Primary Health Care in Nigeria

A Case Study of Kano State

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PRIMARY HEALTH CARE IN NIGERIA: A CASE STUDY OF KANO STATE

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BCG	Bacillus Calmette-Guérin (Vaccine)
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
CHEWs	Community Health Extension Workers
CRF	Consolidated Revenue Fund
GAVI	Global Alliance for Vaccines and Immunizations
IDA	International Development Association
MDAs	Ministries Departments and Agencies
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
NCH	National Council on Health
NDHS	National Demographic Health Survey
NERICC	National Emergency Routine Immunization Coordination Centre
NPHCDA	National Primary Health Care Development Agency
PHCs	Primary Health Care Centres
JCHEWs	Junior Community Health Extension Workers
RI	Routine Immunisation
TSA	Treasury Single Account
UHC	Universal Health Coverage
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organization

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1.0 Executive Summary

According to the WHO[1], primary healthcare is the most efficient and cost-effective approach to achieve Universal Health Coverage. Primary health care is an integrated and people-centred approach to health and wellbeing that starts with individuals, families and communities. It is the foundation of health systems providing health care to people and ensuring that they receive quality health care whenever they need it.

Despite some progress recorded, the Nigerian health system is still faced with several challenges resulting in poor health indices. The 2018[2] National Demographic Health Survey recorded a maternal mortality ratio of 512 deaths per 100,000 live births, this means that approximately 5 out of 1,000 women die during pregnancy, childbirth or within 42 days after childbirth from causes related to or made worse by childbirth. The report also estimated an infant mortality rate of 67 deaths per 1,000 live births, neonatal mortality rate at 39 deaths per 1,000 live births and under-5 mortality rate at 132 deaths per 1,000 live births. To put this into context, this translates into more than 1 in 8 children in Nigeria die before their 5th birthday.

In addition, the primary health care system in Nigeria is faced with barely functional facilities, with insufficient human resources, regular commodity stock outs, essential medicines not always available, poor power and water supply, inadequate availability of diagnostic equipment and general poor standard of care[3]. The lack of confidence in the health system has led to poor demand for health care services and has not helped improve the health indices in the country.

Changing the current situation requires strengthening the health system, especially at the primary health care level through the provision of adequate and sustainable funding, improvement in the quality of

1 WHO 2019: Universal Health Coverage Key facts (Retrieved from *https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)* on Nov. 21 2019)

2 National Demographic Health Survey report 2018

3 Aregbeshola, B. S., & Khan, S. M. (2017). Primary Health Care in Nigeria: 24 Years after Olikoye Ransome-Kuti's Leadership. Frontiers in public health, 5, 48. doi:10.3389/fpubh.2017.00048

women die during pregnancy, childbirth or within 42 days after childbirth from causes related to or made worse by childbirth

services delivered, availability of the right mix and competence in human resources and most important, community ownership and involvement to instill transparency and accountability in the health system.

In order to advocate for improvements and greater accountability in the primary health care system in Nigeria, there is a need to define the ideal service provisions in primary healthcare centres in Nigeria and map out the current status of primary health care as it relates to this ideal.

With a wide and complex range of initiatives – including policy improvements, new sources of funding channels, fragmented deployment of funding and other interventions to strengthen primary health care structures, processes and outcomes, it is difficult to get a clear picture of the current state of primary health care sector across the country. Nigeria has a complex political structure with its federal system of government and there has been a great diversity in funders, providers and the clients – across the public and private sectors. As much as this provides an opportunity for a variety of approaches, it also poses the challenge of keeping track of what is going on in primary health care across the country. Currently, there are quite a number of initiatives in the public, private and not-for-profit sectors aimed at improving primary health care. The complexity in primary health care provision in Nigeria makes accountability and advocacy particularly difficult as stakeholders are not always aligned in their activities, priorities and objectives.

This report lays out the issues faced in the Nigerian primary health care sector, outlining the relevant stakeholder which include institutions, funding sources and influencers in primary care in Nigeria. The report maps out the stakeholders and proposed and targeted and effective advocacy agenda for primary health care in Nigeria.

In order to show primary health care provision at the state level, this report will look at primary health care service provision in Kano State as a case study, evaluating whether the state's primary health care provision is in line with the minimum standards of primary health care as outlined by the Ministry of Health. This will help focus attention on the areas in primary health care that advocacy is needed and ensure there is accountability in primary health care service provision.

2.0 Key Health Indicators

There are many data sources that provide details of health indicators in Nigeria. These include the National Demographic and Health Survey (NDHS) , the District Health Information System (DHIS), United Nations Children's Emergency Fund (UNICEF) Standardised Monitoring and Assessment of Relief and Transitions (SMART) nutrition Survey, Multiple Indicator Cluster Survey (MICS) , Lot Quality Assurance Survey and data from the Institute for Health Metrics and Evaluation (IHME) . All these surveys differ in methodology used to calculate the health indicators and provides details on how the country is performing across different health indicators that have a direct impact on primary health care.

Figures 1-6 show a trend analysis of some of the indicators from the National Demographic Health Survey, focused on services delivered at the Primary Healthcare Centres (PHCs). It is important to get a view on how Nigeria is performing across these key health indices as it focuses the attention on the critical importance of strengthening primary health care in saving lives.

2.1 Trends in Critical Primary Health Care Indicators

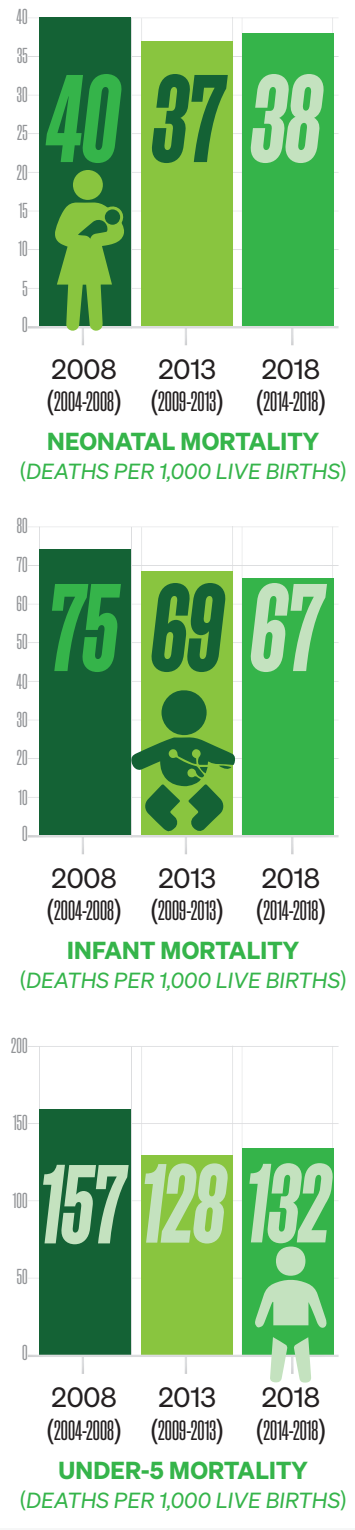
We have chosen five key indicators to reflect the performance of primary health care provision in Nigeria. These five indicators are a reflection of health status that can be achieved through the provision of care mostly at the primary health care level. They include:

a. Child mortality
b. Maternal health
c. Nutritional status
d. Sexual and reproductive health
e. Vaccination coverage
f. Malaria

2.1.1 Child mortality

Nigeria continues to account for one of the highest infant deaths per 1,000 live births in the world. The current target for Sustainable Development Goal (SDG) 3 is for a reduction in under-five mortality to no more than 25 per 1,000 live births by 2030. Nigeria still has to make significant progress in improving outcomes for under-fives.

Figure 1: Trends in Childhood Mortality



SOURCE: NDHS 2008, 2013 AND 2018 REPORTS

$1.5bn *Amount Nigeria loses annually in productivity, to maternal mortality according to the UN Population Fund*

For childhood mortality indicators measured for deaths per 1,000 live births, neonatal mortality was 40, 37 and 38 deaths in 2008, 2013 and 2018 respectively. In the same vein, infant mortality was 75, 69 and 67 deaths per 1,000 live births in 2008, 2013 and 2018 respectively. Under-five mortality decreased from 157 deaths per 1,000 live births in 2008 to 128 deaths in 2013 and then increased to 132 deaths in 2018. Critical to the goal of reducing infant mortality rates is the need to strengthen the provision of primary health care facilities.

2.1.2 Maternal health

Access to antenatal care is improving, but improvement is slow. The 2008, 2013 and 2018 NDHS reports showed that 58%, 61% and 67% of women age 15-49 years received antenatal care by a skilled provider during a live birth, while 35%, 36% and 39% of births were delivered in a health facility, in 2008, 2013 and 2018 reports respectively.

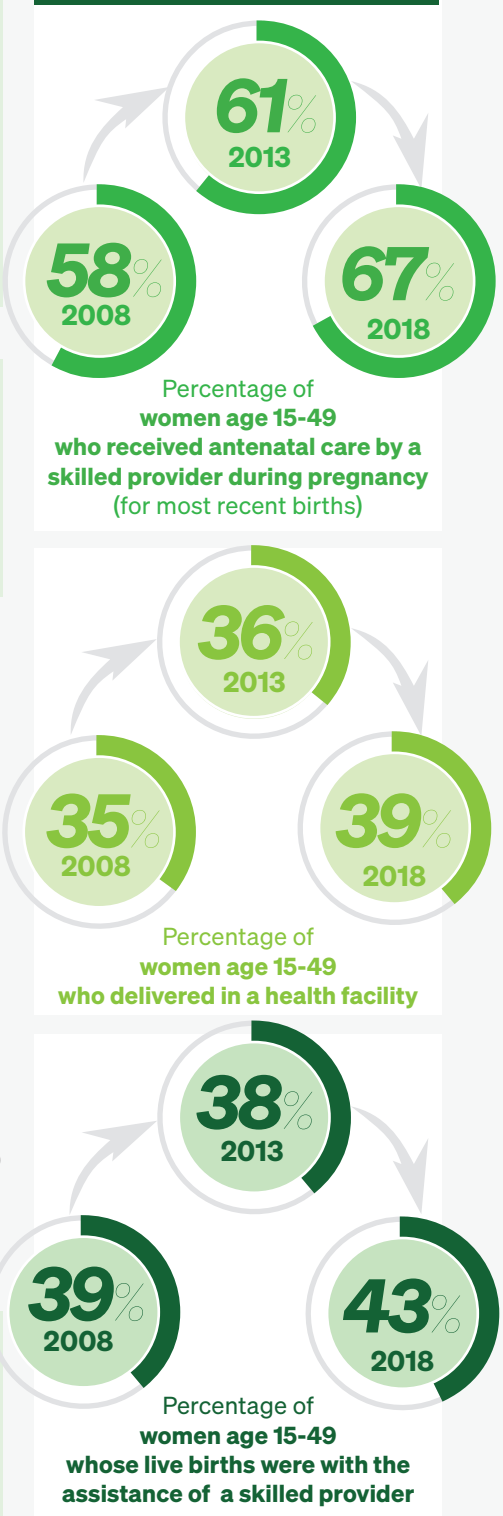
Just over two-fifths of women are giving birth with the aid of a skilled health professional, for the remaining three-fifths, their births would be in their communities with the aid of a Traditional Birth Attendant (TBA), or in some cases, women give birth alone. The availability of skilled workers at health facilities has the potential to significantly reduce the number of women that die during childbirth.

According to the UN Population Fund, Nigeria loses about $1.5bn in productivity to maternal mortality annually. Despite efforts in advocacy and implementation of programs towards reducing preventable maternal mortality, the most vulnerable women and children in Nigeria are continuously faced with great barriers to accessing quality health care on time. Remote communities lack adequate medical resources, health workers and infrastructure to meet women and children at the points of need pre-pregnancy, during pregnancy and post-pregnancy.

2.1.3 Nutritional status

The nutritional status of Nigerian children is not improving. The percentage of stunted children decreased from 41% in 2008 to 37% in 2013, but remained unchanged in 2018. For the percentage of children wasting, it increased from 14% in 2008 to 18% in 2013, and decreased to 7% in 2018. The percentage of overweight

Figure 2: Trends in Maternal Health Care



SOURCE: NDHS 2008, 2013 AND 2018 REPORTS

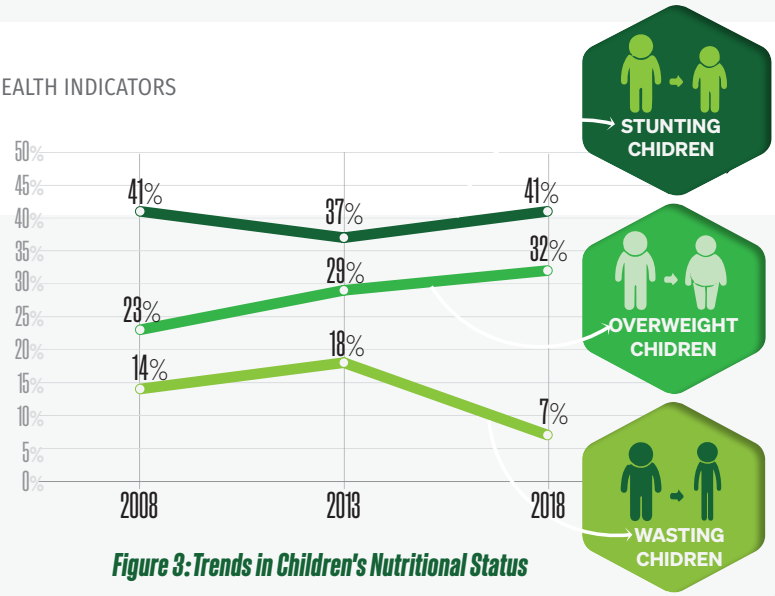


Figure 3: Trends in Children's Nutritional Status

children increased from 23% in 2008 to 29% in 2013, and back to 23% in 2018.

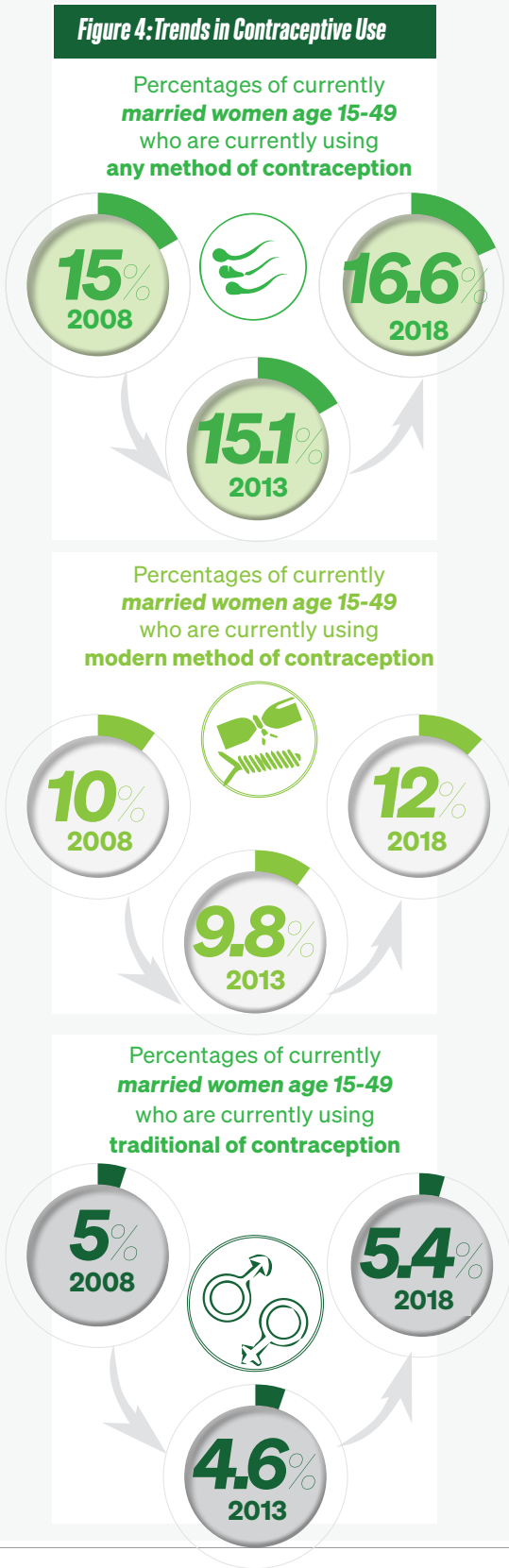
Nigeria is faced with the double burden of malnutrition, underweight and overweight and obese children. Many interventions have been put in place to address the issues around malnutrition, from Community Management of Acute Malnutrition (CMAM) sites to interventions that involve the fortification of food items with Vitamin A. Advocacy efforts need to be strengthened for pregnant women to have access to nutritious foods and once they give birth, support in breastfeeding.

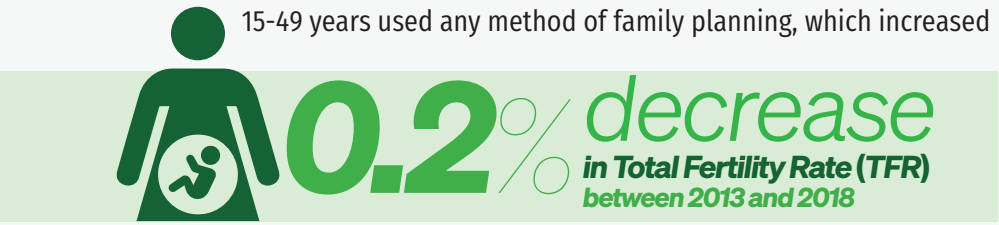
2.1.4 Sexual and Reproductive Health

Nigeria has committed to increasing the modern contraceptive prevalence rate (mCPR) to 27% for all women, as part of the country's Family Planning 2020 commitment. Evidence of marginal progress can be seen in the decreased total fertility rate (TFR) from 5.5 births per woman according to the 2013 Nigeria Demographic and Health Survey (NDHS) to 5.3 births per woman in 2018.

Further progress can be seen in the increased contraceptive prevalence rate (CPR) among married women from 15% to 17%, however regional differences has meant there are variances in the CPR across the geo-political zones in Nigeria. The country has experienced challenges pushing up the CPR, due to stock-outs and funding issues which have hampered access to contraceptives.

Figure 4 shows that in 2008, 15% of currently married women age 15-49 years used any method of family planning, which increased





marginally to 15.1% in 2013 and 16.6% in 2018.

Also, 10% of women age 15-49 years used a modern method of contraception in 2008 which decreased to 9.8% in 2013 and then increased to 12% in 2018. In 2008, 5% of women within the same age group use a traditional method of contraception, in 2013 there was a slight increase to 5.4% and a decrease to 4.6% in 2018.

Access to well functioning and well-stocked health facilities is critical in enabling Nigeria to meet contraceptive use target. Advocacy efforts therefore need to be targeted at ensuring that there is sustainable funding for reproductive health services and access to contraceptives meets the needs of the different user groups, from adolescents to older women at different life stages, approaching their fifties.

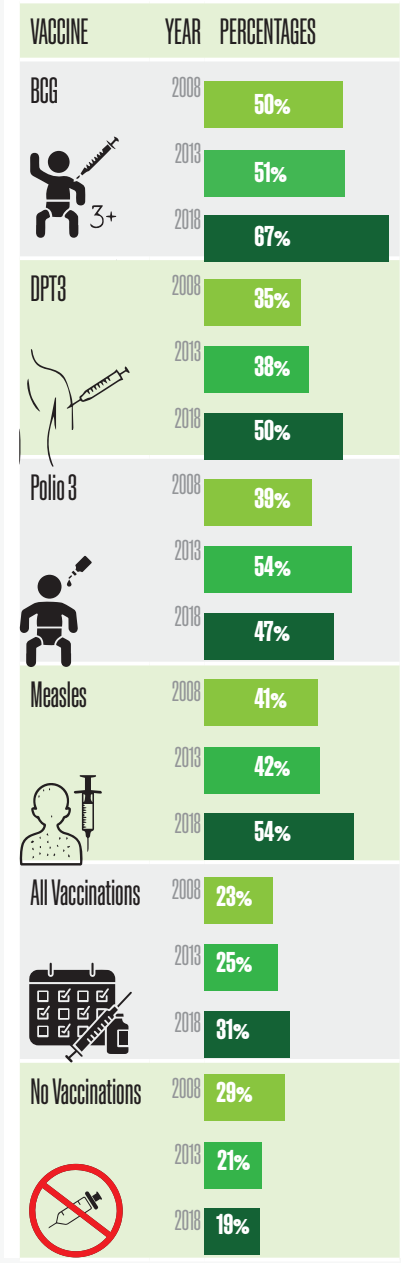
2.1.5 Vaccine Coverage

There has been a constant increase in coverage of vaccinations on the routine immunisation schedule from 2008 to 2018 except for Polio 3 where coverage was 39% in 2008, 54% in 2013 and 47% in 2018. Consequently, the percentage children that received all vaccines increased from 23% in 2008 to 31% in 2018, while the percentage of children who did not receive any vaccination decreased from 29% in 2008 to 19% in 2018.

Regional variations continue to exist for immunisation coverage and the country still has significant progress to make to achieve the 75% coverage for the effective control of all Vaccine Preventable Diseases. Continued progress in pushing up routine immunisation rates will require strengthening the primary health care system, improving access to vaccines as well as improving the cold chain and logistical infrastructure in Nigeria.

8% increase
in children that received all vaccines between 2013 and 2018

Figure 5: Trends in Vaccination Coverage



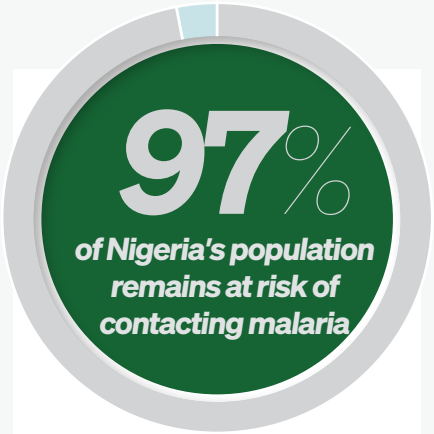
SOURCE: NDHS 2008, 2013 AND 2018 REPORTS

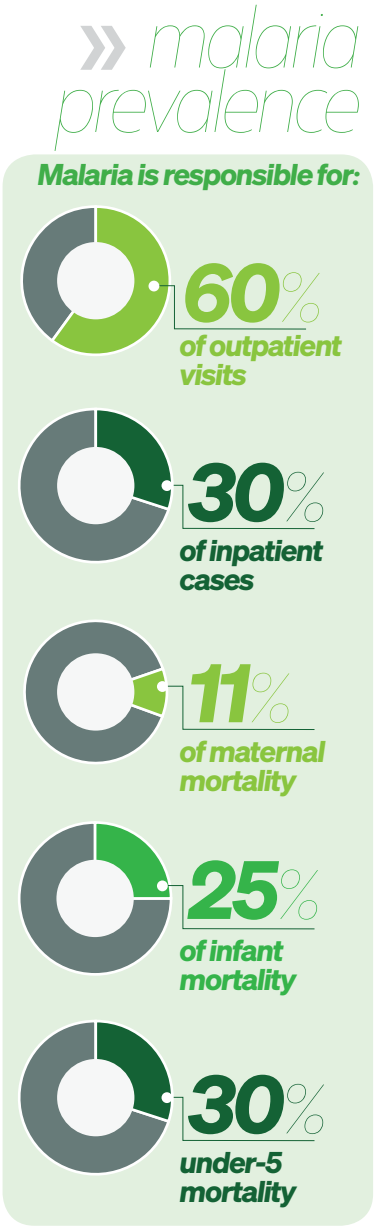
2.1.6 Malaria

Despite the improvement in malaria indicators from the Multiple Indicator Cluster Survey (MICS) report 2011 to 2016/2017 (as seen in Figure 6), malaria remains a severe public health problem in Nigeria.

Nigeria accounts for about 25 per cent of the malaria burden in Africa, representing the highest contribution to the global burden[1]. Malaria continues to bear the greatest toll on children under age 5 and pregnant women. In 2015, there were an estimated 100 million malaria cases with over 192,284 deaths recorded in Nigeria. Malaria remains a risk for 97% of Nigeria's population.

The prevalence[2] is greatest among children between the ages of 6-59 months in the South West, North West and North Central regions. It is responsible for approximately 60 per cent of outpatient visits and 30 per cent of inpatient cases. It is also believed to contribute up to 11 per cent of maternal mortality, 25 per cent of infant mortality, and 30 per cent of under-5 mortality. The root causes of high malaria prevalence include the unacceptable low usage of Long-Lasting Insecticides Treated Nets (LLINs), poor uptake of Intermittent Prevention Treatments in pregnancy (IPTp) and poor sanitation. Even though over 60 million LLINs have been distributed across the country, the main challenge remains getting individuals and communities to utilise the nets, as well as their distribution to those most at risk.





1 WHO: World Malaria Report, 2018 Retrieved from https://www.who.int/malaria/media/world-malaria-report-2018/en/ on Monday, 13 January, 2020

2 US Embassy: Nigeria Malaria Factsheet, 2011 Retrieved from https://photos.state.gov/libraries/nigeria/231771/Public/December-MalariaFactSheet2.pdf on Monday, 13 January, 2020

192,284 *approximate number of* ***recorded deaths from malaria prevalence*** *amongst children under age 5 and pregnant women in Nigeria in 2015*

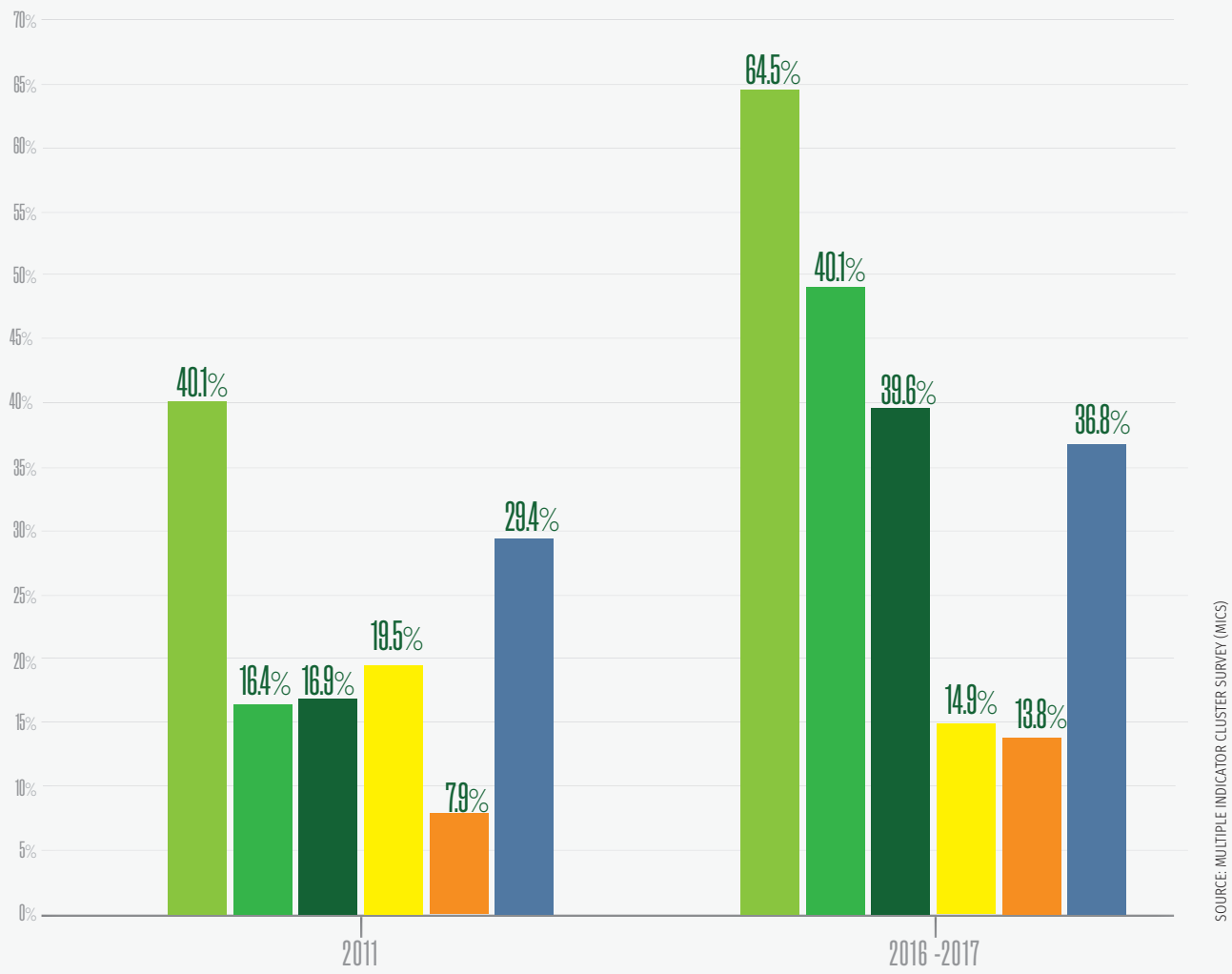


Figure 6: Trends in Malaria Indicators

LEGEND

- Household with at least on ITN
- SeriChildren under five who slept under an ITN the previous dayes 2
- Pregnant women who slept under an ITN the previous night
- Intermittent preventive treatment for malaria
- Malaria diagnostic usage
- Anti-malaria treatment for children under-5

3.0 Key Stakeholders in Primary Health Care

Nigeria operates a three-tier federal system of government comprising the federal government, state and local governments. The constitution of Nigeria[1] Constitution of the Federal Republic of Nigeria (1999) is silent and not clear on the functions and responsibilities of each tier of government in the provision and oversight of health care services. However, the National Health Policy prescribes a system in which primary health care is under the purview of local governments, while the state and federal governments are responsible for the management of secondary and tertiary health care services respectively[2]. However, this has never been fully operationalised and tertiary hospitals in Nigeria still manage a large patient load of cases that can easily be managed in primary health care centres. Referral pathways are generally underdeveloped.

The lack of clarity in the designation of responsibility for primary health care has resulted in the existence of diverse management structures with poorly defined roles and responsibilities between the three tiers of government, leading to poor coordination and insufficient accountability for the management of existing primary health care centres. The lack of clarity on where the responsibility for PHC lies, makes advocacy difficult. The impact on advocacy activities has been that it has not always been targeted at the relevant institutions, in the right tier of government who should be accountable when issues arise with service delivery, due to a lack of clarity on what the responsible institutions are.

Major stakeholders in primary health care delivery system include:

- ***people (communities)***
- ***government***
- ***health care workers***
- ***development partners***
- ***private sector***
- ***civil society organisations***

Stakeholders in primary health care in Nigeria can therefore be regarded as those entities integrally involved in the health care system and who would be substantially affected by reforms to the system. The major stakeholders in primary health care delivery system include the people (communities), the three tiers of government, health care workers, development partners, private sector, and civil society organisations.

3.1 Government

The Government in this context refers to all government Ministries, Departments and Agencies (MDAs) who have responsibilities in the delivery of primary health care services in Nigeria, including the federal and state Ministries of Health, Finance, Budget

1 Constitution of the Federal Republic of Nigeria (1999)
2 FMoH. Revised National Health Policy. Abuja: Federal Ministry of Health; 2004.

and National Planning, National and State Primary Health Care Development Agencies, National and State Health Insurance Agencies, the National and State Houses of Assemblies and Local Government Health Authorities.

The federal and state ministries of health and their parastatals establish the framework within which health care is provided to the country's citizens. In Nigeria, Primary Healthcare Centres in the public sector centres are all owned by state governments. The health care workers are employed by state governments and in some cases by local governments. Financing for primary health care comes from all the tiers of government through various funding streams. The National Primary Health Care Development Agency provides oversight and central procurement of some commodities such as vaccines, used in PHCs, while most of the other commodities are procured by the PHC through three funding mechanisms; 1) direct procurement and distribution from state governments (or development partners) 2) from user fees; 3) from health insurance capitation fees.

Government is also responsible for the aggregation of data from patients and providers to develop population-level metrics that measures progress and informs their health and health economic policies. In practical terms, it is paramount that the government arms mentioned above demonstrate commitment through adequate funding for the primary health care system through their different mechanisms.

One of the critical roles of government is promoting access to essential and quality health services across every level of care, especially at the primary health care level. This involves the building and maintenance of infrastructure, training and retraining of the workforce and provision of materials and equipment for effective health care service delivery.

3.2 Health Care Workers

Health care workers involved in primary health care delivery in Nigeria include doctors, nurses/midwives, community health extension workers (CHEWs)/JCHEWs, laboratory scientists/

Health care workers involved in primary health care delivery in Nigeria include

- ***doctors***
- ***nurses***
- ***midwives***
- ***Community Health Extension Workers (CHEWs)/JCHEWs***
- ***laboratory scientists***
- ***technicians***
- ***health assistants***
- ***and others***

technicians, and health assistants among others[1].

These health workforces are critical in providing quality health care service and ensuring patients' satisfaction. They are required to practice patient-centred care, which means providing the patient with care that is respective and responsive to their needs, informing them about the care they are receiving, putting their needs at the forefront of decision making about their care. The disposition of health care workers is very important in enhancing public perception and utilisation of primary health care services.

3.3 The People (Community)

The community has an ethical responsibility for their own health. Communities are critical stakeholders in the delivery of primary health care system in Nigeria. When communities are involved in the planning, implementation and evaluation of primary health care services, it promotes community ownership. Through community mobilisation, the people are spurred to take ownership and provide solutions to health issues that they face in their local communities. Community mobilisation is an approach for creating support for primary health care, especially in rural areas where a large proportion of the Nigerian population live, and the worst health indices are found. The key aspects of community mobilisation include community entry, community dialogue, and operation of development and health committees. The community is a critical stakeholder in formulating better informed advocacy as well as improving accountability in primary health care at the local and state level.

The mechanism for community involvement in primary health care delivery in Nigeria is mostly through the Ward Health Development Committee (WHDC). The WHDC draws its membership from all community areas in the Ward. Members include the traditional/ religious leaders, women and youth groups, professional

Membership of Ward Health Development Committee (WHDC) includes:

- ***traditional/religious leaders***
- ***women***
- ***youth groups***
- ***professional***
- ***professional associations***
- ***cooperative societies***
- ***other influential members of the ward***

1 A.O., Aigiremolen & I., Alenoghena & Eboreime, Ejemai & Chukwuyem, Abejegah. (2014). Primary Health Care in Nigeria: From Conceptualization to Implementation. Journal of Medical and Applied Biosciences. 6. 2277-54.

associations, cooperative societies, and other influential members of the ward. It would normally consist of representatives from each of the villages in the ward.

3.4 Development Partners

Some of the strategic donor/development partners involved in the delivery of primary health care services in Nigeria include GAVI, the Vaccine Alliance, Bill & Melinda Gates Foundation, UNICEF, UNDP, the Global Fund, World Health Organisation (WHO), Global Financing Facility and Save the Children. The list of development partners is not exhaustive, however, it is important to note that some of these development partners have specific areas of support. GAVI has invested significantly in supporting immunisation services[1] and strengthening health systems, the Bill & Melinda Gates Foundation has largely focused on the polio eradication effort, as well as supporting states in health system strengthening and nutrition[2]. UNICEF is a critical partner in the area of child nutrition and vaccine procurement, as well as maternal and child health.

3.5 The Private Sector

The private sector is a critical player in the health system in Nigeria. The Nigeria health system is characterized by a mix of public and private sector financing and delivery of care. At present over 75% of health care expenditure by Nigerian patients is out-of-pocket, with a large share of this being spent in the private sector. The 75% out-of-pocket is also not uniformly distributed, and it is likely to be a lot higher in the cities and in southern Nigeria. The private sector provides a mix of goods and services including direct provision of health services, medicines and medical products, financial products, training for the health workforce, information technology, infrastructure and support services (e.g. health facility management). More opportunities need to created for the private sector to play a larger role in building the capacity of the public sector, in order to

Strategic donor/development partners and their focal areas in the delivery of primary health care services in Nigeria

GAVI ALLIANCE
- **supporting immunisation services**
- **strengthening health systems**

BILL & MELINDA GATES FOUNDATION
- **polio eradication efforts**
- **health system strengthening**
- **supporting nutrition**

UNICEF
- **child nutrition**
- **vaccine procurement**
- **maternal and child health support**

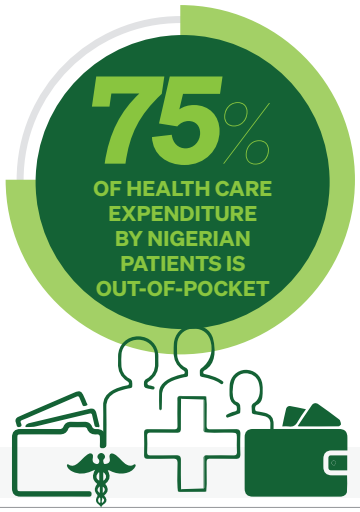
UNDP
- **addressing development challenges**

GLOBAL FUND
- **investments in reducing the number of deaths from AIDS, TB and malaria**

WORLD HEALTH ORGANISATION
- **improving access to quality essential services**
- **improve access to essential medicines and health products**

GLOBAL FINANCING FACILITY
- **improve reproductive, maternal, newborn, child, and adolescent health (RMNCAH) results**
- **ensure sustained investments for scaled-up RMNCAH services**

SAVE THE CHILDREN
- **strengthening health systems**
- **supporting maternal and child health**



1 GAVI support for Nigeria (Retrieved from https://www.gavi.org/country/nigeria/ on Thursday, 21 2019)

2 Gates Foundation support for Nigeria (Retrieved from https://www.gatesfoundation.org/Where-We-Work/Africa-Office/Focus-Countries/Nigeria on Thursday, 21 2019)

strengthen the primary health care in Nigeria through public-private partnerships (PPPs). Examples include the model being deployed by PharmAccess Foundation through the Medical Credit Fund (MCF). The fund enabled improved access to finance for selected facilities in Nigeria. The Medical Credit Fund, through its financial partners, enables low interest rates by providing partial guarantees and technical assistance to mitigate risks.

3.6 Civil Society Organisations

Civil society organizations (CSOs) are strategic in advocacy and raising public awareness for the effective delivery of primary health care services in the Nigerian health system. They are key institutions that facilitate communication between policymakers and are the voice representing the interest of the community. Advocacy by civil society organisations supports and often helps build the internal capacity of community based organisations. To strengthen advocacy efforts in primary health care, CSOs with common interests and aligned objectives have formed coalitions that have pushed for policy reforms in the health sector as well as driving increased transparency in the health policy making.

The 2014 National Health Bill was drafted by the CSO community and drove sustained advocacy till its assent by the President. Some CSOs in the Nigeria primary health care space include the following: Civil Society Legislative Advocacy Centre (CISLAC), Connected Development, Health Reform Foundation of Nigeria, Evidence for Action and Women Advocates for Vaccine Network.

Civil society organisations involved in advocacy and raising public awareness for the effective delivery of primary health care services :

- ***facilitate communication with policymakers***
- ***support and help build the internal capacity of community-based organisations***
- ***form coalitions that push for policy reforms in the health sector***
- ***drive increased transparency in health policy making***

4.0 The Care Package Expected from Primary Health Care in Nigeria

The types of services delivered under primary health care are broad-ranging and include general practice services, prevention and health screening, early intervention, treatment and management of some illnesses. In addition, services may be targeted to specific population groups such as older people, mothers and children, young people, people living in rural and remote areas. Primary health care services may also target specific conditions and health care needs, such as maternal and child health, sexual and reproductive health, drug and alcohol treatment, oral health, cardiovascular disease, asthma, diabetes, mental health, and obesity.

Primary health care services may target specific conditions and health care needs such as:

- ***maternal and child health***
- ***sexual and reproductive health***
- ***drug and alcohol treatment***
- ***oral health***
- ***cardiovascular disease***
- ***asthma***
- ***diabetes***
- ***mental health***
- ***obesity***

4.1 Outline of Minimum standards for Primary Health Care

The minimum standard[1] for primary health care in Nigeria as defined by the National Primary Health Care Development Agency (NPHCDA) are categorised under the following headings:

- **Health infrastructure:** Types/levels of PHC facilities including recommended infrastructure dimensions, furniture and equipment
- **Human resources for health:** Minimum recommended staff number and cadre for each type of health facility
- **Service provision:** Recommended minimum PHC services for each facility type including the minimum requirement of medical equipment and essential drugs (from the National Essential Drugs list) required to achieve these services.

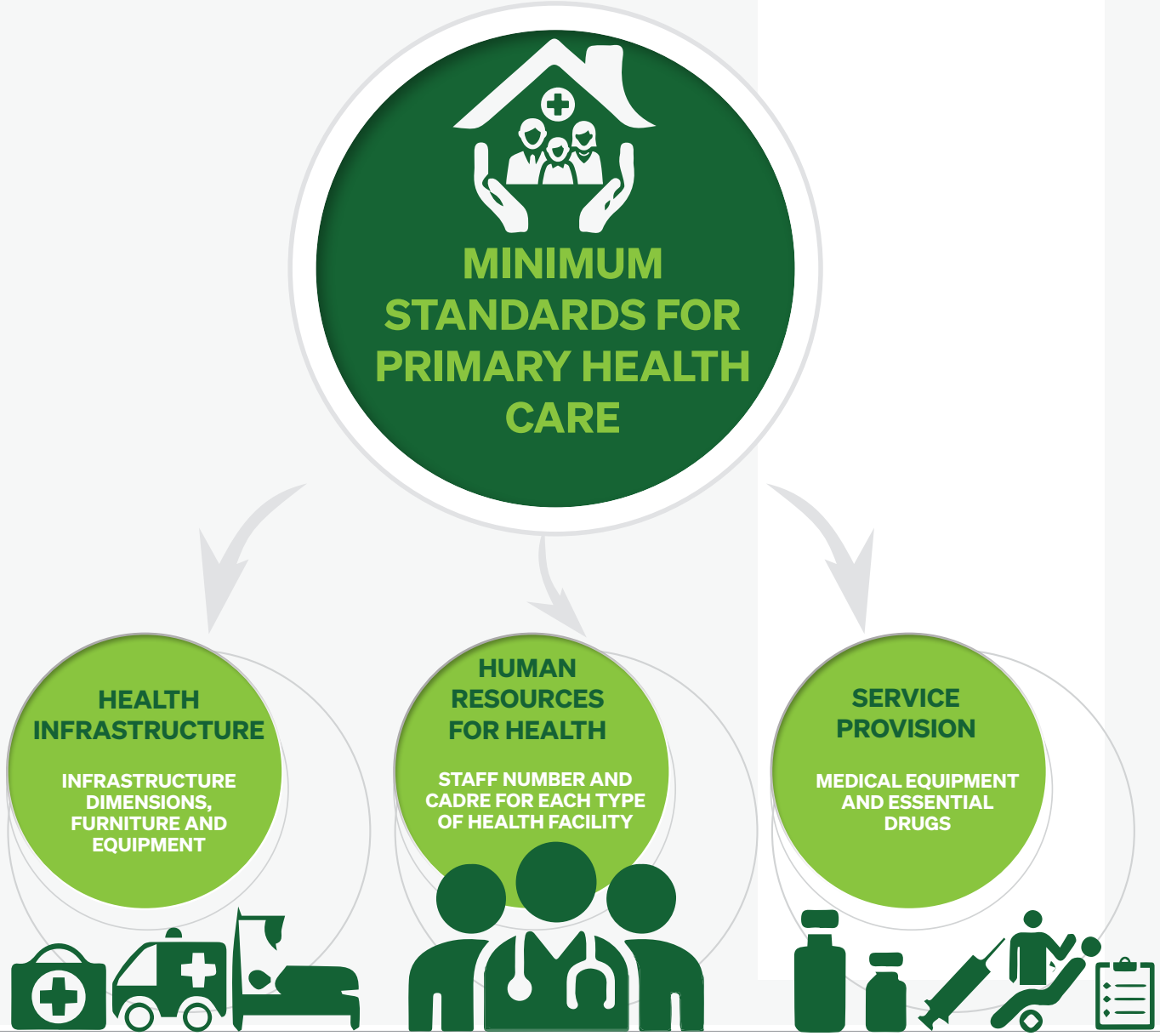
4.2 Importance of Minimum Standards in Primary Health Care

As Nigeria strives to achieve UHC there is need for the continuous development of PHC in terms of infrastructure, human resource availability and service provision. This is the focus of the Minimum Standards for PHCs. It is a vital tool for effective supervision, monitoring and evaluation and to aid effective planning, development and delivery of PHC services.

1 National Primary Health Care Development Agency (NPHCDA): Minimum Standards for Primary Health Care in Nigeria.

The minimum standard puts a check on human resources, infrastructural development and service provision required at the Primary Health Care level. Adherence to the minimum standard by states and LGAs, will lead to improved service delivery at the Primary health care centers. The minimum standards are aligned with the goal of ensuring that all Nigerians have equitable access to health.

Over the past few years, many PHCs have been built by the various tiers of government that do not meet these minimum requirements, and many do not sustain the minimum requirements over time.



5.0 Funding Streams in Health Care Delivery

There are various sources of health care financing, especially for primary health care existing across the world, including Nigeria. These sources include, tax-based public sector health financing, household out-of-pocket health expenditure, private sector (donor funding), community-based health expenditure, and social health insurance schemes. External financing of health care includes grants and loans from donor agencies such as the World Bank, the World Health Organization (WHO), private funds and foundations among others.

The government and its parastatals at the federal, state and local levels are key financing agents for health care delivery in Nigeria. According to the National Health Accounts report[1] of 2016, total health expenditure increased from N1.9 trillion in 2010 to N3.9 trillion in 2016. The burden of health care finance is borne predominantly by households representing 75.2% in 2016. The report further shows that 30.6% of these funds are expended across retailers and other providers of medical goods including pharmacies and chemists; 22.3% in secondary facilities and 6.3% in PHCs.

1 National Health Accounts Report 2010-2016

5.1 Sources of Funding for Health Care

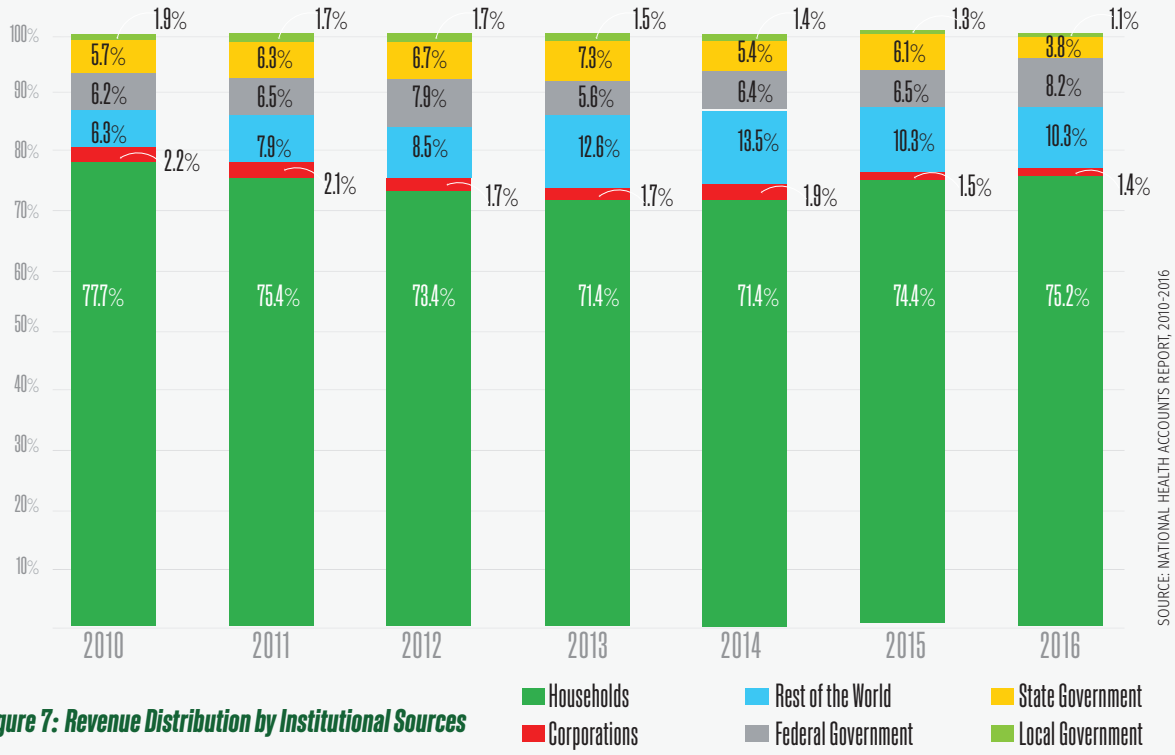


Figure 7: Revenue Distribution by Institutional Sources

1.7% increase
in federal government's contribution to health financing between 2015 and 2016

Figure 7 shows the percentage contribution of critical stakeholders in the Nigerian health sector. From the chart, the local government has the least contribution to health financing with 1.1%, 3.8% from state governments, 8.2% from the federal government, 10.3% from donor partners, 1.4% from corporations and 75.2% from households (out-of-pocket). Most significantly, contributions from the federal government increased from 6.5% in 2015 to 8.2% in 2016. Notably, GAVI and Bill & Melinda Gates are major contributors to the increase in donor spending from N114.4 billion in 2010 to N385.3 billion in 2016.

5.2 Trends in Health Budget Allocation

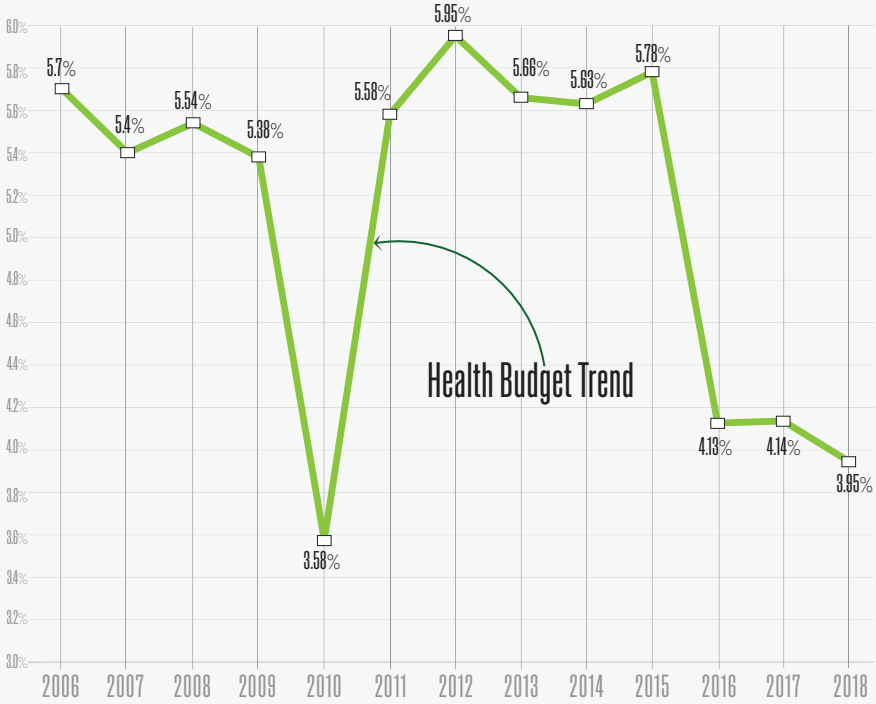
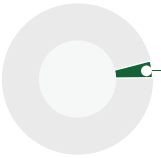


Figure 8: Health Budget Trends

₦271bn increase
in donor spending in the health sector between 2010 & 2016

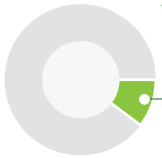
stakeholder contributions
to health financing in Nigeria

1.1% local governments



3.8% state governments

8.2% federal governments



10.3% donor partners

1.4% corporations

75.2% households (out-of-pocket)

₦340bn *Nigeria's total health budget for 2018 which represents 3.95 per cent of the total budget of N8.6trn*

0.19% decrease *in the budget allocation to the health sector as a proportion of the national allocation between 2017 and 2018 in Nigeria*

Table 1: Health Budget Analysis

YEAR	HEALTH BUDGET (N)	NATIONAL BUDGET (N)	% HEALTH
2006	106,940,000,000	1,876,302,363,351	5.70
2007	122,399,999,999	2,266,394,423,477	5.40
2008	138,178,657,132	2,492,076,718,937	5.54
2009	154,567,493,157	2,870,510,042,690	5.38
2010	164,914,939,156	4,608,616,278,213	3.58
2011	235,966,483,244	4,226,191,559,259	5.58
2012	282,771,771,425	4,749,100,821,171	5.95
2013	282,501,464,455	4,987,220,425,601	5.66
2014	264,461,210,950	4,695,190,000,000	5.63
2015	259,751,742,847	4,493,363,957,157	5.78
2016	250,062,891,075	6,060,677,358,227	4.13
2017	308,464,276,782	7,441,176,486,758	4.14
2018	340,456,412,880	8,612,236,953,214	3.95

SOURCE: PACFAH@SCALE (HTTPS://WWW.SLIDESHARE.NET/STATISENSE/2018-PROPOSED-HEALTH-BUDGET-ANALYSIS)

From the health budget trend above, resource allocation in the health sector has remained below 6% from 2013 to 2018 which is far less than WHO recommendation and Abuja Declaration target of 15% allocation as a proportion of the national allocation, agreed by African Union Heads of States in 2001. Not only is it below the target, it is also reducing as a proportion of the national budget.

Table 2: NPHCDA Budget appropriation and releases

YEAR	APPROPRIATION	RELEASES	% OF BUDGET APPROPRIATION RELEASED
2017	19,382,242,968.00	15,791,121,222.51	81%
2018	23,303,284,603.00	21,383,777,887.09	92%

SOURCE: NPHCDA

Budget release has been a huge challenge for MDAs under the Federal Ministry of Health, including NPHCDA. The table above shows budgetary allocation and releases for NPHCDA from 2017 to 2018 as presented by representative of the Executive Director in the 3rd Annual Summit of the Legislative Network on Universal Health Coverage held in Abuja, November 2019.

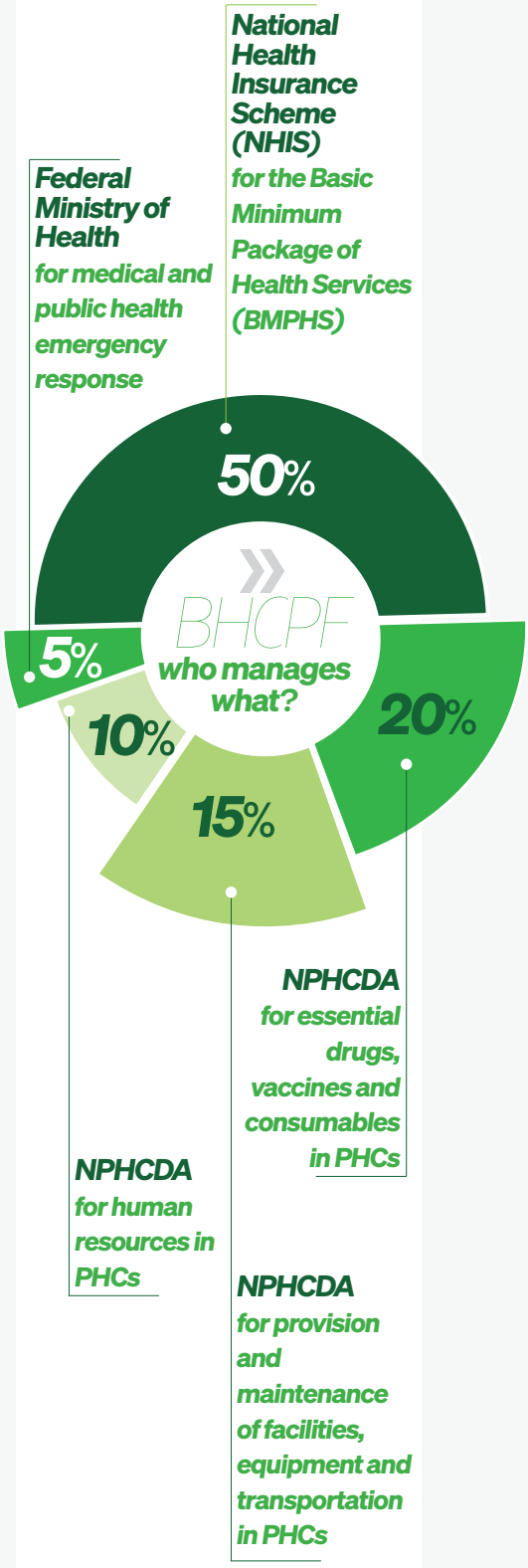
6.0 Initiatives to Improve Primary Health Care

Over the years, efforts have been made to strengthen the primary healthcare system to improve the funding delivery of high-quality services to poor and vulnerable Nigerians. Some of these initiatives include:

6.1 The Basic Health Care Provision Fund

Over the past two decades, Nigeria in its bid to achieve a functional health care system that addresses the needs of its citizens, has seen increased investment in primary health care. In 2014, the National Health Act which provides a legal framework for the establishment of systems to support and facilitate far-reaching reforms in Nigeria was signed into law. The Act made provision for the Basic Health Care Provision Fund (BHCPF) which is derived from at least 1% annual Consolidated Revenue Fund (CRF) of the federal government, donor support and other funding sources, to be managed by government-established institutions for the effective implementation and delivery of Basic Health Care Package of Health Services (BHCPHS) as the country advances towards achieving Universal Health Coverage (UHC).

Other interventions which are a prerequisite to accessing the BHCPF at the state level include the establishment of a functional primary health care board/agency and mandatory state health insurance schemes. States or local governments are also required to make a commitment of not less than 25% counterpart funds[1] of the total cost of the project to access the fund. The Act stipulates that 50% of the fund will be managed through the National Health Insurance Scheme to pay for the Basic Minimum Package of Health Services (BMPHS) to be provided in primary and secondary levels of care. NPHCDA will manage 45% of the fund from which 20% will be used to provide essential drugs, vaccines and consumables in Primary Healthcare Centres (PHCs), 15% will be used for the provision and maintenance of facilities, equipment and transportation in PHCs and 10% will be used for human resources in PHCs. The remaining 5% of the fund is to be used by the Federal Ministry of Health to respond to medical and public health emergencies. The BHCPF should provide free antenatal care and free care to children. These services should be located



1 National Health Act 2014: (retrieved from https://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/2018/07/01_-Official-Gazette-of-the-National-Health-Act-FGN.pdf on September 20, 2019)

close to where people live and should include simple, easy to follow guidelines for common conditions and supply of essential drugs.

The implementation manual of the BHCPF clearly describes the flow of funds from the Central Bank of Nigeria Treasury Single Account (TSA) to the health facilities' commercial accounts for utilisation. To be able to access the funds, NPHCDA reviews the health facilities to ensure that the PHC:

- has conducted a baseline assessment
- has one nurse or midwife. In the absence of a nurse or midwife, the PHC must have at least 2 CHEWs
- has a good building or requires minimal renovation that can be completed with N600,000 or less.

The table below shows the number of PHCs by states qualified to receive the fund through the NPHCDA gateway based on the listed criteria above. These states are where facility assessments were conducted in different states and listed below are the number of PHCs that qualified in each selected state.

Table 3: Qualifying Phcs to Receive Funds Based on Review of Baseline Assessment

STATE	NUMBER OF PHCS
Abia	112
Ebonyi	13
FCT	29
Osun	54

SOURCE: NPHCDA

6.2 Primary Health Care Under One Roof

Primary Health Care Under One Roof (PHCUOR) is a strategy to improve coordination within the health system. It aimed to improve uniformity in access and quality of care for the majority of the population. The Federal Ministry of Health through NPHCDA introduced the policy in 2010, in response to the challenge of weak governance at the lower levels of the government and lower levels of the health system. The National Council on Health (NCH) approved PHCUOR as a national policy in its 54th session in May 2011. The PHCUOR policy recommends that each state government establishes an agency to govern all aspects of PHC thus eliminating the problem

» PHCUOR

Primary Health Care Under One Roof MANDATE improve all aspects of PHC governance at the lower levels of the government and lower levels of the health system

of fragmented governance. The major impact of the change in terms of human resources is that it pulled out health care workers, previously under the employment of LGAs to a new agency under the State Ministry of Health.

The NCH in its 58th Session in 2013 further approved the national guidelines for its implementation as well as the policy document through its Resolution 29. The guidelines identify a conceptual framework for implementing the policy which consists of nine specific domains- Governance & Ownership, Legislation, Minimum Service Package, Repositioning, Systems Development, Operational Guidelines, Human Resources, Funding Sources & Structure and Office Setup. It also outlines specific steps and approaches involved in establishing a functional SPHCDA. While some aspects of the policy were considered adaptable to context, these nine domains were considered the core components, which every state was expected to implement.

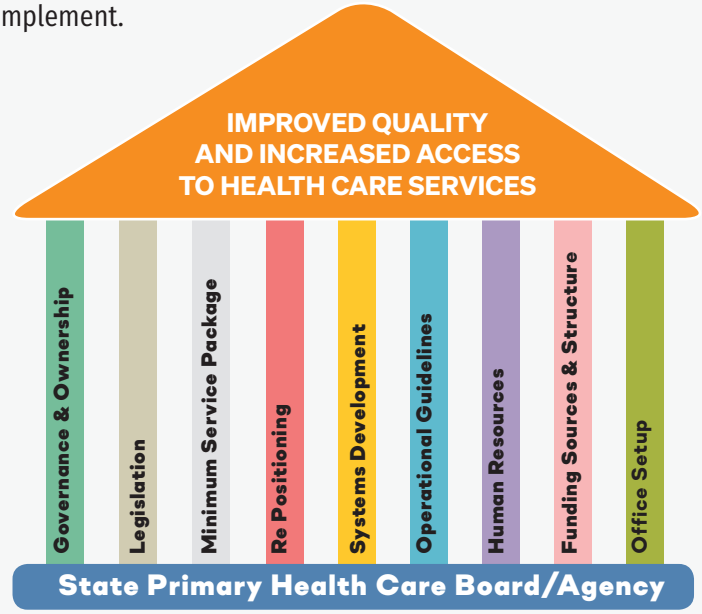
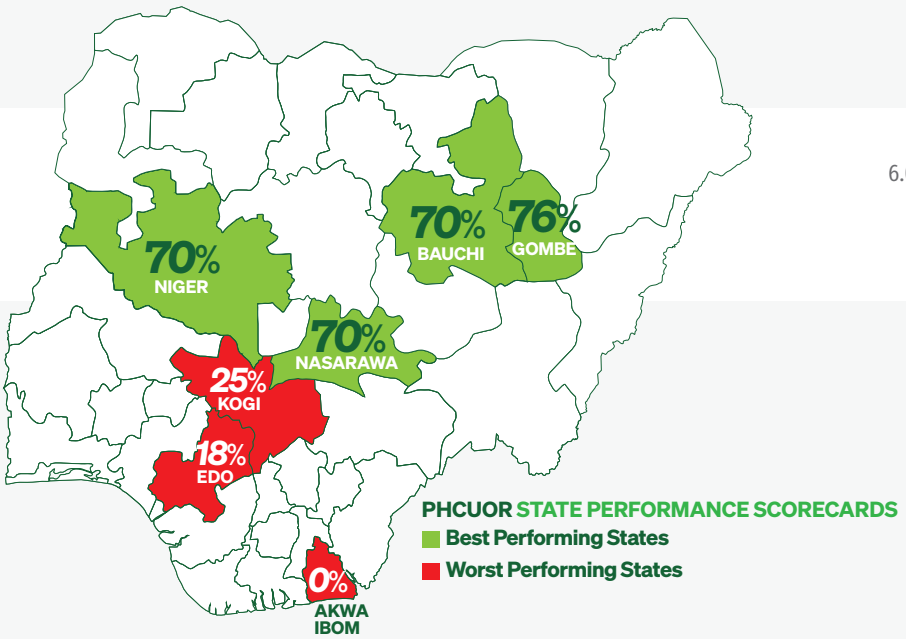


Figure 9: Nine Pillars of PHCUOR

NPHCDA has produced four series of state performance scorecards. The scorecards are aimed at assessing the level of adherence of states to the national guidelines on the establishment of governance structures for implementing PHCUOR, as well as identifying areas in which states need further support. The scorecard further provides a platform for peer review on PHC reforms in Nigeria. The fourth and



latest scorecard for 2018 showed that Gombe (76%), Niger (70%), Bauchi and Nasarawa (70%) States were the best performing states, while states that did not perform as well were Akwa Ibom (0%), Edo (18%), and Kogi (25%)[1].

6.3 PHC Revitalisation Initiative

In 2016, the former Honorable Minister of Health, Professor Isaac Adewole, announced the federal government's initiative to revitalise PHCs in the country starting with 110 PHCs[2] as a pilot with a financial commitment of N550m. The Honourable Minister also mentioned that the revitalisation initiative would be replicated in 10,000 electoral wards working in partnership with state governments.

In 2018, the Executive Director of NPHCDA reported that about 4,000[3] PHCs had been renovated or were in the process of revitalisation. There is no information available to us on which 4,000 PHCs have been revitalised, and where the funding for each revitalised PHC has come from. The challenge with this initiative from the onset was that PHCs are the responsibility of state governments, while the initiative was being driven by the Federal Ministry of Health. There is no evidence to show that a coherent plan for revitalisation was developed in consultation in consultation with the state governments. There was not sufficient commitment at the towards the commitment buy the Honourable Minister of Health.

Revitalisation does not just refer to infrastructural development, rather it includes the provision of equipment, medicine supply chain, water, electricity, efficient human resource delivering quality

1 National Primary Health Care Development Agency. Implementation Status of Primary Health Care Under One Roof (PHCUOR) Scorecard 4 Report, 2018.

2 "FG Commits N550m for revitalization of 110 PHCs": Punch News (retrieved from *https://punchng.com/fg-commits-n550m-revitalisation-110-phcs/* on October 2, 2019)

3 "4,000 PHCs renovated across Nigeria – Official": Premium Times News (retrieved from *https://www.premiumtimesng.com/health/health-news/299431-4000-phcs-renovated-across-nigeria-official.html* on November 5, 2019)

$500m *International Development Association (IDA) credit from the World Bank for SOML to run over four years with an emphasis on results*

» CHIPS

Community Health Influencers, Promoters and Services (CHIPS) Programme

linked to the PHC revitalisation initiative

would deploying 200,000 CHIPS across the country

aimed at reducing maternal and child morbidity and mortality

» SOML

Saving One Million Lives (SOML) Initiative

aimed at improving the maternal and child health outcomes

adopts the 'Programme for Result - PforR' approach

utilises existing country systems and processes

$122m already disbursed to states based on the performance of their respective Disbursement Linked Indicators (DLIs)

health care services. The Community Health Influencers, Promoters and Services (CHIPS) Programme, a new programme at NPHCDA is linked to the PHC revitalisation initiative. The programme is aimed at deploying 200,000 CHIPS across the country, to strengthen the 'One functional PHC per ward strategy' of the Federal Government. The goal of the CHIPS programme is to reduce maternal and child morbidity and mortality by creating demand for and equitably increasing access to essential primary health care services.

6.4 Saving One Million Lives Programme for Results

The Federal Government of Nigeria in 2012 launched the 'Saving One Million Lives (SOML)[1] Initiative through the Ministry of Health with the aim of improving the maternal and child health outcomes in the country. The initiative which addresses Maternal Newborn and Child Health (MNCH) adopting the 'Programme for Result – PforR' approach, received a $500 million International Development Association (IDA) credit from the World Bank to run over four years with an emphasis on results. The program pillars of focus include improving maternal, newborn and child health and routine immunisation coverage, polio eradication, elimination of mother to child transmission of HIV, scaling up access to essential medicines and commodities, malaria control and improving child nutrition. While this is a credit to the Federal Government, it is distributed to states as grants using performance based indicators.

The programme utilises existing country systems and processes, with states receiving almost 82% of the credit sum as an incentive for improved performance using the Disbursement Linked Indicators (DLIs). DLIs are the specific measures against which performance is measured and rewarded under the Programme for Results. The indicators were carefully chosen in consultation with the state governments and other key stakeholders based on the SOML program document. In 2018, a total of $122,348,000.00[1] was disbursed to states based on the performance of their respective DLIs.

1 Saving One Million Lives Disbursements (retrieved from http://somlpforr.org.ng/wp-content/uploads/2019/03/2018%20DISBURSEMENT%20TOTAL.pdf on November 18, 2019)

54% ***Nigeria's national RI percentage coverage as at March, 2019 according to the2018 Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey***

6.5 National Emergency Routine Immunisation Coordinating Centre (NERICC)

The National Emergency Routine Immunisation Coordination Centre (NERICC) was established in 2017 following the need to strengthen the coordination of Nigeria's routine immunisation programme. This initiative was geared towards improving the country's immunisation coverage, a growing concern in the public health space. The centre is saddled with the following objectives:

- Improve detection and responsiveness in the resolution of routine immunisation (RI) gaps
- Strengthen leadership and accountability
- Strengthen coordination
- Increase data visibility, quality and use for action at all levels
- Increase fixed and outreach services for immunisation for traditional vaccines especially in very low performing states.

The centre was also established at the state and LGA levels known as the State Emergency Routine Immunisation Coordination Centre (SERICC) and the Local Emergency Routine Immunisation Coordination Centre (LERRIC) respectively. These coordinating centres are set up to review overall immunisation activities per month, discuss progress, identify potential areas for improvement and acknowledge the best performing health facilities in the immunisation program across states and LGA levels[1]. The 2016/2017 Multiple Indicator Cluster Survey/National Immunisation Coverage Survey report showed that the Nigeria's national Routine Immunisation (RI) Coverage stood at 33% prior to the establishment of NERICC in 2017. The implementation of NERICC's strategic intervention has helped improve the immunisation coverage in Nigeria. The 2018 Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey report showed a National RI of 54% as at March 2019, with large differences between states.

» NERICC

National Emergency Routine Immunisation Coordinating Centre (NERICC)

established to strengthen the coordination of Nigeria's routine immunisation programme

geared towards improving immunisation coverage

known at state as SERICC and LGA levels as LERRIC

1 Nigeria Health Watch. Lessons from Kaduna: improving immunisation coverage through local emergency coordination centres (Retrieved from *https://nigeriahealthwatch.com/lessons-from-kaduna-improving-immunisation-coverage-through-local-emergency-coordination-centres/#.XdZxAG5Fw2x* on November 212019)

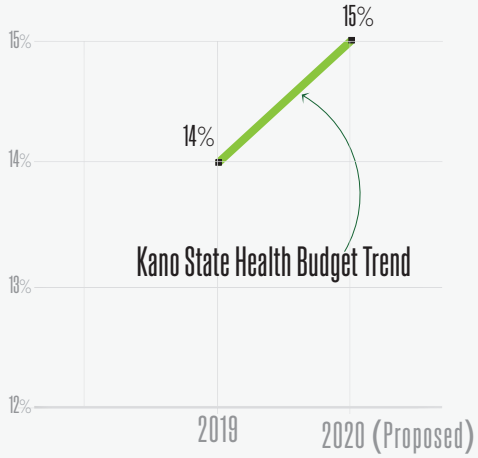
7.0 A Case Study of Primary Health Care in Kano State

7.1 Introduction

The monitoring of service delivery in Primary Healthcare Centres was an initiative of Nigeria Health Watch in collaboration with Connected Development (CODE) and was designed to monitor progress in the implementation of primary health care services particularly maternal, newborn and child health services.

Kano State was chosen for the case study because it is the second most populous state in Nigeria and has faced several challenges delivering health care to its citizens, with the result that the state has poor health indices. The focus of the project is on MNCH services, including family planning, immunisation, antenatal and /postnatal services etc.

Figure 10: Health care funding in Kano State



YEAR	HEATH BUDGET (N)	KANO STATE BUDGET (N)	% SHARE FOR HEALTH
2019	31,505,320,496	219,970,976,010	14
2020 (proposed)	30,704,861,047	197,683,353,659	15

SOURCE: TBC

Despite the reduction in Kano State heath budget from N31,505,320,496 in 2019 to N30,704,861,047 as proposed in 2020, the percentage of health budget to the overall state budget increased from 14 per cent in 2019 to 15 per cent as proposed in 2020. This means that Kano State would meet the Abuja Declaration commitment, allocating at least 15% of the state budget to health.

why Kano State?

2nd most populous state in Nigeria

faced several health care delivery challenges

affected by poor health indices

1% increase

in Kano State health budget allocation between 2019 and 2020 (proposed) Budget

Table 4: Kano State 2019 approved and 2020 proposed budget by sectors

SECTORS	PERSONNEL COST (2019)	PERSONNEL COST (2020)	OVERHEAD COST (2019)	OVERHEAD COST (2020)	CAPITAL EXPENDITURE (2019)	CAPITAL EXPENDITURE (2020)	TOTAL (2019)	TOTAL (2020)
Administrative	4,276,353,688	3,864,182,955	11,423,683,849	7,337,024,800	8,424,996,080	2,674,100,000	24,125,033,617	13,875,307,755
Economic	5,918,110,131	5,135,343,903	3,304,592,867	61,942,467,68	59,577,019,801	76,206,651,088	68,799,722,799	87,536,241,759
Law & Justice	4,325,047,963	4,837,264,813	2,314,756,626	1,897,689,967	3,803,000,000	3,703,000,000	10,442,804,589	10,437,954,780
Social Service	47,032,498,508	44,194,289,059	7,455,791,864	6,512,684,513	62,115,124,632	35,126,875,794	116,603,415,005	85,833,849,366
TOTAL	**61,552,010,290**	**58,031,080,730**	**24,498,825,206**	**21,941,646,048**	**133,920,140,513**	**11,771,0626,881**	**219,970,976,010**	**197,683,353,659**

SOURCE: KANO STATE

7.2 Rationale

Patients are often not fully aware what to expect from Primary Healthcare Centres (PHCs). The monitoring of service delivery in Kano State is aimed at providing greater clarity whether states are following the guidelines on the minimum standard of care that should be offered at PHCs. This is to assist in better informing advocacy efforts and improving accountability in primary health care. There are innovative projects that are taking place at the PHC level, but not enough is known about the experiences of patients.

Looking at PHCs, a more in-depth analysis of what services are available to patients, needs to be better understood. It is not enough to say that a PHC facility exists in a specific area. In addition, it is necessary to investigate if the PHC has the required stock, staff, is accessible to people, and also delivers quality services.

Aim: The assessment aims to provide information that will promote accountability in Nigeria's primary health care sector by advancing the use of evidence in health reporting, policy analysis and informed advocacy that would lead to positive change.

» aim of assessment

Provide information that will promote accountability in Nigeria's primary health care sector

» ASSESSMENT CARRIED OUT IN

49

select PHCs

across LGAs in Kano State

7.3 Methodology

The assessment was carried out using both qualitative and quantitative methods. 49 PHCs across Local Government Areas (LGA) in Kano State were selected across different LGAs in Kano State.

Quantitative research: Each of the selected PHCs were administered a questionnaire directed to the officer 'In-charge' or the highest ranked staff of the PHC. The questions were drawn from the minimum standards for Primary Health Care in Nigeria developed by NPHCDA.

objective of assessment

ascertain conformity of PHCs to the minimum standards of care as outlined in the minimum standards for primary health care

The objective was to ascertain if the PHCs were conforming to the minimum standards of care as described by the minimum standards.

Qualitative research: In-depth interviews and Focus group Discussions with key stakeholders at the LGA, and community levels were conducted. This was deployed through a developed interview guide with open-ended questions to further explore information from all respondents.

Nigeria Health Watch leveraged on its partnership with CODE to enroll enumerators from the state to conduct the assessment. The enumerators were trained on the research tools and also these were simulated before deployment. The enumerators were grouped in pairs and each group had a leader who facilitated the data collection process.

The Kano State Primary Health Care Development Agency was notified before the commencement of the assessment.

7.4 Key Findings

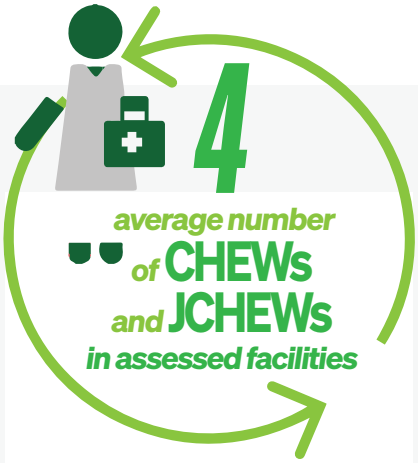
PHCs were established to provide accessible, affordable and available primary health care to people[1]. They are the foundation of health systems providing health care to patients and ensuring that they receive quality health care whenever they need it. This assessment was designed to analyse service delivery, coverage of care and quality of care at Primary Healthcare Centres in Kano State. The questionnaire was administered in 49 PHCs and was answered by the PHC worker 'In-charge' or the most senior ranked person in each PHC. The results were analysed to determine the level of personnel/ staff strength, service delivery and general infrastructure in these PHCs.

7.4.1 Personnel/Staff Strength:

Findings from the questionnaire indicate that:

- Only five (11.2%) facilities had a medical doctor posted there; 44 (89.7%) facilities did not have a doctor. On the average, at least one doctor visited the facility they were posted to 4.25 days each week.

1 Primary health centre. Available at https://en.wikipedia.org/wiki/Primary_health_centre {Accessed on December 20, 2019}



- Most facilities had CHEWs posted there. There was an average of four CHEWs in each facility. Results also showed that the average number of Junior CHEWs per facility was four.
- 30 (61.2%) facilities indicated that resident nurses/midwives were posted there. There was an average of 2 nurses per facility. On average, at least one nurse/midwife visited the facility they were posted to five days per week.
- Other cadre of staff,
  - 17 (34.7%) indicated that a Pharmacy Technician was posted to their facility.
  - 21 (42.9%) facilities indicated that a Medical Records Officer was posted to their facility.
  - 45 (91.8%) facilities indicated that they had an Environmental Health Officer posted there.
  - 32 (65.3%) facilities indicated that they had a Lab Technician posted there.
  - 36 (73.5%) facilities indicated that they had a Health Attendant posted there.
  - 35 (71.4%) facilities indicated that there is no Security Personnel posted there.
  - 7 (14.3%) facilities indicated that they had an Ambulance Driver posted there.

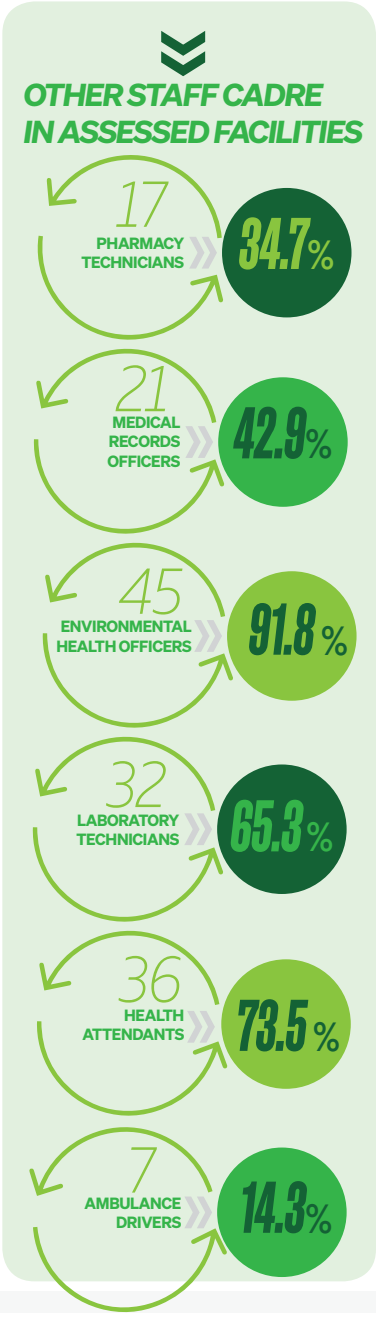
Human resources for health are at the heart of delivering effective PHC services. There appears to be a shortage of staff, especially doctors as results show that almost 90% of the PHCs assessed do not have a doctor.

The National Primary Health Care Development Agency (NPHCDA) minimum requirement[1] for staff in a PHC is as follows:

1 Medical officer if available

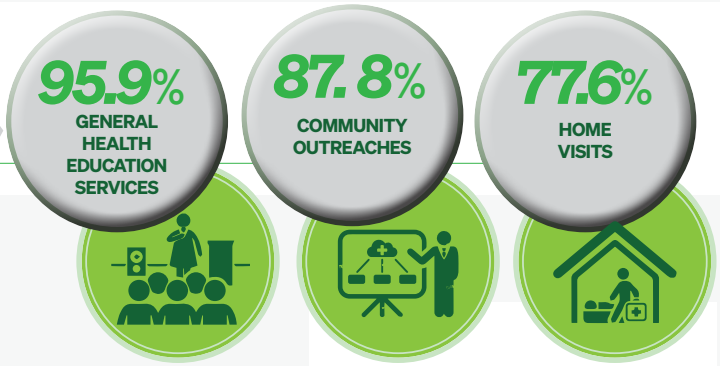
1 Community Health Officer (must work with standing order)

4 Nurses/midwives



1 Minimum-standards-for-primary-health-care-in-nigeria. Available at *https://www.google.com/search?q=minimum-standards-for-primary-health-care-in-nigeria.pdf&oq=minimum-standards-for-primary-health-care-in-nigeria.pdf&aqs=chrome..69i57j69i60.30914167j0j7&sourceid=chrome&ie=UTF-8* {Accessed on December 20, 2019}

HEALTH EDUCATION AND PROMOTION SERVICES OFFERED IN ASSESSED PHCS



3 CHEW (must work with standing order)

1 Pharmacy technician

6 JCHEW (must work with standing order)

1 Environmental Officer

1 Medical records officer

1 Laboratory technician

2 Support staff Health Attendant/Assistant

2 Security personnel

1 General maintenance staff

Any PHC that is operating with less than the number of staff listed above is functioning below capacity and this might affect the quality of care being provided.

MINIMUM REQUIREMENT FOR STAFF IN A PHC

1 MEDICAL OFFICER (if available)	4 NURSES// MIDWIVES
1 COMMUNITY HEALTH OFFICER (must work with standing order)	3 CHEW (must work with standing order)
1 PHARMACY TECHNICIAN	6 JCHEW (must work with standing order)
1 ENVIRONMENTAL OFFICER	1 LABORATORY TECHNICIAN
1 MEDICAL RECORDS OFFICER	2 SECURITY PERSONNEL
2 SUPPORT STAFF HEALTH ATTENDANT/ ASSISTANT	1 GENERAL MAINTENANCE STAFF

7.4.2 Service Delivery

Findings from the questionnaire indicated that:

- **Health Education and Promotion:**

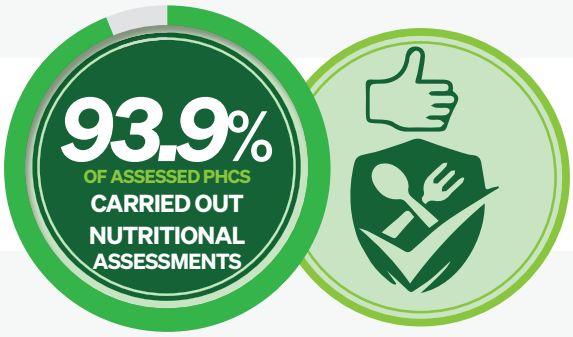
  In a majority of the PHCs assessed, Health Education and Promotion services were being offered. A further analysis revealed that 95.9% of the facilities offered General Health Education services, 87. 8% carried out Community Outreaches and 77.6% carried out Home Visits.

- **MNCH**

  Most of the PHCs assessed provide MNCH services. In more than 80% of the PHCs, MNCH services - Antenatal, Delivery, Post Natal Care, Promotion of Exclusive Breastfeeding, Growth Monitoring and IYCF - are being offered. Further analysis revealed that 95.9% offer antenatal services, 33 (67.3%) offer delivery services, 83.7% provide post-natal care, 91.8% promote exclusive breastfeeding, 89.8% offer growth monitoring services and 91.8% support IYCF.

- **Nutrition**

  The majority of the PHCs assessed offered nutrition services – 93.9% of the facilities helped their patients identify locally available foods; 89.9% provided nutritional education; 93.9% offered screening services for nutritional-related problems



(e.g. anaemia, goitre); 83.7% had food demonstration sessions; 93.9% carried out nutritional assessments.

- **Family Planning**

  Most of the PHCs offered family planning services – 98% provided counselling and motivation for family planning services; 95.9% dispensed male and female condoms; 91.8% dispensed oral contraception and 85.7% dispense other forms of contraceptive e.g. injectables, IUD.

- **Immunisation**

  More than 90% of the facilities offered immunisation services – 100% provided routine immunisation; 98% participate in immunisation campaigns/outreaches; 100% provided follow-up/reminder services to caregivers; 98% assist in the provision of routine immunisation; 95.9% assisted in the management of Adverse Effect Following Immunisation (AEFI); 98% assist in the identification of Acute Flaccid Paralysis.

- **HIV**

  Of the facilities surveyed, 77.6% provided voluntary counselling and testing; 75.5% offered treatment of opportunistic infections e.g. tuberculosis; 69.4% provided community/home-based care and support and 46.9% offered follow up care for people living with HIV.

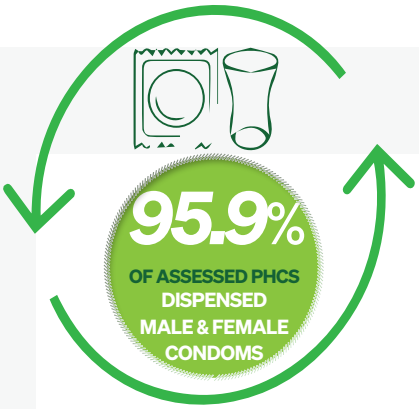
- **Malaria**

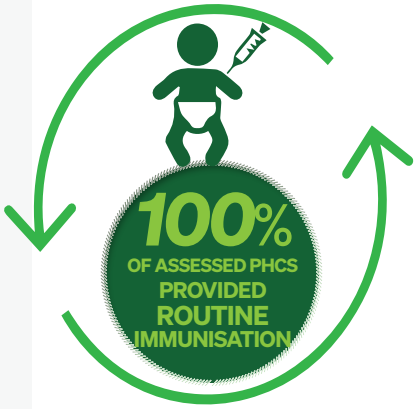
  Of the facilities surveyed, 100% assessed and distributed Insecticide Treated Nets, provide Intermittent Preventative Treatment (IPT) for malaria and pregnant women and referral services; 95.5% provided 2-way referral services and 85.7% provided 2-way referral services.

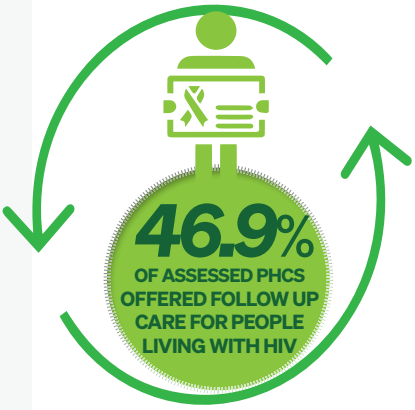
  A high quality of care is essential for building trust in and for ensuring the sustainability of the health system. According to the NPHCDA, health services that ought to be provided in PHC centres daily and at all times, include the following:

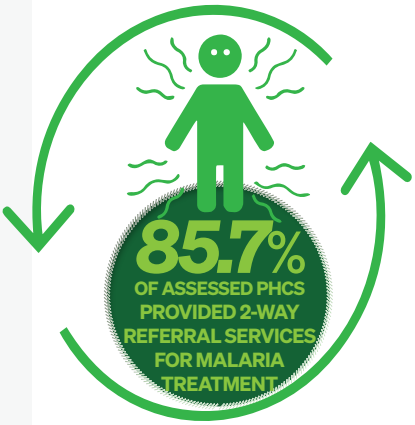
  a. Education and Promotion

  b. Health Management and Information System









c. Routine Home Visits and Community Outreach
d. Maternal, Newborn and Child Care
e. Family Planning
f. Promotion of Proper Nutrition and Food Education
g. Minimum Standards for Primary Health Care in Nigeria
h. Immunisation
i. HIV/AIDS
j. Malaria
k. Curative Care
l. Water and Sanitation
m. Oral health
n. Community Mental Health
o. Maintenance of PHC Records
p. Monitoring
q. Supervision
r. Waste Disposal
s. Adolescent Health
t. Basic Laboratory Services

Our findings show that most services are offered by a majority of the primary health centres assessed. However, the percentage of facilities that offer MNCH services is low. According to the recently released 2018 NDHS, only 21.5% of deliveries in Kano State are attended to by skilled birth attendants. This provides some insight into where advocacy efforts need to be targeted.

While services like health promotion and education, nutrition education and immunisation are significantly represented, the assessment does not show whether the facilities also offer mental health care and care of the elderly as these are an essential component of PHC services.

HEALTH SERVICES THAT OUGHT TO BE PROVIDED IN PHCs DAILY AND AT ALL TIMES

- *Education and Promotion*
- *Health Management and Information System*
- *Routine Home Visits and Community Outreach*
- *Maternal, Newborn and Child Care*
- *Family Planning*
- *Promotion of Proper Nutrition and Food Education*
- *Minimum Standards for Primary Health Care in Nigeria*
- *Immunisation*
- *HIV/AIDS*
- *Malaria*
- *Curative Care*
- *Water and Sanitation*
- *Oral health*
- *Community Mental Health*
- *Maintenance of PHC Records*
- *Monitoring*
- *Supervision*
- *Waste Disposal*
- *Adolescent Health*
- *Basic Laboratory Services*

7.4.3 General Infrastructure

Infrastructure constitutes the backbone of the primary health care system. It is not enough for a primary health

» service readiness

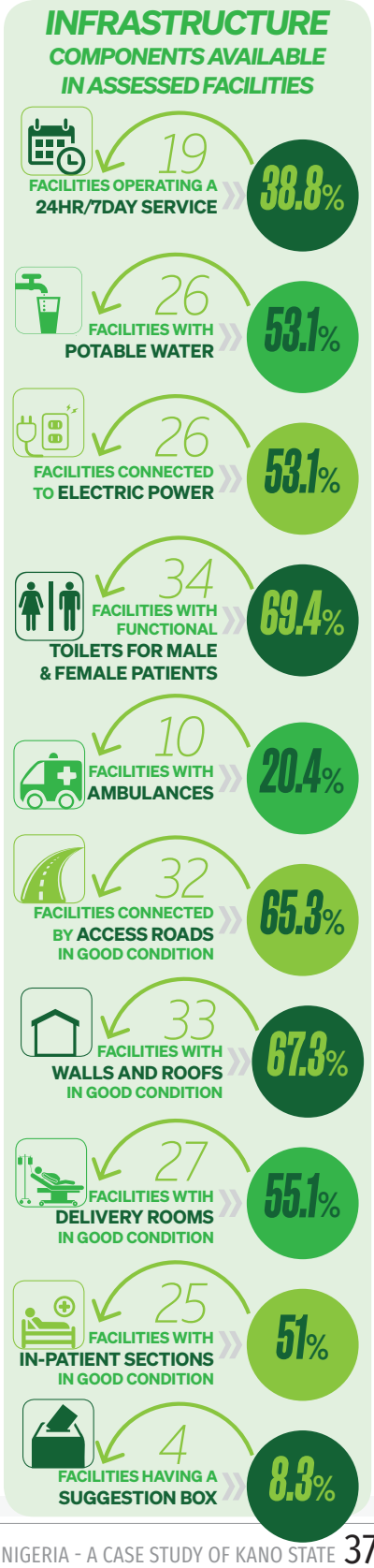
Results revealed limited service readiness. For example, power supply, emergency transportation system and good sanitary infrastructure are poor in many PHCs

care centres to have a physical structure in a community, it must also be well equipped to deliver quality service and timely interventions.

The PHCs were assessed to determine the different components of infrastructure available. Results revealed the following:

- 19 (38.8%) facilities operate a 24hr/7day service
- 26 (53.1%) facilities have potable water.
- 26 (53.1%) facilities are connected to electricity, i.e. the national grid, solar or generator.
- 34 (69.4%) facilities have functional toilets for male and female patients.
- Ambulances are available in 10 (20.4%) of the facilities assessed.
- Access roads to 32 (65.3%) facilities are in good condition.
- The walls and roofs in 33 (67.3%) facilities are in good condition.
- Delivery rooms in 27 (55.1%) facilities are in good condition.
- The in-patient section in 25 (51%) facilities are in good condition.
- 4 Facilities (8.3%) have a suggestion box.

The availability of basic amenities supports an enabling working environment. Results revealed that service readiness was limited. For example, power supply, emergency transportation system, and good sanitary infrastructure are poor in many of the PHC facilities. Health care services are being performed in facilities with insufficient infrastructure. Adequate infrastructure is required by any health care system to enhance delivery of services in an efficient, effective and timely manner.



7.5 Qualitative Results

The qualitative interviews, consisting of Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) with a targeted pool of patients and persons-in-charge at the facilities visited were transcribed and analysed and then separated into themes. Quotes from respondents were grouped under the following themes:

- Health Seeking Behaviour
- Common Complaints
- Optimal Services
- Facility Primary Need

7.5.1 Health seeking Behaviour

Findings revealed that health-seeking behaviour among respondents differ. For reasons ranging from, distance to facility, poor access roads and late resumption time of hospital personnel, some respondents prefer to visit the native doctor or chemist/pharmacy first, when they fall sick.

> ***"We usually use traditional herbs and medicine; considering the fact that the stress of going to the hospital is too much. So, it is better to use herbs. Another reason is that the hospital personnel does not resume early, so a patient will have to wait for long to get medical attention."***
> *– RESPONDENT, KUMBOTSO COMMUNITY*
>
> ***"I think the chemist is the best. That is the first place I will go to if I have a fever. I will go and buy Paracetamol. But if the sickness is more than what the chemist can handle, I will have to go to a hospital."***
> ***"Most of the people here go to the native doctor, because the hospital is far away from here. To get to the hospital one will have to use either bicycle, or motorcycle, or donkey; in some cases, one might have to cross a river before getting to the hospital."***
> *– RESPONDENT, KUMBOTSO COMMUNITY*

The respondents who prefer to visit the hospital first, do so for various reasons,

> ***"We go to the community hospital because they provide good services. They also offer pregnancy tests, injections, etc. We as leaders also encourage people to visit the hospital."***
> *– RESPONDENT, KANO MUNICIPALITY*
>
> ***"We go to the hospital in Dawaki because unlike the one in Gurjiya, the personnel are always there, with drugs and beds for admission if need be."***
> ***"Because the services are effective and affordable, the drugs are subsidised, and some are given for free. Also, we as leaders sensitise the people on the importance of going to the hospital when the need arises."***
> *- RESPONDENT, KANO MUNICIPALITY*
>
> ***"They know that when they first try traditional medicines, they don't get well. So, why not just come to the hospital, where you will be tested, and told what is wrong with you."***

*We go to the hospital in **Dawaki** because unlike the one in Gurjiya, the **personnel are always there, with drugs and beds for admission if need be**.*

RESPONDENT, KANO MUNICIPALITY, ON PREFERENCES AND REASONS FOR ACCESSING PHC FACILITIES

"They come to the hospital here in Madobi. Mostly, the women come in for antenatal care and childbirth. In fact, our statistics show that between January 2019, and August 2019, the hospital has received 706 child births."
– RESPONDENT, MADOBI COMMUNITY

7.5.2 Common Complaints

The minimum service components of PHC include maternal and child health care, including family planning, immunisation against the major infectious diseases, health education, proper nutrition, basic sanitation, provision of essential drugs, etc. In Kano State, some of the common illnesses that cause respondents to visit the PHCs are malaria, typhoid, ulcer, hypertension, etc.

"The complaints we get the most are malaria, common cold, diarrhoea, and dysentery. In all, malaria is the highest. In some instances, we have cases of typhoid. But it is very rare. Malaria is the dominant disease here."
- RESPONDENT, ABBAS COMMUNITY

"Malaria, Typhoid, and Ulcer. These and Cholera, are the most common diseases here."
"Since the hospital was upgraded to health spot, we have cases of malaria, women in labour, and the likes. But if there are cases that they can't handle, they refer them to the general hospital in Gwarzo or Bichi. The most common cases are malaria and cholera."
– GADANAYA COMMUNITY DISTRICT HEAD

"Malnutrition in children (especially when the mother does not know the proper way to wean the child), measles, and whooping cough in children that were not immunised."

7.5.3 Optimal Services

Attitude of health workers is a key determinant to how a client perceives service delivery at a health facility. Evidence above suggests that the different facilities assessed are understaffed and this might cause sub-optimal services to be provided. Some respondents describe the health workers as empathetic and caring,

"*Some of them are very empathic and caring, others are not".*
"Honestly, there are no complaints. Most of the workers here have good *human relations. That's why we don't have issues coming here."*
– RESPONDENT, TURAI COMMUNITY

One respondent believes that the late resumption and early closure of the PHC near him is not good service. Another thinks that a more diligent work force and availability of works will make for good service.

*The **complaints we get the most are malaria, common cold, diarrhoea, and dysentery**. In all, malaria is the highest. In some instances, we have cases of typhoid. But it is very rare.*

RESPONDENT, ABBAS COMMUNITY ON COMMON ILLNESSES THAT CAUSE RESPONDENTS TO VISIT PHCs

"They resume work between 11am and 12pm, and they close at 2p.m."

– RESPONDENT, GURJIYA COMMUNITY.

"I want to plead with the hospital personnel to be more diligent in their work and make drugs more available."

– RESPONDENT, GURJIYA COMMUNITY

7.5.4 Facility Primary Need

Health care facilities, facility infrastructure refers to the physical, technical and organisational components or assets that are required for the delivery of health care services. The needs in the facilities assessed, as mentioned by the respondents include, structure, equipment, maternal health services, improved emergency response, increased service hours, basic drugs, power supply, skilled service providers and security.

"We need a good source of power for the hospital, there are leakages in the building; and the taps are bad. We also need an ambulance in the hospital. An arrangement was made with an emergency; line for commuters to call in situations of emergency."

– RESPONDENT, KANO MUNICIPALITY

"The hospital is in need of more staff i.e., nurses, doctors and midwives to run shifts so that the hospital will be open at all times to serve the community better. A standard Laboratory should also be provided. We need a store for drugs. We also need scanning and X-ray services."

– RESPONDENT, KANO MUNICIPALITY

"We need more beds in the hospital, wards, and toilets. Because there are only two toilets in the hospital for both male and female use. Likewise, the ward is used for both male and female, they are not separated."

– RESPONDENT, KURA COMMUNITY

"We plead with the authorities to help in renovating and upgrading the hospital to standard, so that it can serve the community better."

–RESPONDENT, GURJIYA COMMUNITY

"They should get a security personnel, more work equipment, more doctors, so that there are no queues."

– RESPONDENT, DAWAKIN TOFA

"The hospital is also in need of a permanent doctor, because the doctors

We need more beds in the hospital, wards, and toilets. There are only two toilets in the hospital for both male and female use. Likewise, the ward is used for both male and female, they are not separated.

RESPONDENT, KURA COMMUNITY, ON HEALTH CARE AND FACILITY INFRASTRUCTURE NEEDS IN THE FACILITIES ASSESSED

we have had over time are corps members; and once they leave, we would usually have to wait till another corps member is posted here."
– RESPONDENT, TARAUNI PHC

*"**We need a lot of things. For example, we don't have an ambulance here. For example, there's a woman in the delivery room right now who has prolonged labour but there is no ambulance to move her from here."***
– RESPONDENT, ABBAS PHC

7.6 Discussion of Results

Health seeking behaviour has been defined as, 'any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy.'

Factors that influence health seeking behaviour include socioeconomic status, knowledge, perception on health, beliefs of causation of certain diseases, attitude to life, literacy level, distance to health facility, costs of treatment, delayed attention in hospitals, trust and confidence in health providers. Results suggest that community members who use the PHCs assessed have a good health seeking behaviour. Although some respondents mention that they either patronise traditional medicine or visit the chemist/pharmacy when they fall sick, most respondents say that they visit the hospital first.

Adequate infrastructure is required by any health care system to deliver appropriate services at a health facility. Human resources, functional road networks, adequate water supply, electricity are all often outside the remit of primary healthcare centres, yet they define the quality of services provided. The absence of the necessary infrastructure can severely affect service delivery.

Our results reveal that all the PHCs assessed seem to lack some component of the basic requirements as outlined by the NPHCDA minimum standards for PHCs. Based on this minimum standard, some basic infrastructure and human resource are expected to be found in a PHC facility. This is essential in order to facilitate delivery of timely and efficient services to health care users.

» health seeking behaviour

Community members who use the PHCs assessed have a good health seeking behaviour. Most respondents say that they visit the hospital first before seeking alternatives.

» adequate infrastructure

All PHCs assessed seem to lack some component of the basic requirements as outlined by the NPHCDA minimum standards for primary health care centres.

7.7 Conclusion

Universal Health Coverage (UHC) is the aspiration that all individuals and communities receive the health services they need without suffering financial hardship. Achieving the mandate of UHC is very important for fast tracking human development in Nigeria. Achieving the health-related sustainable development goals (SDGs), including universal health coverage (UHC), will not be possible without a stronger primary health care[1] system. Therefore, in order to achieve UHC, government needs to re-examine the services provided at PHCs in order to re-equip them with necessary infrastructure and human resource to enhance their service quality and readiness.

This case study in Kano State provides an insight into service delivery and the implementation of minimum standards in primary health care across the different LGAs in the state. It is clear that there are gaps in service delivery and adherence to the minimum standards for primary health care. The resultant effect is poor health seeking behaviour among patients in the state. The results of the service delivery monitor also provides evidence of where advocacy efforts should be targeted at a state level. The service delivery monitoring could be rolled out into different states as this would provide further evidence of how the minimum standard of care is being implemented across the different geo-political zones in Nigeria.

1 Advancing the science and practice of primary health care as a foundation for universal health coverage: a call for papers. Available at https://www.who.int/bulletin/volumes/97/8/19-239889/en/ {Accessed on December 20 2019}

» call to action

Government needs to re-examine the services provided at PHCs and re-equip them with necessary infrastructure and human resource to enhance their service quality and readiness, in order to achieve UHC.

» conclusively

It is clear from the assessment that there are gaps in service delivery and adherence to the minimum standards for primary health care in Kano State. The resultant effect is poor health seeking behaviour among patients in the state.

8.0 Appendix

8.1 Questionnaire

Checklist/Questions for Health Workers

Name of PHC:_____

LGA:_____

Nameofinterviewer:_____

Phone no of interviewer:_____

Name of interviewee:_____

Designation of interviewee: _____

Phone no of interviewer_____

Personnel (Officer In-charge)

Is there a Medical Doctor posted to this facility? Yes [ ] No [ ]

How many days per week does the doctor come to the facility [ ]

Comment: _____

_____

How many Community Health Extension Workers (CHEWs) are in this facility? [ ]

How many midwives/nurses are in this facility [ ]

How many days per week do the midwives/nurses come to the facility [ ]

Comment (if any): _____

_____

Is there a Pharmacy technician posted to this facility? Yes [ ] No [ ]

How many Junior Community Health Extension Workers (JCHEWs) are in this facility? [ ]

Is there a medical records officer posted to this facility? Yes [ ] No [ ]

Is there an environmental health officer posted to this facility? Yes [ ] No [ ]

Is there a lab technician posted to this facility? Yes [ ] No [ ]

Is there a health attendant in this facility? Yes [ ] No [ ]

Is there a security personnel in this facility? Yes [ ] No [ ]

Is there a driver for the ambulance in this facility? Yes [ ] No [ ]

INDICATOR	STATUS		
	Yes (1)	No (0)	Comment
HEALTH EDUCATION AND PROMOTION			
Do you provide general health information to patients? Carry out health education classes?			
Does the facility do community outreach?			
Does the facility carry out home visits?			
MATERNAL, NEWBORN AND CHILD CARE			
Antenatal Care			
Delivery			
Post-natal care			
Promotion of exclusive breastfeeding			
Growth monitoring			
Support for weaning (IYCF)			
NUTRITION			
Identification of locally available foodstuff			
Home, school and communal gardening			
Nutritional education including food hygiene			
Screening for nutritional-related problems (e.g anaemia, goitre)			
Food demonstration			
Nutritional assessment (e.g mid upper arm circumference and identification of malnutrition in children and adults)			
FAMILY PLANNING			
Counselling and motivation for FP			
Dispensing of male and female Condoms			
Dispensing of oral contraceptives			
Dispensing of other forms of contraceptive e.g injectables, IUD			

8.2 Services

IMMUNISATION			
Provision of routine immunisation, TT, BCG, OPV, DPT, Y F, MV etc.			
Participation in immunisation campaigns/ outreaches			
Provision of follow-up/reminders to caregivers			
Assist in the provision of routine immunisation			
Assist in the management of Adverse Effect Following Immunisation (AEFI)			
Assist in the identification of Acute Flaccid Paralysis (AFP)			
HIV			
Voluntary counselling and testing			
Follow up care for people living with HIV (PLWHIV)			
Treatment of opportunistic infections (e.g TB)			
Community/home-based care and support			
MALARIA			
Distribution of Insecticide Treated Nets (ITNs)			
Intermittent Preventive Treatment (IPT) for pregnant women			
REFERRAL			
Counselling and motivation for referral			
Effecting referrals for all cases (two-way referral)			
Mobilising support as required from the community to effect referrals			

INDICATOR	STATUS		
	Yes	No	Comment
24hrs/7days operation of services			
Is there potable water?			
Connection to electricity (National Grid, Solar, Generator)			
Functional toilets for male and female patients			
Availability of Ambulance			
Access road to the facility in good condition			
Walls and roofs in good condition			
Delivery room in good condition			
In-patient section in good condition			
Availability of suggestion box			

8.3 Key Informant Interview (KII)

a. What are the commonest illnesses that bring people to this facility?

b. In your opinion, what areas do you think the facility needs to improve?

8.4 Community Members (FGD)

a. When people fall sick in this community where do they first seek care?

b. What makes you decide where to first seek care?

c. What are the major illnesses members of this community visit the health facility for?

d. How far do you live from the health facility? i.e distance

e. How long did you have to wait to be seen by a health worker at the health facility?

f. What do you think about the services provided by the health facility?

g. How were you received by the health workers?

h. Are services available in the facility whenever you need it?

i. How can the facility improve its services?

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