticipated to access the facilities.
- Communication was also a challenge as supervisors and data collectors could not reach one another on time due to lack of functional communication networks in several communities.
- Safety issues also deterred one of the supervisors from visiting some locations like Jos East where crisis was reported by the CAID partners.
- Delays with getting approvals to conduct some of the assessments on time. Assessment could however not be conducted with facilities in AMAC as approval was not received.
- Challenges of securing appointments for interviews were very tasking especially with the policymakers at both the LGA and State levels. This is so because most of the LGA health officials do not reside within the communities they serve.
- Lack of cooperation by some LGA officials in providing information due to the perceived 'sensitivity' tied to data sharing.

Key Findings

Infrastructural and Human Resource Capabilities

Infrastructure

This section addresses the availability of the various infrastructures required to effectively provide services to the clients without stress. The issues addressed here include: equipment, communication & IT facilities including HMIS, physical structures (as it relates to the buildings) WASH facilities (including infection control), roads, electricity etc.

General Findings

According to the minimum requirements for PHCs set by the National Primary Healthcare development agency, of the 73²² facilities visited, population-wise, only 16 met the criteria of servicing between 10,000 and 20,000 target populations. The catchment population of these 16 facilities ranges from between 10,000 (catchment population for PHC Umogidi in Benue State) to 44,480 (catchment population for PHC K-Magani in Kaduna State).

Furthermore, across the research States, only one of these PHCs is located in an urban area while the rest are sited in rural areas with the number of communities being served by each of these CAID-supported PHCs ranging from 1 to 36 communities.

Only 13 of the PHCs meet the standard minimum land area of 2,475 square meters, the lowest being 26.6 square meters while the PHC with largest land size is located on a land of 40,000 square meters. Of these facilities, the farthest from the last community served measures approximately 49 km (49,000 meters) in Benue State while the least farthest from the last community served is less than 1,000 meters (750 meters) in Anambra State.

Below: Staff Quarters serving the PHC in Oye Achina Anambra State. All staff accommodation assessed were in deplorable states



Physical Infrastructure

Most of the facilities visited do not have a means of identification. Only less than half (45.2%) can be easily identified with a sign post.

Of all the facilities visited, more than half (64.4%) appear to be in good conditions although fewer than this (49.3%) do have cracked walls. Furthermore, of all these facilities, a little above half (50.7%) have cemented floors, less than a quarter (21.9%) have rough floors and tiled floors respectively while a large proportion (58.9%) have leaking roofs. Security-wise, only 24.7% of the facilities (18 of 73) have perimeter fencing. With the foregoing, 28 facilities were found to require major renovations while 25 require minor renovations with respect to the main facility building (without the inclusion of toilet facilities). (Please check appendix table 1 for more details)

In total, only 38.4% of the supported facilities are connected to the national electricity grid- 7 PHCs in Anambra, 3 in Benue, 9 in Kaduna, 4 in Plateau State and 5 in FCT. Other sources of power in use across these facilities include solar (8.2%) and generator (23.3%) with at least 3 PHCs per state using generators as their alternative source of power supply with the exception of FCT which has 5 PHCs that use generators as their alternate power supply source. However, of all the facilities that use generators, only 14 facilities have functional ones with only 10 of the generators having fuel or battery at the time of this assessment.

The availability of water in facilities is a standard that cannot be compromised for sanitation, hygiene and consequently infection control. Regarding the availability of water supply, of the total facilities visited, only 22 use the NPHCDA recommended motorized bore hole. Also, 7 facilities depend on rain water, 8 facilities rely on surface waters like streams, rivers and dams while 16 depend on dug wells. However, of all the facilities that have sources of water supply, only 48 facilities have a water outlet within 500m while 5 facilities do not have any source of water supply.

The availability of toilet facilities also raises concern. Of the total facilities visited, a total of 23 do not have a toilet facility at all. Furthermore, amongst facilities that have toilet facilities, 18 have pit latrines, 12 facilities use piped sewer system/septic tank while only 17 have a flush system.

In the event of emergencies, based on the NPHCDA standards, a PHC is required to have at least one ambulance vehicle. However, of all the facilities visited, only eight facilities (11%) have referral system while 2 have emergency transportation system (which includes motorcycles and car). However, only 4 facilities have ambulance vehicles as means of emergency transportation. None exists across the supported facilities in Anambra State. Although most of the facilities (79.1%) have access roads, only 24.7% of these roads are tarred with some posing difficulties to smooth transportation to and from the facilities.

Accommodation

Regarding the availability of accommodation for staff, only 22 of the 73 facilities visited (30.1%) provide some form of accommodation for some of their staff. However, all were in deplorable states and none meets the recommendations of the NPHCDA on the type and structures that should be erected for staff which is 2 units of 1 bedroom flat; those who have accommodation only have single rooms to live in.

Communication

Besides the network fluctuation and lack of communication signals in other sites, 23 (31.5%) of the visited facilities have any functional means of communications. Regarding the availability of IT facilities, only 2 (2.7%) of the visited facilities have functional computers /internet facilities while only 1

Below: Dilapidated facility at Iri Gida, Kaduna State



facility has a functional short-wave radio for radio calls. (See appendix table 2 for state-specific data)

Regarding the state of the infrastructure, one of the respondents in Anambra State opined: *'the service of the security personnel is insignificant and equal to zero. I came all the way from Lagos and there is a clear significant difference from what was happening in the Lagos PHC sector and what is on ground here. There should be an improvement in the structures and operational standard to at least entice people to utilize the PHC. Can you imagine no more than one competent health personnel in this big PHC?'*

Basic Equipment

This subsection speaks to the overall basic equipment available across all the facilities visited in all the CAID supported States.

Table 4: Basic equipment available across all the facilities

Equipment	Available and Functional N (%)	Not Available or Not Functional N (%)
Blood pressure machine or cuff	57 (78.1)	16 (21.9)
Stethoscope	60 (82.2)	13 (17.8)
Adult weighing scale	60 (82.2)	13 (17.8)
Infant scale	50 (68.5)	23 (31.5)
Thermometer for measuring body temperature	49 (67.1)	23 (31.5)
Light source to ensure visibility such as lamp or flash light for patient examination	43 (58.9)	28 (38.4)
Infusion kits for intravenous solution	37 (50.7)	36 (49.3)
Needle holder	34 (46.6)	38 (52.1)
Scalpel handle with blade	25 (24.7)	47 (50.7)
Retractor	18 (24.7)	52 (71.2)
Surgical scissors	35 (47.9)	37 (50.7)
Nasogastric Tubes 10-16 FG	6 (8.2)	64 (87.7)
Tourniquet	46 (63.0)	27 (37.0)
Sutures both absorbable and non-absorbable	43 (58.9)	29 (39.7)
Self-inflating bag and mask for resuscitation-adult (Ambubag)	8 (11.0)	64 (87.7)
Self-inflating bag and mask for resuscitation-pediatrics (Ambubag)	11 (15.1)	61 (83.6)
Micro-nebulizer	4 (5.5)	67 (91.8)
Equipment to measure oxygen saturation such as a pulse oximeter	2 (2.7)	68 (93.2)
Oxygen distribution system	8 (11.0)	62 (84.9)

Across all the supported facilities, most of the facilities (82.2%) have functional stethoscope while a few (2.7%) have functional pulse oximeter for measuring oxygen saturation. Also, only a little above a quarter of the facilities (78.1%) have functional pressure machine /cuff available. Furthermore, functional thermometer was found to be scarce across all sites, as only a little above half (67.1%) of the facilities have it.

Human Resources

'The workload is too much for me, I cannot always meet the need of the clients. The only available option I have is to seek for the assistance of community members who I also out of my personal pocket give little amount of money. I need more hands in this PHC. Most of the time, I do refer even cases I can handle to Kandudi Hospital due to time. This hospital should be operating 24hrs but we don't have accommodation and whenever I go to the LGA or other health programmes and the JCHEW is unavoidably absent, the place remains closed' –

Officer-in-Charge of one of the assessed PHCs

This section speaks to the availability of both skilled and unskilled workforce required for the successful running of the health facilities assessed.

Table 5: Human resource (total)

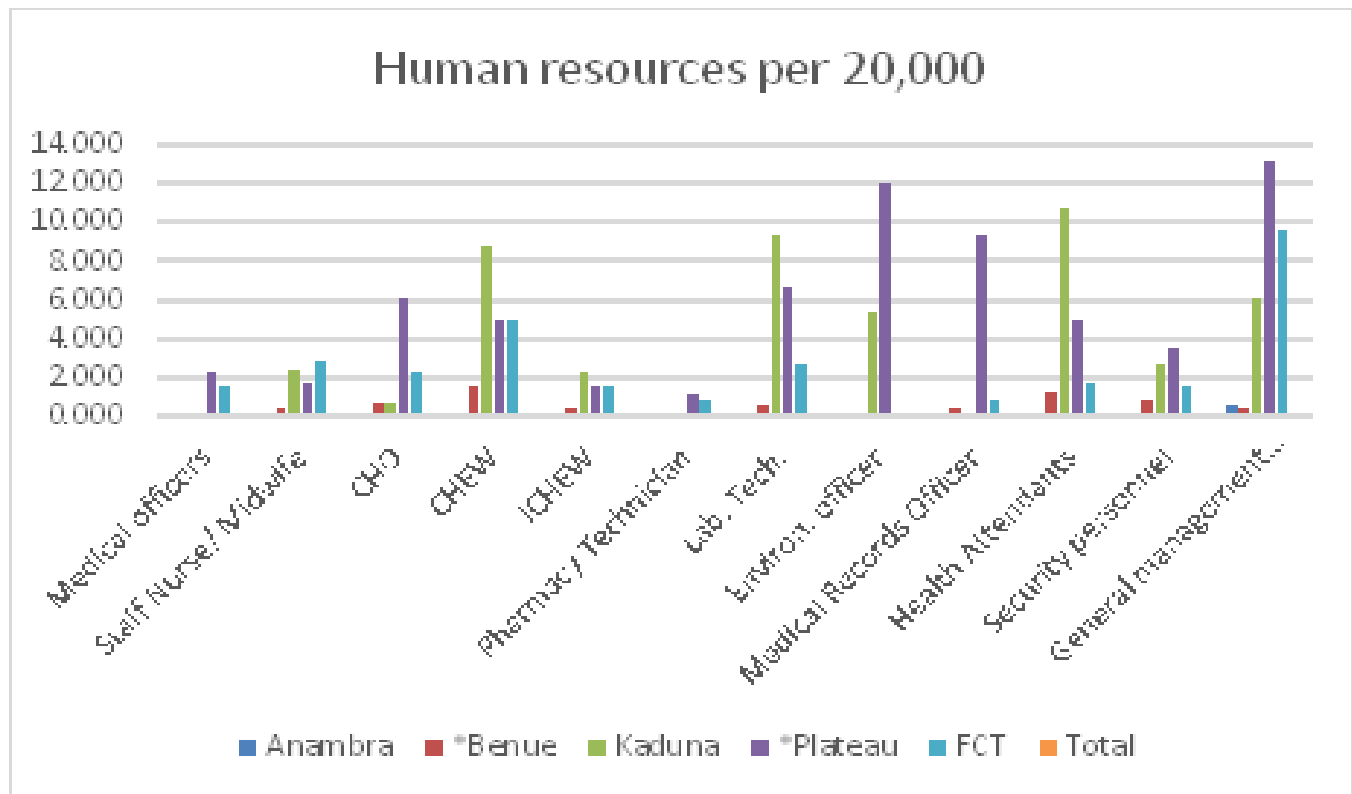
State	Medical officers	Staff Nurse/ Midwife	CHO	CHEW	JCHEW	Pharmacists	Pharmacy Technician	Lab. Tech.	Environ. officer	Medical Records Officer	Health Attendants	Transport personnel	Security personnel	Cleaners (Gen. Maint)	Laundry (Gen. Maint)	Gardeners (Gen. Maint)	Catchment area population
Anambra	1	7	1	4	4	0	0	0	0	0	2	0	2	5	0	1	233,264
*Benue	1	10	4	26	12	0	0	3	0	2	14	0	9	2	0	0	111,976
Kaduna	0	14	1	39	20	0	0	14	8	0	32	5	8	5	1	3	30,110
*Plateau	4	12	11	27	17	2	2	12	22	17	18	2	13	22	0	2	36,689
FCT	4	30	6	39	24	1	2	7	0	2	9	3	8	20	3	2	52,487
Total	10	73	23	135	77	3	4	36	30	21	75	10	40	54	4	8	464, 526

***Benue: 4 PHCs namely PHC, Edeje, PHC, Adagbo, PHC, Ojuwo-Ojekele, PHC, Ofoke did not provide information on their catchment area population neither was the LGA able to provide it.**

***Plateau: 7 PHCs namely PHC, Baltep, PHC, Lalin, PHC, Din, PHC, Talgwang, PHC, Sabon Fobur, PHC, Mabudi and PHC, Amper did not provide information on their catchment area population.**

From table 5 above, across all the PHCs in the 5 project States (including the FCT), there is a varying number of health workforce ranging from none across supported facilities in Kaduna State to 4 medical doctors in FCT-PHCs. Also, the least number of nurses & midwives ranges from 7 in Anambra-supported PHCs to 30 in FCT-supported PHCs.

Figure 1: Human Resources per 20,000 (Please see appendix table 10 for details)



***Benue: 4 PHCs namely PHC, Edeje, PHC, Adagbo, PHC, Ojuwo-Ojekele, PHC, Ofoko did not provide information on their catchment area population neither was the LGA able to provide it.**

***Plateau: 7 PHCs namely PHC, Baltep, PHC, Lalin, PHC, Din, PHC, Talgwang, PHC, Sabon Fobur, PHC, Mabudi and PHC, Amper did not provide information on their catchment area population.**

The overall medical official ratio to catchment area population (per 20,000) across states is 0.430 which is very low compared to the NPHCDA standard which requires that a PHC serving between a population of between 10,000 and 20,000 must have at least 1 doctor in its employ. In Anambra State, the ratio of available medical officers per catchment area population was found to be 0.0009 per 20,000 and 0.0152 per 20,000 in the FCT. For staff nurses/midwives across the states, in Anambra State, the ratio is 0.150 per 20,000 while it is 2.325 per 20,000 in Kaduna State and 2.856 per 20,000 in the FCT. These figures fall well below the required standards of health-workers to catchment area population ratio.

For laboratory technicians, Kaduna State has a ratio of 9.299 per 20,000 population while across facilities in the FCT the ratio is 2.667 laboratory technicians per 20,000 population. With respect to the number of CHOs available, the rates also vary across the supported States- Anambra State is 0.086 per 20,000; Kaduna State is 0.664 per 20,000 and 2.858 per 20,000 in the FCT.

The dearth of human resources and its attendant challenges could be aptly captured in the words of one of the OICs: *“The workload is too much for me, I cannot always meet the need of the clients. The only available option I have is to seek for the assistance of community members who I also out of my personal pocket give little amount of money. I need more hands in this PHC. Most of the time, I do refer even cases I can handle to Kandudi Hospital due to time. This hospital should be operating 24hrs but we don’t have accommodation and whenever I go to the LGA or other health programmes and the JCHEW is unavoidably absent, the place remains closed”.*

Training and Capacity Building Needs

Of the 73 facilities visited, regarding the availability of skills to carry-out service provision effectively, only 13 (17.8%) of the visited facilities have staff who had received training on some important health care lines. 15 (20.5%) of the total facilities reported having staff that have been trained on *Diabetes mellitus* diagnosis, 18 (24.7%) on health care waste management while 25 (34.2%) reported having staff trained on TB diagnosis and management of TB/HIV co-infection.

Also, 26 facilities (35.6%) reported having at least one staff that has been trained on BEmOC; 27 (37.0%) on modified life-saving skills, 34 (46.6%) on diagnosis of hypertension, 37 (50.7%) on IMCI and promotion of proper nutrition & food education while 40 (54.8%) facilities have staff that had received trainings on family planning.

In addition, 46 facilities (63.0%) were trained on infant and young child feeding counselling; 47 (64.4%) on PMTCT; 48 (65.8%) on ANC services; 50 (68.5%) on HIV testing; 51 (69.9%) on HIV counselling; 54 (74.0%) on Intermittent Preventive Treatment of malaria in pregnancy and 57 (78.1%) on EPI. Also, staff of most of the facilities visited (78.1%) were of the opinion that they need training and retraining including refresher trainings. (*Please see appendix table 3 for state-specific details*).

Furthermore, it was also found that none of the facilities visited have guidelines for the various areas of services they provide to their catchment communities. This however raises some questions on their capacity to provide the right skilled services.

Status of Available Services

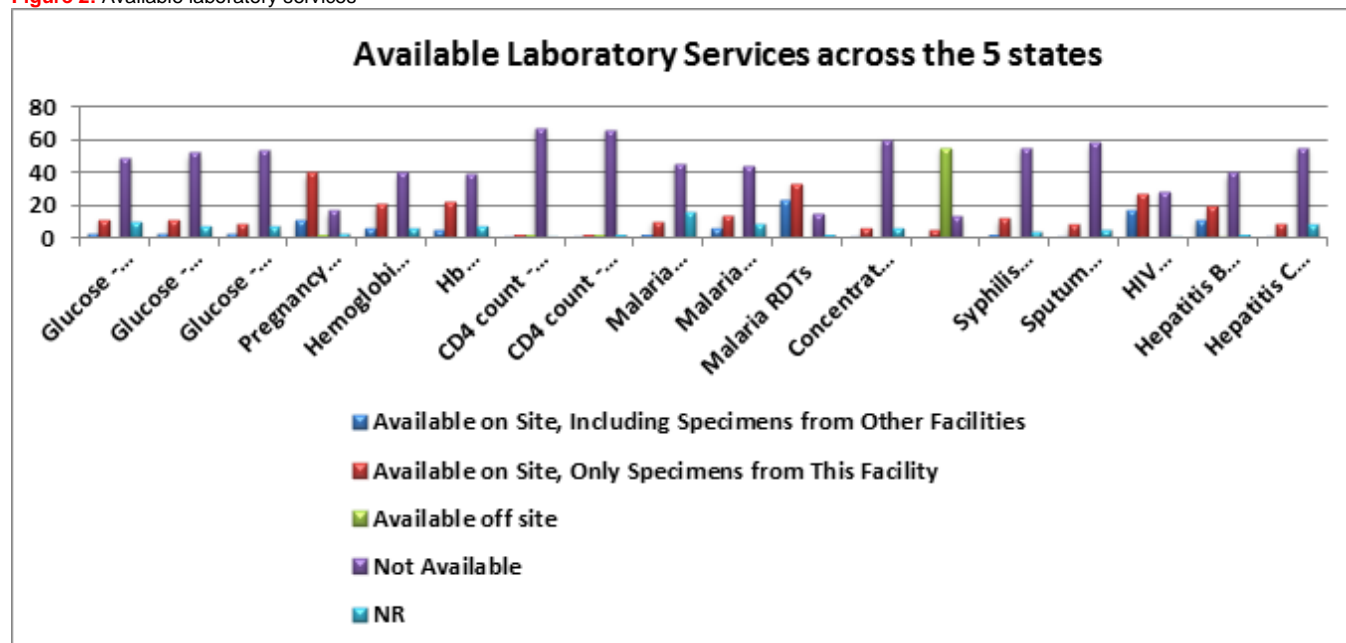
This section speaks to all the services provided across the 5 States (including the FCT). It shows that the supported facilities currently have the capacities to provide the services to the catchment communities. Across the entire CAID programme implementation communities (PHCs), only 39 (53.4%) have dedicated delivery beds while only 37 (50.7%) provide in-patient care. Furthermore, 59 (80.8%) offer modern family planning method with injectable contraceptives 56 (76.7%) being the most offered method.

Also, 68 (93.1%) of these facilities offer ANC services while only 45 (61.6%) offer obstetric care. However, 57 (78.1%) of these facilities provide new-born care, while 64 (87.7%) provide child health services in addition to 67 (91.7%) that provides malaria services. Furthermore, 49 (67.1%) provide HIV services but only 32 (43.8%) provide simple laboratory services²³. Also, only 26 (35.6%) provide youth friendly service across the supported facilities. (*Please appendix table 4 for state-specific information*).

Laboratory Services

Across the 73 supported facilities visited, malaria testing by RDTs was present in 33 (45.2%) facilities. HIV antibody testing also by RDT was present in 27 (36.9%) facilities while Hb estimation by manual method was found in 22 (30.1%) facilities. All these laboratory tests were found to be the most common laboratory services that are offered by these facilities onsite for specimens collected. Furthermore, 55 (75.3%) get their mantoux test done in offsite laboratories. In addition, 3% provide pregnancy tests using urine rapid test and CD4 count while 1 facility does Hepatitis B rapid testing on off-site basis.

Figure 2: Available laboratory services



All the facilities visited both in Anambra and Plateau States do not do any laboratory investigations outside of the facilities. Only 1 facility each in FCT, Kaduna and Benue perform investigations outside the facility. However, PHCs in Benue State and the FCT do carry out pregnancy tests by rapid urine testing outside of the facility. In the same vein, facilities in both Benue and Kaduna States do conduct CD 4 count investigations (both absolute and percentage) off-site. (Please appendix table 5 for state-specific figures)

Under-five Specialized Services

This section speaks to basic under-five services that the facilities in the supported communities provide regularly to under-five children whenever they are presented at the facility.

Table 6: Services available for children under-five

Services	Available	Not Available	%Y	% N
Routine Vitamin A supplementation	51	20	69.9	27.4
Iron supplementation	61	11	83.6	15.1
Growth monitoring	55	16	75.3	21.9
Treatment of child malnutrition	55	17	75.3	23.3
Zinc supplementation	42	29	57.5	39.7
Immunization services	71	1	97.3	1.4
Are Measles, DPT-HB, Polio and BCG vaccines available?	53	18	72.6	24.7

With respect to services provided to under five children, almost all of the facilities (97.3%) provide immunization services while a little above half (57.5%) provide Zinc supplementation. Furthermore, all the supported facilities in Anambra (9), FCT (10) and Plateau States (13) offer immunization services. However, as at the assessment time, not all of these facilities have vaccines to use as only 12 in Plateau and 7 PHCs in Anambra reported the availability of vaccines as at the time of the survey. (Please appendix table 7 for state-specific figures)

Medical Outreach Services

Across all the CAID supported States, only facilities in 3 States offer outreach services especially to hard-to-reach communities within their catchment area. The spread is as follows- Anambra, 1 (Orumba North); Benue, 4 (Agatu, Apa, Otukpo and Tarka) and Plateau, 4 (Mabudi, Riyom, Jos East and Kanke) .

Service Support Programmes and Schemes

This section speaks to programmes and schemes (donor-funded or government –supported) that are available across the CAID –supported States and are supporting the PHCs as required.

Table 7: Service Support Programmes (Summary)

	Anambra (N=9 facilities) N (%)	Benue (N=19) N (%)	FCT (N=10 facilities) N (%)	Kaduna (N=22) N (%)	Plateau (N=13) N (%)	Total (N=73) N (%)
	Available	Available	Available	Available	Available	
Drug revolving fund	1 (11.1)	12 (63.2)	7 (70.0)	21 (95.5)	6 (46.1)	47 (64.4)
Free MCH	5 (55.6)	11 (57.9)	6 (60.0)	9 (40.9)	7 (53.8)	38 (52.1)
SURE-P MCH	1 (11.1)	2 (10.5)	2 (20.0)	4 (18.1)	5 (38.5)	14 (19.2)
MSS	1 (11.1)	2 (10.5)	4 (40.0)	1 (4.5)	1 (7.7)	9 (12.3)
Community Based Health Insurance (Fund)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Safe Motherhood Demand Side Initiative	6 (66.7)	2 (10.5)	4 (40.0)	0 (0.0)	2 (15.4)	14 (19.2)
Other programmes being implemented	3 (33.3)	2 (10.5)	0 (0.0)	0 (0.0)	7 (53.9)	12 (16.4)

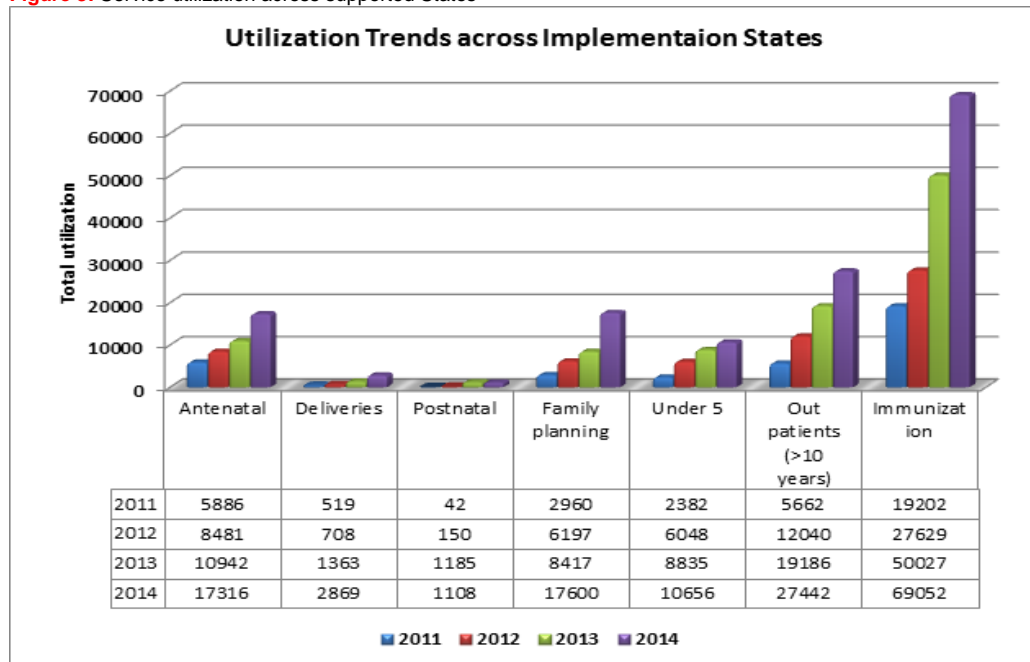
From the table above, Drug revolving fund (DRF) is supporting 47 of the 73 facilities visited; free MCH programme is operative in 38 facilities. However, CBHIS seemed non-existent across all the PHCs visited in all the supported States. It was also found that any facility that has the presence of MSS will not be provided support through the SURE-P programme. *(Please see table 8 above for details).*

Utilization and Service Delivery

Service Utilization Trends

This section shows the progress recorded in the areas of service utilization and uptake of healthcare services across the various CAID states over a period of four years.

Figure 3: Service utilization across supported States



Findings from this assessment show some level of improvement in the uptake of services across the facilities assessed. There is an increase in service utilization across the States from 2011 to 2014. Utilization of ANC services for example increased from 5,886 (2011) to 17,316 (2014).

The same trend was seen with respect to the number of child deliveries carried out in these States as the number of women who visited these supported PHCs for deliveries rose from 519 (2011) to 2,869 (2014). Regarding attendance of these facilities for postnatal care, there was a sharp increase from 42 (2011) to 1,108 (2014) which is a drop from the 1,185 in 2013.

The decrease in utilization recorded may be due to lack of 24 hour services as most of the OICs live outside the community where they work for lack of accommodation and the huge cost of transportation coupled with the lack of required drugs, poor aesthetic appearance of the PHCs and lack of adequate man-power.

In addition, the fact that clients have to procure most drugs may have contributed to the sharp drop in utilization between 2013 and 2014. One of the clients in her words said “how can a poor and old widow like me pay money beyond my expectation to get treated at the PHC? I have four dependents; my late son’s children and I bare all their expenses in the midst of struggle, the one that pains me most is medical expenses whenever they are sick. Going to a Private Hospital is not the best option because I cannot afford to pay. Please government should come to my aid”.

It was also observed that patronage of these PHCs for family planning services increased from 2,960 (2011) to 17,600 (2014) in addition to the increase recorded from 2,382 (2011) to 10,656 (2014) in the number of under-five children who received care.

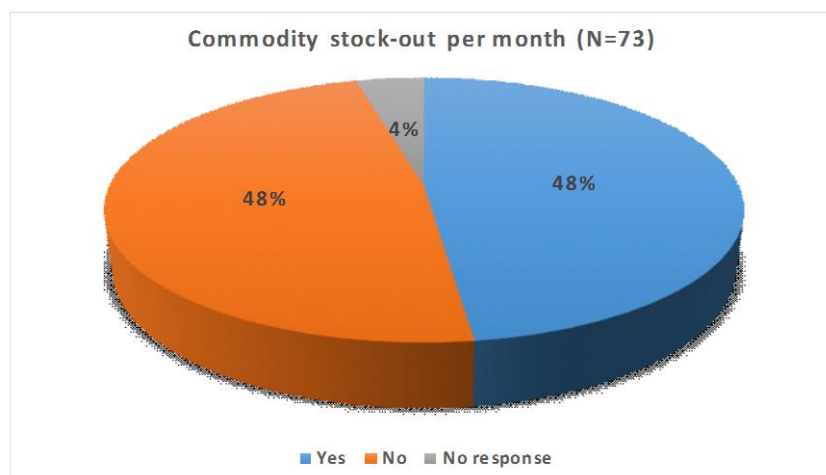
Furthermore, the number of outpatient clients visiting these facilities got a boost from 5,662 (2011) to 27,442 (2014) while immunization services also got some boost as the number of children immunized rose from 19,202 (2011) to 69,052 (2014). (Please see appendix table 8 below for States’ details).

‘How can a poor and old widow like me pay money beyond my expectation to get treated at the PHC? I have four dependents; my late son’s children and I bare all their expenses in the midst of struggle, the one that pains me most is medical expenses whenever they are sick. Going to a private hospital is not the best option because I cannot afford to pay. Please government should come to my aid’

Commodity Stock-outs

As service utilization increases including drugs dispensing, there is a very high tendency for stock-outs if the logistics are not well-managed. This section looks at the number of facilities that reported commodity stock-outs in the last one month.

Figure 4: Report commodity stock-out across supported facilities



Across the supported facilities in the States, 48% reported commodity stock-outs. However, among these facilities, Anambra State (88.9%) reported the most stock-outs.

These observed stock-outs were so because consumables are often not provided for the facilities but some drugs especially malaria drugs (and in small quantities where provided). For example, clients have to procure consumables like sutures, cotton wool, intra-venous fluid tubes etc. Therefore, there is need for the government to take ownership of the PHCs being the closest to the people and provide the essential consumables.

Health Management Information System

This section highlights the availability of required documentations for proper running of facilities including HMIS reporting.

Table 8: Availability of required documentation including HMIS

Measurement criteria	Available N (%)	Not Available N (%)
Storage Facility for Documents	14 (19.2)	50 (68.5)
Disease Notification form	28 (38.4)	29 (39.7)
Referral Form	23 (31.5)	38 (52.1)
Functional Two-way Referral	20 (27.4)	34 (46.6)
HMIS Software	3 (4.1)	47 (64.4)
Dedicated trainer officer to handle HMIS reporting	8 (11.0)	22 (30.1)
Availability of essential Drug List	37 (50.7)	5 (34.5)
Presence of Pharmacy Section	36 (49.3)	36 (49.3)
Shelves in the Pharmacy section	33 (45.2)	36 (49.3)
Drugs properly arranged in the Pharmacy	23 (31.5)	46 (63.0)
Room Thermometer available	9 (12.3)	59 (80.8)
Bin card	35 (47.9)	37 (50.7)
Daily dispensing registers	32 (43.8)	31 (42.5)
Requisition books	30 (41.1)	32 (43.8)
Monthly Pharmaceutical/Laboratory inventory Register	20 (27.4)	43 (58.9)
Updated Inventory control/stock cards	34 (46.6)	35 (47.9)

Measurement criteria	Available N (%)	Not Available N (%)
Minimum Re-order level for drugs stocked	40 (54.8)	30 (41.1)

From Table 8 above, only 14 (19.2%) of the assessed PHCs have facilities for storing their documents and files which speaks to the challenges faced with information retrieval from the facilities. In addition, 28 (38.4%) of the assessed facilities have disease notification forms. Only 3 (4.1%) of the assessed facilities have HMIS software with only 8 (11.0%) facilities having trained staff to handle the reporting.

Regarding issues with drugs availability, stocking and dispensing, only 35 (47.9%) of the facilities seen have experienced stock-out in the last month. This may be due to the fact that drugs are not supplied as required. For example one of the OICs said: *'The only drug government supplies us is the malaria drug, other drugs are procured by the hospital and offered to patients at a cost, so oftentimes we have no drugs to work with'. Furthermore another OIC opined that: 'Whenever other drugs apart from malaria drugs are available, they are drugs provided by the NGOs'.*

A little above half 37 (50.7%) has essential drug list while pharmacy section is present in only 36 (49.3%) of all the facilities visited with just 33 (45.2%) having shelves on which drugs could be arranged or stacked as required. However, only 23 (31.5%) has a neatly arranged pharmacy section.

Inventory control tools are not very common across all the visited PHCs as only 35 (47.9%) have bin cards, 32 (43.8%) daily dispensing registers, 30 (41.1%) requisition books, 20 (27.4%) monthly pharmaceutical/laboratory inventory register and 34 (46.6%) updated inventory control/stock cards.

Table 9: Available routine registers

Registers	Available N (%)	Not Available N (%)	No Response N (%)
Outpatient register	64 (87.7)	3 (4.1)	6 (8.2)
Delivery Register	55 (75.3)	14 (19.2)	4 (5.5)
Antenatal Register	66 (90.4)	4 (5.5)	3 (4.1)
Newborn register	31 (42.5)	22 (30.1)	20 (27.4)
Family Planning	59 (80.8)	6 (8.2)	8 (11.0)
Under 5 clinic Register	27 (37.0)	28 (38.4)	18 (24.7)
Immunization Register	62 (84.9)	8 (11.0)	3 (4.1)
Inpatient Register	32 (43.8)	20 (27.4)	21 (28.8)
Discharge summary	19 (26.0)	26 (35.6)	28 (38.4)

Across the Facilities visited, Outpatient Register is available in 64 (87.7%) of them, Antenatal Register in 66 (90.4%), Delivery Register in 55 (75.3%), Family Planning Register in 59 (80.8%) and Immunization Register in 62 (84.9%).

New-born Register is available in only 31 (42.5%), Discharge Summary register in 19 (26.0%), Under 5 Clinic Register in 27 (37.0%), and Inpatient register in 32 (43.8%) facilities. Records of the patients who present with other illnesses like malaria fever etc. are often documented within the out-patient registers.

Standard Precautions for Infection Control

This section looks at the availability of simple but basic requirements for infection control/prevention.

Below: Files and documents eaten by termites at Igu Health Post Bwari, FCT

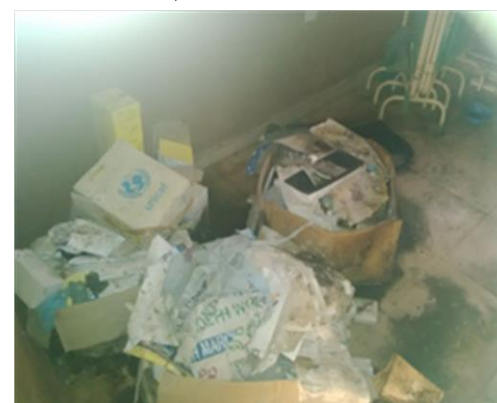
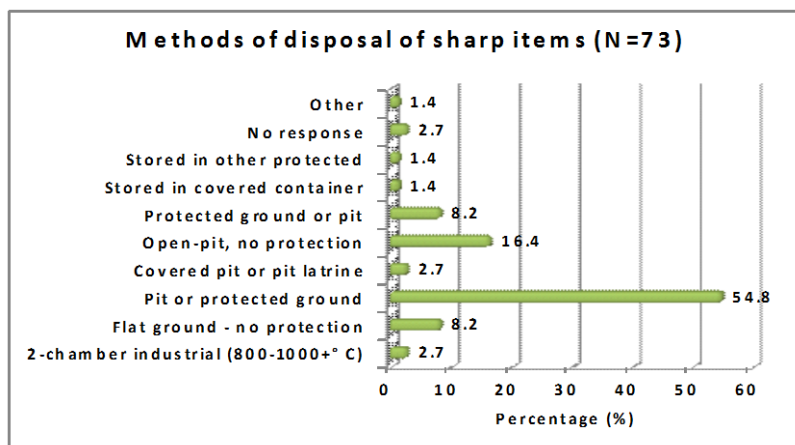


Table10: Infection control across the supported sites

Equipment	Yes N (%)	No N (%)	No response N (%)
Wash-hand basins	66 (90.4)	6 (8.2)	1 (1.4)
Soap	57 (78.1)	14 (19.2)	2 (2.7)
Environmental disinfectant such as bleach or alcohol available today in this facility	49 (67.1)	24 (32.9)	0 (0.0)
Protective shoes	33 (45.2)	40 (54.8)	0 (0.0)
Latex gloves	49 (67.1)	24 (32.9)	0 (0.0)
Medical masks	24 (32.9)	49 (67.1)	0 (0.0)
Needles and syringes	59 (80.0)	11 (15.1)	3 (4.1)
Sharp boxes for disposal of used needle and syringes	68 (93.2)	5 (6.8)	0 (0.0)
Waste disposal bins of the right colours	17 (23.3)	20 (27.4)	36 (49.3)

Across all supported facilities, hand-washing seems the most popular infection prevention practice in place as 66 facilities have the process in place. Furthermore, less than half of the facilities had disinfectants, protective shoes, latex gloves, medical masks and waste disposal bins of the right colours (49, 33, 49, 24 and 17 respectively). Although a larger proportion disposes sharp items inside pits/protected grounds (54.8%), 16.4% still use open pit without protection (*Figure 4 below*).

Figure 5: Method of disposing sharp items



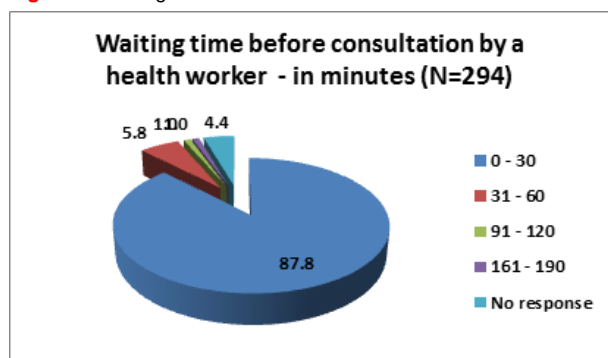
Other Service Delivery Issues: Client Perspective and Community Involvement

Clients' Perspective

Waiting time

This section addresses the perception of clients regarding the quality of services received from the facilities across all the CAID-supported States.

Figure 6: Waiting time



Across the supported communities 88% reported waiting for between zero and 30 minutes before seeing a health-worker for consultation. (*Please see table 11 below for state-specific information*). Although, the average waiting time at a PHC is not supposed to be more than 1 hour²⁴, the very low waiting time observed may be due to the fact that fewer people now visit facilities due to cost issues, poor state of most facilities, lack of adequate manpower, etc.

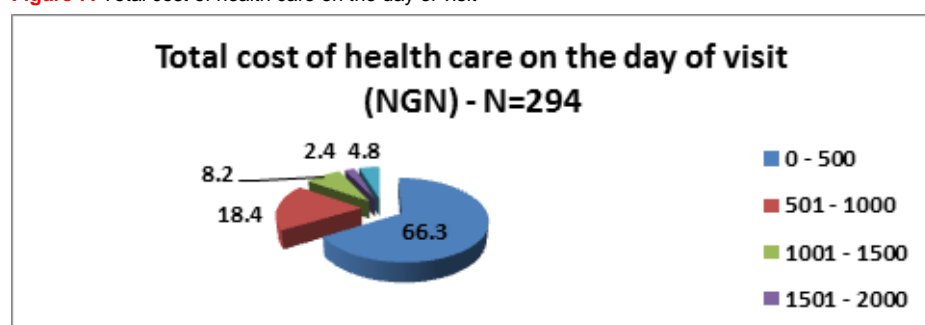
Table 11: Waiting time by State

State	Waiting Time				
	0 – 30 minutes	31 – 60 minutes	91 – 120 minutes	161 – 190 minutes	No response
	N (%)	N (%)	N (%)	N (%)	N (%)
Anambra	34 (94.4)	1 (2.8)	0 (0.0)	0 (0.0)	1 (2.8)
Benue	68 (89.5)	2 (2.6)	1 (1.3)	3 (3.9)	2 (2.6)
Kaduna	80 (92.0)	1 (1.1)	1 (1.1)	0 (0.0)	5 (5.7)
Plateau	45 (81.8)	8 (14.5)	1 (1.8)	0 (0.0)	1 (1.8)
FCT	31 (77.5)	5 (12.5)	0 (0.0)	0 (0.0)	4 (10.0)

Cost of care (NGN)

This section shows the total cost (NGN) of receiving care across all the facilities on the last day of visit. This cost includes registration, drugs and transportation costs.

Figure 7: Total cost of health care on the day of visit



Across all the supported facilities, the total amount expended on receiving care varies. However, majority of the respondents (66.3%) reported spending not more than NGN 500 before receiving care on the last day of visit. (*Please see table 12 below for state-specific information*).

Table 12: Cost of care (by state)

Cost of care (NGN)					
State	0 – 500 N (%)	501 – 1000 N (%)	1001 – 1500 N (%)	1501 – 2000 N (%)	2001+ N (%)
Anambra	23 (63.9)	9 (25.0)	3 (8.3)	0 (0.0)	1 (2.8)
Benue	55 (72.4)	11 (14.5)	8 (10.5)	1 (1.3)	1 (1.3)
Kaduna	70 (80.5)	12 (13.8)	4 (4.6)	1 (1.1)	0 (0.0)
Plateau	31 (56.4)	10 (18.2)	4 (7.3)	4 (7.3)	6 (10.9)
FCT	16 (40.0)	12 (30.0)	5 (12.5)	1 (2.5)	6 (15.0)

Perception of Service Delivery

This section looks at how clients see the disposition of health workers towards them at their last visit. Responses received, though varying, are encouraging.

Table 13: Perception of service delivery

Perception of service delivery	N=294		
	Agree N (%)	Disagree N (%)	No Response N (%)
Health workers are courteous and respectful	280(95.2)	12 (4.1)	2(0.7)
Health workers explained the condition of clients'	284 (96.6)	8 (2.7)	2 (0.7)
Waiting time to be seen by a health provider is reasonable	251 (85.4)	35 (11.9)	8(2.7)
Had enough privacy during visit	259 (88.1)	29 (9.9)	6(2.0)
Health workers spent sufficient amount of time	279 (94.9)	6 (2.0)	9(3.1)
Opening hours meet the clients' needs	225 (76.5)	62(21.1)	7(2.4)
Health workers are thorough and careful	278(94.6)	12 (4.1)	4(1.4)
Health workers care about clients' health	277 (94.2)	7(2.4)	10(3.4)
Trust in skills and abilities of health workers	275 (93.5)	16(5.4)	3(1.0)
Health workers are friendly and approachable	119 (40.5)	161(54.8)	14(4.8)

Across all facilities, responses received about the health workers were quite encouraging. Of the 294 clients interviewed, 280 agreed that health workers were courteous and respectful, 279 were of the opinion that they were accorded sufficient length of time during consultation and care. Furthermore, 277 of the clients reported that health workers were thorough and careful. However, it is noteworthy to mention that most of the respondents (161) did not agree that respectful health workers could also be friendly. Summarily, respondents generally see health workers across the PHCs as welcoming and that they would like to visit them again. *(Please see appendix table 9 for state-specific figures)*

Community Involvement

In-order to have an understanding of how the LGAs relate with the communities, 17 LGA HODs (health) out of 20 were interviewed. Findings from these respondents showed that each supported State (communities) have at least 1 CDC. According to the table below, Kaduna State (1) have the least number of CDCs while the highest number of CDCs was found in Benue State (8) *(Please see table 24 below for details)*.

In addition, 14 LGAs participate in the identified CDC meetings: 6 LGAs in Benue State, 4 in Plateau State, 2 in Anambra State, 1 in Kaduna State and 1 municipal council in the FCT¹. Furthermore, across these CAID supported sites, CDCs from only 9 LGAs (Anambra-2, Benue-5, Kaduna-1, and Plateau-4) participate actively in community outreach services organized by facilities domiciled in their respective communities. Also, across the supported communities, CDCs in 9 LGAs (Anambra-1, Benue-3, Plateau-4 and the FCT-2) contribute towards outreach activities being conducted within their communities by their respective LGAs.

As a means of feedback, most LGAs have a mechanism of communicating challenges, success stories etc. to the State from the communities and vice versa. In addition, 2 LGAs in Anambra, 6 in Benue, 1 in Kaduna, 4 in Plateau and 1 in the FCT do provide feedbacks to the concerned communities mostly through monthly review meetings at the LGA secretariat where officers of the various CDCs are invited to for feedback.

¹ In Abuja Area Councils are used instead of LGAs

Emerging issues

Infrastructure and Human Resource capacities

Infrastructure

Overall, the facilities assessed were in fair condition with 28 (38.4%) requiring major renovation. Only one-third of the facilities have accommodation facilities for staff which can be an issue for effective 24 hour service delivery.

There are challenges with power supply with only 28 (38.4%) connected to the power grid. Others utilize alternate power sources such as solar power 6(8.2%) and generators which incur additional operational expenses. There is minimal provision for emergency transportation. Only 8 (11%) of facilities have provision for emergency transportation such as ambulances, cars and motor bikes. Only 3 (4.1%) facilities in total have ambulances.

Human Resources

Inadequate human resource is a critical and cross-cutting challenge. CHEWs and JCHEWs are the most available cadre of staff overall except in one state (Anambra). There is a limit to the range of services that this cadre is authorized to provide.

There is a shortage of pharmacists/pharmacy technicians – none were available in 3 states (Anambra, Benue and Kaduna). Environment health officers were also absent in three states (Anambra, Benue and FCT) making them the second most unavailable cadre of health workers.

Training focus has been in the areas of family planning, ANC, HIV/PMTCT, malaria and child services (immunization and infant feeding). Clear gaps in capacity building are in the areas of healthcare waste management, TB and opportunistic infections management, and non-communicable diseases especially diabetes.

Status of Available Services

Across the assessed facilities, the most widely available services were found to include: malaria (91.8%), child services like nutrition, diarrhoea, upper respiratory tract infections etc.) at 87.7% and new-born care (78.1%). However, the least available services include youth friendly (35.6%) and TB (23.3%) services respectively.

More often than not, laboratory services are not available on-site. In some instances, when they are not available on-site, facilities find it difficult to access these services off-site. Examples of laboratory services in this category include CD4 count tests and ZN smears – though Mantoux tests are accessible in most facilities off-site. The tests that are predominantly available overall are those that utilize rapid test kits.

Outreach services are not common, only 11 (15.1%) of the facilities assessed offered these services. Furthermore, the level of support provided by special programmes and initiatives like the DRF, MSS, SURE-P, CHIS, etc. are low generally, although some states appear to have more presence of these programmes than others e.g. DRF is present in more than half (64.4%) of facilities in Kaduna State, Free MCH is also operative in most (52.1%) of facilities in Benue State. while the MSS is present in less than half (40%) of the facilities visited in the FCT – possibly due to their proximity to the NPHCDA.

Utilization and Service Delivery

Across the States, there has been a steady increase in utilization across all service lines in the last 4 years (2011-2014). Most widely used services at this level of care are immunization, out-patient, child services, ANC and family planning. Delivery and post-natal services reflect relatively low utilization. For delivery services, this may be attributable to the low availability of staff (nurses and midwives) at these facilities.

Commodity stock-outs are still common with about half (46.6%) of the facilities having experienced stock-outs in the month prior to the assessment. Most of the basic drugs are generally not available and this includes basic commodities like analgesics (like PCM), vitamin tablets (like vitamin C tablets, folic acid, vitamin A) and syrup, antibacterial drugs and ointments (like amoxicillin and penicillin ointment respectively), antiseptics and disinfectants (Izal, Purit, methylated spirit, iodine, etc.) and family planning commodities especially injectibles. Stock-outs (within the timeframe) were particularly high in Anambra (90%) – this may feed into the strikingly low utilization of family planning services.

Facilities generally have basic components for injection control (water, soap, gloves, and sharp disposal boxes). Areas for improvement include appropriate waste disposal, protective gear (masks, protective shoes) and colour-coded disposal bins.

Other Service Delivery Issues: Client Perspective and Community Involvement

Majority of the clients (87.8%) indicate a waiting time of between 0-30mins for a consultation with the health care worker. The overall perception of quality of service delivery and the health workers was positive across board.

Most LGAs have active community development committees (CDCs) at the LGA level though not necessarily at the ward level. Despite their presence however, there is no structured feedback mechanism between these community committees and the health facilities.

Recommendations

Infrastructure and Human Resource capacities

Create a hub and spoke model for service delivery among supported facilities. Based on infrastructure and staff availability, certain facilities should be designated for basic out-patient services while others designated (supported and staffed) to provide 24 hour MCH services. This will ensure compliance to NPHCDA and other clinical standards governing service delivery.

To support the hub and spoke model, emergency transportation services must be functional, available to and sufficient for facilities within defined catchment areas. These services must be well structured to include a formal referral network and implementation support.

Appropriate task-shifting should be encouraged for health workers in line with the new task-shifting policy guidelines to expand the scope of services the lower level of staff can safely and appropriately deliver.

Community volunteers can also be engaged and trained to support service delivery at the facilities as appropriate. These trainings can be in areas such as basic life-saving skills, counseling services, medical records, etc. This will relieve the shortage of staff in the interim. Community structures can provide token stipends and non-monetary incentives for these volunteers. Health care waste management and infection control must be strengthened at this level of care.

Status of Available Services

Capacity to conduct basic investigations should be strengthened with the use of rapid test kits where available and appropriate. This should include approved kits with high sensitivity and specificity. Also, new innovative approaches and technologies such as blood grouping test kits and MCH combo test kits which combine multiple tests (hepatitis, syphilis and blood group required for ANC) should be explored.

Appropriate national and state-level structures and agencies should be engaged to improve programme coverage. These structures include SURE-P, MSS, NHIS and other initiatives.

Utilization and Service Delivery

Commodity logistics need to be strengthened. Appropriate government structures need to be engaged in this regard.

Innovative approaches can also be explored in the different LGAs such as community-driven drug revolving funds and structured partnerships with local pharmacies/PPMVs to ensure affordable and regular availability of commodities at the PHC point.

Other Service Delivery Issues: Client Perspective and Community Involvement

Community structures need to be strengthened to implement structured supervision and feedback mechanisms for health in their various wards. Training (clinical and non-clinical issues) should be provided for all cadres of staff across all the PHCs as it appears that they are often left out in training matters.

Conclusion

The service utilization of all the facilities assessed increased over the years (from 2011-2014). The health worker/population ratio of some facilities does not meet the NPHCDA standard which should be taken into consideration. With respect to the availability of functional equipment, some facilities do not have the basic equipment required for a PHC according to the NPHCDA minimum standard. This is so because some health workers have resorted to using unskilled hands to help them cope with the clients' surge.

Most of the staff across the assessed facilities are not IT savvy which makes it difficult to install and use the HMIS software. This component helps in the storage of monthly data which will be submitted to the state and LGA. In the NPHCDA minimum requirement for a PHC, it was stated that a PHC must have at least one computer for both storage of data and online communication.

Only few of the facilities assessed have a structured referral system which is a source of concern. Serious attention is required in the aspect of training of staff because training enhances the effectiveness, efficiency and productivity of the staff. More than 50% of the facilities assessed do not offer TB and youth friendly services which key to the realization of the goals of primary health care.

Most of the facilities visited reported being disconnected from the health system. Some of the health workers interviewed complained of poor or non-available supportive supervision since being posted out while others complained to have worked for more than 10 years in the same facility without assistant(s). One health worker, as a result of overwork, decided to engage his wife as his assistant in the facility. There is serious need to address issues of staff shortages, rotation, motivation and remuneration especially as it affects those in hard-to-reach rural communities.

Most facilities are in a state of serious disrepair and neglect. The effect of rain and excessive sunshine are visible across most of the facilities which makes it difficult to keep records as most are often damaged by water while those not damaged by water have been misplaced-some health workers do go home with facility records for fear of being damaged by rain. For effective record keeping, the structures of affected facilities should be repaired together with all damaged record cabinets.

Accommodation in line with the NPHCDA directives should be put in place to enhance 24-hour service availability, staff motivation and improve health workers' dignity especially the rural staff.

Water and sanitation should be given adequate attention as most of the facilities lack adequate and dignified toilet facilities, some even do not have. To maintain a healthy and hygienic environment, water issues need to be tackled in addition to availability of power (connection to the national grid and the alternative sources).

With respect to patient satisfaction, only few of the clients interviewed agreed to the fact that the health workers are friendly and approachable. This is a source of concern because the attitude of the health workers will have an effect on the uptake of services in the health facilities

In all most of these facilities require serious attention for them to be able to provide the required basic services in line with the requirements of the NPHCDA for PHCs to their various catchment areas.

Appendix

Below: Breakdown of assessed facilities (by State, LGA)

State	Local Government Area (LGA) (19)	Health Facilities (73)
Anambra	Orumba North	PHC Awa
		PHC, Obinagu Ndiowu
		PHC, Ubaha Ndiowu
	Aguata	Model PHC, Nkpologwu
		Model PHC, Ora-eri
		Model PHC, Umuoru Uga
		Model PHC, Awalasi Uga
		Model PHC, Oye Achina
		Model PHC, Ebele Achina
Kaduna	Kajuru	PHC, K/Magani
		PHC, Kallah
		HC, Dan-Bagudu
		PHC, M/Kajuru
		PHC Kufana
		HC, Idon-Gida
		PHC, Afogo
		HC, Doka
		HC, Iburu
		PHC, Idon
		HC, Gefe
		HC, D/Gaiya
		HC, Ung.Pada
		HC, Rafin Kunu
		HC, S/Gari Afogo
		HC, Iri Gari
		HC, Iberah
		HC, Iri Station
		HC, Kurmin Idon
		HC, Libere
HC, Idu		
HC, Ang. Aku		
Benue	Otukpo	PHC, Olakpoga
		PHC, Umogidi
	Agatu	PHC, Egba
		PHC, Edeje
		PHC, Aila
	Apa	PHC, Adagbo
		PHC, Ojuwo-Ojekele
	Vandeikya	PHC, Ofoke
		PHC, Ageva
	Tarka	PHC, Tyemimongo
		Leemp (PHC) Uyorako
		Family Support Program
	Kwande	Atso Health Care Center
		Upev Health Clinic
	Oju	Primary Health Care Kohol
		PHC, Obusa
		PHC, Ucho

State	Local Government Area (LGA) (19)	Health Facilities (73)
Plateau	Logo	PHC, Okpoma
		PHC, Kyoogh
	Langtang South	PHC, Nagane
		PHC, Gamakai
		PHC, Talgwang
		PHC, Mabudi
		PHC, Baltep
	Mikang	PHC, Lalin
		PHC, Din
	Riyom	PHC, Danto
	Jos East	PHC, Sabon Fobur
	Kanke	PHC, Shiwer
		PHC, Amper
	Barakin Ladi	PHC, Gashet
PHC, Rabuwak		
FCT	Kuje Area Council	PHC, Gaube
		PHC, Pegi
		PHC, Sundaba
		PHC, Gbaupe
	Bwari Area Council	PHC, Gaba
		PHC, Bwari
		PHC, Zhiko
		PHC, Igu
		PHC, Ushafa
		PHC, Barangoni

The State Level Reports can be accessed on the links below:

<http://www.christianaid.org.uk/Images/PHC-Assessment-Anambra-Sept-2015.pdf>

<http://www.christianaid.org.uk/Images/PHC-Assessment-Benue-Sept-2015.pdf>

<http://www.christianaid.org.uk/Images/PHC-Assessment-FCT-Sept-2015.pdf>

<http://www.christianaid.org.uk/Images/PHC-Assessment-Kaduna-Sept-2015.pdf>

<http://www.christianaid.org.uk/Images/PHC-Assessment-Plateau-Sept-2015.pdf>

This report summarizes the findings of the Assessment of Primary Healthcare Centres in selected states Nigeria located in Christian Aid Supported Communities in Anambra, Benue, Kaduna, Plateau States and the Federal Capital Territory (FCT) with financial and technical assistance from Christian Aid Nigeria Country Programme. The opinions expressed in this report are those of the authors and contributors and do not necessarily reflect the views of Christian Aid. Christian Aid is not liable for damages arising from interpretations and use of this material by a reader.

End notes

- ¹ Primary Health Care In Nigeria: Strategies and Constraints in Implementation (2014) (www.ajol.info/index.php/ijcr/article/download/107665/97532)
- ² National Strategic Health Development Plan – NSHDP (2010-2015)
- ³ Assessments were not conducted in AMAC (including the 2 PHCs within the council-PHCs Gui and Orozo1) due to the delay in approval to conduct assessments. 2 other facilities were added in Benue State (PHC, Umogidi and PHC, Ojuwo-Ojekele)
- ⁴ These 2 State interviews include only Anambra and Plateau States.
- ⁵ This is with the exception of the HODs Health in Kuje Area and Abuja Municipal Area Councils (KMC and AMAC respectively).
- ⁶ This excludes facilities in AMAC.
- ⁷ The catchment populations of 9 facilities were not available.
- ⁸ <http://www.kh.undp.org/content/cambodia/en/home/mdgoverview/>
- ⁹ National Strategic Health Development Plan – NSHDP (2010-2015)
- ¹⁰ World Health Organization. Primary health care. Health for all monograph No 1. Geneva. 1978.
- ¹¹ Primary Health Care In Nigeria: Strategies and Constraints in Implementation (2014) (www.ajol.info/index.php/ijcr/article/download/107665/97532)
- ¹² National Strategic Health Development Plan – NSHDP (2010-2015)
- ¹³ A project which incorporates all the elements of Christian Aid Nigeria's health work, using an integrated approach to deliver community health and HIV responses through trained community-based agents
- ¹⁴ A malaria prevention project funded by Episcopal Relief and Development (ERD) and implemented in the Federal Capital Territory, Plateau, Benue and Anambra states
- ¹⁵ A programme that supports communities in Anambra, southeastern Nigeria to hold state and local government and their leaders to account, take part in the decision-making that affects their lives and raise their voices to demand the rights and services to which they are entitled.
- ¹⁶ A project that aims at building on the malaria prevention work already carried out in communities and trial community access to rapid diagnostic testing and World Health Organization-recommended treatments.
- ¹⁷ A project designed to strengthen support services and livelihoods for people living with HIV and their families. Funded by Comic Relief, it also advocates for laws and policies that address stigma, denial and discrimination.
- ¹⁸ Assessments were not conducted in AMAC (including the 2 PHCs within the council-PHCs Gui and Orozo1) due to the delay in approval to conduct assessments. 2 other facilities were added in Benue State (PHC, Umogidi and PHC, Ojuwo-Ojekele)
- ¹⁹ These 2 State interviews include only Anambra and Plateau States.
- ²⁰ This is with the exception of the HODs Health in Kuje Area and Abuja Municipal Area Councils (KMC and AMAC respectively).
- ²¹ This excludes facilities in AMAC.
- ²² The catchment populations of 9 facilities were not available.
- ²³ These services include simple RDT for pregnancy, HIV and malaria with few offering blood glucose tests.
- ²⁴ <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/primarycarehpsacriteria.html>

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