Monitoring Maternal, Newborn and Child Health Projects

(Federal, Katsina and Kaduna States)

(Mainstreaming Social Justice In Public Life)

Monitoring Maternal, Newborn and Child Health Projects

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ABBREVIATIONS AND ACRONYMS

AKTH	Aminu Kano University Teaching Hospital
AMSfPHC	Approved Minimum Standards for Primary Health Care in Nigeria
ANC	Ante Natal Care
BHCPF	Basic Health Care Provision Fund
CHC	Community Health Centres
CHEW	Community Health Extension Workers
CSJ	Centre for Social Justice
FCT	Federal Capital Territory
FGN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IT	Information Technology
IVF	InVitro Fertilization
JCHEW	Junior Community Health Extension Workers
JUTH	Jos University Teaching Hospital
KSHDP	Katsina State Health Development Plan
LUTH	Lagos University Teaching Hospital
LGA	Local Government Area
LGC	Local Government Council
MDAs	Ministries, Departments and Agencies of Government
MNCH	Maternal, New born and Child Health
MSP	Minimum Service Package
NHA	National Health Act

NOFIC	National Obstetric Fistula Centre
NPHCDA	National Primary Health Care Development Agency
OPD	Out Patient Department
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCUOR	Primary Health Care Under One Roof
SOML	Saving one Million Lives
SPHCDA	State Primary Health Care Development Agency
SPHCUOR	State Primary Health Care Under One Roof
TB	Tuberculosis
UNCESCR	United Nations Committee on Economic, Social and Cultural Rights
UNICEF	United Nations Children Fund
UPTH	University of Port Harcourt Teaching Hospital
WHO	World Health Organization

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EXECUTIVE SUMMARY

The key findings, conclusions and the recommendations that follow them are reproduced below.

A. The Federal Monitoring Exercise

1. Conclusions

1.1 PHCCs as Constituency Projects and Allocations not fully Implemented: Many of the allocations for PHCCs are for constituency projects of federal lawmakers. The allocations for most of the PHCCs have not been fully implemented. In places where construction took place, facilities and equipment were not provided. The construction did not take into consideration the deployment of staff that would manage the facilities. The allocations seem to be contract driven instead of being driven by the need for improvement and expansion of service delivery.

1.2 No Needs Assessment to Inform Location of PHCCs: It is evident that there was no needs assessment by the authorities before PHCCs were located in the communities. The decision to build the PHCCs was more of politics than based on the need of the community. PHCCs were sited very close to general hospitals or existing PHCC facilities. In some instances, what was needed was the rehabilitation and upgrade of existing facilities instead of building new ones. And this affected the demand for services in so many locations. The location of these facilities would have been informed by data from the National or State Health Management Information System. But this does seem to be the case.

1.3 Community Ownership was Lacking: There was no consultation between the authorities who took the decision to build PHCCs and the communities that were to benefit from its services. In many instances, the communities did not have a sense of ownership or even think that the project was a necessity in the first instance. Again, there seems to have been no consultation between the management of existing PHCC facilities and the authorities who took the decision to locate new PHCCs or fund the upgrade of existing ones. The foregoing challenges have created a gap that affects the functionality of the PHCCs.

1.4 Poor/No Consultation and Interface between Federal, State and Local Government Authorities: PHC is within the domain of States and LGCs. Federal Government only builds infrastructure but is not involved in the day to day running of the PHCCs. For PHCCs built by the FGN to be functional, there should have been an agreement, a memorandum of understanding between the FMoH, State and LGC authorities whereby the later will take over, post personnel and take charge of overhead

costs of the new facilities. Otherwise, the buildings will be overtaken by rodents and weeds and this was the situation in some federally constructed PHCCs. This problem would have been handled if adequate consultation was made with the state authorities and LGCs to ensure a seamless transition between capital and infrastructure development and personnel and overhead funding.

1.5 Disparity in Allocations for Construction of PHCCs For a new project which involves the construction of PHCC, it was discovered that while some facilities had allocation that is up to forty five million naira, other facilities had allocation that is not more than sixteen million naira. There is apparently no rationale for such huge disparity. Considerations for the construction of new PHCCs should be based on the Approved Minimum Standards for PHC (AMSfPHC) in Nigeria, where costs for certain provisions are benchmarked. The AMSfPHC has standards for the required number of rooms, land area, wards, staff quarters and other facilities; the cost of meeting the standards should have been predetermined and used as a basis for uniform allocations, especially for new PHCCs. The cost may be different for the equipping of existing PHCCs; where there is existing equipment, the costing should be based on remaining equipment to be purchased.

1.6 Inadequate Human Resources in the PHCC: In most of the PHCCs visited, the personnel requirements were not met; most of the PHCCs have just few staff and relied on volunteers. The volunteers are given stipends out of the voluntary will of staff at the PHCCs. None of the PHCCs visited had the full complement of the minimum recommended staff number and cadre - midwife or nurse/midwife, 2 CHEW, 2 JCHEWS, attendants/assistants and 2 security personnel.

1.7 Inadequate Infrastructure and Equipment: Most of the facilities visited did have the full complement of the supporting health infrastructure as prescribed in the AMSfPHC in Nigeria. This would have meant the PHCC being sited in a land area of not less than 2,475 square metres, clean water source from a motorized borehole, detached building with at least 5 rooms with walls and roof in good condition, functional doors and netted windows. Other requirements include fenced premises with gate and generator house, connection to national electric grid and other alternative sources of power, staff accommodation provided within premises - 2 bedroom apartments, sanitary waste disposal, functional separate male and female toilets, etc. In locations where boreholes were dug and alternative power supplies such as solar panels and inverters are provided, they are not fully optimized due to poor maintenance culture.

All the PHCCs visited show that there is hardly consideration for the welfare of staff. There are no provisions for staff quarters, even where they are; they are not good enough for human habitation. Equipment such as delivery kits, beds, wheel chair, dissecting and dressing forceps, solar refrigerator, etc. were lacking in some of the facilities.

1.8 Project Implementation Status: In most of the tertiary health institutions, it was evident that projects allocated for MNCH were either started, abandoned, ongoing or completed. This is unlike the facilities in some communities which had allocations in the federal budget but did not start at all. This might be attributed to the existence of strong systems and management at the tertiary institutions. For PHCCs in communities, many of them are constituency projects caught in the crack between the MDAs and federal legislators.

1.9 Multiple Allocations in Budgetary Provision for MNCH Projects in Tertiary Institutions: MNCH and PHC projects in tertiary institutions have varying degrees of allocations for the same budget head re-occurring in every budget cycle. It is not clear what the total costs of the projects are and if they were fully released and utilised. Without access to information, it is difficult to track the exact amount needed to complete these projects and to know when the allocations have surpassed the actual amount needed.

1.10 MNCH Projects at Tertiary Health Institutions are of High Value: The MNCH projects situated in tertiary health institutions are of high value; from the need assessments to implementation and actual service delivery of the projects. These show adherence to quality and standards which if replicated across the country can improve the PHC delivery as well as MNCH indicators.

1.11 Access to Health Budget Information: The FMoH and its parastatals and agencies have deliberately withheld the financial information about the implementation of projects from Nigerians. The FMoH has even refused to respond to freedom of information requests. The Ministry has failed to discharge its duty under section 2 (3) (d) (v) of the Freedom of Information Act which requires it to provide and cause to be published on a regular basis, information relating to the receipt or expenditure of public or other funds of the institution. Again, the FMoH is under obligation by section 2 (4) of the Freedom of Information Act to ensure that such information is widely disseminated and made readily available to members of the public through various means, including print, electronic and online sources and at its offices.

1.12 State Primary Health Care Under One Roof: The benefits of the PHCUOR have not materialized as the states visited (with the exception of Lagos) are yet to set up the system.

1.13 Engaging the Basic Health Care Provision Fund: States are yet to anticipate their engagement of the federal Basic Health Care Provision Fund (established under the National Health Act) which will require counterpart funding from the states.

2. Recommendations

2.1 PHCCs Allocations: FGN should adopt good and fit practices in budgeting, especially in revenue forecasts to ensure that expected revenue will be available to fund

the projects in the federal budget. Contract driven projects should be replaced with projects focused on expansion and improvement of service delivery. Appropriated funds should be released on time to ensure effective project delivery.

2.2 Needs Assessment to Inform Location of PHCCs: The location of new PHCCs should be informed by evidence based on a needs assessment and informed by data from the National or State Health Management Information System. Location of health projects should no longer be driven by political expediency. These projects should get into the budget after scaling the hurdle of criteria listed for admission of projects under the medium term sector strategies.

2.3 Community Ownership is Imperative: Projects of this nature should get community buy-in and ownership from the conceptualization stage. Adequate consultation will guarantee community support and eventual uptake of the services offered in the facilities. It will also guarantee that such projects are not duplicated and existing facilities are upgraded in a value for money approach.

2.4 Adequate Consultation and Interface between Federal, State and Local Government Authorities: The FMoH or National Primary Health Care Development Agency should enter into a memorandum of understanding with states and local governments where new PHCCs are to be located. The memorandum of understanding is to guarantee that the facilities will be utilized through state and LGC commitment of personnel and overhead resources to make the facilities functional. It is even suggested that the federal budget should focus on strengthening existing and functional PHC facilities, to improve service delivery, instead of commencing the construction of brand new facilities.

2.5 Allocations for Construction of PHCCs should be Standardized: Following the AMSfPHC in Nigeria, allocations for the construction, furnishing, etc. of PHCCs should be standardised unless in situations where the topography makes the construction costs more expensive.

2.6 Human Resources in the PHCC: The personnel requirements of PHCCs should be benchmarked upon the AMSfPHC in Nigeria. The human resource challenge calls to mind the need to enforce the provisions of the National Health Act on certification of health institutions.

2.7 Infrastructure and Equipment: The infrastructure and requirement of PHCCs should be benchmarked upon the AMSfPHC in Nigeria. The infrastructure and equipment challenge calls to mind the need to enforce the provisions of the National Health Act on certification of health institutions.

2.8 Dissemination of Good Practices: In situations where successes have been recorded, for instance, in the implementation of PHC projects in tertiary health

institutions, the good practice should be disseminated for possible replication by other project implementing agencies.

2.9 Access to Health Budget Information: The FMoH and its parastatals and agencies should strictly and meticulously comply with the full gamut of the Freedom of Information Act to make budgetary information accessible to all Nigerians.

2.10 Establish State Primary Health Care Under One Roof: Effort should be made to actualize full implementation of the State Primary health Care under One Roof. The scores obtained from the implementation of the PHCOUR, Using the Nine PHCOUR parameters of governance and ownership, legislation, minimum service package, repositioning, system development, operational guideline, human resources, funding source and structure and office set up, from the states covered in this monitoring exercise shows that Rivers State has the highest in the implementation of the SPHCOUR with 73%, followed by Bauchi 67%, Katsina 59%, Lagos 50%, Kaduna 46%, Plateau 28% and Imo State, the least with 8%.

2.11 States Should Consider Providing for State Level Basic Health Care Provision Fund: State governments should consider establishing a State Level Basic Health Care Provision Fund (BHCPF) and make a deduction of not less than 1% of their states Consolidated Revenue Fund to fund the BHCPF. This should be taken as a key priority to improve the health status of citizens in consideration of the fact for states to access the BHCPF, they will be required to provide a counterpart fund of 25% of the cost of the project.

B. Katsina State Monitoring Exercise

3. Conclusions

3.1 Poor MNCH Indicators: Katsina State's MNCH indicators are poor, below the national average and urgent action needs to be taken to improve the situation. The signing of the State Primary Health Care Under One Roof is a good platform to harmonize the needs of the PHCCs and provide adequate funding and institutional reforms for the proper management of PHC and MNCH services**.**

3.2 The Health Budget: Even though there is increasing appropriation for health in the state budget, the releases are far less than the appropriated sums. The state seems not to be using the maximum of its available resources for the progressive realization of the right to health. Many of the innovations and service delivery initiatives are funded by donors.

3.3 Shortage of Staff: A common challenge in all the PHCCs visited is shortage of qualified staff. Most facilities lack the full complement of staff as stated under the AMSfPHC in Nigeria. Most of the personnel utilized at the PHCCs are casual workers, assistants and CHEWS.

3.4 Decrepit Buildings: Many of the buildings housing the PHCCs are dilapidated and require renovation. From the floors, windows and doors, painting, the ceilings and roofs, a good number of the Centres require renovation of their buildings.

3.5 Poor Facilities: Most of the facilities at the PHCCs require upgrade. Water and electricity were common needs in virtually all of the PHCCs. Alternative power supply such as generators and solar panels needs to be installed and routinely maintained to power equipment like fridge, boreholes, etc. Evidently, the non-functional solar facilities are a product of poor quality of the initial installation and lack of maintenance.

3.6 Needed Equipment: The full complement of equipment identified in the AMSfPHC in Nigeria is not available in majority of the visited PHCCs.

3.7 Drugs Supply: There is an impressive supply of drugs in most of the PHCCs visited. Through the MNCH2, and the SPHCDA, patients have largely enjoyed free drugs in the PHCCs. However, in some PHCCs, patients have to pay for drugs which are meant to be given for free**.**

3.8 24hours Service Lacking in Some PHCCs: Some PHCCs visited, which should be open for 24 hours service have been reduced to function for only seven to eight hours. This poses a high risk for emergency services. In cases where a patient requires emergency services, the time lag available for such patient to access a distant PHCC might worsen his or her condition and may lead to loss of lives.

3.9 Lack of Training for Staff: It was observed that most of the personnel did not receive adequate training. The volunteers and casual staff including medical attendants have not been exposed to training in the past three years. They are only supervised by visiting qualified staff who might not have the time to offer them the much required training.

3.10 Routine Immunization: Routine Immunization has been mainstreamed at the PHCCs. Most of the facilities visited have days for immunization and usually record good turnout of beneficiaries. With the support of international partners, SOML, MNCH2, etc., vaccines have been provided at the PHCCs and this is accessed free of charge.

4. Recommendations

4.1 Improved Budget Allocation and Releases: The state government needs to consider ring-fencing the allocation to the health sector, especially the votes for PHC and MNCH to ensure that budgeted sums are released and utilized. The state should appropriate, release, cash-back and utilise not less than 10% of its overall budget resources for the health sector.

4.2 Use Health Management Information System to inform Planning and Budget: The state government, using the State Health Management Information System, should identify PHCCs which require upgrade and use the data for its planning and budgeting.

4.3 Establish a state Level BHCPF: The state government should proactively establish the Basic Health Care Provision Fund with 1% of its CRF or a counterpart fund to take advantage of grants from the federal BHCPF.

4.4 Start a Compulsory and Universal Health Insurance Scheme: Attract more funding for primary health care by enacting a mandatory contributory health insurance scheme. Community based health insurance scheme can be introduced at the communities with subsidized premiums and concessions for vulnerable groups such as the aged, children and pregnant and nursing mothers while formal and informal sector health insurance scheme should be set up for citizens at the urban centers

4.5 Hire more Qualified Staff: The state should hire more qualified health personnel and evenly distribute them across the state. The staffing should aim at meeting the full complement of staff as stated under the AMSfPHC in Nigeria. The state should de-emphasize the engagement of casual workers and volunteers.

4.6 Renovate Decrepit Buildings: The decrepit buildings housing the PHCCs should be renovated. From the floors, windows and doors, painting, the ceilings and roofs, the Centres should wear a new look.

4.7 Improve Facilities: The water and electricity challenge common in the PHCCs should be addressed. Alternative power supply such as generators and solar panels needs to be installed and routinely maintained to power equipment like fridge, boreholes, etc. Quality assurance standards should be deployed in the procurement of goods and works for solar facilities; warranties should be secured from installers and suppliers to guarantee the quality of the initial installations. This should be followed up with routine and timely maintenance.

4.8 Needed Equipment: The state government should take concrete and targeted steps to ensure the progressive availability of the full complement of equipment identified in the AMSfPHC in Nigeria in the PHCCs.

4.9 Drugs Supply: The state government working with development partners should improve on the existing supply of drugs and ensure that patients do not have to pay for drugs which are meant to be given for free**.**

4.10 24hours Service in PHCCs: More personnel recruitment and provision of supporting facilities will guarantee that 24 hours service is restored in most PHCCs. Ambulance services should also be made available for emergency evacuation.

4.11 Training for Staff: Continued training of professional staff, volunteers and casual workers should be guaranteed through the plan, policy, budget continuum. Funding should be made available for training and retraining.

4.12 Routine Immunization: The state should enforce relevant laws that provide for compulsory immunization and if possible, punish parents and guardians who withhold their children from taking advantage of the free immunization services.

4.13 Effectively Utilize Constituency Projects: Members representing various constituencies at the state and federal parliaments should rather than building new PHCCs, identify the existing PHCCs in their community and partner with the state government to make them functional up to the minimum required standard. This should form part of their constituency projects to the communities.

4.14 Effective Legislative Oversight: Legislators should ensure effective and proper oversight of the management of resources and services rendered at the PHCCs.

4.15 Effective Citizens Oversight: CSOs should engage in monitoring and oversight of the state of PHCCs and the services they render and use the monitoring results to engage policy makers.

5. Kaduna State Monitoring Exercise

5.1 Poor Water Supply: Most of the PHCCs have a borehole but for a multiplicity of reasons, the boreholes are not functional. It is not enough to award a contract and spend money in the drilling and construction of borehole and at the end of the day, water is not available to the beneficiaries. Proper hydrological surveys should precede the siting and construction of a borehole. It is a waste of public resources and increases the hardship faced by the intended beneficiaries when such money is spent and no value is gained.

5.2 Poor Sanitary Conditions: Some PHCCs have no toilet at all whilst others use pit latrine and dirty flush toilet facilities. Water scarcity further complicates the situation. This is not a tolerable situation in a health facility.

5.3 Lack of Functional Renewable Energy Installations: Most of the renovated PHCCs have provision for inverters, solar panels and solar fridges. However, due to lack of maintenance, the renewable energy installations are either not properly working or not functional. While the provision of this facility has been proven to be the best energy option for PHCCs, they must be properly maintained to serve the purpose. Further, it seems the suppliers and installers of these renewable energy facilities do not provide a warranty to the state and evidently, there are no maintenance contracts to ensure that they are serviced at regular intervals.

5.4 Disconnection from Available Grid Electricity: Some of the facilities have been disconnected from supply available from the national grid and this worsens the challenge of access to electricity.

5.5 Inadequate Space and Conditions of Buildings: Some of the facilities do not have adequate space - being a minimum of 5 rooms, walls and roofs were in poor condition without functional doors and netted windows. Some of the facilities do not have enough rooms to accommodate delivery and outpatient services, including patients that come for immunization. Majority of the facilities do not have staff quarters

5.6 Lack of Security: The monitors discovered that services of casual workers were withdrawn from the state health services and this affected the security personnel of PHCCs in the state. The absence of security personnel poses grave danger to the protection of staff and equipment in the PHCCs. There is need to immediately reconsider the decision and employ security personnel for the PHCCs and also provide adequate fencing of the facilities.

5.7 Inadequate MNCH Equipment: Most of the facilities visited lacked vital MNCH equipment; they rely mostly on donor assistance for the provision of these equipment. This does not guarantee sustainability. It should be the responsibility of the state and local governments to ensure that adequate equipment is available in the PHCCs in accordance with the AMSfPHC.

5.8 Non Observance of 24hrs Services in most PHCCs: The minimum standard is for PHCCs to operate 24hours on a shift basis. However, most of the facilities do not operate 24hours service. This will affect patients who are in dire need of emergency services at night. Efforts should be made to ensure that the right environment is created for PHCCs to run 24hours service.

5.9 Disproportionate Distribution of Personnel: Some of the PHCCs visited had adequate staff while others have very little number of staff. There is the need to train and engage more qualified hands and for even distribution of the available human resources for health.

5.10 Reasonable Service Provision: Most of the PHCs offer all the required minimum service provided by the service guidelines in the AMSfPHC. This is commendable; for PHCs where some of the services are not offered, efforts are ongoing to train some of the staff to acquire the skills and begin operation in the PHCC. The state government should facilitate the operation of the AMSfPHC in all the PHCCs.

5.11 Free Services: While treatment in some PHCCs including drugs is free, others charge fees for their services. It may be more equitable for the state to articulate its minimum core obligations to citizens based on available resources and make it available free of charge to all. Any service beyond the minimum provisions should be

paid for. The current approach seems discriminatory and is not based on any empirical foundations.

5.12 The Health Budget: Budgetary allocations to health look reasonable on paper. But release of the appropriated sums lags and this leads to public underfunding of health care.

6. Recommendations

The following recommendations flow from the above findings and conclusions.

6.1 Improve Water Supply: Proper hydrological surveys should precede the siting and construction of boreholes. The contracts should be awarded to reputable companies who would equally be bound to provide a warranty on their service and installed equipment. Again, routine maintenance of facilities will guarantee that they are functional.

6.2 Improve Sanitary Conditions: This is a clear case of emergency that demands that proper flush toilets be available in all PHCCs and that managers of the facilities be placed under obligation to ensure their cleanliness and maintenance. Availability of water will also improve sanitary conditions.

6.3 Functional Renewable Energy Installations: Contracts for the procurement of renewable energy materials should be given to reputable vendors and installers. Furthermore, it is imperative that suppliers and installers of these renewable energy facilities provide warranties to the state. Maintenance contracts to ensure that they are serviced at regular intervals should also be built into the supply and installation contracts.

6.4 Connection to Available Grid Electricity: All PHCCs should be connected to electricity supply available from the national grid and adequate overhead costs set aside for regular payment of electricity tariffs. Indeed, it makes eminent sense for all PHCCs to procure prepaid metres.

6.5 Improve Space and Conditions of Buildings: The renovation exercise provides the opportunity for the facilities to be provided with adequate space being a minimum of 5 rooms, walls and roofs in proper conditions with functional doors and netted windows, enough rooms to accommodate delivery and outpatient services, including patients that come for immunization, staff quarters, etc.

6.6 Improve Security: The facilities should be secured through fencing and the employment of security guards as well as liaison with the security authorities in the area including the police and civil defence.

6.7 Provide PHC/MNCH Equipment: The state government should provide adequate funding for procurement of equipment. Liaison with development partners including

donors, the private sector, etc. will increase resources available for procurement of equipment as stated in the AMSfPHC.

6.8 Ensure 24hrs Services in PHCCs: The state should guarantee, through the provision of adequate personnel and facilities that PHCCs operate 24hours a Day.

6.9 Even Distribution of Personnel: There is the need to train and engage more qualified hands and ensure even distribution of the available human resources for health. The state should consider incentives for qualified personnel working in rural areas.

6.10 Free Services: It is pertinent and equitable for the state to articulate its minimum core services to be made available to all citizens based on available resources. These services should be made available free of charge to all. Any service beyond the minimum provisions should be paid for.

6.11 Improve Health Funding: The state government should consider establishing a special fund or a state level BHCPF which would be used to attract counterpart funding from the federal level BHCPF.

6.12 Compulsory and Universal Health Insurance: Attract more funding for primary health care by fully implementing the Kaduna State Contributory Health Insurance Scheme. The insurance scheme should be made compulsory and universal. Premiums from community based health insurance scheme can contribute largely to the funding of the PHCCs.

6.13 Liaison with Federal Legislators: The state government should liaise with members representing various constituencies in the state at the National Assembly; rather than their requesting for resources to build new PHCCs, identify the existing PHCCs in their communities and partner with the state government to make them functional up to AMSfPHC in Nigeria. This should form part of their constituency projects to the communities.

6.14 Effective Citizens Oversight: CSOs should engage in monitoring and oversight of the state of PHCCs and the services they render and use the monitoring results to engage policy makers for improved service delivery.

1. INTRODUCTION

1.1 Background

Inadequate budgetary provision for health across all tiers of government is a major contributor to Nigeria's poor maternal and child health indicators. Certainly, this leads to the poor funding of primary health care (PHC) and its primary health care centres (PHCC). Since 2014, Nigeria's federal budgetary allocation to the health sector has averaged 4.72 percent of the total budget. The bulk of the health budget is for recurrent expenditure with little allocation for capital expenditure. Between 2010 and 2018, capital expenditure for health has average 19.72 percent of the federal health budget as shown in Table 1.

Table 1: Capital Allocation to the Health Sector 2010-2018

Year	Total Health Budget	Capital Health Budget	Capital Health Budget as % of Total Health Budget
2010	164,914,939,155	53,006,615,191	32.14%
2011	257,870,810,310	55,411,957,377	21.49%
2012	284,967,358,038	60,920,219,702	21.38%
2013	282,501,464,455	60,047,469,275	21.26%
2014	264,461,210,950	49,517,380,725	18.72%
2015	259,751,742,847	22,676,000,000	8.73%
2016	250,062,891,075	28,650,342,987	11.46%
2017	308,464,276,782	55,609,880,120	18.03%
2018	356,450,966,085	86,485,848,198	24.26%
Average	269,938,406,633	52,480,634,841.67	19.72%

Source: Budget Office of the Federation

Despite the meagre allocation to the health sector, the capital component is not fully released and cash backed and this leads to poor utilisation and project implementation. Generally, the procurement system for health project implementation fails to guarantee value for money with its cardinal parametres of economy, efficiency and effectiveness. This creates a huge health infrastructure gap and negatively affects the provision of health services at the primary, secondary and tertiary levels.

A breakdown of Nigeria's health expenditure indicates that both state and federal governments have focused spending at the secondary and tertiary levels while PHC has

not attracted the level of funding required to improve service delivery. Unfortunately, majority of Nigerians (especially mothers, infants and children) are poor, with a good number living in rural areas and places where PHCCs attend to their preventive and curative care. Pregnant and nursing mothers require antenatal and postnatal care, routine drugs, immunisation and provision of delivery kits. Nigeria's maternal, new born and child health (MNCH) indicators resulting from this state of financing and service delivery is summarized in Table 2.

Table 2: MNCH Statistics in Nigeria

Indicator	Performance
Maternal mortality ratio (per 100 000 live births)	814
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)	26.3
Proportion of births attended by skilled health personnel (%)	43
Under-five mortality rate (per 1000 live births)	104.3
Neonatal mortality rate (per 1000 live births)	34.1

Source: World Health Statistics 2018, World Health Organization

Apart from the poor budgetary funding of PHC, there is a gap in the implementation of laws and policies such as the National Health Act (2014) and the PHC Under One Roof (PHCUOR). Their full implementation would have facilitated the proper alignment of PHC projects and at the same time, guarantee proper management of budgetary allocations to the sector. Also, the process for the selection and funding of some PHC projects in the federal budget leaves much to be desired. It has been observed that there is a yearly ritual of providing for PHCCs and MNCH services in the federal budget including components of MNCH in the vote of tertiary health institutions. Thus, the federal government embarks on the construction of PHCCs but cannot run them. This leaves the state and local governments with the task of providing the personnel and overhead costs of running the PHCC. In some instances, the building and facilities have been left to rodents and overgrown by weeds. There is no evidence to show that these budgetary provisions have led to the improvement of MNCH indicators at the state or national levels.

Constituency projects for MNCH appear consistently in the budget; they are repeated with different budgetary figures annually, and the reason for their repetition cannot be ascertained. It is therefore imperative to ascertain whether the funds allocated for these projects were released by the Ministry of Finance or whether the projects have been completed or abandoned. It is also important to find out the impact of concluded PHCC and similar projects on intended beneficiaries. Thus, the research leading to this study seeks to address the root causes of poor infrastructure and service delivery at the PHCCs.

1.2 Rationale and Study Objectives

The expenditure of public funds is a trust, in which the spending agencies are under obligation to be accountable to citizens. Under section 30 of the Fiscal Responsibility Act, the Ministry of Finance through the Budget Office of the Federation is duty bound to produce quarterly budget implementation reports. The reports are hardly produced on time and the last budget implementation report on the website of the Budget Office of the Federation as at August 2018 is the draft report of the third quarter of 2017. Also, by section 2 (3) (d) (v) of the Freedom of Information Act, all public institutions including the Federal Ministry of Health (FMoH) and its parastatals are under obligation to publish information relating to the receipt or expenditure of public and other funds of the institution.

Further, the NHA in section 2 (d) requires the Federal Ministry of Health to: *"ensure the preparation and presentation of an annual report of the state of health of Nigerians and the National Health System to the President and the National Assembly"*. Again in section 35 (3) of the NHA, it is provided that: "*The Minister and Commissioners shall publish annual reports on the state of health of the citizenry and the health system of Nigeria including the states thereof".* However, the provisions in all the afore-stated laws and policies have been honoured in the breach. Against the background of Nigeria's poor health indicators, especially in the area of MNCH, it became imperative to set machinery in motion for monitoring and reporting on the expenditure of public resources. This is with a view to improving value for money, holding duty bearers to account and empowering the beneficiaries.

The objectives of the study leading to this report are:

- To determine the extent of implementation of constituency projects for PHC.
- To determine the extent of implementation of MNCH projects approved in tertiary health institutions.
- To determine the challenges in the implementation of MNCH projects in both PHCs and tertiary health institutions and make recommendations for improvement.
- To conduct advocacy from the findings on the state of the PHCCs on the visited projects sites and make specific recommendations for systemic improvement.

1.3 Study Methodology

The project involves monitoring PHCCs across the Federation. Six states across the six geopolitical zones were selected namely: South East - Imo; South South - Rivers; South West - Lagos; North Central - Plateau; North East - Bauchi and; North West - Kano. It considered MNCH projects that have received funding from the federal budget between the years 2014-2017. Two projects were selected from each zone; they include one

MNCH project in a secondary or tertiary institution and a PHC constituency project. However, in Imo State, where no MNCH project was located at the tertiary or secondary institution, only PHCCs were visited.

Places visited include: Amaokpara Community in Nkwerre LGA and Amanaogu in Orsu Local Government Area (LGA) were visited to monitor the construction of ongoing Amaokpara Comprehensive Health Centre Nkwerre and equipping and furnishing of PHCC in Amanaogu Autonomous Community Orsu, respectively in Imo State. In Rivers State, University of Port Harcourt Teaching Hospital (UPTH) and Isiodu Emohua LGA were visited to monitor the construction of Amenity Centre in UPTH and construction of PHCC in Emohua. In Lagos State, Lagos State University Teaching Hospital (LASUTH) and Ajah LGA were visited to monitor the completion and equipping of Children Emergency Centre, equipping of Assisted Reproductive Centre in LASUTH and the construction of PHCC at Ajah, Eti-Osa federal constituency. In Plateau State, the Jos University Teaching Hospital (JUTH) and Gora, Fursum District in Jos East LGA were visited to monitor the construction of In Vitro Fertilisation Centre JUTH and the PHCC in Gora, Fursum District.

In Bauchi State, the National Obstetric Fistula Centre (NOFIC) and Hanafari District, Jamare were visited to monitor the construction of a theatre complex, three operating suites with offices, recovery room and sterilization unit (NOFIC); and the construction of PHCC Jama'are. In Kano State, Aminu Kano University Teaching Hospital (AKTH) and Tudun Wada LGA were visited to monitor the construction of post basic nursing school and furnishing AKTH and the construction and equipping of model PHCC, Tudun Wada.

A freedom of information request letter was sent to the Federal Ministry of Health (FMoH) to obtain relevant information concerning the cost of the above projects and their status of completion. However, as at the time of visiting the facilities and computing this report, CSJ is yet to get a response from the FMoH. The project officer managed to get the information on the above projects based on desk research and the cooperation he received from most of the staff of the facilities visited. A four year budget allocation trend analysis was conducted from 2014 to 2017 to identify the appropriations allocated to the monitored projects.

The key research questions focused on extracting information on the following details:

- Name of the contract/project code
- Year the contract was awarded
- Name of the Ministry/Implementing Agency responsible for the implementation of the contract
- Name and details of the contractor handling the project.
- Allocations in the federal budget over the years
- Terms and details of contract

- Releases and payments to the contractor
- Status of the contract (completed, ongoing, stopped, abandoned, rating by percentage)
- Date of completion or stoppage of work
- Whether contract implementation met the requirements as indicated in the terms of the contract
- Challenges to contract execution? If yes, nature of the challenge
- Beneficiary awareness of the contract
- Situation before the contract
- Value addition and impact on the proposed beneficiaries
- Whether project meets industry standards such as the National Minimum Service Package for Health infrastructure, equipment, human resources and services

1.4 Challenges and Limitation to the Exercise

Between the years 2014-2017, there were more than 1000 projects in the federal budget for construction and or renovation of PHCCs whose status of completion or utilization cannot be ascertained. This intervention is only limited to a fragment of such projects. The spread of ongoing MNCH projects nationwide requires citizens and civil society oversight. The major challenge experienced in the exercise was the inability to cover so many PHCs facilities and to obtain information on the financial status of the projects visited. The project authorities in the field insisted that they have no mandate to release project details without authorization from the supervising agency and FMoH. CSJ had sought to collaborate with the FMoH for joint capital budget monitoring exercise, or in the alternative, to get authorisation letter to monitor the ministry's capital projects. However, the collaboration and approval did not come.

The monitor, in the course of inspecting a PHC project site at Amanaogu community in Orsu LGA was threatened with violence. He had to leave the community although he had obtained the bulk of needed information before the threat. It is regrettable that Nigeria is still at the level where individuals will descend so low and fail to understand that accountability for expenditure of public funds is a fundamental trust under a democracy.

2. GUIDING STANDARDS: THE RIGHT TO HEALTH PERSPECTIVE

These are the standards that will guide the evaluation of the PHC and MNCH projects and their functionality in terms of service delivery to the beneficiaries.

2.1 International Covenant on Economic, Social and Cultural Rights (ICESCR)

Nigeria is a State party to the International Covenant on Economic, Social and Cultural Rights (ICESCR) which in article 12 provides for the right to health. In fleshing out the parametres of the right, the following normative attributes were assigned to the right to health by the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR)[1].

> *13. The right to health in all forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party.*
>
> *(a). **Availability:** Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health such as safe and portable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs*
>
> *(b). **Accessibility**: Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:*
>
> *Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable and marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.*
>
> *Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups such as ethnic minorities and indigenous populations, women, children adolescents, older persons, persons with disabilities and persons with HIV/AIDs. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes access to buildings for persons with disabilities.*

[1] See General Comment No.14 approved in the year 2000.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

***(c). Acceptability:** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate. i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.*

***(d). Quality:** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter-alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.*

14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art 12.2 (a) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre-and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.

2.2 Approved Minimum Standards for Primary Health Care in Nigeria

The National Primary Health Care Development Agency (NPHCDA) has set approved minimum standards for PHCCs in Nigeria. The minimum standards were defined under Health Infrastructure, Human Resources for Health and Service Provision. Table 3 below shows the standard for PHCCs.

Table 3: Approved Minimum Standards for Primary Health Care in Nigeria

HEALTH INFRASTRUCTURE	HUMAN RESOURCES FOR HEALTH	SERVICE PROVISION
DEFINITION: IT MEANS THE TYPES/LEVELS OF PHC FACILITIES INCLUDING RECOMMENDED INFRASTRUCTURE DIMENSIONS, FURNITURE AND EQUIPMENT	MINIMUM RECOMMENDED STAFF NUMBER AND CADRE FOR EACH TYPE OF HEALTH FACILITY	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 SERVICE
MINIMUM LAND AREA - 2,475 SQUARE METRES	MIDWIFE OR NURSE MIDWIFE	HEALTH EDUCATION AND PROMOTION
AVAILABILITY OF A CLEAN WATER SOURCE AT LEAST MOTORIZED BOREHOLE	2 CHEW (MUST WORK WITH STANDING ORDER)	HEALTH MANAGEMENT INFORMATION SYSTEM
A DETACHED BUILDING WITH AT LEAST 5 ROOMS WALLS AND ROOF MUST BE IN GOOD CONDITION WITH FUNCTIONAL DOORS AND NETTED WINDOWS. FUNCTIONAL SEPARATE MALE AND FEMALE TOILET FACILITIES WITH WATER SUPPLY WITHIN THE PREMISES	2 JCHEW 4 SUPPORT STAFF HEALTH ATTENDANT/ASSISTANT	ROUTINE HOME VISITS & COMMUNITY OUTREACH
BE CONNECTED TO THE NATIONAL GRID AND OTHER REGULAR ALTERNATIVE POWER SOURCE	2 SECURITY PERSONNEL	MATERNAL, NEWBORN AND CHILD CARE-
HAVE A SANITARY WASTE COLLECTION POINT. HAVE A WASTE DISPOSAL SITE		FAMILY PLANNING
BE CLEARLY SIGNPOSTED, VISIBLE FROM BOTH ENTRY AND EXIT POINTS		PROMOTION OF PROPER NUTRITION AND FOOD EDUCATION
BE FENCED WITH GATE AND GENERATOR HOUSES		IMMUNIZATION
STAFF ACCOMMODATION PROVIDED WITHIN THE PREMISES: 2 BEDROOM APARTMENTS		HIV/AIDS
THE BUILDING MUST HAVE SUFFICIENT ROOMS AND SPACE TO ACCOMMODATE: CLIENT OBSERVATION AREA, CONSULTING AREA, DELIVERY ROOM, FIRST STAGE ROOM, INJECTION AND DRESSING AREA, LYING-IN WARD (4 BED), PHARMACY SECTION RECORD SECTION , STAFF STATION STORE, TOILET FACILITIES (OR VIP TOILET)WAITING/RECEPTION AREA		TUBERCULOSIS

FURNISHING BENCHES – 8, CHAIRS – 10, CUPBOARDS – 2, CURTAINS FOR WINDOWS AND DOORS – ALL		MALARIA
DELIVERY BED - 1 · EXAMINATION COUCH - 2 · OBSERVATION BEDS - 4 · SCREEN - 2 · WASH HAND BASIN - 2 · WHEEL CHAIR - 1 · WRITING TABLE – 3		CURATIVE CARE
MEDICAL EQUIPMENT		ESSENTIAL DRUGS
ADULT WEIGHING SCALE - 2 · AMBUBAG - 1 · ARTERY FORCEPS – 2		WATER AND SANITATION
BABY WEIGHING SCALE (1), BED PAN (4) BED SHEETS (2) PER BED, · CLINICAL THERMOMETERS, (2) COLD BOXES – (1) CORD CLAMPS – (1) PACK CURTAINS, 1 PER WINDOW, CUSCOS SPECULUM (2), DISPOSABLES FACEMASK, GLOVES E TC) - 1 PACK EACH, DISSECTING FORCEPS - 2 , DRESSING FORCEPS – 2, DRESSING TROLLEY – 1, ENEMA KITS – 2, EPISIOTOMY SCISSORS - 2 , FOETAL STETHOSCOPE - 2 , INSTRUMENT TRAY – 2, KIDNEY DISHES – 4, KIDNEY DISH - 2 , LANTERNS, BUCKETS - 2 EACH , MULTISTIX TEST KITS - 1 PACK OF 100 NEEDLE HOLDING FORCEPS - 2 , ORT DEMONSTRATION EQUIPMENT - * 1 SET *CUP, JUG, WASH BASIN, TOWEL, BUCKET, STANDARD BEER OR/AND SOFT DRINK BOTTLES REFRIGERATOR – 1, SCISSORS - 2 , SIMS SPECULUM – 2, SOLAR REFRIGERATOR - 1 , SPHYGMOMANOMETER - 2 , STADIOMETER - 1 , STETHOSCOPE - 2 STERILISATION EQUIPMENT - 1 , STOVE – 1, SUCTION MACHINE OR (MUCUS EXTRACTORS) -1 , TAPE RULE – 1, URINARY CATHETER - 2 OF EACH SIZE, GEO STYLE VACCINE CARRIERS (GSVC) – 2, ICE PACKS - 4 PER GSVC		ORAL HEALTH
		MONITORING
		SUPERVISION

		WASTE DISPOSAL
		ADOLESCENT HEALTH
		MONITORING
THE FACILITY SHOULD RUN FOR 24 HOURS		

Source: Minimum Standards for Primary Health Care in Nigeria, National Primary Health Care Development Agency[2]

2.3 The National Health Act

Section 11 of the National Health Act (NHA) makes provision for the allocation of one percent of the Consolidated Revenue Fund for the implementation of the Basic Health Care Provision Fund (BHCPF). According to S. 11 (3)-(4) of the NHA: (3) Money from the Fund shall be used to finance the following:-

- *(a) 50% of the Fund shall be used for the provision of basic minimum package of health services to citizens, in eligible primary or secondary health care facilities through the National Health Insurance Scheme;*
- *(b) 20 percent of the Fund shall be used to provide essential drugs, vaccines and consumables for eligible primary health care facilities;*
- *(c) 15 percent of the Fund shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities;*
- *(d) 10 percent of the Fund shall be used for the development of human resources for primary health care; and*
- *(e) 5 percent of the Fund shall be used for Emergency Medical Treatment to be administered by a Committee appointed by the National Council on Health.*

The Act further provides that states and local government shall make a counterpart fund contribution of 25% to access the grant for any of these services. Since 2014 when the Act was passed into law, it is only in 2018 that the National Assembly included the BHCPF into the supplementary capital estimate of the budget. It will suffice to say that the non-implementation of this section of the NHA is partly responsible for the negligence of PHC services in most states of the Federation[3].

2.4 Federal Government Policy on the Revitalization of PHCCs

The Federal Government has a policy of revitalizing 10,000 PHCCs nationwide. In 2017, the sum of N1bn was allocated for the revitalization of PHCs in the budget; this was followed by the flag off of PHCC Kushigoro in the Federal Capital Territory (FCT). It is a fact that the provision of PHC facilities is a function assigned to state and local governments. The states are expected to set up a State Primary Health Care Under One Roof (SPHCUOR) to coordinate the needs of the PHCCs at the local government level. This is necessary because most local government councils (LGCs) are starved of funds; allocations to the LGCs are controlled by state governors and only released to

[2] https://www.medbox.org/countries/minimum-standards-for-primary-health-care-in-nigeria/preview
[3] The NHA 2014

them based on what the states deems to be priority. This has made it difficult for the LGCs to manage PHCCs effectively. With the SPHCUOR, the State Primary Health Care Agency takes charge of the management of all PHCCs in the state. It provides equipment, staff and facilities. Unfortunately, most states have not set up the SPHCUOR. PHC is still left under the management of the LGCs.

3. FINDINGS FROM THE MONITORING OF PRIMARY HEALTH CARE CENTRES AND MNCH PROJECTS IN FEDERAL HEALTH INSTITUTIONS

3.1 Comprehensive Health Centre Amaokpara in Nkwerre Local Government Area Imo State

Background: In the 2014 federal budget, the sum of N47.5 million was allocated for the construction of Amaokpara Comprehensive Health Centre with the code NPHCDA005009148. This was stated to be an ongoing project. In the 2015 budget, the sum of N40 million was allocated for the outstanding debt for construction of Amaokpara Comprehensive Health Centre Contract No. NPHCDA/001008685. It was stated to be ongoing project. In 2017, there was a provision of ten million naira (N10, 000,000.00) for water reticulation with code NPHCD95431797 and another ten million naira (10,000,000.00) with code number NPHCD95431797 for completion of Amaokpara PHCC. For the three years, a total sum of N107, 500,000.00 has been allocated for this PHCC. However, in 2014, the project was described as ongoing which means that funds may have been allocated to this project before 2014.

Findings: Upon visitation of the project site, it was discovered that no new PHCC was under construction in Amaokpara; the only existing PHCC in Amaokpara was built over 20 years ago. The only work done to the existing PHC was replacement of the roof of the main building and purported patching of the PHCC floors. There were holes on the floors of the main ward and on the surrounding pavements of the building. Part of the poor renovation work done was filling of these holes with clay sand. Ceiling fans were procured for the main ward. The estimate of work done on the PHCC would not cost up to N1million.

Picture 1: The PHCC in Amaokpara

Challenges in the PHCC: The wards and facilities are dilapidated. The dilapidated facilities include labor ward, children's ward, laboratory, dispensary and theatre. The facilities are hardly in use due to the extent of dilapidation. Patients generally avoid receiving health care at the PHCC because of the poor state of facilities. It lacks water and electricity, lacks adequate furniture and clean toilet facilities. Pit toilet is utilized by the staff and patients. Despite the spaces available in the PHCC, there are no rooms for pharmacy section or record section. The maternity ward is also used for dispensary. Major equipment required for MNCH services are lacking. Some of the equipment lacking at the PHC include artery forceps, ambu bags, cord clamps, curtains, speculum,

facemasks, dressing trolleys, episiotomy scissors, instrument trays, etc. The staff quarters is extremely dilapidated; the other quarters in the PHCC are very old with dilapidated roof, which is not fit for human habitation. The PHCC is not fenced; the fence was recently demolished due to ongoing road construction in the front section.

Picture 2 shows the patched floor claimed to have been renovated while picture 3 is debris inside the Children's ward.

Picture 2: Patched floor

Picture 3: Debris Inside Children's Ward

Picture 4 is the dilapidated female ward; Picture 5 is the fallen signpost while Picture 6 shows the staff quarters.

Picture 4: Dilapidated Female Ward

Picture 5: Fallen Sign Post of the PHCC

Picture 6: Dilapidated Staff Quarters

The children's ward and staff quarters of the PHCC have been abandoned due to their very poor state. The PHCC offers all the services related to MNCH; but it offers only testing and counseling for HIV/AIDs. The PHCC has inadequate staff - 3 senior CHEWs, 2 junior CHEWs, 1 Midwife, 1 Laboratory Technician and 1 security guard**.**

Comment: The allocations for this PHCC in the budget have not been effectively utilized. We cannot ascertain if the money for this project was fully released as budgeted. If the funds were released, it should be fully accounted for and used to rehabilitate the PHCC. The allocation should also be used to provide equipment that will make the PHCC functional.

3.2 Equipping and Furnishing of a Primary Health Centre in Amanaogu Autonomous Community, Orsu LGA, Imo State.

Background: In 2014, the sum of N19 million was appropriated for equipping and furnishing of a PHCC in Amanaogu Autonomous Community, Orsu LGA, Imo state with project code NPHCDA005009209. It was stated to be a new project. No other allocation was made for the same project in the 2015, 2016 and 2017 budget.

Findings: Upon visitation of the project site, it was discovered that the PHCC has been constructed, completed and equipped in 2015. However, since its completion, the facility is yet to be commissioned for use. The new PHCC consist of a main ward, with two other adjoining rooms, it has a consulting section. The new PHCC also has provision for two self-contained apartment as staff quarters and an engine room. Due to lack of utilization of the equipment provided in the new PHC, the management of the old PHCC which is also located in the same site had to convert some of the equipment for use in the old PHCC where service is being offered. It was discovered that the benches provided for the new PHCC were kept outside the facilities and it has been damaged by rain. The old PHCC offers most of the MNCH services; but it does not offer services related to family planning, nutrition, tuberculosis and oral health. The old PHCC is connected to the electricity grid, it also has generator which provides alternative power supply. The old PHCC offers free drugs to HIV/AIDs patients and for malaria patients. The old PHCC has a waiting section, consulting and labor room, injection room and a pharmacy section.

Challenges of the Existing PHC: The existing PHCC is an old building which lacks good toilet facilities, the staff and patients utilise pit toilet. It also lacks water supply. The front view of the PHCC is fenced but without a gate, the back of the PHC is not fenced; this can compromise the security of the PHCC. It has inadequate staff, with just one nurse midwife and two CHEWS. There are no security personnel in the PHCC.

Comments: The new building should be commissioned, opened for use, more staff should be employed in the PHCC and the premises should be completely fenced. Equipment as stipulated in the approved minimum standards should be made available to the PHCC.

Picture 7: The Constructed PHCC at Amanaogu *Picture 8: Furniture and Beds spoilt by rain*

Picture 9: Another view of the PHCC *Picture 10: Signpost of the PHCC*

3.3 Construction of Amenity Centre, University of Port Harcourt Teaching Hospital

Background: In the 2016 budget of the FMoH, the sum of seventeen million, seven hundred and ninety seven naira, three hundred and thirty one thousand (N17,797,331) was allocated for the construction of the Amenity Centre in University of Port Harcourt **and** no other allocation was made for this project in subsequent budgets. Pictures 11,12, 13 and 14 show what the construction site looks like.

Picture 11: Abandoned Construction Site *Picture 12: Abandoned Site*

Picture 13: Abandoned Blocks

Picture 14: Abandoned Site

Findings: Upon visitation of the project location, it was found that the contract was awarded to Tangent Construction Company in 2010 and it was abandoned in 2011 due to non-release of funds. The project stopped at foundation level. The granite, sand and blocks procured for use are dumped at the project site as shown in the above pictures. Evidently, the 2016 budget funds were not properly used.

Comment: The abandonment of an ongoing project after resources have been spent on it is a waste of resources and this should be discouraged. A proper inventory of all ongoing/abandoned projects should inform new budgeting. It is important to find out the reasons why this project was stopped since 2011 despite the re-allocation of funds for it in the 2016 budget.

3.4 Construction of PHCC in Isiodu Emohua LGA, Rivers State

Background: In 2014, the sum of N47million was allocated for the construction of PHCC at Isiodu Emohua LGA, Rivers State. It has a project code NPHCDA005009188; it was stated to be a new project. The project didn't receive any further allocation in subsequent budgets.

Findings: Upon visitation to the project site, it was discovered that the project has been fully completed but not yet in use. The site has been overtaken by weeds. It was completed since 2015 but the doors, window fittings and other external fittings of the house has been stolen by thieves. Despite the completion of the new PHCC, the community still uses the front section of the community hall as its PHCC. The facility in use has no wards apart from the reception. The PHCC in use only exists for consultations. It has no facilities for delivery of pregnant women. It refers patients to the PHCC in Aluu LGA which is 2 kilometres from Emohua**.** Pictures 15 and 16 tell the story.

Picture 15: Completed but Abandoned Site *Picture 16: Another view of the Abandoned Site*

Comment: The people of Emohua Community have not benefitted from the newly constructed PHCC. There is no value for the money spent. Honourable Andrew Uche, who was a one time member of the House of Representatives attracted the project as a constituency project to his community; he was also a onetime local government chairman and the current chief of staff to the Rivers State Government - but the PHCC has been abandoned after construction. Evidently, the community did not participate in the selection and design of the project as it does not appear to be their priority. Again, it seems there was no collaboration and agreement between the state and local government and the authority that designed the constituency project.

3.5 Equipping of Children Emergency Centre and Equipping of Assisted Reproductive/IVF Centre LUTH

In 2014, the sum of twenty four million, four hundred and thirty six thousand, two hundred and sixteen naira (N24, 436,216) was allocated for the equipping of assisted Reproductive/IVF Centre, with project code LUTH001007807. It was stated to be an ongoing project. In the same year, N60 million was allocated for the completion of Children Emergency Centre with project code LUTH003007823; it was also stated to be an ongoing project**.** In 2015, the sum of thirty four million, nine hundred and ninety nine thousand, five hundred and seventy four naira (N34, 999,574) was also allocated for equipping of the Children Centre while the Reproductive/IVF Centre received another twenty five million, nine hundred and ninety nine thousand, nine hundred and sixty six naira (N25, 999,966). They were both stated as ongoing projects. In 2016, there was allocation of the sum of twenty eight million naira (N28, 000,000) for the completion of 3 storey Children Accident and Emergency Complex (80% completed ongoing project) but no further allocation was given for the equipping of the Reproductive/IVF Centre. In 2017 budget, there was another allocation of thirty five million naira (N35, 000,000) for the completion of Children Accident and Emergency Centre**.** From 2014 till 2017, the

completion of Children Emergency Centre got a total allocation of one hundred and twenty three million naira (N123, 000,000) and N34.9m for equipping the Children Centre. The IVF/Reproductive Centre got a total allocation of fifty million, four hundred and thirty six thousand, one hundred and eighty two naira (N50,436,182).

Findings: Upon visitation to the project site, it was discovered that the project for the equipping of IVF/Reproductive Centre was awarded to Unique Instrument and Science Company Limited in 2012 and was completed in 2016. The construction of the Emergency Centre was awarded in the year 2011 to Akin John Nigeria Limited.

Picture 17: Existing Pediatric Centre

Picture 18: Showing the Sign to the IVF Centre

Comment: The researcher was not allowed to visit the project site for the completion of the three storey children emergency centre; as a result, he could not verify the claim of the LUTH project officer that the centre is 90% completed. The LUTH project officer stated that what was left of the Children Emergency Centre is fixing of ramps. There is an existing one story pediatric ward in the Teaching Hospital which is already in use. The site for the new one could not be ascertained. The researcher was also not allowed to see the equipment procured for the IVF Centre.

3.6 Construction of Primary Health Centre at Ajah Eti-Osa Federal Constituency, Lagos State

Background: In 2014, the sum of twenty three million, seven hundred and fifty thousand naira (N23, 750,000) was allocated for the construction of PHCC Ajah in Eti-Osa Federal Constituency with project code NPHCDA005009077. It was stated to be a new project**.**

Findings: The visit to Ajah, Eti-Osa LGA revealed that no new PHC was constructed. The only available PHC in Ajah was constructed more than 20 years ago by the Lagos State Government.

Challenges: The current PHCC in Ajah has a challenge of flooding, which affects users and staff of the PHCC. During the rainy season, water overflows from the drainage and surges into the PHCC, leaving it in a very unhygienic condition. Visitors and staff must put on protective booth to access the facility during the rainy season.

Pictures 19 and 20 - the Old PHCC at Eti-Osa LGA, Lagos State

Comment: It cannot be ascertained if funds were released for this project since 2014; the health officers in Eti-Osa LGA were not aware of any new PHCC built in any of the five wards in Eti-Osa. If funds were released, they should have been used to upgrade the existing PHCC and tackle the flood disaster in the PHCC.

3.7 Completion of the IVF Centre Jos University Teaching Hospital

In 2016, the sum of forty six million, seven hundred and twenty five thousand naira (46,725,000) was allocated for the construction of IVF Centre, with project code JUTH_01017496. It was provided for as a new project. There is no other allocation for the project in subsequent budgets.

Findings: Upon visitation of the project site, it was discovered that the IVF Centre has been completed in 2017. The contract was awarded in 2016 to Low Pond Construction Company. It was completed in less than one year. However, the Centre is yet to be put to use.

Comment: The speed of project implementation is quite commendable. The pictures of the completed project are shown in Pictures 21 and 22.

Picture 21: Back View of the Completed IVF Centre

Picture 22: Front View of the Completed IVF Centre

3.8 Construction of Primary Health Centre at Gora Fursum District, Jos East LGA Plateau State

Background: In 2014, the sum of twenty eight million, five hundred thousand naira (N28, 500,000) was allocated for the construction of PHCC at Gora Fursum District, with a project code NPHCDA005009075. It was stated to be a new project**.** There was no other allocation for this project in subsequent budgets.

Findings: During the visit to Fursum Gora, it was discovered that the PHCC has been constructed and put to use.

Challenges: The PHCC has no fence; it lacks staff quarters and has only one toilet which is situated inside the labor room. Necessary rooms are lacking in the PHCC, such as; injector room, consulting room, record section, store and dressing area. The facility lacks a wheel chair and has just one observation bed. MNCH equipment such as bed pan, bed sheets, cord clamps, cuscus speculum, disposable facemask, enema kits, sterilizers, sphygmomanometer, etc. are also lacking. The facility has a solar panel to pump water but the solar system is faulty. The ice packs used to preserve the vaccines for immunization are sourced from the LGA secretariat because there is no light in the entire Gora community to preserve the vaccines**.** The PHCC lacks adequate staff; it has only 1 senior CHEW, 1 Junior CHEW and 1 Nurse. It has a volunteer security and three attendants who work for free.

Picture 23: The New PHCC Building

Picture 24: The Old Building that Collapsed

Picture 25: The Observation Bed

Picture 26: The only available Toilet

Comments: Before the construction of the new PHCC, the former building housing the old PHCC became dilapidated and collapsed. Thus, the construction of the PHC was timely and it serves the entire Gora community. However, efforts should be made to provide alternative power supply to the PHCC, expand the facilities to include staff quarters, more offices, toilets and fencing for the premises. The necessary PHC and MNCH equipment and materials should also be provided to the facility.

3.9 Construction of Primary Health Care Centre at Hanafari District Jamaare, LGA Bauchi State

Background: In 2014, the sum of twenty three million, seven hundred and fifty thousand naira (N23, 750,000) was allocated for the construction of PHCC at Hanafari District, Jamaare. It has a project code NPHCDA005009076; it was stated to be a new project. There is no further allocation to the project in subsequent budgets.

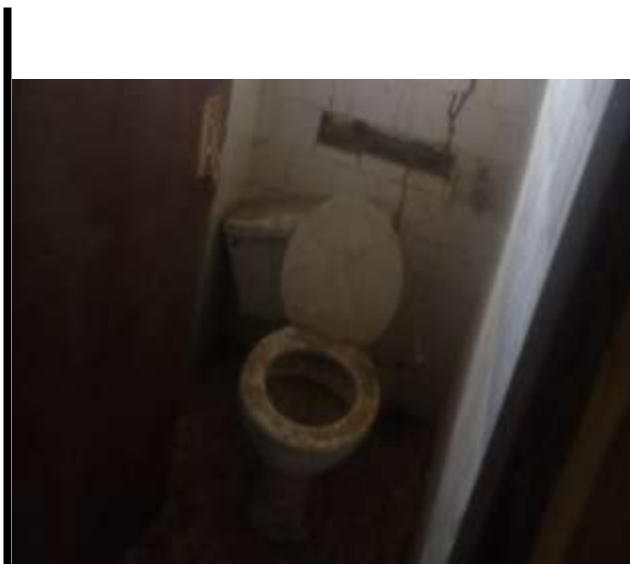
Findings: Upon visitation to the project site, it was discovered that no new PHCC was constructed. The existing PHCC was constructed by the state government and it has been in existence for more than 20 years. It is now in a very poor state.

Challenges: The PHCC at Hanafari lacks electricity; it is not connected to the grid. It lacks water; the available hand pump borehole is faulty. The roof of the PHCC in the general ward and most of the offices have leakages with broken ceilings which pave way for free flow of water into the wards during rainy season. The toilets of the PHCC are in bad condition and have been abandoned due to lack of water. Basic MNCH equipment needed in the PHCC are also lacking. Items such as bed pan, dissecting forceps, dressing trolley, enema kits, episiotomy scissors, etc. are not available. The PHCC lacks qualified personnel; the only available personnel are two JCHEWS, four attendants and volunteer security. Due to the condition of the PHCC, residents prefer to patronize Jamaare General Hospital which is 8 kilometres away from the community. Pictures 27 - 30 describe the situation.

Picture 27: Front View of the PHCC

Picture 28: The Dilapidated Wards

Picture 29: The Squalid Toilet *Picture 30: Water-logged Floor*



Comment: The PHC has enough space with about 12 rooms which requires upgrade. Efforts should be made to determine what happened to the funds meant for the construction of the PHCC. The funds should be released to renovate the existing PHCC and make it functional to deliver service to the people.

3.10 Renovation of Administrative Block and Construction of Theatre Complex, Three Operating Suites with Offices, Recovering Room And Sterilization Unit National Obstetric Fistula Centre (NOFIC), Bauchi

Background: In 2016, the sum of twenty five million, one hundred and five thousand, six hundred and ninety seven naira (N25, 105,697.00) was appropriated for the renovation of the administrative block of NOFIC. While the sum of fifty three million, nine hundred thousand naira (N53,900,000) only was allocated for the construction of theater complex comprising of three operating suites with offices, recovering room and sterilization unit. There was no other allocation for these projects in subsequent budgets.

Findings: On visiting the project site, it was discovered that as at April 2018, the medical ward, part of the theatre complex, had been completed. The theatre complex which has a 36 bed capacity is 70% complete. However, there is no equipment in the medical ward. The construction of the operating suites was suspended due to lack of funds. What is left in the operating suites is flooring and fittings. For the construction of the administrative block, three administrative blocks have been completely renovated; three other blocks are just at 20% completion stage.

The pictures below tell the story of the progress of work.

Picture 31: The Outside of the Theatre Complex

Pictures 32 and 33: Operating Suites and Offices under Construction

Picture 34: Completed Administrative Block

Picture 35: Uncompleted Administrative Block

Comment: Before the construction work at NOFIC, it has been utilizing the facilities at General Hospital in Ningi. The current site, which is now regarded as a permanent site was donated to it by the LGC. Efforts should be made to complete the remaining work at NOFIC, so that treatment can commence at the permanent site.

3.11 **Construction and Furnishing of Post Basic Nursing School in Aminu Kano University Teaching Hospital Kano**

In 2014, the sum of forty five million naira (N45, 000,000.00) was allocated for the construction of Post Basic Nursing School. It has a project code AKTH004005879 and it was stated to be an ongoing project. Also in 2015, the sum of thirty six million, five hundred and twenty six thousand, two hundred and eighty naira (N36,526,280) was allocated for the same project; it has a project code AKTH004005879 and it was stated to be an ongoing project. The project also received another funding in 2016, to the tune of sixteen million, nine hundred and eighty nine thousand, six hundred and sixty naira. (N16, 989,660). It has a project code AKTH_02015991 and it was stated as a new project. Funding for this project was also provided in the 2017 budget to the tune of thirty seven million, five hundred and forty one thousand, two hundred and sixty four thousand naira (N37, 541,264). The total sum allocated for this project from 2014 till 2017 amounts to One hundred and thirty six million, fifty seven thousand, two hundred and four naira (N136,057,204).

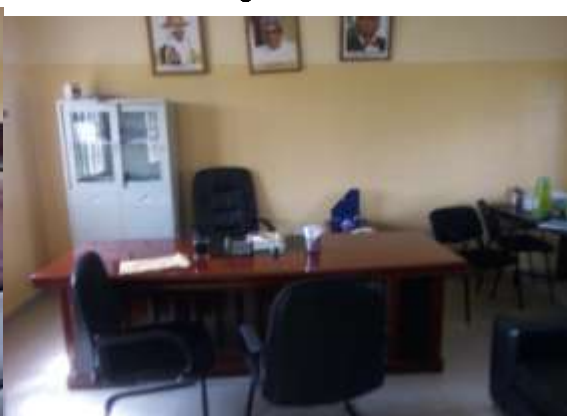
Findings: On a visit to the project site, the project, which is for the Post Basic-Pediatric Nursing Programme, awarded to Umka Integrated Services in 2014 has been completed in 2017. The furniture and equipment have been fully supplied. The completed project has five offices for lecturers, a common room, lecture room, two class rooms, an IT class room, library and a clinical instruction room. Each of the rooms is equipped with modern furniture and air conditioners. It was observed that the Post Basic Nursing School will need an additional auditorium, a security office, and a staff cleaning office. There is already an existing 36 bed student hostel which was constructed in 2008. However, there is an abandoned building in the same site which was started in 2011 and abandoned in 2013. The abandoned building has eight blocks for eight different post basic programmes which would have served the school for eight different nursing programmes.

Comment: The building which has been abandoned is not a good procurement decision. The sum allocated for this new project could have been used to complete the building which will serve for eight different post basic nursing programmes. It simply shows lack of efficiency in the planning and implementation of projects in Nigeria. Efforts should be made to complete the abandoned building so as to accommodate more programmes.

Picture 36: The Completed Building *Picture 37: The Abandoned Building*

Pictures 38 and 39: The Classroom Furnishing for the Completed Building

Pictures 40 and 41: Still on Furnishing



3.12 Construction and Equipping of Model Primary Healthcare Centre, Tudun Wada, Kano State

Background: In 2014, the sum of thirty eight million naira (N38,000,000) was allocated for the construction and equipping of Model PHCC, Tudun Wada. It has a project code

NPHCDA005009056 and was stated as a new project. This is the only allocation allotted to the project.

Findings: Upon visiting Tundun Wada, it was discovered that there is no new PHCC constructed. The existing PHCC has been there for more than 55 years. Tudun Wada also has a General Hospital, which is some meters away from the PHCC.

Challenges: The existing PHCC in Tudun Wada is in a very poor condition. It has only two offices and a general consulting section. The PHCC is starved of funds by the local government; it lacks almost all the MNCH equipment. It has inadequate staff; only a senior CHEW and one JCHEW. It also has a laboratory technician and an ANC attendant. Due to the poor state of the PHC, it does not take delivery for pregnant women. The PHC also lacks toilet, it is not fenced and has no security**.** Pictures 42 and 43 tell the story of the state of the PHCC.

Picture 42: The Old Building of PHCC, Tudun Wada

Picture 43: Inside the PHCC, Tudun Wada

Comment: The PHCC is in dire need of renovation and efforts should be made to upgrade its facilities, post adequate personnel and make it functional.

3.13 State Primary Health Care Under One Roof

In all the states visited, apart from Lagos, the SPHCUOR has not been implemented. The management of PHCs is still left under the administration of the local governments. The local government is poorly funded and its resources have been hijacked by state governments. The Policy of PHCUOR has been described thus[4]:

> *Primary Health Care Under One Roof (PHCUOR) is a policy to reduce fragmentation in the delivery of Primary Health Care (PHC) services which involves the integration of all PHC services under one authority. Fragmentation has been identified as the most significant problem facing PHC services, and significantly affects utilisation rates and health indices. Key elements of the Primary Health Care Under One Roof policy include:*

- *Integration of all PHC services delivered under one authority;*
- *A single management body with adequate capacity to control services and resources, especially human and financial resources;*
- *Decentralized authority, responsibility and accountability;*
- *The three ones principle: one management, one plan and one monitoring and evaluation system;*
- *An integrated and supportive supervisory system;*
- *An effective referral system between and across the different levels of care;*
- *Enabling legislation and regulations.*

The SPHCUOR will therefore improve health service delivery and in the long run improve health indicators.

3.14 Poor Funding of PHC at the State Level

The available evidence indicates poor funding PHC at the state and local government levels. The National Health Act (2014) focuses inter alia on protecting the right to health of vulnerable Nigerians. It made provision for the deduction of 1% from the Consolidated Revenue Fund of the Federal Government to fund the Basic Health Care Provision Fund (BHCPF). States are yet to anticipate their engagement of the federal BHCPF which will require their making provisions for counterpart funding.

[4] http://resources.healthpartners-int.co.uk/resource/bringing-primary-health-care-under-one-roof-9-factsheets-for-implementation-prrinn-mnch/

4. CONCLUSIONS FROM THE MONITORING EXERCISE

4.1 PHCCs as Constituency Projects and Allocations not fully Implemented: Many of the allocations for PHCCs are for constituency projects of federal lawmakers. The allocations for most of the PHCCs have not been fully implemented. In places where construction took place, facilities and equipment were not provided. The construction did not take into consideration the deployment of staff that would manage the facilities. The allocations seem to be contract driven instead of being driven by the need for improvement and expansion of service delivery.

4.2 No Needs Assessment to Inform Location of PHCCs: It is evident that there was no needs assessment by the authorities before PHCCs were located in the communities. The decision to build the PHCCs was more of politics than based on the need of the community. PHCCs were sited very close to general hospitals or existing PHCC facilities. In some instances, what was needed was the rehabilitation and upgrade of existing facilities instead of building new ones. And this affected the demand for services in so many locations. The location of these facilities would have been informed by data from the National or State Health Management Information System. But this does seem to be the case.

4.3 Community Ownership was Lacking: There was no consultation between the authorities who took the decision to build PHCCs and the communities that were to benefit from its services. In many instances, the communities did not have a sense of ownership or even think that the project was a necessity in the first instance. Again, there seems to have been no consultation between the management of existing PHCC facilities and the authorities who took the decision to locate new PHCCs or fund the upgrade of existing ones. The foregoing challenges have created a gap that affects the functionality of the PHCCs.

4.4 Poor/No Consultation and Interface between Federal, State and Local Government Authorities: PHC is within the domain of States and LGCs. Federal Government only builds infrastructure but is not involved in the day to day running of the PHCCs. For PHCCs built by the FGN to be functional, there should have been an agreement, a memorandum of understanding between the FMoH, State and LGC authorities whereby the later will take over, post personnel and take charge of overhead costs of the new facilities. Otherwise, the buildings will be overtaken by rodents and weeds and this was the situation in some federally constructed PHCCs. This problem would have been handled if adequate consultation was made with the state authorities and LGCs to ensure a seamless transition between capital and infrastructure development and personnel and overhead funding.

4.5 Disparity in Allocations for Construction of PHCCs For a new project which involves the construction of PHCC, it was discovered that while some facilities had allocation that is up to forty five million naira, other facilities had allocation that is not

more than sixteen million naira. There is apparently no rationale for such huge disparity. Considerations for the construction of new PHCCs should be based on the Approved Minimum Standards for PHC (AMSfPHC) in Nigeria, where costs for certain provisions are benchmarked. The AMSfPHC has standards for the required number of rooms, land area, wards, staff quarters and other facilities; the cost of meeting the standards should have been predetermined and used as a basis for uniform allocations, especially for new PHCCs. The cost may be different for the equipping of existing PHCCs; where there is existing equipment, the costing should be based on remaining equipment to be purchased.

4.6 Inadequate Human Resources in the PHCC: In most of the PHCCs visited, the personnel requirements were not met; most of the PHCCs have just few staff and relied on volunteers. The volunteers are given stipends out of the voluntary will of staff at the PHCCs. None of the PHCCs visited had the full complement of the minimum recommended staff number and cadre - midwife or nurse/midwife, 2 CHEW, 2 JCHEWS, attendants/assistants and 2 security personnel.

4.7 Inadequate Infrastructure and Equipment: Most of the facilities visited did have the full complement of the supporting health infrastructure as prescribed in the AMSfPHC in Nigeria. This would have meant the PHCC being sited in a land area of not less than 2,475 square metres, clean water source from a motorized borehole, detached building with at least 5 rooms with walls and roof in good condition, functional doors and netted windows. Other requirements include fenced premises with gate and generator house, connection to national electric grid and other alternative sources of power, staff accommodation provided within premises - 2 bedroom apartments, sanitary waste disposal, functional separate male and female toilets, etc. In locations where boreholes were dug and alternative power supplies such as solar panels and inverters are provided, they are not fully optimized due to poor maintenance culture.

All the PHCCs visited show that there is hardly consideration for the welfare of staff. There are no provisions for staff quarters, even where they are; they are not good enough for human habitation. Equipment such as delivery kits, beds, wheel chair, dissecting and dressing forceps, solar refrigerator, etc. were lacking in some of the facilities.

4.8 Project Implementation Status: In most of the tertiary health institutions, it was evident that projects allocated for MNCH were either started, abandoned, ongoing or completed. This is unlike the facilities in some communities which had allocations in the federal budget but did not start at all. This might be attributed to the existence of strong systems and management at the tertiary institutions. For PHCCs in communities, many of them are constituency projects caught in the crack between the MDAs and federal legislators.

4.9 Multiple Allocations in Budgetary Provision for MNCH Projects in Tertiary Institutions: MNCH and PHC projects in tertiary institutions have varying degrees of allocations for the same budget head re-occurring in every budget cycle. It is not clear what the total costs of the projects are and if they were fully released and utilised. Without access to information, it is difficult to track the exact amount needed to complete these projects and to know when the allocations have surpassed the actual amount needed.

4.10 MNCH Projects at Tertiary Health Institutions are of High Value: The MNCH projects situated in tertiary health institutions are of high value; from the need assessments to implementation and actual service delivery of the projects. These show adherence to quality and standards which if replicated across the country can improve the PHC delivery as well as MNCH indicators.

4.11 Access to Health Budget Information: The FMoH and its parastatals and agencies have deliberately withheld the financial information about the implementation of projects from Nigerians. The FMoH has even refused to respond to freedom of information requests. The Ministry has failed to discharge its duty under section 2 (3) (d) (v) of the Freedom of Information Act which requires it to provide and cause to be published on a regular basis, information relating to the receipt or expenditure of public or other funds of the institution. Again, the FMoH is under obligation by section 2 (4) of the Freedom of Information Act to ensure that such information is widely disseminated and made readily available to members of the public through various means, including print, electronic and online sources and at its offices.

4.12 State Primary Health Care Under One Roof: The benefits of the PHCUOR have not materialized as the states visited (with the exception of Lagos) are yet to set up the system.

4.13 Engaging the Basic Health Care Provision Fund: States are yet to anticipate their engagement of the federal Basic Health Care Provision Fund (established under the National Health Act) which will require counterpart funding from the states.

5. RECOMMENDATIONS FROM THE FINDINGS

5.1 PHCCs Allocations: FGN should adopt good and fit practices in budgeting, especially in revenue forecasts to ensure that expected revenue will be available to fund the projects in the federal budget. Contract driven projects should be replaced with projects focused on expansion and improvement of service delivery. Appropriated funds should be released on time to ensure effective project delivery.

5.2 Needs Assessment to Inform Location of PHCCs: The location of new PHCCs should be informed by evidence based on a needs assessment and informed by data from the National or State Health Management Information System. Location of health projects should no longer be driven by political expediency. These projects should get into the budget after scaling the hurdle of criteria listed for admission of projects under the medium term sector strategies.

5.3 Community Ownership is Imperative: Projects of this nature should get community buy-in and ownership from the conceptualization stage. Adequate consultation will guarantee community support and eventual uptake of the services offered in the facilities. It will also guarantee that such projects are not duplicated and existing facilities are upgraded in a value for money approach.

5.4 Adequate Consultation and Interface between Federal, State and Local Government Authorities: The FMoH or National Primary Health Care Development Agency should enter into a memorandum of understanding with states and local governments where new PHCCs are to be located. The memorandum of understanding is to guarantee that the facilities will be utilized through state and LGC commitment of personnel and overhead resources to make the facilities functional. It is even suggested that the federal budget should focus on strengthening existing and functional PHC facilities, to improve service delivery, instead of commencing the construction of brand new facilities.

5.5 Allocations for Construction of PHCCs should be Standardized: Following the AMSfPHC in Nigeria, allocations for the construction, furnishing, etc. of PHCCs should be standardised unless in situations where the topography makes the construction costs more expensive.

5.6 Human Resources in the PHCC: The personnel requirements of PHCCs should be benchmarked upon the AMSfPHC in Nigeria. The human resource challenge calls to mind the need to enforce the provisions of the National Health Act on certification of health institutions.

5.7 Infrastructure and Equipment: The infrastructure and requirement of PHCCs should be benchmarked upon the AMSfPHC in Nigeria. The infrastructure and equipment challenge calls to mind the need to enforce the provisions of the National Health Act on certification of health institutions.

5.8 Dissemination of Good Practices: In situations where successes have been recorded, for instance, in the implementation of PHC projects in tertiary health institutions, the good practice should be disseminated for possible replication by other project implementing agencies.

5.9 Access to Health Budget Information: The FMoH and its parastatals and agencies should strictly and meticulously comply with the full gamut of the Freedom of Information Act to make budgetary information accessible to all Nigerians.

5.10 Establish State Primary Health Care Under One Roof: Efforts should be made to actualize full implementation of the State Primary health Care Under One Roof. The scores obtained from the implementation of the PHCOUR, Using the 9 PHCOUR parameters of governance and ownership, legislation, minimum service package, repositioning, system development, operational guideline, human resources, funding source and structure and office set up, from the states covered in this monitoring exercise shows that Rivers State has the highest in the implementation of the SPHCOUR with 73%, followed by Bauchi 67%, Katsina 59%, Lagos 50%, Kaduna 46%, Plateau 28% and Imo State, the least with 8%.

5.11 States Should Consider Providing for State Level Basic Health Care Provision Fund: State governments should consider establishing a State Level Basic Health Care Provision Fund (BHCPF) and make a deduction of not less than 1% of their states Consolidated Revenue Fund to fund the BHCPF. This should be taken as a key priority to improve the health status of citizens in consideration of the fact for states to access the BHCPF, they will be required to provide a counterpart fund of 25% of the cost of the project.

PART B: KATSINA STATE

6. INTRODUCTION

6.1 Background

Katsina State proposed the rehabilitation of 136 PHCCs in the 2018 state budget. The PHCCs are under the control of Local Government Councils (LGCs). The paucity of funds at the LGCs has reflected in the poor quality services rendered at the PHCCs. It takes the intervention of development partners and constituency projects of members of the National Assembly to support PHCCs in some LGCs. Whether the Katsina State Government will keep the promise by revitalizing PHCCs in the state will be known at the end of the 2018 budget implementation cycle.

According to the Katsina State Health Development Plan 2010-2015, the total population of the state is about 6 million, of which 4% are infants, 20% under 5s, and 22% are women between the ages of 15-49. The state has one of the highest maternal mortality rates in the country and efforts should be directed at addressing this problem. It has 1,427 health facilities, 21 general hospitals and 22 Community Health Centres (CHCs). ANC attendance is about 55% but delivery in health facilities by skilled attendants is about 10%. There are 480 midwives and 981 nurses in the state. Table 4 shows the key MNCH indicators of the state.

Table 4: Katsina State MNCH Indicators

Neonatal Mortality Rate	55/1,000
Infant Mortality Rate	114/1000
Under Five Mortality Rate	269/1,000
Maternal Mortality Rate	1000/100,000
ANC Attendance	55%

Source: KDSHDP 2010-2015

However, Katsina State has recorded some positive development in the management of its health system. This is noticeable in the signing of the State Primary Health Care Under One Roof (SPHCUOR). Through the SPHCUOR, the state has the opportunity to address weaknesses in the PHC system which includes poor state of facilities and inadequate human resources. The State also won the first position amongst the North Western States in the implementation of grants for the Saving one Million Lives (SOML) project. To boost the number of attendants at health facilities, the state has through the SOML provided free services for delivery and also provides free kits to mothers after delivery. The State Ministry of Health has set up a committee to conduct needs assessment on the state and functionality of PHCCs. This will provide useful data for the state to spend its PHC resources from an informed and evidence based perspective.

The state has increased the health budget from 6.41% of overall budget in 2015 to 11.2% in 2018. The bulk of increase went to the capital budget. Table 5 shows the four year trend analysis of the Katsina State health budget allocation.

Table 5: Katsina State, Health Vote as Percentage of Overall Budget 2015-2018

Year	Overall State Capital Allocation	Overall State Recurrent Allocation	Total State Allocation	Capital Health Allocation	Recurrent Health Allocation	Total Health Allocation	% Of Capital Health Allocation To Overall State Capital Allocation	% Of Recurrent Health Allocation To Overall State Recurrent Allocation	% Of Total Health Allocation To Overall State Allocation
2015	75,480,180,420	34,589,660,750	110,069,841,170	1,856,890,190	5,195,925,985	7,052,816,175	2.46%	15.02%	6.41%
2016	70,638,767,790	43,395,483,880	114,034,251,670	1,107,126,070	5,835,777,850	6,942,903,920	1.57%	13.45%	6.09%
2017	96,357,166,650	47,679,310,358	144,036,477,008	6,729,361,995	5,976,583,270	12,705,945,265	6.98%	12.53%	8.82%
2018[5]	160,083,369,485	51,409,821,610	211,493,191,095	17,259,951,145	6,591,722,785	23,851,673,930	10.78%	12.82%	11.28%

The increase in the 2018 budget will only meet expectations if the vote is fully released, cash backed and implemented. Available reports from 2017 show that out of N6.7bn allocated to capital projects for health, only N1.7bn was released by the end of the third quarter leaving a variance of 5bn[6]. This is less than 20% implementation for 75% of the budget year.

The MNCH indicators of Katsina State are poor and needs massive infusion of resources to change the tide. The resources will include human resources for health, information, technology and financial resources, etc.

6.2 Monitoring PHCCs in Katsina State and Methodology

The project involved the monitoring of selected PHCCs in Katsina State, to determine inter alia the state of the facilities, usage, to identify the challenges and possible needs of the beneficiaries of the PHCCs. It is also aimed at determining the level of efforts of government, developmental partners and the public to make PHC functional at the rural areas. Specific recommendations are given based on the facilities visited.

Katsina State has 32 Local Government Councils. However, based on available resources, monitoring was restricted to 2 PHCCs each in five LGCs. The PHCCs include Katsina State Primary Health Centre in Katsina West LGA; MCH Tsagero in Rimi LGA; Community Health Centre Jani, in Mani LGA; Primary Health Care Centre Doka in Marshi LGA; Primary Health Care Centre Muduru in Mani LGA; Makurda Primary Health Care Centre, Rimi LGA; Community Health Centre Kaita LGA; Maternal

[5] The 2018 figures are from the budget proposal as we did not have access to the approved 2018 Katsina State budget.

[6] See the budget speech of the governor during the presentation of the 2018 budget to the State House of Assembly on November 13, 2017.

Child Health Centre, Shinkafi Katsina LGA. The monitors visited the PHCCs, interviewed staff and took pictures. In some PHCCs, the officials in charge were willing to provide information about the state of facilities. In some facilities, where information could not be obtained from the officials of the PHCCs, the monitors report was based on their observation and information gathered from further enquiries with volunteers associated with the PHCC.

Beyond the monitoring visit, the project embarked on desk research for information and statistics to validate findings and to provide an anchor for the study.

6.3 Limitations of the Exercise

The monitors could not obtain vital information such as the budgetary allocations to the PHCC and the management of resources of the PHCC. Obtaining official authorization was almost impossible. The monitoring did not focus on service delivery but rather focused on the state of the PHC facilities. As a result of this, performance of health care workers and management of PHCCs was not documented.

7. FINDINGS ON THE STATE OF PHCCs IN KATSINA STATE

7.1 Katsina State Primary Health Care Centre, Kofa Guga

State of PHCC: The Katsina State PHCC located in Kofar Guga is in Kastina West LGA. It serves about 70 percent of the population in the LGA. It is a distance of 20 kilometres from the State's General Hospital. The PHCC is located in the same building with the State Primary Health Care Development Agency (SPHCDA). Ordinarily, one would expect that the PHCC should receive adequate attention since it is very close to and shares the same premises with the SPHDA's office. The monitors observed that the building looks very old and dilapidated. The building is more than 20 years old. A well renovated building meant for a World Bank health project is situated in the same premises with the PHCC and the SPHCDA. While the SPHCDA and the World Bank facility look decent, the PHCC looks decrepit with falling roofs. The PHCC has minimum facilities such as beds for outpatient and delivery services. Water is available and is sourced from a borehole while the facility is connected to the national electricity grid; and a stand by 12KVA generator provides backup power. The facility has the required number of personnel as indicated in the AMSfPHC in Nigeria. The staff works in shifts at the PHCC.

Picture 44: The SPHCDA *Picture 45: The front view of the PHCC Kofa Guga*

Picture 46: Inside the PHCC Kofa Guga

Recommendation: The building should be renovated to the minimum standard.

7.2 MCH Tsagero Rimi LGA

State of PHCC: The clinic is located in Rimi LGA. Rimi is a distance of 21.7 kilometres from Katsina General Hospital. The PHCC was renovated in 2017. The PHCC runs for 24 hours in a day but it needs more human resources; it has only 5 attendants, one midwife and a visiting doctor who comes just two times in a week (Wednesdays and Saturdays). Drugs are available and patients are offered free drugs. There was provision for solar power but due to lack of maintenance, it is no longer in use. There is an electricity generator set but it is not fuelled when needed due to lack of resources. Torch lights are used to attend to patients at night. Other materials lacking in the PHC are solar fridge, forceps, labor bed, etc. The only available labor bed is in need of repairs.

Picture 47: Labour Ward

Picture 48: MCH Tsagero Rimi Building

Picture 49: Deserted Outpatient Ward in the PHC in need of Beds

Recommendations: There is need for recruitment of more staff, repair the solar panel, provide solar fridge and provide for more labor beds and delivery materials such as forceps, hand gloves, etc. Improvement of the overhead and running cost of the facility is imperative.

7.3 Community Health Centre Jani, Mani LGA

State of PHCC: The Community Health Centre is located in Mani LGA which is 33.6Km from the Katsina State General Hospital. The LGA has a population of 176,966 and land area of 784km. The community health centre offers services such as outpatient/ inpatient service, maternity ANC services, family planning, laboratory, pharmacy, dental, x-ray and routine immunisation service. The Centre is very well patronized by residents of the LGA. The facility was recently renovated in February 2018 by the state government. The facility receives a minimum of 50 persons on Mondays for immunization. During the visit, the monitoring team witnessed a team of vaccinators from the SPHCDA who came to vaccinate locals against meningitis. The Centre has 14 staff made up of nine permanent staff and 5 casual staff. A visiting doctor comes to the Centre three times in a week. The Centre lacks a midwife. Delivery is conducted by volunteers from the School of Nursing. Beneficiaries are given free vaccinations at the Centre. The major challenge of the Centre includes inadequate staff, especially midwives.

Picture 50: The front view of the Health Centre

Picture 51: The Outpatient Ward

Recommendations: Since the facility runs 24 hour services, skilled staff should be recruited to meet up with the human resource demand of the centre.

7.4 Primary Health Care Centre Doka Marshi LGA

State of PHCC: The PHCC is located in Marshi LGA which shares border with the Republic of Niger. It is 52km to Katsina General Hospital. The PHCC was built for the LGA by the Millennium Development Goals office in 2001. It has a well-built structure but the facility is becoming dilapidated. It is only open for public use from 8am to 2pm; therefore it is not available for emergency treatment outside of these hours. The facility lacks electricity; from observation, it is not connected to the national electricity grid.

There is no provision for alternative power supply. The facility lacks water; local water vendors are patronized when there is need for water. The health centre is not adequately staffed; it has only 5 permanent staff and 5 casual staff. On assessment of the facilities, it was noticed that doors have been eaten up by termites, ceilings are broken, toilets are left unkept. The wards are not conducive for the treatment of patients. The laboratory has been abandoned and is now used as a store.

Through the help of WHO, a consulting doctor is sent on routine visit to the PHCC to supervise its services. UNICEF supplies nutritional kits to the PHCC for malnourished children who visit the PHCC during the immunization period. Through MNCH2 sponsored by UKAID, the PHCC receives free drugs and immunization which is administered to patients during immunization visits.

Pictures 52 and 53: Unkept Toilets at Doka Marshi PHCC

Picture 54: Falling Ceilings

Picture 55: Door Eaten by Termites

Picture 56: Laboratory Converted to a Store

Picture 57: Front View of the Facility

Recommendations: Recruit more staff, especially professional staff, such as nurses and a midwife and convert the facility to a 24 hours service. Renovate the internal and external parts of the building; repair the solar panel to power the facility and get a functional solar fridge; provide water supply and ensure adequate resources for overhead expenditure.

7.5 Primary Health Care Centre Muduru Mani LGA

State of PHCC: The PHCC Muduru is another health facility visited in Mani LGA. From Muduru to Jani CHC which are both in Mani LGA is 36km. The PHCC has a standard building. It however lacks some major amenities such as water and adequate power supply. It relies on the national grid which is epileptic. In the event of power failure, the PHCC resorts to the use of phone lights to attend to patients. The available generator is used for the laboratory. Water is procured from water vendors. There is a solar power installation but it is not functional. The PHCC has 20 permanent staff and 7 casual workers. Pregnant women are given free drugs during the antennal and post-natal services.

Picture 58: Out Patient Ward

Picture 59: Front View of the PHCC

Recommendations: The authorities should provide borehole for access to clean water; the solar panel should be made functional and facilities to guarantee that the PHCC meets the AMSfPHC should be provided.

7.6 Markurda Primary Health Care Centre, Rimi LGA

State of PHCC: Makurda PHC is located in Rimi LGA and it is 42 kilometres to Katsina General Hospital. The PHC which is located by the road is not fenced, hence exposing the facility to the danger of theft and insecurity. The PHCC formerly runs 24 hours service with workers placed on shifts. However, the shift service has been withdrawn and workers resume by 8am and close by 2pm. The PHCC formerly had 29 staff, namely, 1 community health officer, 5 senior community health extension workers, 2 environmental health technicians, 1 Nurse, 1 pharmaceutical technician, 2 Junior community health workers, 1 dental technician, 2 dental assistants, 1 pharmacy assistant, 1 laboratory assistant, 6 community health assistants, 2 attendants , 1 watch man and 1 driver. The story is different now because the PHCC has only 9 staff - 7 permanent staff and 2 casual workers.

The facility lacks adequate facilities; there are no forceps to use during delivery; PCV machine is lacking; the hospital lacks water and electricity; labor room has only two beds and just one for newly born babies; no screen at the labor room. The outpatient wards has seven portioned blocks which is not conducive for patients. The mattress at the wards are torn and riddled with bed bugs. It is interesting to note that this PHCC once attended to a minimum of 35 women for delivery per week but currently very few visit the PHCC and for those who come, they refer most of their patients to the General Hospital, Katsina. Pregnant women with emergency conditions stand the risk of being exposed to the danger of losing their lives or that of their un-born babies in this facility.

Picture 60: Bedbug/Termite riddled Mattress inside the Outpatient Ward of the PHCC

Picture 61: Empty Labor Room-with no facility to conduct delivery

Recommendations: The PHCC should be fenced; equipment and supplies needed in the labor and delivery wards should be provided. More staff should be recruited and the PHCC should resume 24hours service. A borehole is needed and functional solar panels to power water and electricity supply should be installed at the PHCC.

7.7 Primary Health Care Centre Yandaki, Kaita LGA

State of PHCC: The PHCC is located in Kaita LGA; Kaita shares a border with the north of the Republic of Niger. The distance of the PHCC to Katsina General Hospital is 10 kilometres. Yandaki PHCC was recently renovated under the UKAID renovation of facilities intervention scheme in 2016/2017. Despite the renovations, the PHC lacks some facilities such as water. A borehole was dug for the PHC but it is not functional due to lack of maintenance. The PHCC patronizes water vendors. Drugs are purchased in this PHCC. It is not given for free as witnessed in other PHCCs visited. There is a solar panel meant to power some of the facilities but the solar installation is faulty. The only available generator is a small generator used by the laboratory technicians. The PHCC which runs a 24 hour service is short staffed. Nine volunteers who work at the PHCC are hardly paid any form of allowance. A volunteer who has worked in the PHCC for five years complained that she gets only 1000 naira monthly for her services.

Recommendations: The authorities should recruit more personnel and train the existing volunteers as well as provide adequate compensation and benefits. Repair and upgrade the solar panels to provide alternative power supply and to power the borehole. The borehole should be repaired and made functional. The SPHCDA and the MNCH2 should monitor the dispensation of drugs and ensure that drugs meant to be given out for free are not sold to patients. The pictures below tell the story of PHCC.

Picture 62: Front View of the PHC, Yandaki

*Picture 63: The Outpatient Ward of PHC, Yanda*ki

7.9 Community Health Centre, Kaita LGA

State of PHCC: The PHCC is located in Kaita LGA. Kaita shares a border with the north of Republic of Niger. The distance between the PHCC Yandaki to the Community Health Centre (CHC) is 10 kilometres. CHC Kaita offers services such as OPD, routine immunization (Mondays and Wednesdays), pharmaceuticals, antenatal care (Mondays, Tuesdays and Wednesdays), postnatal care, delivery, child spacing, in patient care, laboratory, dental, Christian Health Association of Nigeria Programmes (Wednesdays), prevention of mother to child transmission of HIV and HIV Counselling and Testing (PMCT/HCT). The facility has a very big building with more than 20 blocks which contains 2 female wards, 1 male ward, 1 maternity ward, 1 laboratory, 1 immunization unit, an out-patient department, a dental clinic, etc. It also has staff quarters. Although the CHC has a well-built structure and a solar system that provides light and water for the running of the facility, the solar battery is very weak and doesn't last more than 2 hours. The CHC has some internal challenges which include shortage of staff. There are only two doctors who run shifts and have to attend to the large number of people

that frequents the health centre. The maternity ward has only one permanent staff, the rest are volunteers. The CHC is provided a running cost of just N20,000 monthly which is not enough to fuel the generator, in the event of power outage. The pictures below speak of the facilities of the CHC.

Picture 64: A Volunteer Worker attending to a Patient in a Male Ward: Empty beds and spaces shows more beds and mattresses are needed

Picture 65: some of the Blocks within the CHC Premises, Kaita

Recommendations: The CHC Kaita needs more staff. The state government should recruit more staff and collaborate with development partners to provide laboratory equipment. The solar batteries should be replaced and upgraded to serve the facility. The monthly overheads/allowance for running the facility should be improved.

7.9 Maternal Child Health Centre Shinkafi, Katsina

State of PHCC: The Centre is located in Katsina LGA. The facility was built in 1980 during Ibrahim Badamasi Babangida's military regime. It got another building in 1997 with the support of Petroleum Trust Fund. Currently, the two buildings are dilapidated and very old. In 2003, through the Millennium Development Goals office, another building was provided. The three buildings are in the same compound and they are still

in use. The facility has ambulance service which is used for emergency evacuation. Unlike other facilities visited, drugs are not given for free in the Centre. Patients who patronize the facility pay for their drugs. The facility lacks water supply. According to a respondent, the submersible pump was stolen and is yet to be replaced. The facility also lacks adequate staff, community health workers are utilized to attend to patients in the Centre. Although there are adequate maternity beds in the Centre, patients prefer to go to the General Hospital in Katsina, which is just 4km from the Centre, for primary health care services. The pictures below illustrate the state of the facility.

Picture 66: The old building which requires renovation

Picture 67: Facilities in the Old Building

Picture 68: The New Building Constructed by MDGs Office

Picture 69: Facilities in the New Building

Recommendations: The authorities should renovate the old buildings and provide water supply and electricity. Also, there is the need to recruit adequate qualified staff to complement the community health workers in the facility.

7.10 Community Health Centre, Mashi LGA

State of PHCC: This CHC is another health centre in Marshi Local Government which shares border with the Republic of Niger. It is 52 kilometres to Katsina General Hospital. The CHC is 23 kilometres to Doka Primary Health Care in Mashi LGA. The CHC was built in 1991 by former President Ibrahim Babangida. A new building was put up as a constituency project by a member of the House of Representatives. The new building is yet to be utilized. However, the current building is equipped with adequate facilities such as a functional generator set and adequate beds in the wards. The PHC has adequate staff including permanent and casual workers. Drugs are provided free to patients who come to the Centre through the MNCH2 intervention. However the Centre lacks water due to the fact that the solar powered borehole has failed. There are two ambulances, one of them is not functional and needs to be repaired. Pictures 70 and 71 show the old and new buildings respectively.

Picture 70: The Old Building, CHC Mashi

Picture 71: The New Building CHC, Mashi

Recommendations: The solar powered borehole should be repaired to provide water to the CHC; the second ambulance should also be repaired to serve the facility in the event of emergencies.

8. CONCLUSIONS AND RECOMMENDATIONS

8.A CONCLUSIONS

8.1 Poor MNCH Indicators: Katsina State's MNCH indicators are poor, below the national average and urgent action needs to be taken to improve the situation. The signing of the State Primary Health Care Under One Roof is a good platform to harmonize the needs of the PHCCs and provide adequate funding and institutional reforms for the proper management of PHC and MNCH services**.**

8.2 The Health Budget: Even though there is increasing appropriation for health in the state budget, the releases are far less than the appropriated sums. The state seems not to be using the maximum of its available resources for the progressive realization of the right to health. Many of the innovations and service delivery initiatives are funded by donors.

8.3 Shortage of Staff: A common challenge in all the PHCCs visited is shortage of qualified staff. Most facilities lack the full complement of staff as stated under the AMSfPHC in Nigeria. Most of the personnel utilized at the PHCCs are casual workers, assistants and CHEWS.

8.4 Decrepit Buildings: Many of the buildings housing the PHCCs are dilapidated and require renovation. From the floors, windows and doors, painting, the ceilings and roofs, a good number of the Centres require renovation of their buildings.

8.5 Poor Facilities: Most of the facilities at the PHCCs require upgrade. Water and electricity were common needs in virtually all of the PHCCs. Alternative power supply such as generators and solar panels needs to be installed and routinely maintained to power equipment like fridge, boreholes, etc. Evidently, the non-functional solar facilities are a product of poor quality of the initial installation and lack of maintenance.

8.6 Needed Equipment: The full complement of equipment identified in the AMSfPHC in Nigeria is not available in majority of the visited PHCCs.

8.7 Drugs Supply: There is an impressive supply of drugs in most of the PHCCs visited. Through the MNCH2, and the SPHCDA, patients have largely enjoyed free drugs in the PHCCs. However, in some PHCCs, patients have to pay for drugs which are meant to be given for free**.**

8.8 24hours Service Lacking in Some PHCCs: Some PHCCs visited, which should be open for 24 hours service have been reduced to function for only seven to eight hours. This poses a high risk for emergency services. In cases where a patient requires emergency services, the time lag available for such patient to access a distant PHCC might worsen his or her condition and may lead to loss of lives.

8.9 Lack of Training for Staff: It was observed that most of the personnel did not receive adequate training. The volunteers and casual staff including medical attendants have not been exposed to training in the past three years. They are only supervised by visiting qualified staff who might not have the time to offer them the much required training.

8.10 Routine Immunization: Routine Immunization has been mainstreamed at the PHCCs. Most of the facilities visited have days for immunization and usually record good turnout of beneficiaries. With the support of international partners, SOML, MNCH2, etc., vaccines have been provided at the PHCCs and this is accessed free of charge.

8.B RECOMMENDATIONS

8.11 Improved Budget Allocation and Releases: The state government needs to consider ring-fencing the allocation to the health sector, especially the votes for PHC and MNCH to ensure that budgeted sums are released and utilized. The state should appropriate, release, cash-back and utilise not less than 10% of its overall budget resources for the health sector.

8.12 Use Health Management Information System to inform Planning and Budget: The state government, using the State Health Management Information System, should identify PHCCs which require upgrade and use the data for its planning and budgeting.

8.13 Establish a state Level BHCPF: The state government should proactively establish the Basic Health Care Provision Fund with 1% of its CRF or a counterpart fund to take advantage of grants from the federal BHCPF.

8.14 Start a Compulsory and Universal Health Insurance Scheme: Attract more funding for primary health care by enacting a mandatory contributory health insurance scheme. Community based health insurance scheme can be introduced at the communities with subsidized premiums and concessions for vulnerable groups such as the aged, children and pregnant and nursing mothers while formal and informal sector health insurance scheme should be set up for citizens at the urban centers

8.15 Hire more Qualified Staff: The state should hire more qualified health personnel and evenly distribute them across the state. The staffing should aim at meeting the full complement of staff as stated under the AMSfPHC in Nigeria. The state should de-emphasize the engagement of casual workers and volunteers.

8.16 Renovate Decrepit Buildings: The decrepit buildings housing the PHCCs should be renovated. From the floors, windows and doors, painting, the ceilings and roofs, the Centres should wear a new look.

8.17 Improve Facilities: The water and electricity challenge common in the PHCCs should be addressed. Alternative power supply such as generators and solar panels needs to be installed and routinely maintained to power equipment like fridge, boreholes, etc. Quality assurance standards should be deployed in the procurement of goods and works for solar facilities; warranties should be secured from installers and suppliers to guarantee the quality of the initial installations. This should be followed up with routine and timely maintenance.

8.18 Needed Equipment: The state government should take concrete and targeted steps to ensure the progressive availability of the full complement of equipment identified in the AMSfPHC in Nigeria in the PHCCs.

8.19 Drugs Supply: The state government working with development partners should improve on the existing supply of drugs and ensure that patients do not have to pay for drugs which are meant to be given for free**.**

8.20 24hours Service in PHCCs: More personnel recruitment and provision of supporting facilities will guarantee that 24 hours service is restored in most PHCCs. Ambulance services should also be made available for emergency evacuation.

8.21 Training for Staff: Continued training of professional staff, volunteers and casual workers should be guaranteed through the plan, policy, budget continuum. Funding should be made available for training and retraining.

8.22 Routine Immunization: The state should enforce relevant laws that provide for compulsory immunization and if possible, punish parents and guardians who withhold their children from taking advantage of the free immunization services.

8.23 Effectively Utilize Constituency Projects: Members representing various constituencies at the state and federal parliaments should rather than building new PHCCs, identify the existing PHCCs in their community and partner with the state government to make them functional up to the minimum required standard. This should form part of their constituency projects to the communities.

8.24 Effective Legislative Oversight: Legislators should ensure effective and proper oversight of the management of resources and services rendered at the PHCCs.

8.25 Effective Citizens Oversight: CSOs should engage in monitoring and oversight of the state of PHCCs and the services they render and use the monitoring results to engage policy makers.

PART C: KADUNA STATE

9. INTRODUCTION

9.1 Background

Starting from 2017, the Kaduna State Government proposed to revitalize 255 PHCs annually. In the 2017 budget, the state allocated the sum of N2.9bn for renovation and upgrading of 255 PHCs. However in 2018, the sum for construction, renovation and upgrading of PHCs was reduced to N1.0bn. The overall capital budget performance of the state in 2017 was 21.9%[7].

Tables 6 and 7 show the allocation to the health sector in the state for 2015 -2018.

Table 6: Health Vote as Percentage of Overall Budget 2015-2018

Year	Total State Budget	Capital Health Allocation	Recurrent Health Allocation	Total Health Budget	Health as a % of State Budget
2015	200,728,155,312.00	8,198,983,555.00	8,836,880,031.00	17,035,863,586.00	8.49%
2016	172,322,648,891.57	6,661,683,063.73	6,368,394,844.00	13,030,077,907.73	7.56%
2017	214,921,110,176.68	10,490,384,272.00	14,277,588,251	24,767,972,523	11.52%
2018	216,650,173,912	17,576,392,530	17,119,881,856	34,696,274,387	16.01%

Source: Kaduna State Budgets 2015-2018

Table 7: Percentages of Health Capital and Recurrent Votes 2015-2018

Year	Overall State Capital Allocation	Overall State Recurrent Allocation	Overall Capital Health Allocation	Overall Recurrent Health Allocation	% Of Capital Health Allocation To Overall State Capital Allocation	% Of Recurrent Health Allocation To Overall State Recurrent Allocation
2015	127,472,368,940.00	73,255,786,372.00	8,198,983,555.00	8,836,880,031.00	6.43%	12.06%
2016	108,272,676,649.57	64,049,972,242.00	6,661,683,063.73	6,368,394,844.00	6.15%	9.94%
2017	131,455,817,381.15	83,465,292,795.53	10,490,384,272.00	14,277,588,251	7.98%	17.11%
2018	131,209,175,860	85,440,998,051	17,576,392,530	17,119,881,856	14%	20%

Source: Kaduna State Budgets 2015-2018

Table 6 shows that over the last four years, the vote has been undulating; from 8.49%, 7.56%, 11.52% and 16.01% for the years 2015, 2016, 2017 and 2018 respectively. For 2018, more of the resources have been channeled to recurrent expenses which got

[7] KDSG 2017 annual budget implementation report.

20% of the overall state recurrent budget whilst the capital allocation was 14% of overall state capital allocation. Table 7 shows progressive increase in the vote to the sector. The percentage vote to the sector should be sustained and eventually increased through greater domestic resource mobilization.

If these budgetary votes have been fully implemented, the Kaduna State Government would have taken progressive steps towards the fulfillment of the right to health in the state.

Kaduna State's MNCH indicators are poor as shown in Table 8.

Table 8: Kaduna State's MNCH Indicators

Indicator	Performance
MMR	1,025/100,000
Infant Mortality Rate	114/1000
Child Mortality Rate	269/1000
Percentage delivered in a health facility	32.4 %
Percentage without ANC	44.2%
Percentage of children with all basic vaccinations	35.3%

Source: Kaduna State Strategic Health Development Plan 2010-2015 and National Demographic and Health Survey, 2013

Health care services are provided in the state from a total of 1,692 health care facilities; 40.2% of these facilities belong to the private sector. 95.5% of these facilities are for primary health care, 3.2% secondary health care whilst 0.3% are tertiary health institutions. From the above information, the functionality, quality of the human resources for health and supporting equipment of the PHCCs will therefore go a long way in determining the quality of health care available to the residents of the state. Functional and quality services at the PHC level will also contribute to the reduction of infant, child and maternal mortality and morbidity.

9.2 Methodology

The project involved the monitoring of selected PHCCs in Kaduna State, to determine inter alia the state of the facilities, usage and to identify the challenges and needs of the PHCCs. It is also aimed at determining the level of efforts of government, developmental partners and the public to make PHC functional at the rural level. Beyond the monitoring visit, the project embarked on desk research for information and statistics to validate findings and to provide an anchor for the study.

Kaduna State has twenty three LGAs. However, the monitors selected two PHCCs each in five local governments to conduct the monitoring exercise. The monitoring ensured that the PHCCs were selected to cover the senatorial zones of the state. For the sake

of comparison, one renovated PHCC and one un-renovated PHCC was selected in each local government. This was done with a view to determining the extent of functionality of the renovated facilities and to provide evidence for attention to be given to PHCCs that have not benefitted from renovation. The PHCCs visited include; (1) Kasuwan Magani in Kajuru LGA; (2) Maraba Kugana Ward, Kajuru LGA; (3) Makera Kaduna South LGA; (4) Kurunmashi, Kurunmashi Ward, Kaduna South LGA; and (5) Mando Afaka, Igabi LGA. Others are (6) Birnin Yaro Kwarautasha Ward, Igabi LGA; (7) Hanwa, Hanwa Ward, Sabon Gari LGA; (8) Dogarawa Ward, Sabon Gari LGA; (9) Danjinjiri Sekina, Unajuma Ward Zaria LGA and (10) Dutsen Abba Ward, Zaria LGA. The monitors met with the officials in charge of the PHCs to obtain information about the facilities.

9.3 Limitation of the Exercise

Kaduna State has over 1,682 health care facilities in the state and 96.5% of these facilities are PHCCs. The state government has taken up the renovation of 255 PHCCs as the first implementation phase of its policy to revitalize PHCCs in the state. However, the monitoring exercise was limited to monitoring of two PHCCs per local government - one renovated PHCC and a PHCC yet to be renovated. There is need to expand the monitoring to cover other PHCCs. The sources of information obtained on the state of the PHCCs were limited to voluntary information provided by the officers in charge of the PHCC and in cases where the officer in charge was not around; the staff of the PHCCs volunteered the information. The actual cost of renovation and details of contract signed could not be ascertained. This would have helped the monitoring team determine if the revitalization of the PHCCs fulfilled the requirements of value for money and fitness of purpose. The prevailing bureaucracy in government circles made it difficult to obtain official approval from the state authorities on the financial commitments as well as procurement procedures adopted in the implementation of the renovation of the PHCCs.

10. FINDINGS ON THE STATE OF PHCCs IN KADUNA STATE

10.1 PHCC Kasuwan Magani in Kajuru LGA

State of the PHCC: PHCC Kasuwan Magani is in Kajuru LGA, which is located in the southern part of Kaduna State. The PHCC was renovated by the state government. It has constant power supply from the national grid and a 12 KVA Mikano Generator which was supplied by the Centre for Integrated Health Programme. A small generator is used to pump water. Other facilities in the PHCC include solar fridge but the battery of the inverter is weak and requires replacement. The facility is made up of 15 rooms and one staff quarter. The PHCC provides all the services specified in the AMSfPHC and also undertakes cervical cancer screening. It has adequate staff and runs 24 hours service. The PHCC has most of the necessary equipment except kidney dishes, multistix text kits and suction machine. The delivery room cannot take more than three deliveries at a time. The PHCC is not fully fenced, it lacks adequate security as the present security man works as a volunteer. This creates a security risk to staff and equipment. Patients pay for their drugs, except when there is a provision for free drugs.

Picture 72: Primary Health Care Centre Kasuwa Magani

Picture 73: Generator, Overhead Tank, Solar Batteries and Fridge for the Facility

Recommendation: The PHCC should be properly fenced and provided with security. The equipment lacking in the PHCC should be provided - including shelve for filing of documents**.**

10.2 PHC Maraba Kugana Ward, Kajuru LGA

State of the PHCC: The PHCC is 10 kilometres to PHCC Kasunwa in the same Kajuru LGA. Unlike PHCC Kasunwa, it is yet to be renovated. There is no electricity in the facility; according to the findings, the electricity was disconnected from the national grid as a result of debt owed by the PHCC. Electricity generator is not available as the PHCC relies on the use of lanterns at night. The inverters installed at the PHCC were not working. There is also no flush toilet in the facility. The facility has 11 rooms without staff quarters. Major equipment required for MNCH services are lacking such as bed pan, face masks, solar fridge. The facility provides services required in the AMSfPHC except attending to tuberculosis. However, a staff of the PHCC was recently sent on training for TB. But she is yet to commence operations as the equipment for the deployment of TB services has not been provided. Drugs are given free to pregnant women and children under 5, while other patients are expected to pay for their drugs. The monitors observed that most of the roof in the facility is dilapidated and broken, causing rain to destroy properties inside the rooms. The security situation of the facility is poor, but recently, a casual worker was engaged.

Picture 74: Front View Of Primary Health Care Centre Maraba Kugana

Picture 75: the Leaking Roof

Picture 76: The Drugs Sections

Recommendation: The PHC should be fully renovated and furnished with the lacking equipment in accordance with the AMSfPHC.

10.3 Primary Health Care Centre Makera, Kaduna South LGA

State of the PHCC: Kaduna South LGA has its headquarters located at Makera. The PHCC is among the ones renovated by the state. It has constant supply of power and a Mikano Generator as alternative power supply. The solar powered borehole provided for the facility is not working; it requires servicing and change of some parts. The monitor discovered that though the PHCC has been renovated, it is still very small. It has just 10 rooms and runs a 24 hour service. The total number of staff in the PHCC is 28 including 13 volunteers. Pregnant women and children under 5 receive free drugs at the facility. The PHCC has most of the required MNCH equipment except disposable face masks. The PHCC lacks security.

Picture 77: The Primary Health Care Makera Kaduna South Local Government Area

Picture 78: The PHCC's Borehole which is not working

Picture 79: The PHCC's Solar Fridge

Picture 80: Waiting Room

Picture 81: Patients' Ward

Recommendation: The solar panel should be upgraded to power the borehole and security should be provided for the PHC. The unavailable equipment should be provided.

10.4 Kurminmashi PHCC, Kurunmashi Ward, Kaduna South LGA

State of PHCC: The distance from Kurminmashi PHCC to Makera is 11.8km; they are both located in Kaduna South LGA. Unlike Makere PHCC, the Kurminmashi PHCC is yet to be renovated. The PHCC relies on public grid for electricity. The PHCC has a very big compound with uncompleted buildings but only 5 rooms are in use. It lacks major equipment needed for MNCH services. The monitors discovered that equipment such as refrigerator, cord clamps, face masks, kidney dishes, towel, stadiometer, sterilizer, stove suction machine are lacking. Other equipment from the AMSfPHC list lacking at the PHCC include mucus extractor and urinary catheter. There is no supply of free drugs for both pregnant women and children under 5. Patients buy their drugs at the PHCC. The PHCC also lacks adequate security as miscreants and drug addicts come into the place to smoke all manner of drugs. The staff complained of the security risk posed by these infiltrators.

Picture 82: Pictures of Primary Health Care Centre Kurunmashi

Picture 83: Waiting Section and Rooms in the PHCC

Picture 84: Uncompleted Buildings

10.5 PHCC Mando Afaka, Igabi LGA

The PHCC is one of the 23 health facilities located in Igabi LGA. It is 46.2km to Kaduna South**.** The PHCC is one of the renovated facilities in the state. A two room uncompleted building was recently completed and renovated in the PHCC. The facility lacks power supply, the electricity connection was disconnected by the distribution company. It lacks a generator set and relies on lantern to carry out its services at night. A solar panel was installed to power the solar fridge. The PHCC lacks water supply due to unavailability of power to pump water; water is sourced from water vendors. The facility has 20 staff that runs shift services. Some basic MNCH equipment are lacking such as adult weighing scale, thermometer, cord clamps, enema kits, episiotomy scissors, sphygmomanometer, suction machine and urinary catheter. Only anti-malaria drugs are provided free in the PHCC, patients pay for all other drugs. The facility lacks adequate security. It has only two beds for out-patient ward observation and only one labour bed**.** The family planning room which is connected to the labour room needs to be separated.

Pictures 85: Primary Health Care Mando Afaka *Picture 86: PHC's Waiting Section*

Picture 87: PHC's Borehole-Not working

Pictures 88: PHC's Record Room

Recommendation: The authorities should provide equipment lacking at the PHCC.

10.6 PHCC Birnin Yero Kwarautasha Ward, Igabi LGA

State of the PHCC: The PHCC is 40 km to PHCC Mando both in Igabi LGA. The PHC is yet to be renovated under the PHCC renovation programme of the state. The facility has just five rooms. It relies on power supply from the distribution company. It has no generator. It has 13 staff made up of five volunteers, 4 technical staff, 2 senior CHEW, 1 JCHEW and a medical laboratory staff. The PHCC runs a shift service from 8am to 8pm. Part of the challenges of the PHCC is lack of water, security and some MNCH equipment such as baby weighing scale, sphygmometer and suction machine. Free drugs are not available at the PHCC.

Pictures 89: Primary Health Care Birnin Yaro Kwarautasha Ward, Igabi LGA

Recommendation: Provide functional water source and back up electricity supply. Also provide equipment lacking in the PHCC as recommended in the AMSfPHC.

10.7 PHCC Hanwa, Hanwa Ward, Sabon Gari, LGA

State of PHCC: The PHCC is located in Sabon Gari, LGA which is 80km to Kaduna town. It is one of the renovated PHCCs in Kaduna State. The PHCC has power supply from solar energy. However, it was discovered that the light trips off at night; this may be due to lack of maintenance of the solar panel. The borehole provided for the facility is not functional. The borehole has only produced water once since its installation, and several efforts to get a consultant to rectify the problem has failed. The monitoring team tried to reach the consultant seeking explanations for the failure of water supply at the PHCC. Speaking with the consultant on phone, he explained that Hanwa, being a rocky terrain posed difficulty in accessing water from the soil. According to him, the engineers dug the estimated depth to get water and all they could get was very small quantity of water which produced the initial supply to the PHC. He explained that they dug up to 100 meters and the situation remained the same. He expressed hope that during the rainy season, the soil would produce more water and it will become easy to get supply. The facility runs in shifts, closes by 9pm and has a total number of 16 staff. It has 14 rooms. The renovation made provision for the construction of a male ward, and expansion of the female ward, including the construction of an outpatient department. Two new toilets were built and the existing toilet was renovated. The renovation also involved painting of the building. The PHCC lacks some basic MNCH equipment and materials such as Ambubag, bed sheets, cuscus speculum, face masks, eneka kits, shpygonometer, stadiometer, suction machine, etc. Patients do not receive free drugs at the facility. According to the officials in charge, the facility is not among the six zones selected to benefit from the free drug scheme. However, MNCH2 occasionally intervenes by providing free drugs for children under 5 and for nursing mothers.

Pictures 90: Primary Health Care Hanwa, Hanwa Ward, Sabon Gari LGA

Pictures 91: Non-Functional Solar Panel Borehole and Solar Cold room

Recommendations: Provide functional electricity and water source and the necessary equipment as prescribed in the AMSfPHC.

10.8 PHCC Dogorawa Ward Sabon Gari LGA

State of PHCC: The PHCC Dogorawa is 11.7km to the PHCC in Hanwa both in Sabon Gari LGA. It is not among the renovated PHCs in the state. The monitor discovered that the PHCC has been cut off from electricity supply due to its indebtedness to the Electricity Distribution Company. The facility lacks water supply. It has just 3 rooms, which consist of a consulting room shared with the head of the PHCC, labour room and a waiting room used for ANC and multi-purpose services. The number of staff is 17 consisting of 2 N-Power staff, 7 technical staff, six volunteers and 2 casual security men. Some vital MNCH equipment and materials are lacking in the PHCC, such as cold boxes, cord clamp, face mask, towel, solar fridge, suction machine and catheter. Some of the basic minimum services such as tuberculosis, oral care and curative care cannot be accessed in this PHCC. The facility refers patients to Limi General Hospital which is 5km from the PHCC.

Essentially, the facility lacks adequate rooms, beds and enough space to accommodate patients and persons who come for immunization. The toilets are in very poor condition and for one year, the PHCC has been without electricity supply.

Pictures 92: Front View of Primary Health Care Dogarawa Ward, Sabon Gari LGA

Picture 93: Multi Purpose Room, Front Desk Office, ANC, Outpatient Ward

Recommendation: The authorities should provide functional access to water, electricity supply; increase the number of rooms and bed space; provide functional toilets. The necessary equipment required to meet the AMSfPHC standards should be supplied to the PHCC and it should be renovated.

10.9 PHCC Dutsen Abba Ward Zaria LGA

State of PHCC: The PHCC is located in Zaria LGA, which is one of the most populous cities in Kaduna State. It is 73km to Kaduna Central, the state capital. The PHCC is one of the renovated PHCCs in the state. It has constant power supply, however two days before the monitoring exercise, the electricity pole was damaged by a moving vehicle. There is also constant supply of water and a generator which is able to power the 17 rooms in the PHCC. There are 11 permanent staff in the PHCC, 8 of them are technical staff. Free malaria drugs and family planning commodities are given to patients. Apart from this, every other drug is paid for including drugs for children under 5 and pregnant mothers.

Picture 94: Primary Health Care Centre Dutsen Abba Ward, Zaria LGA

Apart from HIV/AIDS and TB, the PHCC provides all the services under the AMSfPHC. The officer in charge of the facility explained that the training process for the commencement of this service is on-going. The facility is newly built, a two day old facility as at the time of monitoring on 27th April, 2018. As a result, the facility is yet to be provided with furniture and beds. The request for this has been made. Part of the MNCH equipment lacking in the facility include forceps, enema kits, instrument tray, solar fridge, manometer, wash hand basin, suction machine, sterilizer and catheter.

Recommendation: The authorities should fully equip and furnish the PHCC and post the right complement of staff as required by the AMSfPHC.

10.10 PHC Danjinjiri Sekina, Ungjuma Ward, Zaria LGA

The PHCC has not benefitted from the ongoing renovation of PHCCs across the state. For the past five years, the PHCC has been without power supply. Despite the lack of supply from the Distribution Company, there is no generator to provide alternative power supply to the facility. A consultant came to the facility three years ago to install inverters but the project was stalled after three months. The PHCC also lacks water supply, staff of the facility use their personal resources to buy water from water vendors. The PHCC runs shift services of 8am to 4pm. The building of the PHCC is dilapidated; the last renovation was done five years ago by PATHS2 project. There has been no security in the PHCC in the last three years. Basic MNCH equipment are lacking in the PHCC. The lacking equipment and materials include adult weighing scale, baby weighing scale, bed sheets, cord clamps and face masks. The delivery kits utilized by the PHCC were supplied by UNICEF. The PHCC has just 4 rooms which include; a consulting room, environmental room, ANC room and delivery room. Drugs are not available for free, except anti-malaria drugs which is supplied to the PHCC by the National Malaria Elimination Program of the Federal Ministry of Health.

Picture 95: A dilapidated wall of the PHC showing the state of the PHC building

The PHCC has 3 staff made up of 2 CHEWS and one JCHEW. Some services such as TB are not provided at the PHCC, patients are referred to Tuberculosis and Leprosy Centre Saye which is 10km from the PHCC. Also, nutrition services are not provided at the facility, patients are referred to Baba Ndodo PHCC which is 2km from the facility. The facility lacks beds, furniture, shelves and the toilet sewage system is blocked. PHCC staff are compelled to go to neighboring houses each time they have to use the toilet.

Picture 96: Dirty Toilets not in use due to Blocked Sewage System

Recommendation: The PHC should be considered for renovation and the challenges identified in personnel, equipment, materials and other facilities rectified.

11. CONCLUSIONS AND RECOMMENDATIONS

11. A CONCLUSIONS

The renovation of PHCCs in Kaduna State is an ongoing intervention which would reposition the PHC facilities in the state. The key issues identified are summarized as follows.

11.1 Poor Water Supply: Most of the PHCCs have a borehole but for a multiplicity of reasons, the boreholes are not functional. It is not enough to award a contract and spend money in the drilling and construction of borehole and at the end of the day, water is not available to the beneficiaries. Proper hydrological surveys should precede the siting and construction of a borehole. It is a waste of public resources and increases the hardship faced by the intended beneficiaries when such money is spent and no value is gained.

11.2 Poor Sanitary Conditions: Some PHCCs have no toilet at all whilst others use pit latrine and dirty flush toilet facilities. Water scarcity further complicates the situation. This is not a tolerable situation in a health facility.

11.3 Lack of Functional Renewable Energy Installations: Most of the renovated PHCCs have provision for inverters, solar panels and solar fridges. However, due to lack of maintenance, the renewable energy installations are either not properly working or not functional. While the provision of this facility has been proven to be the best energy option for PHCCs, they must be properly maintained to serve the purpose. Further, it seems the suppliers and installers of these renewable energy facilities do not provide a warranty to the state and evidently, there are no maintenance contracts to ensure that they are serviced at regular intervals.

11.4 Disconnection from Available Grid Electricity: Some of the facilities have been disconnected from supply available from the national grid and this worsens the challenge of access to electricity.

11.5 Inadequate Space and Conditions of Buildings: Some of the facilities do not have adequate space - being a minimum of 5 rooms, walls and roofs were in poor condition without functional doors and netted windows. Some of the facilities do not have enough rooms to accommodate delivery and outpatient services, including patients that come for immunization. Majority of the facilities do not have staff quarters

11.6 Lack of Security: The monitors discovered that services of casual workers were withdrawn from the state health services and this affected the security personnel of PHCCs in the state. The absence of security personnel poses grave danger to the protection of staff and equipment in the PHCCs. There is need to immediately reconsider the decision and employ security personnel for the PHCCs and also provide adequate fencing of the facilities.

11.7 Inadequate MNCH Equipment: Most of the facilities visited lacked vital MNCH equipment; they rely mostly on donor assistance for the provision of these equipment. This does not guarantee sustainability. It should be the responsibility of the state and local governments to ensure that adequate equipment is available in the PHCCs in accordance with the AMSfPHC.

11.8 Non Observance of 24hrs Services in most PHCCs: The minimum standard is for PHCCs to operate 24hours on a shift basis. However, most of the facilities do not operate 24hours service. This will affect patients who are in dire need of emergency services at night. Efforts should be made to ensure that the right environment is created for PHCCs to run 24hours service.

11.9 Disproportionate Distribution of Personnel: Some of the PHCCs visited had adequate staff while others have very little number of staff. There is the need to train and engage more qualified hands and for even distribution of the available human resources for health.

11.10 Reasonable Service Provision: Most of the PHCs offer all the required minimum service provided by the service guidelines in the AMSfPHC. This is commendable; for PHCs where some of the services are not offered, efforts are ongoing to train some of the staff to acquire the skills and begin operation in the PHCC. The state government should facilitate the operation of the AMSfPHC in all the PHCCs.

11.11 Free Services: While treatment in some PHCCs including drugs is free, others charge fees for their services. It may be more equitable for the state to articulate its minimum core obligations to citizens based on available resources and make it available free of charge to all. Any service beyond the minimum provisions should be paid for. The current approach seems discriminatory and is not based on any empirical foundations.

11.12 The Health Budget: Budgetary allocations to health look reasonable on paper. But release of the appropriated sums lags and this leads to public underfunding of health care.

RECOMMENDATIONS

The following recommendations flow from the above findings and conclusions.

11.13 Improve Water Supply: Proper hydrological surveys should precede the siting and construction of boreholes. The contracts should be awarded to reputable companies who would equally be bound to provide a warranty on their service and installed equipment. Again, routine maintenance of facilities will guarantee that they are functional.

11.14 Improve Sanitary Conditions: This is a clear case of emergency that demands that proper flush toilets be available in all PHCCs and that managers of the facilities be placed under obligation to ensure their cleanliness and maintenance. Availability of water will also improve sanitary conditions.

11.15 Functional Renewable Energy Installations: Contracts for the procurement of renewable energy materials should be given to reputable vendors and installers. Furthermore, it is imperative that suppliers and installers of these renewable energy facilities provide warranties to the state. Maintenance contracts to ensure that they are serviced at regular intervals should also be built into the supply and installation contracts.

11.16 Connection to Available Grid Electricity: All PHCCs should be connected to electricity supply available from the national grid and adequate overhead costs set aside for regular payment of electricity tariffs. Indeed, it makes eminent sense for all PHCCs to procure prepaid metres.

11.17 Improve Space and Conditions of Buildings: The renovation exercise provides the opportunity for the facilities to be provided with adequate space being a minimum of 5 rooms, walls and roofs in proper conditions with functional doors and netted windows, enough rooms to accommodate delivery and outpatient services, including patients that come for immunization, staff quarters, etc.

11.18 Improve Security: The facilities should be secured through fencing and the employment of security guards as well as liaison with the security authorities in the area including the police and civil defence.

11.19 Provide PHC/MNCH Equipment: The state government should provide adequate funding for procurement of equipment. Liaison with development partners including donors, the private sector, etc. will increase resources available for procurement of equipment as stated in the AMSfPHC.

11.20 Ensure 24hrs Services in PHCCs: The state should guarantee, through the provision of adequate personnel and facilities that PHCCs operate 24hours a Day.

11.21 Even Distribution of Personnel: There is the need to train and engage more qualified hands and ensure even distribution of the available human resources for health. The state should consider incentives for qualified personnel working in rural areas.

11.22 Free Services: It is pertinent and equitable for the state to articulate its minimum core services to be made available to all citizens based on available resources. These services should be made available free of charge to all. Any service beyond the minimum provisions should be paid for.

11.23 Improve Health Funding: The state government should consider establishing a special fund or a state level BHCPF which would be used to attract counterpart funding from the federal level BHCPF.

11.24 Compulsory and Universal Health Insurance: Attract more funding for primary health care by fully implementing the Kaduna State Contributory Health Insurance Scheme. The insurance scheme should be made compulsory and universal. Premiums from community based health insurance scheme can contribute largely to the funding of the PHCCs.

11.25 Liaison with Federal Legislators: The state government should liaise with members representing various constituencies in the state at the National Assembly; rather than their requesting for resources to build new PHCCs, identify the existing PHCCs in their communities and partner with the state government to make them functional up to AMSfPHC in Nigeria. This should form part of their constituency projects to the communities.

11.26 Effective Citizens Oversight: CSOs should engage in monitoring and oversight of the state of PHCCs and the services they render and use the monitoring results to engage policy makers for improved service delivery.