Part 1
MINIMUM STANDARDS FOR PRIMARY HEALTH CARE SERVICES NATIONWIDE IN NIGERIA

Report of a consultancy assignment

Prof. MC Asuzu & Dr. MO Ogundeji
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CHAPTER 1
BACKGROUND & TERMS OF REFERENCE

1.1 Terms of reference for the consultants

The terms of reference given to the consultants for this exercise noted that the National Primary Health Care Development Agency (NPHCDA) provides support for the National Health Policy in all matters relating to primary health care (PHC) in Nigeria. Subsequent to this mandate, one of its core functions is the development of effective systems of supervision, monitoring and evaluation of PHC based on national guidelines and standards. Adherence to a set of minimum standards for PHC system is fundamental to the effective functioning of any health facility and is an essential element for the delivery of quality health care.

It was further stressed that the absence of such minimum standards for PHC service has deprived policy makers and health professionals of valuable advocacy tools and undermined efforts at effective supervision, monitoring and evaluation. In addition, it has also hindered effective planning and development of PHC services. The overall goal of the project is to develop universal levels of static health facilities and the minimum standards for PHC structures, systems, equipment and service delivery nationwide.

The project would require the consultants to undertake all such processes and activities as contained in the subsequent paragraphs or that may arise, or be duly communicated in the course of executing the project. All processes and activities would culminate in the development of *a manual on minimum standards for PHC in Nigeria.*

The areas for which minimum standards need to be defined would include:

a. ***Health infrastructure*****:** Types or levels of PHC facilities

b. ***Human resources for health*****:** Minimum recommended staff number and cadre for each type of health facility

c. ***Service provision*****:**

i. Recommended minimum sets of PHC services for each facility type
ii. Recommended minimum medical equipment for each facility type
iii. While the National Essential Drug list remains the standard for Nigeria, minor recommendations would be made for future consideration.

The specific activities the consultants were to carry out included:

- Conducting extensive literature review, interviews and documentation on all existing materials on PHC standards;

- Developing a zero draft for presentation and discussion with a technical working group of health officers and stakeholders;

- Reviewing the zero draft based on the meeting with the Technical Working Group and developing a Draft +1 document. The Consultants would present this second draft to a larger forum of stakeholders for their criticism, input and recommendations; and

- Finalizing the manual on minimum standards for PHC in Nigeria.

The time frame was a total of twenty-one (21) man-days in phases was envisaged for the completion of the assignment and would consist of;

- 10 days for documentations and development of a zero draft.
- 5 days for effecting modifications to the draft document based on the meeting with the technical working group
- 3 days for finalization of the document after a stakeholders meeting.
- A total of 3 days for meetings.

1.2 **Detailed itinerary**

A detailed itinerary was developed at the first meeting with the consultants when the methodology of the exercise was agreed as spelt out below. It was also accepted by the Technical Group at the NPHCDA on the suggestion of the consultants at this first meeting that if this document is to be a Nigerian community document, even this zero-draft should be done with at least some basic minimum community consultation. A minimum of three states in three geopolitical or climatic and socio-cultural zones in Nigeria was to be consulted before this draft would be developed. It was also agreed to visit Lagos State, which quite un-representative of any geo-political or socio-cultural zones in Nigeria, was reported to have a very efficient and model PHC system that could be beneficial in the execution of this assignment.

CHAPTER 2
METHODOLOGY

2.1 First meeting at Abuja.

Following the terms of reference and the invitation of the two consultants to a meeting on 22/06/06 at the NPHCDA Headquarters at Abuja with nine principal officers concerned (see Appendix 1), the consultants requested that if this work is intended to be as thorough and well done as suggested in the TOR, it would be necessary for even this zero draft of the minimum standards document to be as "bottom-up" in its design and involve community and stake-holders as much as possible. In that way, these stakeholders will be expected to buy into it from the outset and so, to be willing to adopt and implement it afterwards. However, in view of the financial constraints that would seem to be the case here, it was agreed that three grassroots consultations in three states only, representing the southern, the middle belt and the far northern states respectfully, would be used for this purpose. The states and locations chosen for this were Oyo/Ibadan for the southern states, Plateau/Jos for the middle belt states and Bornu/Maiduguri for the far northern states. The latter was later changed to Kano/Kano for the same financial constraint reasons by the NPHCDA. Somebody at the meeting however mentioned that Lagos State was doing exceptionally well in PHC, far beyond the other states in the country. We therefore decided to visit Lagos State also; and to discuss and see things for ourselves with the key personnel at the State Secretariat at Alausa, Ikeja Lagos (see appendix for the list of participants at the discussions there). The NPHCDA Zonal Co-ordinators in the areas concerned were to facilitate the arrangement of these meetings, for and with us.

Some strategically identified stakeholders in PHC in each of the four locations were to be mobilized to meet with us for this survey. They were to collect and keep for us to see, any documents they use in the given state for minimum standards, curriculum, training methods or of policy regarding the four items in the TOR; namely, facilities, services, personnel and equipments. The following PHC personnel were to be requested to take part in the meeting/surveys: the state director of PHC/disease control; exemplary and experienced medical officer of health (or in his absence or non-existence in the given state, then the LGA PHC co-ordinator); one CHO, CHEW, (community) nurse and midwife each. The principals of the local schools of hygiene and/or health technology and the state programme officers of the individual components of the PHC services may also be invited as the state director of PHC and the zonal coordinator of NPHCDA may deem useful to do.

The state visits however were only to assist with the sourcing of literature on minimum standards for PHC in the country and around the world. It was expected that with the findings and suggestions from the state visits and the literature review and experience of the consultants, the minimum standard packaging zero document will be produced.

2.2 State-based meetings

2.2.1 State-based visits and conduct of meetings

After the meeting at Abuja, the consultants had a couple of meetings and dialogue to develop the issues and questions to be addressed at these meetings. Consultation meeting and surveys were thereafter carried out with the stakeholders at the geo-political and socio-cultural zones in the selected states as follows:

1. Oyo State at the (PriHEMAC) office of one of the consultants on the 19th of July; 7 people (excluding the consultants) attended the meeting.
2. Lagos State at the office of the State Director of PHC/DC on the 26th of July, 5 people (excluding the consultants) attended this meeting.

3. Plateau State at the office of the State Director of PHC/DC on the 2nd of August, 8 people, excluding the consultants, took part in this exercise.
4. Kano State at the office of the State Deputy Director of PHC/DC on the 16th of August, 13 PHC staff of the state attended this meeting.
The lists of the participants in these meetings are shown in the appendices.

In Lagos and Jos, the notice for our visit was reportedly received prior to our arrival but no preparation for our visit had been made before we got to the office of the Director, PHC/DC. No documents were made available to us except the ones that were quickly hand written mostly from national guidelines. On the other hand, although the people at Kano had not received any information of our coming, yet, the State Deputy Director of PHC in charge of training immediately summoned all the PHC programme officers in the State MOH as well as principals of both the Schools of Hygiene and Health Technology. They also collected a few very useful documents for us.

2.3 Key findings from state visit meetings as challenges and obstacles to PHC
The major findings of these meetings and key informant group discussions are presented below under health infrastructure, human resources and PHC services. They are recognised as challenges and obstacles that must be resolved in order to establish appropriate minimum standards for the PHC system in Nigeria.

2.3. Health Infrastructure and equipment
i). Construction of health facilities by individuals.
In some states and local governments, individuals, groups and even politicians have gone ahead, all on their own, to construct health facilities without consultation with the people; only later, to hand it over to the government or communities to be used as PHC centres. This, they often believe to be signs of how they love or care for the people. Generally, these facilities have only added more confusion and service problems to the difficult PHC situation on the ground because, very often, the buildings do not conform to any given format of buildings for PHC. This is especially one reason for standardizing these PHC physical facilities so that people keep to these standards when building what they feel should in the long run be given over to the government/for this purpose.

ii). Existing confusion about the names used for the various health facility types
There is still some confusion about the names used for the various health facility types, where or at what level of the PHC system they belong, the person who should be responsible for their building and maintenance as well as the functions they should perform. Despite the many years of implementing holistic health care, implied by the PHC approach and so the phasing out of the terms maternity centres and dispensaries, some places and some individuals still build or maintain these terms in their old and now unacceptable senses of self-existing stand-alone facilities. These terms should no longer be used except as sections or units in a holistic health facility of the modern health- rather than disease-oriented health services. *There is great need to educate all the PHC staff on the need to stop these confusions and to completely eliminate any such unwholesome uses – another reason for the standardization of these terms in the country.*

iii). Frequent changes in the design of buildings approved for the various types of PHC centres
There have been many changes in the patterns of buildings approved for the various types of PHC centres in the country. Many of those are so expensive and cumbersome that they are such a colossal waste of money to have been given approval for by the NPHCDA. Currently, the plan of the second batch of these ward-based PHC centres by the NPHCDA is different from the ones they built in the first phase. *These buildings must become standardized, make*

for the simplest and functional thing and plough over the unused money (if so) to apply it to something quite useful for the PHC funds. The combination of building large and extensive facilities of which less than half has been able to this habit of be put into any use whatsoever, only to be taken over by rats and mice, should also stop.

2.3.2 Human resources for PHC

iv). *Job description and team work*

There is very serious rivalry in all the states between nurses and midwives on the one hand and the CHOs and CHEWs on the other as reported or noticed at the meetings. Other conflicts between the other health workers that may be found in the PHC services in the states and LGAs – such as environmental health officers and the no longer used terms of community health supervisors, assistants and aids (where the terms are still in use – like in Plateau State) – also exist. Since after the state visits, it has been reported that environmental health has been withdrawn from the health department and made an independent one completely free from health in Oyo, Lagos and Ogun States. This is, to say the least, a very unhealthy thing, considering that environmental health is the core of statutory public health and of the job of the medical officer of health in every country of the world. *All these confusions and conflicts MUST be tackled if anything meaningful in terms of standards is to be achieved in PHC.*

v). Training and employment of PHC staff

In many states, politicians, senior civil servants and other supposedly important persons had cajoled or howsoever else gotten principals of the schools of hygiene and of health technology to admit students to their training programmes against the recommended guidelines by which these admissions should be done. Many of the graduates on qualification have nobody willing to employ them. It was universally agreed that due to the non-employment of the many CHWs already trained, there is already an over-production of these health workers; yet, many communities who ought to have such health workers do not have them. A certain minimum per-capita budget for health care would seem to be mandatory for all LGAs in the country if we are ever going to have PHC extended to all the communities needing it and to have employed all the CHWs already trained for these services so far. This was the decision also arrived at with the German-assisted PHC services in Niger State in 2002.

We also have some CHWs, even sponsored by some of the LGAs for training but who fail to absorb them afterwards. Others are employed and paid such a pittance that they either stay on the job but do little or no job at all, combine the job with a more lucrative patent medicine selling or simply quit and run frank clinics or "hospital" outfits. Even now, there are said to be a society of privately self-employed CHOs and CHEWs. These are people who supposedly are never to practice on their own, unsupervised, and only by the use of the standing orders that they invariably throw away, now practicing completely independently and with no supervision at all. *These abuses MUST be addressed in any genuine attempt to establish standards and to make sense out of the present PHC situation in the country.*

vi. Inadequacy of professional skills.

Lack of staff with clinical competences, especially of midwifery, as well as the equipments for their service delivery has created situations in which patients by-pass such facilities to go to higher levels of care saying that there are "no persons" at the said centres. Also, complaints of failure or unavailability of essential drugs based on the Bamako Initiative principles at many of the centres lead to this situation of the "there is nobody there" syndrome. *Success of the essential drugs supply locally in Nigeria must be seriously tackled*

if we are to develop any meaningful and sustainable standards in PHC in this country.

vii). Unhealthy staff deployment policy for PHC.

PHC in Lagos state was described by the Director of PHC/DC there as being "in a state of confusion" because the state government had decided that the head of all LG departments should be no more than a grade 13 officer. All the other staff in any LGA service department are to be necessarily of lower ranks than such said HODs. Hence, all the qualified medical officers of health, all the senior and experienced nurses, midwives, CHOs, etc, were all being withdrawn and being put in state offices called community health departments where they may no longer perform any clinical duties or actual community-based services! Decisions on minimum standards must take into consideration the fact that PHC is not inferior health care and specialists in PHC or community health such as community physicians, nurses and midwives must be able to complete their careers within the true PHC or community health services – especially as community medical officers/MOHs, community/district nurses or midwives. Moreover, it is to be realized that the local government is a full-fledged government in its own right. Such actions that portray the LGA as a place for nincompoops or inferior people must be stopped.

2.3.3 PHC Services and implementation issues

viii) Need for all-inclusive terminologies in PHC literature and services.

In Lagos State, it was observed that the use of the term "villages" when referring to the lowest levels of communities for PHC services leaves the urban settlements out of the picture. Thus people in the urban areas may feel that PHC does not apply to them, a very bad situation that must be thoroughly avoided. Therefore it is important to use such terms as "settlements" (viz, the "sabon geris", "ama obia", "ama ofuo", "ile titun", etc) and "neighbourhoods" as alternatives wherever villages are mentioned in PHC literature in Nigeria henceforth as standard language. Also, when the alternative name "communities" is used without any further qualifications or specifications, it is to be assumed that these will be villages, towns, settlements and neighbourhoods, depending on the location of the communities.

ix) *Overlapping roles of different levels of governments on PHC.*

There are still vestiges of confusion (or even conflict and lack of understanding and cooperation) between the states and LGAs on the one hand and the PHC staff at both government levels. These confusions, conflicts and lack of understanding concern their roles and responsibilities in PHC as well as the utmost co-operation and collaboration that MUST operate between them. The same is true of the situation between these and those at the federal levels. *These roles, responsibilities and working relationships MUST be clarified and the standards clearly set out by carefully studying and hormonizing the content of the documents that spelt out these roles for all to learn and abide by in an exercise of standards setting if success is to be realized from the exercise*.

x) Community involvement strategies in PHC

The utilization of participatory learning action principles for community development termed *PLACO*[1] in Kano State for PHC implementation was reported to have resulted in a high level of real community involvement in giving land, building health facilities and in participating in running them. Also, the establishment of Integrated Village Health Services (IVHS) Units in Kano State is worthy of more detailed study for adoption at the national level, even though this may have been their adaptation of a principle already recommended from the national level. The IVHS-units consist of a health post, VIP-latrine, and a water point (i.e., a sanitary

well or a borehole) and a VHW or TBA who serves at the health post on a voluntary basis. This is similar to the community self-owned health facility/dispensary system encouraged in Fiji for the attainment of total community health care. In that country the government provides support for 2/3rd of the cost of erecting such a facility by the community, the funds being accessible through the office of the LGA medical officer of health who supervises such community self-help health projects. In both Kano and Plateau State, the staff interviewed reported that they did not have medical officers of health in PHC at the LGA level but that this would be highly desirable if at all possible.

Various models for the advancement of collaboration of state and LGAs in PHC administration were also suggested by the Kano State PHC team at our discussion with them, such as sharing information on their health budget at the highest level of the governments (LGA chairmen, the medical officers of health and the commissioners of health), especially for capital projects, so that unnecessary duplication and unhealthy or even false competition in these regards will be avoided. It will also prevent the economic wastages and other frauds associated with these mal-administrations. Only the community education and involvement in maximizing this PHC action model would seem to be needed now everywhere in that state to have every community to develop such facilities for themselves. The health education component of PHC would do well to train all PHC workers in this regard. Nation-wide research in the application of this type of community involvement through the town hall method had been demonstrated by the Justice, Development and Peace Commission of the Catholic Secretariat in Lagos[2] with the documentation of the modalities for doing so already published and available to those who may choose to do so. Such health education models may be recommended for PHC throughout the country.

xi) Implications of ward health system for PHC implementation

In all the states visited, the people are quite familiar with the *ward system* for PHC implementation that NPHCDA has adopted for a while now and would seem to be actively promoting or pursuing it already. The fact that health facilities and staff are being distributed on political ward basis seems familiar and acceptable to most people interviewed. It would therefore seem to us that this system should be stuck with in this standards development.

xii) Essential drug list (EDL)

The only standards we ever got from these state officers in relation with the essential drug list were for a primary health centre. No standards were identified for the levels and quantity of drugs to be used at the health clinic or health post. *However, a different EDL exists at all these levels of the PHC in other countries (e.g., Fiji and Botswana). It is felt that Nigeria needs to do the same for these levels of the PHC system using our own local factors in determining these.*

CHAPTER 3
REVIEW OF MINIMUM STANDARDS LITERATURE

3.1. Standards setting in health care

The necessity of standard setting in the health services has become widely recognized in the recent times. According to the World Health Organization[3] the purpose of setting health standards as a tool in health services management is to strive to achieve the highest quality of care possible within the resources available. Standards provide degrees of excellence to be pursued in a given exercise or exercises. They provide the basis for monitoring, comparison, supervision and regulation of the given services.

3.1.1 Levels of standards

Since the development and use of standards in health care, two types or levels of standards have come to be recognized – minimum standards to be achieved by all involved in the exercise as well as optimal (ideal or desirable) standards to which all concerned should be striving at. It is also important to note that optimal standards, after a period of time has elapsed and significant effort has been exercised to meet them, may, in fact, become the minimum standards[3]. The request of this exercise is for minimum standards for all of Nigeria. From the experience of the field visits, the conditions of PHC in some of the northernmost part of the country are so poor that setting only such minimum standards which may be attainable in those places will mean that the locations in the south are doing so well and should not bother to do anything for the next century. This will surely not be in the interest of PHC in the country. Therefore, both the requested minimum standards as well as optimal standards will be produced as shown in the WHO document discussed above.

3.1.2 Types of standards

Different types, or in deed classes, of standards have been used in the health services over time[3]. The standards may be directed toward structure, process or outcome. Structural standards apply to the things we use for the services such as human, financial and physical resources (men, money and physical matters). Process standards apply to what we do (such as activities that constitute care, service or management). Outcome standards address the results (both clinical and non-clinical) of what we do with the things we have. The standards covered by this assignment are only in the groups of structural (physical facilities, staff and equipments; but not finances) as well as process (i.e., health services to be provided). It may be useful to cover all aspects of standard setting for PHC in this exercise instead of going to use another time and other resources to do so later.

3.1.3 Process of setting standards

Standards' setting in health services is an all-encompassing process that requires great care[3]. The process usually reflects the appropriate collective judgment about accepted or desired levels of performance and the associated values. In addition, since standards are dynamic and not static, there must be an inbuilt process for the on-going evaluation of their continued relevance and applicability. With use, the standards will need to be reviewed and modified as time goes on – such as every 5 to 10 years at the most as is the standard everywhere else.

3.2 Standard setting in PHC around the world

i) Relevant WHO literature

According to the report of the Alma-Ata Conference on primary health care[4], PHC evolved from experiences with health services delivery in several settings over the immediately preceding couple of decades but especially from the immediately preceding paradigm of community health services by the WHO; namely, that of basic health services (BHS) provision. But PHC,

according to the WHO, is a lot more than the provision of BHS. On its subsequent document on indicators for monitoring primary health care and progress towards health for all, WHO[5] has identified four categories of indicators; namely, health policy, socio-economic, health service provision and quality of life indicators. These indicator categories are broader than those already reviewed above for the general provision of health services. The Alma-Ata conference also specified 8 minimum health service areas that have since been referred to in many places as the minimum service components of PHC. These consist of:

- Education on prevailing health problems and how to prevent them (health education)
- Provision of adequate water and basic sanitation (environmental health)
- Adequate food supply and good nutrition (public health nutrition)
- Maternal and child health including family planning (reproductive and family health)
- Immunization against the common diseases
- Control of common endemic diseases (epidemiology and disease control)
- Treatment of common diseases and injury (primary medical care)
- Provision of essential drugs (community pharmacy practice)

The report clearly shows that PHC is all of community medical and health care as so far known and as any government can accommodate. So, in several countries to date the individual minimum number of the said PHC service content have been increasing; and in the best of such countries, are up to 12 broad practice areas of community medicine and health; viz: dental health; mental health; rehabilitative health (including care of the elderly, the handicapped and/or the disabled); and occupational health. However in some areas people have used single or much narrower activity areas to identify what some call elements of PHC. Thus the FMOH/NPHDA/WHO district health package for all (DHFA) document[6] identified the following 13 minimum PHC components: child survival, safe motherhood, productive life years, immunization, family planning, essential drugs, adult health literacy, household food security, water supplies and sanitation, HIV/AIDS, emergency preparedness and response, health education and Bamako Initiative.

ii) Policies on health manpower development

National and international policies on health manpower development keep changing depending on changing values, mores and circumstances. WHO[7] examined eight health manpower policy objectives generally in the chronological order of their appearance during period I, 1948 – 51; period II, 1952 – 61; period III, 1962 – 72; period IV, 1973 – 80. The observations are shown in Table1 below. It would appear that the lesson from this table is the need to treat all health planning comprehensively whenever such planning is contemplated. In that way, all the ramifications are taken into account at once; instead of planning for competent health man power first and then after their adequate production only to think of their posting, the health facility where they will be working, then geographical coverage, the equipment, etc. This is another reason that this standard setting exercise should be done comprehensively.

Table 1. Health manpower policy objectives approximate evolution in WHO from 1948 to 1980, by time-period and degree of importance*

Objectives	Period I 1948 – 1951	Period II 1952 -1961	Period III 1962 - 1972	Period IV 1973-1980
Quantity of conventional personnel	Xxx	Xxx	xx	X
High quality of medical and nursing education	Xx	Xxx	xx	
Equality of credentials cross-nationally		Xx	x	
Geographical coverage in countries		Xx	xxx	Xxx
Efficiency of production and use of health personnel		X	xx	Xxx
Planning of health manpower			xx	Xxx
Relevance of health personnel		X	xx	Xxx
Integration of the development of health systems and manpower			x	Xxx

*the appropriate degrees of importance are indicated in the various columns, from little importance (x) to very important (xxx)

3.2.1 Current global thinking on human resources for health

In recent years, the health community has realized the health manpower gap in developing countries. In addition, increasing recognition is being accorded to the fact that appropriate and competently skilled manpower is the most important issue in addressing any health issues. In fact, in recognition of the impact on the rising maternal mortality ratio in many developing countries, it is the consensus that the health system should develop a phased incremental human resource development plan[8]. In terms of maternal services, the objective is to increase access to, and use of, skilled attendants where capacity is the strongest, followed by scaling-up of access in other parts of the country in a phased manner. It is believed that all countries can move to a skilled-attendant-for-all model of service delivery, depending on the capacity of each health system to train and appoint skilled attendants and the funding available for this purpose. It has also been reasoned that providing skilled care for all, needs to be seen as a non-negotiable national priority.

However, skilled attendance and institutional delivery alone may not be a good strategy for reducing maternal mortality in populations where a sizeable proportion of mothers deliver at home. Researchers such as Bang and colleagues who demonstrated and showed a 62% reduction in neonatal mortality in rural India through a community based approach that included training of traditional birth attendants and local women to treat sick newborn infants at home[9]. In a recent meta-analysis on traditional birth attendant training and pregnancy outcomes, the data used suggested that TBA training was effective in terms of the outcomes measured, but the authors were unable to demonstrate that it is a cost-effective intervention. However, they concluded that since skilled attendance at birth is a distant reality in many developing countries, effective community-based strategies are needed to help reduce high levels of mortality. They went on to say that if TBAs are to be trained, it is imperative that their training be adequately evaluated in order to develop the strong evidence base that is lacking to-date and that is necessary for sound policy and programming[10]. The latest WHO stand however is that the use of any type of TBAs have not proved useful in reducing maternal or neonatal morbidity or mortality and so, their encouragement should be stopped except for the functions that WHO has listed that TBAs can safely carry out.

3.3 Past efforts at standard setting for PHC in Nigeria

The Nigerian PHC system evolved from our BHS Scheme articulated in the Third National Development Plan of 1975 – 1980. The Nigerian BHSS set its health facilities standards such each BHSS unit of approximately one LGA was to have 1 comprehensive health centre at its apex, 4 primary health centres at what may appear to be the LGA districts and each PHC serving as referral centres for a further four health centre/clinics each. Each comprehensive and PHC was to have one mobile clinic attached to it for its outreach services to communities not adequately served by the physical health facilities. Of course, this standard soon proved unattainable by the country and the standard naturally died a natural death. The BHSS similarly set some standards for health personnel to man each health facility; but as for the physical facilities, none of these ever got fulfilled and the standards set in that programme have since become obsolete.

3.3.1 PHC standards as found in other Nigerian literature.

Many documents produced for PHC in Nigeria, even without setting out to say or specifically saying so, have written down many things in the form of minimum standards. Many times, the expression minimum standards, minimum staff or minimum or standard equipment had been used in many of those documents. However, it was in the work by Ogundeji in trying to record the background and status of PHC activities by 2000 in Nigeria that the first systematic attempt at determining and using some articulate objective system to develop the standards for ascertaining the status of our PHC services was given[11]. This was the opinion of both Ransome-Kuti as well as Adeniyi, in their foreword and review of the book therein, respectively.

3.4 Other relevant historical perspective of the Nigerian PHC services

Records of a few past efforts to develop minimum package of PHC services are the Basic Health Services Scheme contained in *The Nigerian experience* document[12]; the *Minimum District Health Package* in WHO document[13], the *background and status of PHC activities by 2000 in Nigeria document*[11], the NPHCDA[14] *Draft plan of action for the delivery of the Ward Minimum Health Care Package in Nigeria; the FMOH/NPHCDA[1] Operation Training Manual and Guidelines of PHC in Nigeria and NPHCDA*[15]

3.4.1 Basic Health Service Scheme (BHSS)

The basic health unit that was the basis of the BHSS was designed for a population of 150,000 and it took care of the facilities and equipment, personnel and services. Accordingly, there were comprehensive health centres, primary health centres, health clinics and mobile clinics as follows:

The comprehensive health centre, the most sophisticated of them, would be the referral centre for the four primary health centres to serve a population of 50,000. A primary health centre (the intermediate health facility) would serve as a referral centre for four health clinics and serve a population of 20,000. The health clinics were to be the most peripheral health facilities, each serving a population of 2,000. The five mobile clinics were to spread out from the primary health centres. On equipment, the British Ministry of Health assisted the Federal Ministry of Health to draw up the (*standard or minimum)* lists of equipment for the three types of health facilities (health clinics, primary health centres, and comprehensive health centres) that were supplied to those built in various States between 1979 and 1983.

The States refused to comply because it meant constructing 25 health facilities in one local government area. After an expenditure of about ₦200 million at the end of 1983, most of the

facilities remained uncompleted all over the country. Thus major drawbacks of the BHSS were the reliance on structures and equipments whose costs were enormous and unsustainable, little community participation and inter-sectoral collaboration and selection based on political expediency[16]. The training of cadres were also institutional based which still continued to the present time PHC. This institution based training for PHC had contributed in recent years to some of the wrangling experienced among health workers in PHC and as shown by a recent study, CHEWs now aspire to work in private practice and in urban areas[17] instead of the communities where they are being trained to work. Others wish to start private patent medicine stores either while still working for government or more so in exclusive private practice. The lesson of all these would seem to us to be that if we make no effort to remove the same obstacles that prevented the **internationally recognised community health professionals** from working and living in the rural areas, the same or worse things will happen with anybody else we self-deceptively train to work in their places. These problems are long known to be lack of any meaningful rural development, reasonable public transport system to every part of the communities, transportation for reasonable work and coverage of the needed populations, reasonably enhanced earning of people who go to work or live in such areas as the cost of ordinary living, home running and children education will be much higher for such staff.

3.5 Minimum Health Package

i) Minimum standards and Minimum Staff Complement for PHC

The minimum standards for assessing the functionality of different aspects/levels of PHC activities including Health/Development Committees, facilities, equipment, funding, and referral and PHC services had been set in year 2004 in a manual by NPHCDA**[15]**. Among others, the document had suggested the minimum staff complement that would be needed at different levels of PHC facilities. However, in setting standards, availability should be balanced with best practises as only this can ensure qualitative care. This becomes very important because PHC is not synonymous with poor or second best health care meant only for the rural poor or the urban slums**[18]**. PHC is expected to be best health care with the best use of the available resources.

ii) Organization and management structure of Ward Health system

a) Goal and purpose

In 2004, the FMOH in the revised National Health policy[19], among others had given the guideline to the effect that 'each ward in every Local Government or area Council should establish a Ward Development Committee' that shall be responsible for the coordination of planning, budgeting, provision and monitoring of all primary health care services that affect residents of the Ward and other matters incidental thereto.

iii) Standard equipment list (SEL) and minimum equipment package (MEP)

The efforts of NPHCDA to carry out a needs assessment survey recommended that standard equipment list and minimum equipment package that could be used to measure the status of PHC activities in Nigeria. Also, the document had grouped health facilities into 4 types that in the light of the streamlined terminologies for the national health services based on PHC as its SOLID BASE may be listed as:

Type 1: Health post and health clinics (PHC involving government health auxiliaries).
Type 2: Primary health care centres (PHC involving PHC professionals)
Type 3: General hospitals (for secondary health care or state government staff)
Type 4: Specialist and Teaching Hospitals (for tertiary health care).

3.6 PHC Infrastructure: Facilities and Equipment

3.6. 1 Health Physical Infrastructure:

3.6.1.1 General Introduction

Health facilities are static or mobile structures where different types of health services are to be provided by various categories of health workers. These health facilities are in different groups and called different names depending on the structure (building), staffing, equipment, services rendered and by ownership. Ekunwe identified five levels for ease of referrals[16]. These levels are: the community/communal health system, health post, health facility, health care and the hospital which can be district, state, general or teaching. Many other terminologies have arisen over the years on the nomenclature for different health facilities and these include dispensaries, health clinics, health centres, primary health centres, maternities, health posts and primary health centres. However, NPHCDA classified them into. Suffice it to say that the introduction of the Ward Health System was seen as a culmination of efforts to provide appropriate infra-structural facility in support of a viable community-based co-management of integrated PHC services and the provision of a minimum package of equipment, drugs and other supplies for PHC[20]. A drawback of this system is that it relies mainly on the smaller subgroups of health posts for the areas that are far from the ward health centre but within the same ward. As indicated in the equipment list by FMOH, it also presupposes that there would be BASIC equipment in every (ward) primary health centre for caesarean sections should the case arise and there is competent personal on hand to do so. Botswana overcame this problem as at 1988 by instituting clinics with 1/3rd of them running maternity services[15].

Types/Levels of PHC facilities

Types of health facility	**Levels of management**
Teaching/Specialist/Tertiary Hospitals	Federal government
General Hospitals	State government
Primary Health Centre	Local government
Health clinics	District/Ward Development committee (D/WDC)
Health Posts	Village Development Committee (VDC)

3.6.2 Management levels of Health facilities

Every management level is expected to have a health facility corresponding to the types of health services expected to be performed (according to the national health policy).

The higher levels of government/management are generally expected to provide public health facilities/services for the immediate lower level.
As examples:

- the Federal Government is expected to provide at least one tertiary health facility in every State;
- the state government is expected to provide at least one general hospital in every LGA;
- the local government is expected to provide at least one primary health centre in every district/political ward (with DDC);
- the political ward committee (WDC) is expected to provide/support at least one health clinic for a group of villages/communities with about 1000-2000 inhabitants; and
- the community development committee (CDC) is expected to provide/support at least one health post for villages, settlements or neighbourhoods of about 200-500 inhabitants.

Table 2 below illustrates these provisions.

Table 2: Types of government health facilities, levels of management and expected numbers

Types of health facility	Levels of management	Expected numbers
Teaching/Tertiary hospitals	Federal government	1 per State Therefore in 36 States + FCT, 37
General hospitals	State government	1 per LGA, Therefore a minimum of 774 will be expected
Primary health centres	Local government	1 per ward With average of 10 wards per LGA, a total of 7,740 will be expected
Health clinics	Local government and ward development committee (WDC)	1 per group of villages/ neighbourhoods with about 1,500 – 2000 persons
Health posts	Community development committee (CDC)	1 per village or neighbourhood of about 200 – 500 persons As many as the number of villages

3.7 BHSS and health manpower development in Nigeria

One of the most significant, and enduring changes that took place during the BHSS era was in the area of manpower development. Evidently, the changes were consistent with the trend observed by WHO as shown in paragraph 3.1 above. However, as rightly observed by Ekunwe[16], many cadres could not resist the pressure to turn out a large number of health workers, often turning out some inappropriate and half baked staff.

Around 1976 – 1977, a survey of health manpower across the country showed that there were about 40 groups of different health workers in different parts of Nigeria working outside the hospital settings as shown in the list of health workers expected to be retrained as 'core' polyvalent PHC workers. It was in an effort to streamline the admission criteria, training, utilization and their scheme of service that the Federal Government, through the Basic Health Service Scheme Implementation Agency (BHSSIA) of the Federal Ministry of Health (FMOH) decided to regroup them into the following 4 cadres of 'core' *polyvalent* health workers called the BHSS workers then:

- Community health officers (CHOs)
- Community health supervisors (CHS)
- Community health assistants (CHA)
- Community health aides (CHAi)

The last 2 cadres have been redesignated as senior (assistants) and junior (aides) community health extension workers (CHEWs). The supervisor cadre has been phased out and so their training stopped. This was due to the fact that generally, establishment policy allows for only 3 categories of workers who are not university graduates. These are the assistant cadre, technician cadre and technologist cadre.

- The JCHEWs are in the assistant grade,
- SCHEWs, in technician grade, and

- CHOs in technologist grade.

Generally, Nigeria is yet to develop a health manpower plan that describes the categories and numbers of personnel required, in any given health facility and/or community taking into account current staff status, forecasted need and absorptive capacity of the system. Ransome-Kuti[21] had earlier observed that many CHEWs are unemployed and most of those who are employed are wrongly deployed and doing everything but community health work. This situation persists, and the role of doctors in health centres, clinics and dispensaries are either denied or not emphasized or implemented in most of the states.

A number of problems are commonly experienced in various places with PHC workers. Some of the problems relate to professionalism, training programmes, shortages and wrangling as described below.

i) *Professionalism*

WHO[22] observed that different types of health workers have different patterns of thinking; that training in their own profession only does not adequately prepare the members of different health care professions to apply their different disciplines and competencies and stressed that it needs to be supplemented with multi-professional training so that the different professions become aware of their different ways of thinking and acting and gain experience of coordinated team-work, in which each has an essential role to play. However, such observation would seem to be reflecting the result of poor professional training or the lack of such training altogether. True professionalism deals with ethically determining the frontiers of knowledge and skills that are to be recognized as essential to the practice of any given profession and the delineation of the boundaries between any related professions. Also, in the health professions, all training has always been in related work environments in which the professional groups interact, mostly on a regular basis. All true professional training in the health sciences teach the professionals the very important role of each professional discipline in the attainment of the overall goal of such health care – whether of the health and welfare of the individual patient or of the defined community of persons – such as represented in the modern physicians oath that "the health of the patient shall be my primary consideration". This teamwork is the very task of specialty training in the established community health professions; viz, community nursing, community midwifery and community medicine. Unfortunately, the training and practice of the former two have hardly been provided for in Nigeria while provision for training and practice of community medicine has only recently been trying to attain any meaningful status in the country.

ii) *Weaknesses of community health workers programmes and their management*

WHO[23] observed the following general weaknesses in the existing Community Health Workers' (CHWs) programmes:-

- Minimal policy and organizational commitment
  - CHW programmes tended to be "vertical" programmes
  - CHW programmes were implemented with little professional involvement
  - Structural, political and economic factors were neglected
  - Lessons have not been learned from other sectors.
- Poorly defined functions
- Poor selection
- Deficiencies in training and continuing education
- Lack of support and supervision
- Uncertain working conditions
- Undetermined cost and sources of finance
- Lack of monitoring and evaluation

WHO's views has since been supported in Nigeria as exemplified in the blue print for PHC revitalization which posited that one example of conflicts and problems is the failure of senior administrators to agree and work towards an integrated minimum package of PHC services in preference for gigantic and expensive vertical programmes for each component without commensurate impact. The same report recommended standards for CHEWs and those of them who have trained as CHOs to concentrate their activities in the homes or occupational places in the community as some of them that work in health facilities are obliged to perform functions which are outside their competence. It was also recommended that CHOs with nursing/midwifery backgrounds as well as nurses, midwives, laboratory and pharmacy technicians should work mainly in health facilities while the environmental officers should concentrate on environmental services in the homes, institutions, public places and the community[24]. However, the International Confederation of Midwives in their definition of midwife stated that a midwife may practice in any setting including the home, community, hospitals, clinics or health units[25]. In fact in PHC models that work, midwives can be found at the level of the community health clinics or centres[26] and in the communities around them as in Fiji[27].

The success story in primary health care in Sweden occurred because public health authorities developed a policy of training enough midwives to make sure that qualified personnel would attend all home births[28]. The local public health doctor, who could be called upon in case of serious complication and who was held accountable for official reports supervised midwives as early as 1900s. This is the work of medical officers of health worldwide and it has been the recommendation of all reasonable health services provision worldwide since the 1840s.

iii) *Staff shortage at operational level*

This problem of staff shortage has its root mostly in poor funding, planning and management. A lot of the problems relate to recruitment both for basic training and employment, deployment, supervision, appropriate utilization and retention. WHO, (SHS/DHS/92.1 p.22) remarked that Nigeria has an impressive number of health personnel. Unfortunately, most of them either work in urban areas or wrongly deployed. A Nigerian review listed lack of trained staff, e.g., midwives and de-motivated community health extension workers and lack of basic essential obstetric care as some of the major constraints to the achievement of the health related millennium development goals in Nigeria[29]. The document went on to recommend use of skilled human resources like compulsory NYSC doctors and midwives services, and training of community midwives. However, NYSC doctors experience is too new, and born out of very little experience that they too need close supervision in order to practice community medicine well enough. The type of midwives who can operate remote PHC and the delivery services involved with no immediate physician closeness and supervision are the more senior midwives which will be hard to get in the immediate future.

iv) *Inter and intra cadre wranglings*

Inter-cadre wrangling has been defined as a state of strife or opposition among personnel of different professional groups. It is called intra-cadre wrangling when the problem prevails/exists among members of the same group.

a) *Common causes of the wrangling*

Common types of *inter-cadre* wrangling which include CHO vs. Non CHO, Nurse vs. EHO, Nurse CHO vs. Non-Nurse CHO, Nurse vs. Pharmacy Technicians and Nurse vs. CHEWs. Also, the common types of *intra-cadre* wrangling include Nurse vs. Midwife, CHO vs. Non-CHO Nurse, CHO, and EHO VS. NON-CHO EHO. One of the major causes of the wrangling is the ambiguous set of guidelines. For example, FMOH guideline of 1977 stated that *no attempt is being made to stop any school from training health workers* such as public health inspectors,

community midwives, rural health assistants, etc. However, the service of any of the existing health workers will be most effectively used in the BHSS only when such health workers have undergone either a BHSS orientation course or a complete programme on specific subject area. The ambiguity in this guideline continues to be the major source of wrangling among many CHWs in Nigeria. Other causes of wrangling include:

- Difficulty in practical implementation of the national guideline on who should be PHC coordinator;
- the avoidance of community health officer (CHO) course by some senior public health nurses leaving mid-level/younger ones to do it;
- the exclusion of environmental health officers (EHOs) from many CHO training institutions (originally because many did not do well in the clinical aspects of this training);
- lack of managerial skills and professional parochialism among PHC coordinators;
- unyielding commitment of some officials/professional bodies and individuals to their previous beliefs;
- labour unrest/Industrial Arbitration Judgment

b) *Strategies to promote intra-inter cadre harmony*

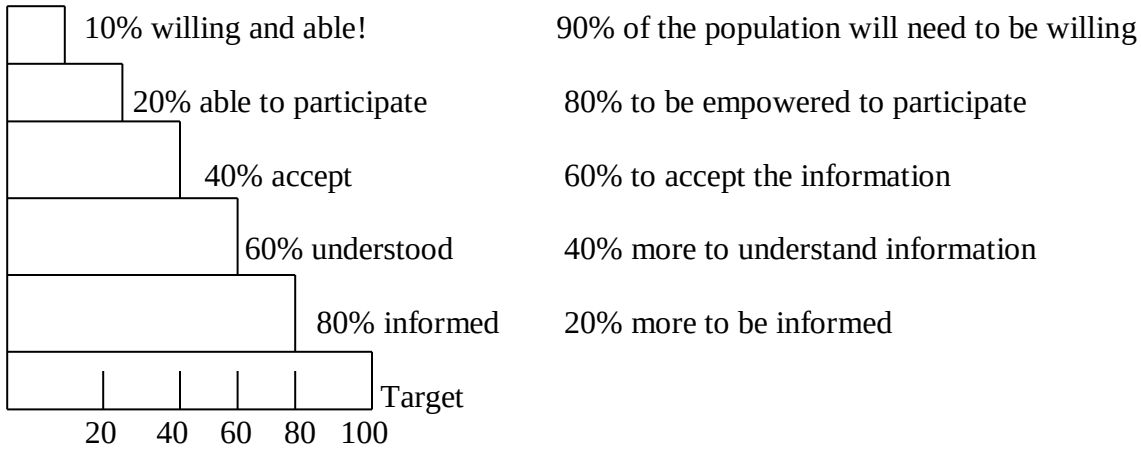
Strategies that could promote inter-intra cadre harmony include:-

- clearer and forward looking guidelines from FMOH;
- upholding the philosophy of PHC – its goal of universal accessibility to health care;
- frequent consultations with professional bodies to effect necessary policy changes;
- strengthening of PHC system to facilitate the much needed national development expected in the 21st century;
- training of senior cadre to provide better leadership on health matters;
- reasonable compensation and payment of wages and salaries be made to health workers;
- greater collaboration between the local government commissions and the state ministries of health;
- employment of more and appropriately trained community physicians, nurses and midwives in LGAs to raise the quality of health care in LGAs health facilities;
- empowerment of schools of health technology, nursing and midwifery to undertake continuing education for LGA health personnel;
- continuous advocacy with LGA authorities in order to sustain the laudable programmes of PHC and the legacy of committed and goal minded health teams.

3.8 *Implications of 'full community participation' in PHC*

It is only through health education/promotion that community mobilization for participation/involvement can be achieved. The definition of PHC actually stresses *'full community participation'*. The phrase 'full community participation' may mean that all the people everywhere should be involved in every aspect of PHC always! In any case, before any member of the community can participate meaningfully in PHC, such person needs information that must be understood and acceptable; such person should also be able and willing (since ability does not always mean willingness) to participate. The intensive process of getting communities adequately mobilized to fully participate in PHC was earlier illustrated by Ogundeji[30] and shown in diagram 1 below. The diagram shows the efforts that may need to be put up by PHC workers to *inform all* in such a way that they will *understand*, convince them to *accept*, and empower them to develop the *ability* and *willingness* to participate.

Diagram 1: showing the proportion of community members who may be ready to participate in PHC



From the diagram it can be seen that up to 90% of any given community may need to be assisted before it can be clearly informed, helped to understand, patiently encouraged to accept, enabled and empowered so that 100% of the community members will fully participate in PHC**.** As such, there would need to be well trained and motivated health educators as indicated in the success story of Botswana where family welfare educators were trained and charged with the sole responsibility of mobilizing communities to participate in health care activities[15]. NPHCDA also incorporated participatory learning and action in the ward health system[31]. In fact as demonstrated in Kano State, the model could be adapted for child survival with favourable outcomes[1].

3.9 Standards for services

For primary health care to be effective the various activity levels for each component of the minimum health package must be known and standards set for its accomplishment. In defining these activity levels, there would be a need to take into cognizance the three broad operational categories of basic health care; priority health interventions and health related interventions[24]. Comprehensiveness is the central point of such an exercise and this is reflected in the Year 2000 targets for South African PHC that included the objective of having "*defined comprehensive services which are to be delivered at primary care level of health service delivery"*. In setting standards for the practice of PHC, the South Africans utilized the principle of Bartho Pele (peoples first)[32] The South African exercise went on further to state that **c**itizens should be given full accurate information about the public service they are entitled to receive. This we believe should be the method to be adopted for Nigeria. The Servicom project already being pursued be the Federal Government is an activity in this direction already. Such an exercise could not be accomplished within the time frame of this current exercise, thus it might be beneficial to ensure that this is done at a later date. However, we have documented the core services to be available at each level of health care delivery according to the staff complement to be at each of the levels as shown in Chapter 4 and Tables 4 a and b for recommended current minimal standards for all Nigerians within the currently available health manpower as well as the optimal when the currently non-comprehensively trained auxiliary health workers get so re-trained as appropriate from the examples of PHC staffing models that worked around the world.

3.10 Standards on essential drugs

According to national guidelines, a regular supply of essential drugs using the BI principles at health facilities and community levels should be based on the Nigerian Essential drug list**[26]**. Essential drugs have been described as those drugs that satisfy the health care needs of the majority of the population; they should therefore be available at all times in adequate amounts and in appropriate dosage forms, at a price the community can afford **[33]**. In setting criteria for its selection,

the following has been recommended: sound and adequate data of efficacy and safety from clinical studies; evidence of performance in different health care settings; availability in a form in which adequate quality, including bioavailability, can be assured; stability in the anticipated conditions of storage and use; and total cost of the treatment; a preference for single compounds. Where drugs appear to be similar in the above respects, comparative pharmacokinetic properties and the availability of facilities for manufacture and/or storage are used as secondary criteria. However, a review of the essential drug list available at the PHC level in Nigeria[26] has revealed some deficiencies that are:

i. The use of antibiotics with doubtful efficacy or unavailable in the present day Nigeria; e.g., Sulphadimidine, Phenoxymethyl penicillin, etc.
ii. Inclusion of streptomycin in the antibacterial section when best practice dictates that reserving it as a bundled drug for tuberculosis would have been more appropriate.
iii. Inclusion of other psychotherapeutic drugs apart from chlorpromazine on the core list.
iv. Some priority neglected conditions with public health significance; e.g., schistosomiasis was not selected
v. Declining chloroquine sensitivity with the subsequent review of antimalaria policy by the FMOH calls for inclusion of artemisinine based combination therapies[34].

WHO[35] in their 2005 revision of the model list recommended the use of a core and complementary list. The core list presents a list of minimum medicine needs for a basic health care system, listing the most efficacious, safe and cost-effective medicines for priority conditions. These priority conditions are selected on the basis of current and estimated future public health relevance, and potential for safe and cost-effective treatment. The complementary list presents essential medicines for priority diseases, for which specialized diagnostic or monitoring facilities, and/or specialist medical care, and/or specialist-training programmes are needed. In case of doubt, medicines may also be listed as complementary on the basis of consistent higher costs or less attractive cost-effectiveness in a variety of settings[34]. Thus drugs like anti-psychotics can be included on the complimentary list rather than the core list.

Another deficiency of the recommended standard in PHC is the listing of outdated anaesthetics like ether[36] that had long been replaced by halothane and Ketamine on the WHO essential drug list[35].

3.11 Examples of models that have worked

It might be instructive to look at health care manpower models that worked elsewhere. In an ideal system, the manpower available at any level should be reflective of the core competences and the services provided. Therefore, it is our view that looking at the models below would not only illustrate best practices in manpower deployment, but would also give a fair idea of the minimum complement of services expected at each level.

The Leyte (Philippines) model[37]

In the Philippines, the rural population are often poor, decimated by curable and preventable diseases as well as malnutrition. In addition, *the trained personnel* often jet out in numbers in search of the Golden Fleece. In 1976, an institute of health sciences was established to tackle these anomalies. The main purpose of this institute was to produce a broad range of health manpower that will serve the underserved communities in region VII comprising Leyte and Samar (two islands of the Philippines). The admission policies of the IHS are built on the same premise of the CHEW in Nigeria; i.e., that a person recruited from underserved areas, with input in the selection by the very community concerned and trained for the necessary health and community–organization skills, would become a health worker committed to rural community service. The lowest level of entry that needs no college entry examination is the **barangay (village) health worker** who is nominated by his village. The IHS has a ladder type curriculum with various points of entry and exit, from the barangay health worker to the full community

physician. The barangay health worker after 11 weeks of course returns to his barangay where the skills learnt are applied. After a period of time, if his barangay is satisfied with his work, they can recommend him for the **community health worker**s course. After this course, he returns again to his barangay who, if his work is satisfactory, can also recommend him for the midwifery board examination, with a 6 months supplementary clinical attachment/training. If the work done in the community is also satisfactory and there is a need in the community for such, the community can further recommend such a person for the **community health nurse** programme. Otherwise the worker, perhaps already a qualified midwife, remains in the community as a community health worker. If there is a need in the community, the community health nurse can be recommended for the **Bachelor of Science in rural medicine** and later if there is need for such, the **medical doctor's program**[37]. Thus, this provides for a 5 level programme with a subsidiary, branch-out, midwifery one. At each subsequent stage of further training, the candidate is required to make good any deficiencies s/he may have in his/her general education for such a training.

A major difference between the Philippino and the Nigerian system is that in the Philippines, the communities are solely responsible for dictating community training needs, suitable candidates and standards of satisfactory service. In addition, all the other community health cadre of workers know it from the start that they are local auxiliaries of community nurses, midwives or doctors as obtains everywhere else internationally. In addition, they have straight course to training higher right to the top, if they satisfy the needs for the existing community health services. All these health workers are also trained in the same school and so have healthy training and interactive experience of the professions as they train. In Nigeria, the local government authorities are saddled with this responsibility but most times the selection, if ever done, is based on political exigencies.

In the Leyte system, there is the opportunity for the health worker to aspire to the highest possible level based on reasonable satisfactory work and community needs and this can go a long way in eliminating cadre wrangling. Another good point in the above system is that classroom based education complements community based education which is "teach by showing" and "learn by doing" approach[37]. Most of the training is in the community and the clinical exposures, when needed, are for very short but very intensive periods and in very active centres which expose the workers to the full variety of all the most serious and difficult health problems they may ever encounter so that they get familiar with those, their managements and when and why to refer the patients for reasonable success in the enterprise.

Schematic presentation of community-based training activities at the Institute of Health Sciences, Leyte The Philippines

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Medical doctor:

- Implementation of innovative approaches in community health development
- Rationalize planning for health service resource allocation. Continued application of clinical skills

Bachelor of science in rural medicine

Application of added clinical skills in minor surgery, basic medicine and therapeutics

Community health nurse:

Design and implementation of: supervisory scheme for lower level health care workers and a family health care plan for risk families, training for indigenous health workers, conduct of

research and epidemiologic investigations

(A branch-off 6 months intensive clinical training for midwifery certification)

Community health worker:
Formulation, implementation and evaluation of community health development jointly with community and agencies with PHC services

Barangay health worker
Development of community profile

***Fiji model*[27]**
In the Fijian system, *volunteer community health extension workers* were trained for the villages (popularly called **village nurses** or, in Fijian, '**nasi-ni-koro'**) as well as, but less so, for the (Indian or non-indigenous Fijian) settlements. However, because of the free health system in Fiji, all the village and settlement dispensaries and their nasi-ni-koro are supervised by the district or zonal community nurses. The community health system is also well set up with nursing districts where the proper community nurse/midwife holds sway in her nursing/midwifery centres also called (community) nursing stations. Alternatively, they may be zonal community nurses operating from the base of a district hospital, primary or comprehensive health centre in which she has ready assistance of a medical doctor or at least, a medical assistant. This has reflected on the health indices that is quite remarkable and as good as in any developed country of the world – infant mortality rate of 16/1,000, contraceptive prevalence rates of 46% of women of childbearing age, maternal mortality rate of 0.1/1,000 births, etc, in 1999. In addition, the level of community participation is quite remarkable, with 37% of the villages and 17% of the settlements in 1999 having self-owned dispensaries[27]. The government provided 67% of the costs of such projects on the basis of satisfactory assurance that the community will provide the other 33% as ascertained and confirmed by the medical officer of health. The only community health auxiliaries in Fiji Islands are the nasi-ni-koro, the community rehabilitative assistants (CRAs) for community rehabilitation services in social and physical rehabilitation and the recently being discussed nurse practitioners in 1999.

***Sweden model*[17]**
The public health authorities in Sweden developed a policy of *training enough midwives* to make sure that qualified personnel would attend all home births. Although training large numbers of midwives was a slow and stepwise process, results were obtained only because there was strong political will. In fact, the causal chain for reduction of maternal mortality in Sweden involved three factors: political commitment, availability of effective techniques, and assistance to most deliveries provided by trained health professionals able to 'culturally' integrate such a technology[17]. The community midwives were supervised and supported right from the beginning by the Swedish public health doctors.

***Botswana model*[15]**
Under PHC, the expansion of services to reach all the communities, especially those in the remote areas, is emphasized. More health posts are also being *staffed with enrolled nurses* in order to increase the range of services that can be provided in these facilities on a daily basis. Another area of emphasis was also the training of family welfare educators who were responsible for mobilizing communities to participate in health activities.

3.12 Statement on models that have worked

A central issue in the models that work is that there was a conscious effort on the part of the governments to provide qualitative services for its people based on the use of the best mix of skilled and properly trained workers assisted by the community workers who were also trained wherever needed. It is quite evident that competency and quality must not be sacrificed on the altar of availability. The **Cuban** and **South African** models, of which we have personal experiences but no accessible documentary references for now, are also of these forms. In Cuba, the best medical graduates are specially induced to specialize in community medicine so that they will serve their people as best as possible. In South Africa, they changed their three and half years of basic nursing training to a 4 year programme with the first 3 years in general nursing and the entire final year in community nursing. Thus since the beginning of effective PHC there, every nurse graduating from the nursing schools is prepared, well orientated and competent to deliver PHC.

Therefore the Nigerian experience should draw on these best practices and the balancing of such factors like strong political will for quality health service, availability, cultural relevance and competence while efforts are going on to move to the optimal level of standards. Government would do well to implement the report of the public service review commission[38] which states that "the government agrees that in order to be able to recruit and retain competent staff, the salaries and conditions of service of local government staff should not be less favourable than those of civil servants" elsewhere.

3.13 The Unification of the Nigerian health services

One of the factors prevalent in most of the successful national health services cited above is the unity of the health services and the mutual respect and co-operation of the health personnel in those countries. In Fiji for example, the same (national) Government of Fiji employed every health service worker whether he worked at the national, regional or local government level health service. This was also the case in Nigeria before the regionalization of 1954. In the other countries, the dichotomy or even (often) frank rivalry and opposition between federal, state and or local governments as is often the case in Nigeria is absent. Every health worker sees him or herself simply as serving the needs of their country people, only differently paid by federal, state or local government. This practice also existed in most States and LGAs in Nigeria before the devolution exercise that took place 1988 –1990.

3.14 Terms recommended to be dropped in the Nigerian health system terminologies

There are two groups of terms to be dropped in the Nigerian health system: these are facility terms and personnel terms.

3.14.1 Health Facility terms:

It is recommended that Types 1 – 4 be used to describe all health facilities in Nigeria as indicated below:

Type 1: Health post and health clinics – terms like dispensaries should be dropped,

Type 2: Primary health care centres -

Type 3: General hospitals – terms like cottage hospital or comprehensive health centres should be dropped

Type 4: Specialist and Teaching Hospitals (for tertiary health care).

3.14.2 Health personnel terms:

It is recommended that community health workers should be trained and retrained to become community doctors and nurses as follows:

Medical doctors and Assitant Medical Officers: drop CHO

All doctors who work in communities should be so trained. All CHOs be redesignated as

Assistant Medical Officers. Arrangement should be made for all CHOs who are able and willing to become medical doctors. The term CHO should therefore be dropped.

Community/Public Health Nurses/midwives: drop CHEWs

All CHEWs of different categories should now be trained and retrained to be known and should serve as assitant nurses/midwives.

CHAPTER 4
SETTING OF NATION-WIDE MINIMUM STANDARDS FOR PHC IN NIGERIA

4.1: Introduction:

Minimum standards if they are going to be practicable and acceptable must be premised on the core competencies and services expected at each level of service delivery. Therefore the following setting of these norms or standards are based on the reality of what is the minimum set of activities that is to be expected at each health care level of the primary health care system, from the furthest, most sparsely supplied northern Nigeria to the most densely populated Kaduna, Port-Harcourt or Lagos. The standards address the different levels of PHC service delivery outlets at the village, settlement, neighbourhood community levels to the political ward communities and up to the apex LGA facility. The specifications include nomenclature, expected services, hours of operation, infrastructure, personnel, medical equipment, essential drugs and other support items.

As is shown, we will expect that the terms health post, (community) health centre or clinic and primary health centre will henceforth be the standard terminologies to be found in the PHC literature. All comprehensive health centres will henceforth become general hospitals. All dispensaries are going to revert to health posts or be upgraded to health clinics and all maternity centres be properly upgraded into primary health centres.

While the top staff in these centres should now be a JCHEW, CHEW and Nurse-midwife-CHO respectively and so determine the extent of each PHC activity listed for the centre that can actually be rendered there (Table 5a), we have also given in Table 5b, the optimum that we must all be looking forward to if we expect progress as ought in the Nigerian PHC system. Currently, we expect the minimum of the top PHC staff at the LGA Apex PHC/Health Office to be a community physician with at least an MPH or community health orientation. In their absence however, a nurse-midwife-CHO may serve. At the optimal PHC practice level in this country, we expect every LGA PHC system to be headed by a community physician as MOH, the PHCs by at least a medical assistant, the health centre/clinic by a community nurse, midwife or nurse-midwife and a health post by a community health worker; all comprehensively trained in multi-valent PHC as they are capable of learning. All the clinical nurses or midwives (obstetric nurses more appropriately called) should never work in any place lower than a PHC; but more appropriately, only in hospitals. All the previous JCHEWs, CHEWs and non nurse/midwife CHO must get retrained into comprehensive community health workers as is done in the Philippines. In order to do this, one school of health technology or hygiene in each geo-political zone is to be converted into a school of health sciences, be affiliated to one urban and one rural or peri-urban LGA for their community health service and one extremely used hospital for their training as is in the Philippines in order to retrain all these people. Meanwhile, all the other schools of hygiene or health technology should drastically reduce their intakes of CHEWs and CHOs and train more of the pharmacy technicians and environmental health officers.

The environmental health officers, medical records officers and laboratory technicians should continue as they are presently working. Efforts should be made to train and designate public health nutritionist and health educator, even if the later is a nurse who opts for additional certificate or diploma training in health education. The use of these officers is there even now in our PHC system and will increase if we pursue it as we ought to do. The rest of the recommendations are presented and discussed below.

4.2 Settlement, neighbourhood and/or village level

4.2.1 *Nomenclature of health facility:*

Health post

4.2.2 ***Expected services:***

- Community mobilization
- Community growth monitoring and promotion
- Offer advise on nutrition especially locally available food materials
- Teach, prepare and give ORT for mild to moderate diarrhoea
- Offer advise on prevention of STI's including HIV/AIDS and distribute condoms as may be advisable
- Mobilize the community on protection of water sources, control of endemic diseases, immunization and environmental sanitation
- Monitor the activities of the VHWs and CBAs (these are expected to have undergone training at a busy Local Government PHC centre for not less than 1 month at an expense to be borne by the community but with training and educational materials provided by the Local Government).
- Record keeping

4.2.3 ***Hours of operation:*** 9.00 a.m-11.00 a.m. It is expected that the rest of their time, 11am to 3.30pm would be spent in the community.

4.2.4 ***Infrastructure:***

4.2.4.1 Building: One room with cross ventilation

4.2.4.2 Furnishings:

- Writing table – 1
- Chairs - 2
- Examination couch - 1
- Screen - 1
- Benches - 2
- Cupboards - 2
- Wash hand basin - 1
- Stove - 1
- Standard beer and soft drink bottles for ORT demonstration
- Sanitary waste collection facility, toilet and water supply within the premises.

4.2.5 ***Personnel:***

Voluntary health workers [VHWs] and/or a community *birth attendants [CBAs*] to be supervised by the JCHEW. (**TBAs are to be retrained and called CBAs*, and used in the limited way reasonable in view of the recent WHO[2] opinion that TBA can:

- partner with skilled providers by encouraging women to enrol for essential pre- and postnatal care;
- act as community educators to lend support for accurate maternal and neonatal health messages;
- identify proganant women in the community who might need maternity seervices and
- distgribute commodities/drugs to pregnant women in the community

4.2.7 ***Medical equipment:***

- Weighing scale - 1
- Stadiometer - 1
- Tape rule - 1

[2] WHO Geneva (2004): Making pregnancy safer: the critical role of the skilled attendants, Dept. of Reproductive Health and Research

- Dressing forceps - 2
- Scissors - 2
- Kidney dish - 2
- Sphygmomanometer - 2
- Stethoscope - 2

4.2.7a Essential drugs: The essential drugs listed on page 184 – 185 of the Operational Training Manual and Guidelines for the Development of PHC System in Nigeria[23] are considered adequate. However, Artemisinine based therapy (ACT) should replace chloroquine. The list includes the following:

Analgesics/antipyretic	-	Paracetamol syrup and tablets
Antimalaria	-	Arthemeter/Lumenfantrine tablets
Haematinics/Vitamins	-	Folic acid tabs, ferrous sulphate tabs, Vitamin B Co tabs and syrup, Vitamin C tabs and syrup, Multivitamin tabs and syrup
Rehydration salts	-	ORS
Wound dressing	-	Cotton wool, gauze bandage, adhesive plasters, TBC, savlon, Eusol, methylated spirit
Anti-helminthics	-	Pyrantel pamoate
Others	-	Condoms, benzyl benzoate, calamine lotion, methylsalicylate ointment, zinc oxide
4.2.7.b Other items:	-	*Bic*ycle

4.2.8 Village Development Committee (Community Development Committee)

4.2.8.1 Composition

- A respectable person elected by the committee members as Chairman.
- An elected literate member of Village/Community shall serve as Secretary
- Representative of religious groups
- Representative of women's groups/associations
- Representative of occupational/professional groups
- Representative of NGOs
- Representative of VHWs/TBAs
- Representative of the disabled
- Representative of Youths
- Representative of Traditional Healers
- Representative of patent medicine dealers

A trusted member of the Committee will serve as Treasurer.

4.2.8.2 Roles and responsibilities of the VDC/CDC

The committee shall:

- Identify health and health related needs in the village/community
- Plan for the health and welfare of the community;
- Identify available resources (human and material) within the community and allocate as appropriate to PHC programmes
- Supervise the implementation of PHC WORK plan
- Monitor and evaluate the progress and impacts of the implementation health activities,
- Mobilize and stimulate active community involvement in the implementation of developed health plans.

- Determine exemptions for drug payment and deferment; but provide funds for the exemptions/deferments.
- Determine the pricing of drugs to allow for financing of other PHC activities.
- Supervise all account books, (Monies at hand should be deposited in a bank within 24 hours or 72 hours at weekends).
- Supervise and monitor quantity of drug supply
- Select appropriate persons within the community to be trained as Village Health Workers (VHWs/TBA) for PHC, AIDS/STD and other programmes.
- Supervise the activities of the Village Health Workers and Traditional Birth Attendants; including review of monthly record of work;
- Remunerate in cash or kind, the Village Health Worker for his/her work in the community;
- Agree with the Village Health Worker the number of hours he/she should work per day;
- Establish a village health post, where there is none already;
- Ensure that VHW/TBA Kits are stocked to top-up level for drugs.
- Liaise with other officials living in the village to provide health care and other development activities;
- Provide necessary support to VHW for the provision of health care services;
- Forward local community health plan to ward level.

4.2.8.3 Operational Guidelines

In following the above terms of reference, the committee shall:

- Meet once every month;
- Record minutes of meetings;
- Minutes of meetings shall be signed by the Chairman and Secretary after adoption at subsequent meetings;
- Comply with the quorum set for starting meetings;
- The Treasurer should record and keep all monies;
- The Treasurer should record all expenditures;
- Where there is a Bank Account, signatories will be the Committee Chairman and Treasurer, and if necessary the Secretary;
- Send minutes of meetings to Wards Development Committee;

4.2.8.4 Functional village health facility

Village health facility (health post) is functional when/it has

- Village Health Worker (VHW);
- VHW has expected essential drugs in the kit or drug cupboard;
- bicycle or canoe(if necessary) for mobility; and
- The activities in the facility are supervised by a CHEW regularly.

4.2.8.5 Functional village development committee

Village development committee is functional when it

- has officers like chairman, secretary, treasurer;
- meets regularly and records minutes of meetings;
- supports and selects for training of VHWs/TBAs;
- utilizes the services of VHWs/TBAs;
- monitors health conditions of the people and takes necessary actions from time to time;
- uses record of work of VHWs/TBAs to discuss in meetings

4.3 Health area level (group of settlements/neighbourhoods in a ward; 2 – 10,000 population)

4.3.1 ***Nomenclature:***
Type 1 health facility (Community **health centre** or clinic)

4.3.2 ***Expected services:***

- Community census and at-risk registration
- Community mobilization for PHC
- Community growth monitoring and promotion
- Mobilize the community on protection of water sources, control of endemic diseases, immunization and environmental sanitation
- Health education on prevailing health conditions
- Monitor *and supervise* the activities of JCHEW.
- Follow-up antenatal between the 1st and 36th week
- Immunization services
- Family planning activities as appropriate
- Child welfare clinics
- Treatment of minor ailments and injuries
- Community census, at-risk registration and home visit for homes not covered by other community health centre/clinics
- Home follow-up of at-risk subjects
- Record keeping

4.3.3 Hours of operation: 8.00 a.m – *4p.m*.; 3 days in the week, 10am – 3pm, in community health work in the communities; 2 days in the week 1 – 3pm, update of health records.

4.3.4 Infrastructure:

4.3.4.1 Building: A detached apartment with sufficient space to accommodate:

- Waiting/reception area
- Staff station
- Consulting area
- Preparatory room
- Injection and dressing area
- Store
- Sanitary refuse bin
- Toilet facilities
- Potable water source

4.3.4.2 Furnishings:

• Writing table	–	3
• Chairs	-	10
• Examination couch	-	2
• Screen	-	2
• Cupboards	-	2
• Wash hand basin	-	2
• Benches	-	4
• Observation beds	-	4

4.3.5 ***Personnel:***

Community midwife	-	1

CHEW (must work with standing order) - 2

Support staff

Health attendant - 1

Security personnel - 2

4.3.6 ***Medical equipment:***

- Sphygmomanometer - 2
- Stethoscope - 2
- Adult weighing scale - 2
- Baby weighing scale - 1
- Bed pan - 4
- Dressing trolley - 1
- Instrument tray - 2
- Kidney dishes - 4
- Artery forceps - 2
- Sims speculum - 2
- Coscos speculum - 2
- Stadiometer - 1
- Tape rule - 1
- Dressing forceps - 2
- Scissors - 2
- Kidney dish - 2
- Clinical thermometers - 2
- Cord clamp
- Episiotomy scissors - 2
- Refrigerator - 1
- Urinary catheter -
- Enema kits - 2
- Multistix test kits

4.3.7a Essential drugs:

Analgesics/antipyretic	-	Paracetamol syrup and tablets
Antimalarials	-	Arthemeter/Lumenfantrine tablets
Haematinics/Vitamins	-	Folic acid tabs, ferrous sulphate tabs, Vitamin B Co tabs and syrup, Vitamin C tabs and syrup, Multivitamin tabs and syrup
Rehydration salts	-	ORS
Wound dressing	-	Cotton wool, gauze bandage, adhesive plasters, TBC, savlon, Eusol, methylated spirit
Anti-helminthics	-	Pyrantel pamoate
Antibiotics	-	Ampicillin + cloxacillin, co-trimozazole, metronidazole,
Contraceptives	-	Condoms, OC pills, foaming tablets,
Others	-	Benzyl benzoate, Whitfield ointment, calamine lotion, methylsalicylate ointment, zinc oxide

4.3.7b Other items: - Communication facility; e.g., GSM

- Motorcycle (1)
- Bicycle (1)

- Stove (1)
- Lanterns (4)
- Buckets (4)

4.3.8 Village Development Committee (Community Development Committee)

4.3.8.1 Composition

4.3.8.2 Roles and responsibilities of the VDC/CDC

4.3.8.3 Operational Guidelines

4.3.8.4 Functional village health facility

4.3..8.5 Functional village development committee

Sections 4,3,8.1 – 4.3.8.5 will be the same and in 4.2.8.1 – 4.2.8.5

4.4.Ward level

4.4.1 Nomenclature:

Type 2 Facility - Primary health *care* centre

4.4.2 ***Expected services:***

- Community mobilization
- Community growth monitoring and promotion
- Mobilize the community on protection of water sources, control of endemic diseases, immunization and environmental sanitation
- Health education on prevailing health conditions
- Monitor the activities of CHEWs and JCHEWs.
- Antenatal, post-natal and immunization services
- Family planning activities
- Child welfare clinics
- Treatment of minor ailments
- Monitor maternal and foetal well-being during labour and provide supportive care.
- Record maternal and foetal well-being on a partograph and identify maternal and foetal distress and take appropriate action, including referral where required.
- Identify delayed progress in labour and take appropriate action, including referral where appropriate.
- Manage normal vaginal delivery and care of the new born.
- Manage the third stage of labour actively.
- Give basic emergency obstetric care
- Give limited in-patient services
- Do good record keeping

44.3.Hours of operation: 24hrs.

4.4.4 Infrastructure:

4.4.4.1 Building : A detached apartment with sufficient space to accommodate

- Waiting/reception area
- Staff station
- 4 consulting rooms
- Pharmacy & Dispensing unit
- 2 delivery room
- Maternity/lying-in section
- In-patient ward section

- Laboratory
- Medical records area
- Injection and dressing area
- 1 minor procedures room
- Store
- Toilet facilities
- Potable water source

4.4.4.2 Furnishings:

All furnishings as listed in the Basic Equipment List for Primary Health Care Facilities in Nigeria[36]

4.4.5 ***Personnel:***

CHO (must work with standing order)	-	1
Nurse/midwife	-	4
CHEW (must work with standing order)	-	3
Pharmacy technician	-	1
JCHEW (must work with standing order)	-	6
Medical records officer	-	1
Laboratory technician	-	1
Support staff		
Health attendant	-	2
Security personnel	-	2
General maintenance staff	-	1

4.4.6 ***Medical equipment:***

- As listed in the Basic Equipment List for Primary Health Care Facilities in Nigeria[36]. However, the following items should be excluded:

1. Anaesthetic machine (pg 5)
2. Caesarean section set (pg 5)
3. Ambulance should be optional at this level (pg 7)
4. Ether, anaesthesia or technical grade, or ethyl acetate (pg 10). Comprehensive emergency obstetric services should be provided at Apex PHC.

4.4.7a Essential drugs: The essential drugs listed on page 185 – 189 of the Operational Training Manual and Guidelines for the Development of PHC System in Nigeria[23] are considered too elaborate and will require a review by the stakeholders. For example, some of the less commonly used drugs like phenoxymethyl penicillin, sulphadimidine, phthalylsulphathiazole could be replaced with frequently used drugs such as co-trimoxazole, Amoxicillin, ampicillin+cloxacillin. Similarly, streptomycin should be reserved solely for the treatment of tuberculosis as *bundled* drugs. Anti-psychotics should be taken out of the core list and placed in a complementary list because this is the current best practice.

4.4.7b Other items:

- Communication facility; e.g., GSM
- Motorcycle (1)
- Bicycle (6)
- Stove (2)
- Lanterns (6)
- Buckets (4)

4.4.8 WDC Committee

4.4.8 1 Composition of the WDC Committee

- Members shall elect the head of the committee
- Ward head Autonomous Clan head (Chairman), but where no such person exists, the most respectable village head or any other person so elected may serve as Committee Chairman. In such a case, the appointment of Chairman should be left entirely in the hands of Committee members;
- The WDC consist of representative from each VDC in the village.
- The members will select the secretary of the committee;
- The Wards Community Development Officer, if available;
- The committee can where necessary co-opt members of health related sector such as Secondary School Principals and Primary School Headmasters, Agric-Extension Workers NEPA/Water Works Staff, NGOs. At least 40% of membership will be women and they should be given effective post.
- Head of health facilities in the area;

4.4.8.2 ***Roles and Responsibilities***

The Ward Committee will:

- Identify health and social needs and plan for them;
- Supervise the implementation of developed work plans.
- Identify local human and material resources to meet these needs;
- Forward all health/community development plans (village, facility and Wards levels to LGA;)
- Mobilize and stimulate active involvement of prominent and other local people in the planning, implementation, and evaluation of projects
- Take active role in the supervision and monitoring of the Wards Drug Revolving Fund/B.I.
- Raise funds for community programmes when necessary at village, facilities and Wards levels;
- Provide feedback to the rest of the community on how funds raised are disbursed;
- Liaise with government and other voluntary agencies in finding solution to health, social and other related problems in the Wards;
- Supervise the activities of the VHWs/TBAs, CHEWS;
- Monitor activities at both the health facilities in the Wards;
- Provide necessary support to VHWs/TBAs;
- Ensure that a Bank account is opened with a reliable bank. The signatories will be as given by the NPHCDA guidelines on the Ward Health Systems document.

4.4.8.3 Operational Guidelines

The Committee shall:

- Meet monthly;
- Record minutes of meetings;
- Recommend that minutes of meetings be signed by the Chairman and Secretary after approval at the next meeting;
- Monitor drug revolving at the Ward/Facility level;
- Ensure that NHMIS forms are correctly filled and submitted on time;
- Give feedback of data collected at LGA PHC Management Development Committee meetings;
- Comply with the quorum of members set for starting the meeting;
- Authorize the Treasurer to record and keep all monies;

- Authorize the Treasurer to spend money only after approval by Committee;
- Instruct the Treasurer to record all expenditure;
- Chose where applicable, the ward referral centre to serve as the meeting venue and Secretariat of the Ward Development Committee;
- Advise, where there is a Bank Account, signatories to be the Committee Chairman and Treasurer, and if necessary, the Secretary;

Send minutes of meetings to Local

4.5 Local government headquarters level (LGA health office + apex PHC facility)

4.5.4 ***Nomenclature of the LGA PHC facility:***
Type 3 Facility (Apex PHC centre & health office}

4.5.2 ***Expected services:***

- Community mobilization for support and utilization of health services.
- Growth monitoring and promotion
- Mobilize the community on protection of water sources, control of endemic diseases, immunization and environmental sanitation
- Health education on prevailing health conditions
- Antenatal, post-natal and immunization services
- Family planning activities
- Child welfare clinics
- Treatment of minor ailments
- Monitor maternal and foetal wellbeing during labour and provide supportive care.
- Record maternal and foetal wellbeing on a partograph and identify maternal and foetal distress and take appropriate action, including referral where required.
- Identify delayed progress in labour and take appropriate action, including referral where appropriate.
- Manage a normal vaginal delivery and care of the new born.
- Manage the third stage of labour actively.
- Provide referral services for lower levels of health care delivery
- Basic or comprehensive emergency obstetric services as per staff availability
- Minor surgical procedures
- Monitoring and evaluation activities
- Malaria, tuberculosis and HIV/AIDS prevention and control activities plus any other disease(s) endemic to the locality.
- Link up with General Hospitals for 2-way referral services
- Coordination of environmental health activities
- Mobile clinical services
- Provide limited in-patient services

4.5.3 Hours of operation: 24hrs

4.5.4 Infrastructure:

4.5.4.1 Building : A detached apartment with sufficient space to accommodate

- Waiting/reception area
- Staff station
- Consulting area
- Preparatory room
- Delivery room
- Maternity/lying-in ward
- Injection and dressing area
- Limited in-patient wards

- Store
- Toilet facilities
- Potable water source
- Administrative offices
- Cold chain office with dry and cold stores
- Laboratory
- Pharmacy

4.5.4.2 Furnishings:

- Writing table – 10
- Chairs - 20
- Examination couch - 4
- Screen - 2
- Delivery table - 2
- Cupboards - 10
- Wash hand basin - 4
- Benches - 10
- Beds - 10

4.5.5 Personnel:

Medical Officer of Health (MOH)*	-	1
Medical officer	-	1
CHO (must work with standing order)	-	2
Nurse/midwife	-	4
CHEW (must work with standing order)	-	2
JCHEW (must work with standing order)	-	2
Pharmacy technician	-	2
Laboratory technician	-	2
Medical records officer	-	1
Support staff		
Administrative officer	-	1
Health attendant	-	2
Security personnel	-	2

** **Qualification:** A medical doctor with a registrable postgraduate medical qualification in public health/community medicine. In the absence of a qualified MOH, a medical doctor should be appointed as **Acting MOH.** The acting MOH must attend a continuing medical education programme in public health/community medicine within 6 months of such appointment.*

4.5.6 ***Medical equipment:***

The basic equipment list for primary health care facilities in Nigeria[36] is considered adequate.

4.5.7a.Essential drugs:

The essential drug list for health facility in the NPHCDA/FMOH training manual[23] is considered adequate with the following modifications:

- Antihelminthics – pyrantel pamoate and levamisole should be added to the list
- Antimalarial drugs – Artemisinine combined therapy (ACT) preparations should replace chloroquine, Quinine

- Antischistosomals – praziquantel should be added to the list
- Antibacterial drugs - some of the less commonly used drugs like phenoxymethyl penicillin, sulphadimidine, phthalysulphathiazole could be replaced with frequently used drugs such as co-trimoxazole, amoxicillin, ampicillin+cloxacillin, ampicillin and benzyl penicillin. Similarly, streptomycin should be reserved solely for the treatment of tuberculosis as bundled drugs.
- Others - Magnesium sulphate

4.5.7b Other items:

- Communication facility; e.g., GSM
- Mobile clinic facility
- Ambulance vehicle
- Motorcycle (2)
- Bicycle (4)
- Stove (2)
- Lanterns (4)
- Buckets (4)

4.5.8 LGA PHC Management Committee.

4.5.8.1 The Composition of the LGA PHC Management Committee

- The Chairman of the LGA (chairman);
- Supervisory Councillor for Health (member);
- The LGA Secretary;
- LGA PHC Coordinator (Secretary);
- A representative of CHO Training Institutions
- Principal of School of Health Technology
- Representative of health-related occupational groups/associations;
- The Chief (or most senior) Community Health Officer in the LGA;
- The Community Development Officer for the LGA;
- The Medical Officer/i/c of the secondary health facility
- Chairman of Ward Development Committee
- Ward heads,
- Representatives of International Organizations having PHC Programmes in the LGA;
- Heads of other health-related departments in the LGA (Education, Agriculture, Works, etc);
- Representatives of NGOs;
- Representatives of Women/Youth Groups;
- Representative of Religious Groups

4.5.8.2 Terms of Reference

The Terms of Reference of the LGA PHC Management Development Committee shall be to:

- Provide overall direction for PHC including endemic, communicable diseases (HIV/AIDS/STD, TBL, Malaria, Onchocerciasis, etc.)
- Plan and manage PHC Services in the LGA
- Health Manpower development for the LGA
- Provide the Operational Guideline for the LGA.

4.5.8.3 Local Government Area PHC Technical Committee

There should be a PHC Technical Committee at the LGA level

4.5.8.3.1 Composition

- LGA PHC Coordinator – Chairman

- All Assistant PHC Coordinators
- Program Managers in the LGA.

4.5.8.3.2 Roles and Responsibilities

- plan and budget for implementation of activities of PHC department and present same to the LGA PHC Management Development Committee;
- identify training needs for Health Workers and make proposals to the LGA PHC Management Development Committee;
- Design minimum acceptable performance standard for monitoring LGA PHC Services and develop monitoring indicators
- Monitor activities of health workers;
- Design supervisory checklist for LGA PHC services;
- Identify health related needs of communities within the Local Government Areas;
- Plan for mobilization of local and external resources to enhance PHC activities;
- Provide feedback to committees at all levels;
- Monitor drug revolving fund for the health services at the LGA level;
- Discuss PHCMIS report and take appropriate action;
- Give feedback of data collected at LGA PHC Management Committee meeting/facility staff/community.
- Review progress of PHC in the LGA and evaluate their indicators.

4.5.8.3.3 Operational Guidelines

In carrying out the above functions, the committee shall:

- Meet monthly;
- Record minutes of meetings;
- Adopt minutes of meetings and ensure that the Chairman and Secretary sign them;
- Comply with the quorum set for starting meetings.

4.5.9 Functionality of different aspects of Development Committees

A Development Committee (DC) at any level will be said to be functional when it has functional health facility and development committee which is properly set up as detailed below:

4.5.9.1 Functional Health facility is a health facility that has

- basic equipment for PHC services;
- can provide basic PHC services;
- has store where drugs and supplies can be safely kept;
- has enough staff to provide 24 hours service daily including weekends; and
- Have health workers with a known team leader.

4.5.9.2 Functional Development Committee is a development committee that: -

- Has elected officers (chairman, secretary, treasurer etc);
- Has bank account;
- Holds meetings regularly (e.g. monthly);
- Keeps minutes of meetings;
- Supports management of health facilities;
- Has different means of generating funds; and
- Uses health data for necessary actions

4.5.9..3 Properly set up development committee

The committee is properly set up when it is/has

- Multidisciplinary/multisectoral membership;
- Broad-based e.g. LGA management committee has at least a member from each political ward; and DC has members from all major communities/villages;

- Gender sensitive/responsive: ideally, at least 40% of members are females;
- Clear and acceptable guidelines on how to raise/spend money, elect/change officers, and withstand ethnic/political/religious pressure/ threats.

4.6 Minimum Standards for Essential PHC Services

In the main document, introductory comments and background information were given on each of the 8 elements of PHC that include health education, WATSAN, NPI, MCH/FP, Nutrition, provision of essential drugs, treatment of minor ailments and control of locally endemic diseases. Similarly such background information was given on the other additional elements of PHC that include care of the elderly, mental health, dental health, handicapped and non-communicable diseases.

4.6.1 Minimum standards for Health Education in PHC

4.6.1.1 Background information
4.6.1.2 Definition of social and community participation
4.6.1.3 Implications of 'full community participation' in PHC
4.6.1.4 Minimum ***Standards of staff and equipment on Health Education***

In order to provide health education services in communities of LGAs, qualified staff and necessary health education tools/equipment are required.

i) ***Staff***

The qualified staff (health educator) will assist to design appropriate relevant health education messages, prepare other health workers to assist by disseminating the messages at every available opportunity, using the right materials/tools.
At least, every LGA should have one qualified health educator.

ii) ***Tools/Equipment***

Health education tools/equipment could include public address system, overhead projector, overhead screens, television set etc.

a} LGA Level:

1 Health education office
1 Public address system
1 Overhead projector screen
1 Overhead projector
2 sets of Television
1 Mobilization vehicle
1 Megaphone
1 set of videocassettes
2 Photo cameras
2 Photograph enlargers
Video recorders/ players

b) Primary Health Centre level

1 Public address system
Posters on all phc services

4.6.2. Recommended Minimum Standards for Nutrition activities in PHC

In the main document, this section includes:
4.6.2.1 Background information
4.6.2.2 Goals and objectives
4.6.2.3 Minimum package (***Essential Nutrition Actions:ENA)*** of nutrition activities
4.6.2.4 Strategies for improved nutritional Status

4.6.2.5 Minimum Package for Nutrition
i) Staff

- there should be at least 2 qualified nutrition officers per LGA
- all categories of health workers should be retrained on lactation management and growth monitoring and promotion

ii) Facilities and equipment

- Health and Nutritional Educational materials.
- Facilities for nutrition demonstration in all wards. (Kitchen and Food demonstration space in designated health facilities, appropriate cooking implements, appropriate refrigerating apparatus, Food demonstration charts, plates, spoons etc, trained health staff).
- Community based growth monitoring in all village areas (Mosley scale, Tape rule, Child health Cards, Compliment of Health workers).
- Food security at household and community levels.

4.6.3 Minimum Standards for WATSAN

In the main document, this section defines water as a transparent, odourless, tasteless liquid that is a compound of oxygen and hydrogen that is universal solvent that is highly essential to life
4.6.3.1 Background information
4.6.3.2 Provision of safe and adequate water supply
4.6.3.3 Environmental Sanitation
4.6.3.4 Objectives for effective Safe water and Basic Sanitation
4.6.3.5 Indicators of the objectives
*4.6.3.*6 Activities to promote adequate supply of safe water and basic sanitation

4.6.3.7Minimum Standards for safe water supply and sanitation

LGA HQ Level
At the LGA level, there should be:

a) Staff: Minimum of *10 (1 per political ward)* Environmental Health Officers, Health educators, engineers and technicians
b) Office for the staff
c) Demonstration area
d) Health education Units

Ward Level at the Primary Health centre

- Health education unit is established in every political ward to provide community mobilization for WATSAN activities.
- Community mobilization for healthy/hygienic living should be carried out in every community.
- Such activities could be carried out during community visits.
- Every community therefore needs to be visited, at least once quarterly

4.6.4 Minimum standards for Maternal and Child Health and Family planning (Safe Motherhood services in PHC

In the main document, this section contains:

4.6.4.1.Situation Analysis
4.6.4.2 Description of safe motherhood
4.6.4.3 Objectives and Targets of safe motherhood
The objectives of MCH by the year 2910 are to:

- Reduce maternal mortality rate by 75%;
- Reduce incidence of low Birth Weight from 20% to l0%;
- Reduce Peri-natal Mortality Rate from 20 per 1000 to 14 per 1,000;
- Increase proportion of pregnant women receiving ante-natal care from 60% to 80%;
- Increase proportion of deliveries attended by skilled hea1th workers to 70%
- Expand utilization coverage of family planning services from 13% to 50%
- Reduce proportion of females undergoing genital mutilation by 30%.

4.6.4.4. Minimum Standards for Safe Motherhood

4.6..4.4.1 Standards for basic and comprehensive EmOC
As the minimum, at least
One (1) Comprehensive Emergency Obstetric Care Centre (CEOC) should be established per LGA.
This centre would provide secondary level care i.e. surgeries (caesarean sections) in addition to the BEOC and ensure availability/immediate access to blood transfusion services.
A) Structures
i) Basic EmOC Functions Performed in a primary health centre without the need for an operating theatre:

- IV/M antibiotics
- IV/M ox toxics
- IV/M anticonvulsants
- Manual removal of placenta
- Assisted vaginal delivery
- Removal of retained products

ii) Comprehensive EmOC Functions requires an operating theatre and is usually performed in genral hospitals:
All six Basic EmOC functions plus:

- Caesarean section
- Blood transfusion

It is recommended that for every 500,000 people there should be at least:
4 facilities offering, Basic EmOC and one facility offering Comprehensive EmOC
B) Staff and equipment
The facilities should be

- Adequately staffed including four (4) midwives for 24 hours coverage daily including weekends and public holidays. Basic staff skill would include ability to perform ‘manual removal of placenta and placenta products.
- Equipped with all basic obstetric equipments.
- basic obstetric drugs; oxytocin, sedatives and antibiotics and IV fluids

4.6..4.4.2 UNFPA's three-pronged strategy to reducing maternal mortality

The following UNFPA's three-pronged strategy to reducing maternal mortality is recommended

- Family planning to ensure that every birth is wanted.
- Skilled care by *a health professional with midwifery skills for every pregnant woman during pregnancy and childbirth*.
- Emergency Obstetric Care (EmOC) to ensure timely access to care for women experiencing complications.

4.6.5 Minimum standards for Immunization practices in PHC

In the main document, this section contains:

3.5.1Basic Immunization

3.5.2 Background

3.5.3 Immunization Schedule

Immunization schedule differs depending on where an individual will obtain his immunization. 5 immunization contacts must be made in static centre or 3 immunization contacts in outreach/mobile centres.

i) *WHO recommendations: Box 1*

WHO[37] recommended childhood immunization schedule is as shown in the box BCG - As soon as possible after birth OPV - One dose at birth (this being called dose Zero) Dose 1 at 6 weeks of age, Doses 2 and 3 spaced at least four weeks apart DPT - Dose 1 at 6 weeks of age, doses 2 and 3 spaced at Least 4 weeks apart Measles - As soon as possible after 9 months of age

ii) <u>*Valid Doses of Tetanus Toxoid*</u>

Doses	Minimum interval
TT1 and TT2	four weeks
TT2 and TT3	six months
TT3 and TT4	one year
TT4 and TT5	one year

iv) *Period of protection after last valid dose*

One dose	no protection
Two doses	15 days to 3 years protection
Three doses	15 days to 5 years protection
Four doses	15 days to 10 years protection
Five doses	Life long protection

iv) *Immunization Schedule in Static Centre: Box 2*

[3]WHO (1988) Coverage Survey WHO/EPI/MLM/CON/88 pp. 38 and 41

Contact	Minimum Target age of child	Type of Vaccine	Dosage	Site	Route of Administration	Storage Temperature
1st	At Birth	BCG OPV0	0.05cc 3 Drops	Right Upper Arm Oral	Intradermal Mouth	-20°C -20°C
2nd	6 weeks of age	DPT 1 OPV 1 HBV 1	0.5cc 3 Drops 0.5cc	Intramuscular Oral Intramuscular	Upper outer quadrant of buttock Mouth Upper arm	-4°C to +8°C -20°C +4°C to + 8°C
3rd	10 weeks	DPT 2 OPV 2 HBV 2	0.5cc 3 Drops 0.5cc	Intramuscular Oral Intramuscular	Upper outer quadrant of buttock Mouth Upper arm	4. °C to +8°C -20°C +4°C to + 8°C
4th	14 weeks of age	DPT 3 OPV3	0.5cc 3 Drops	Intramuscularly Oral	Upper outer quadrant of buttock Mouth	4. °C to +8 °C -20 °C
5th	9 – 11 months	Measles Yellow Fever HBV 3	0.5cc 0.5cc 0.5cc	Subcutaneous Subcutaneous Intramuscularly	Left upper arm Left upper arm Upper arm	-20 °C -20 °C +4.°C to +8°C

4.6.5.4.Minimum Standards for immunization

The aspects of immunization that are assessed here are

i) staff

ii) Cold chain equipment and transportation support and

iii) coverages in % of immunization (antigen by antigen) coverages.

i) Minimum number of recommended staff in facility

ii) *Numbers of cold chain equipment and transportation supports.*
Certain numbers of basic cold chain equipment have been recommended as standards that should be available in the static health facilities as shown in Table 10 below.

Table 9: Standard numbers of cold chain equipment expected in each static health facility and LGA cold store

S/No.	Items	Quantity required at each	
a)	**Cold Chain equipment**	LGA Store	Health Facility
i.	Generator	1	-
ii	Ice pack freezers	1	-
iii	Refrigerators	1	-
iv	Cold boxes	2	1
v	Vaccine carriers	2	2
vi	Ice packs	48	32
vii	Steam sterilizer	1	1
viii	Kerosene Stove	-	1
ix	Thermometers	6	4
b) i.	**Transportation support** Motor Vehicle	1	-
ii	Motorcycle	-	1
iii	Bicycle	-	1very rural areas

Source: EPI 5year plan (1994-1998) of action for boosting EPI coverage pp. 54 - 55

ii) *Coverage*

80% coverage of children below 1 year is the expected standard for each of the antigens.

4.6.6. Minimum standard for Control of communicable/Endemic diseases

This section, in the main document, contains:
4.6.6.1. General Background Information on communicable/endemic diseases that include malaria, tuberculosis, and STI/HIV/AIDS

4.6.6.2 Malaria

Specific Objectives: By 2010;

- At least 80% of those suffering from Malaria have access to affordable and appropriate treatment within 24hours of onset.
- Increase the use of ITN from the current 6.8% to at least 80% for high-risk groups particularly under-5yrs and pregnant women within the plan period
- At least 90% of all pregnant women have access to intermittent prevention treatment.
- Create awareness on environmental sanitation as it affects malaria control in 80% of all wards.

i) Minimum Package for Malaria

To this end a minimum health package for the control of malaria is proposed as follows:
a) Availability of Insecticide Treated Nets (ITNs) for all pregnant women and children under five (5) years of age; and chemicals for re-treatment.
b) Provision and use of Artesonate Combination therapy (ACT) for treatment of malaria.

c) Provision of Sulphadoxine-Pyrimethamine for Intermittent Preventive Treatment
d) Institutionalizing effective case management of malaria in the community and all health facilities.
e) Provision of Sulphadoxine-Pyrimethamine for Intermittent Preventive Treatment for pregnant women

Recommended treatment
The treatment of choice for uncomplicated malaria is Artemisinin Based Combination Therapy (ACT). This consists of the use of an artemisinin derivative and another effective antimalaria medicine.
Recommended ACT for uncomplicated malaria is Artemether-lumefantrine

Box 3 Dosage chart for Artemether-Lumefantrine

Weight	Age	Number of tablets/dose
5 – 14kg	6mths – 3yrs	1 tab. Twice x 3days  2x 3days
15 – 24kg	4 – 8yrs	2 tabs twice daily x 3days  2 x 3 days
25 – 34 kg	9 – 14yrs	3 tabs twice daily x 3 days  2 x 3 days
>35kg	>14yrs	4 tabs twice daily x 3 days  2 x 3days

4.6.6.3 Minimum standard of care for Tuberculosis
Specific objectives: By 2010

- To increase community awareness on the causes, prevention and treatment of TB to at least 80%.
- To ensure availability of drugs for TB therapy to at least 75% of all primary health facilities.

Update knowledge and skill of Health workers to at least 75% on early detection and treatment of cases.

A minimum health package for the control of tuberculosis is proposed as follows:

- Provision of basic laboratory infrastructure and equipment in all wards for case identification of tuberculosis (microscope, slides and slide covers, stains, swaps, sterile sputum receptacles, disposable gloves)
- Availability of drugs and infrastructure for Director Observation Treatment short course (DOTS) (Riframpricin, INH, Pyrazinamide, Streptomycin, Ethambutol etc. for all identified cases).
- Adequate number of well trained and motivated staff on the programme

4.6.6.4 Minimum Package for STI/HIV/AIDS

The following have been identified as targets for this Plan of Action by 2010:

- To increase public awareness of STI/HIV/AIDS to 95% in 5 years

- To increase condoms availability and use by 80% in all communities
- To establish in at least 60% of the wards, community-based voluntary counseling and home-based care centers
- To Institute the management of STI and opportunistic infection at PHC level in at least 70% of LGAs
- To reduce HIV infection rates by 50%.

Based on the implementation strategy, the following minimum is proposed for the control of STI/HIV/AIDS:

- Availability of Voluntary Counselling and Testing (VCT) services; (i.e. a trained counsellor, conducive infrastructure and Rapid Test Kits for HIV) in all LGAs.
- Provision of condoms and establishment of logistic mechanisms for their distribution.
- Treatment of Opportunistic infection (trained staff, appropriate drugs;
- Routine implementation of IEC and BCC activities.

4.6.7. Minimum Standards on Essential Drugs for PHC

In order to establish and maintain regular supply of essential drugs using the BI principles, facilities, WDCs and staff should achieve certain standards:

a) *Facilities:*
All health facilities should have

- essential drugs
- the list of essential drugs (Nigerian Essential drug list in Annex 11)

b) ***Every Ward Development Committee is expected to have***

- DRF Account and
- Storage facilities

c) *Staff*

- Health staff in LGAs should establish DRF Account
- PHC Coordinators of LGAs should be signatories to the Account
- All staff should be trained in essential drugs and financial management
- Every CHO, CHEW should possess and use Standing Orders for quality of care

iii) ***Recommended lists of Minimum stock of drugs in different PHC Centres***

Table 10: List essential drugs and Minimum stock of drugs in different PHC Centres

Item	Primary Health Centre		Health Centre	
	Minimum Stock Level in Doses		Minimum Stock Level in Doses	
Oral Anti-Diarrhoeal	30		10	
Oral Anti –Diabetics	5			
Oral Antacids	20		10	
Oral Anti-hypertensives	20			
Oral Vitamins	30		20	
Oral Antitussives	20		20	
Oral Sedatives	10			
Oral Anti malaria	30		20	
Oral Antibiotics	20		10	
Oral Anti fungal	6			
Oral Anti Emetics	10		10	
Oral Antipyretics	30		20	
Oral Analgesics	30		20	
Oral Anti arthritics	20		10	
Oral Anti Tuberculosis	10			
Oral Anti Asthmatics	10			
Injectable Antimalaria	30		10	
Injectable Anti biotics	30		10	
Injectable Anti pyretics	30		10	
Injectable Egormentrine	10		10	
Injectable Oxytocin	10			
Injectable Antisnake venu	2			
Injectable Anti tetanus	3			
Injectable Anticonvulsants	10		10	
Injectable Anti asthmatics	4			
Injectable Anti diabetics	4			
Injectable sedatives	4			
Types of infusion (ordina)	4		4	
Types of infusion (inducti)			2	
Types of Lotions	3		2	
Types of eye drops	4		4	
Types of ear drops	4		4	
Types of Antifungal	4		4	
Types of Antibiotics Powd	4		4	
Types of cream	4			
Inhaler (Salbutamol)	1			
I.V.Flagyl	2			

4.6.8 Minimum Standards of activities on treatment of minor ailment and injuries

Two areas where standards need be set on treatment of minor ailments are the relevant *Facilities* and *staff*.

i) *Facilities*

Generally, the status of health facilities (as described earlier under facility section) will affect the status of treatment of minor ailments.

However, diarrhoea disease (DD) is one of the ailments that need special facility and equipment for its prevention, and particularly treatment.

Specific Equipment Minimum quantities/numbers required at HF Level

Such equipment for its treatment include:

ORT corners	1 per H/F
ORS sachets	50 per H/F
Management chart	2 per H/F
Benches	1 per H/F
Tables	2 per H/F
Charts	4 per H/F
Bottles	4 per H/F
Cups	4 per H/F
Bowls	4 per H/F
Spoons	2 per H/F
Leveling knives	2 per H/F
Jugs	2 per H/F

ii) *Staff*

All PHC workers need training and/or retraining on current management of these common ailments and the appropriate use of Standing Order.

4.6.9 Minimum Package on Non-Communicable Diseases (NCDs)

In attempt to integrate Non-Communicable Diseases (NCDs) into PHC in Nigeria, an educational booklet was published for PHC workers and their trainers. According to Akinyanju[56] the booklet was to provide basic information on definition, recognition, prevention and treatment of five NCD: hypertension, diabetes, sickle-cell disorders, Glucose-6-Phosphate Dehydrogenase (G6PD) and coronary health disease. G6PD is an important enzyme contained in the red blood cells. When the quantity of this enzyme is reduced in the red blood cells, the individual is said to be G6PD deficient. The first four of these diseases are prevalent in Nigeria and the last is increasing in incidence.

The following minimum package on NCDs is proposed at the primary care level:

- Phased capacity building of health workers for control of NCDs in all facilities.
- Availability of IEC materials on NCDs displayed in all facilities.
- Provision of basic equipments for screening and early diagnosis of NCDs i.e. Sphygmomanometer, Weighing Scale, Hydrometer, Urine Test Kits etc.

[56] Akinyanju O.O. (1993) Non-Communicable Diseases in Nigeria, A manual for PHC workers, FMOH, Lagos.

4.6.10 Minimum Standards for mental health in PHC

Objectives
Reduction of incidence rate of mental disorder
Methods of Achievement

(a) Reducing community-wide harmful influences; e.g. health promotion, legislation;
(b) Cognitive and emotional health (mental hygiene) education;
(c) Provision of services to help people at times of crises;
(d) Early and prompt crisis intervention strategies
(e) Community based rehabilitation programmes.

Personnel
i) The Primary Health Care Service Personnel

- The Community Health Officer
- The Community Health Extension Workers (CHEWs)
- Junior Community Health Extension Workers (JCHEWs)
- Traditional birth attendants/village workers.

ii) *Other Community Health Personnel*

- The Public Health Nurses
- Medical Social Workers
- The Health Educator
- The Public Health Inspectors
- Nutritionists

iii) *Doctors in primary care/general practice* or in various other specialties.
Location or Base
a The community
b. Primary Care Centres:
i. Health Centres
ii. Maternity Centres

4.6.11 Minimum package for Primary oral/dental health

Preamble
Oral health care is an essential part of Health Care and to this end it has to be integrated into health or delivery at every level. At PHC level, the under listed are the basic minimum that must exist in order to realize the objectives of bringing comprehensive health are to the people.

Facilities

- No need of a special room but if available it will help.
- Locally made dental chair is optional
- Instrument for sterilization
- Instrument for oral examination
- Instrument for scaling and polishing
- Revised Standing Orders (manual)
- IEC materials

Consumables

- Consumables for sterilization
- Drugs –Analgesics Antibodies/Vitamins/Dressings
    - Face masks, wooden spatula, cotton-wool
    - Personnel

The staff will include Nurses, CHOs, CHEWs, and JCHEWs who have been trained using the Revised Standing Orders.

4.6.12 Minimum Package for Care of the elderly (geriatric unit) in a P.H.C

The component of a geriatric unit in a PHC centre should comprise infrastructure, equipment and human resources.

i) Infrastructure

These should comprise of at least 2 rooms, first to serve as consulting room, the second a waiting cum recreational room. A functioning laboratory will be helpful.

ii) Equipment

(i) The consulting room should have a table, two chairs, one for the doctor and the other for the patient. Other items are, a mercury sphygmomanometer, stethoscope (Littmann), X-ray viewing box, weighing scales, angel poise lamp, a screen, examination couch, a thermometer, a diagnostic set forceps, galli pots, kidney dishes, foley's catheter, steam sterilizer etc.

(ii) The waiting room/Recreational room should have some easy chairs and low tables for game. These include a television set, video set, educational and medical video films, Journals and health educational materials. Ludos, playing cards, scrabble, monopoly etc. a stationary bicycle for exercise will be of great importance.

(iii) A small laboratory, functional quick diagnosis like FBS, urinalysis etc. There should be a microscope centrifuge, test tubes and racks. Chemicals and reagents.

iii) Human Resources

(i) A general duty doctor whose job is to see all patients and diagnose the age-related illness should treat where possible or refer cases to different consultants as may be necessary.

(ii) A nurse/midwife CHO: preferably that who has psychiatric training in addition to general duty nurse to assist in educating and counselling patients.

(iii) A social worker, or CHEWS (community health extension workers) to counsel patients

(iv) A trained caregiver to give necessary care and to make home visits and follow-up of cases.

4.6.13 Minimum standards for Care of the Handicapped in PHC

Handicap is any continuing disability in the body, intellect, or personality which is likely to interfere with individual' normal growth and development and at times his/her capacity to learn. It is important to note that a handicapped.

Strategies

Village/Ward Levels

The Community Health Worker should:

- define the term "handicap" as any continuing disability in the body, intellect, or personality that is likely to interfere with individual's normal growth and developments, and at times, capacity to learn;
- recognize types of handicap in his or her community such as:
  - Blind
  - Deaf
  - Mentally retarded
  - Learning disabled
  - Emotionally disturbed
  - Mentally disordered
  - Chronic disease (sickle cell, AIDS, cancer, G6PD deficiency, diabetes, heart condition)
  - Destitute and socially handicapped;
- identify the major causes of handicap in his or her community such as:

- Genetic disorders (hereditary e.g. sickle cell diseases etc)
- Congenital malformations e.g. German measles as a prenatal infection etc.
- Infection e.g. measles, tuberculosis of the spine etc.
- Trauma/injury (e.g. head injury)
- Poisoning
- Malnutrition IDD in pregnant women (Kwashiorkor or marasmus)
- Maternal antibodies
- maternal toxaemia (e.g. prematurity)
- veneral diseases

4.7 PHC Support System

Three aspects of support for PHC system where standards need to be established are the funding, referral and Information systems

4.7.1 Referral System

i) Development of criteria for referral of patients

Guidelines/criteria need to be developed on the common conditions that cause disabilities, morbidity and mortality. According to FMOH (1990)[50] patients to be referred are those with conditions not covered by standing orders, not responding to treatment within specified time in the standing orders, rapidly getting worse, and conditions one is in doubt of. Conditions that could call for referral include emergencies, maternal conditions and common ailments. Every PHC worker at the health centre level should be familiar with the value and effective use of standing orders.

ii) Specific information that should accompany patient to and from the hospital

The standard referral form (See Annex 111) that has been developed by FMOH/NPHCDA should be made available and used in all health facilities.

Every health worker at the Primary Health Centre level should be familiar with the value and use of Standing Orders[51].

iii) Training programme for health workers on i) and ii) above

Health workers at the secondary and primary health care levels need to be trained separately and together.

Separate training will assist workers at different levels to recognize their specific roles in referral and how to carry these roles out. Joint training will help health workers to discuss expectations of/by different levels and build positive interactive relationships.

iv) Standard on Referral System

- All cases that need referral services should be referred
- All PHC staff should be trained on referral system
- Enabling environment including provision of basic referral tools – forms, transportation services should be available.
- Referral should be 2-way

4.7.2 Minimum Standards for Financing/Funding in PHC

[50] FMOH (2004) Guidelines and Training Manual for Development of PHC system in Nigeria p.1.6

[51] FMOH (1995) Standing Orders for Community Health Officers and Community Health Extension Workers p.107

Establishing minimum Standards

It is difficult to establish standards in the area of funding PHC activities since just like health affect other sectors, other sectors like: education, agriculture, water, roads, housing etc. have effects of health. This is why the principle of intersectoral collaboration/coordination/cooperation has been stressed in the definition and operations of PHC.

However, in an effort to create impression on standards in PHC financing 2 attributes could be looked at; i) the position of funding of PHC among of sectors in LGA and ii) proportion of amount of money spent actually spent on PHC compared with the total money spent in the LGA in a particular year.

i) *Standard of position*

Since 'health is wealth', it is desirable if every LGA puts 'funding of PHC' in the first position among other-sectors

ii) *Proportion (%) of money spent on PHC*

In view of the importance of health in socio-economic development of any community, at least, 15% of LGA annual budget is to be committed to PHC.

4.7.3 Minimum standards for Health Management Information System (HMIS) activities in PHC

A functional and regularly evaluated HMIS is a very important tool for effective health services delivery anywhere. For the community health/PHC system, the annual report on health and the disease notification records thereof should be continuously reviewed during the year. Such reports are invaluable in monitoring the health services of any LGA.

In this regard, it will be the minimum requirement for each state government to print the current disease notification sheets and bind them in quadruplicates of 52 weeks each. Such forms should used and processed according to national tuidelines

Health data are very important for planning, monitoring and evaluation of health services, programs and projects.

i) Establishment of standards

To ensure the availability of pertinent data, a Health Management Information System (HMIS), should be put in place.

The components of the HMIS include:

- The relevant HMIS data collection forms produced and distributed to all levels
- Officers at different levels trained in HMIS
- A system for the regular collection, collation, analysis and dissemination of the information, both horizontally and vertically, with appropriate feedback to the primary collectors of the data.

CHAPTER 5

LESSONS LEARNT AND RECOMMENDATIONS.

5.1 General observations.

From the history of the development of PHC in Nigeria reviewed here and the problems that have continued to limit real success therein, especially those identified from the informed PHC workers surveyed for this work, the lessons listed below would seem necessary to restate before the recommendations for minimum standards that follow them. In recommending the minimum standards for physical facilities, staff, services and equipments for each level of the PHC services, we have drawn from the several previous standards or recommendations or actual list used for these in the past, nationally or locally in some states and institutions as they existed, exist now or have been officially recommended to be in the immediate future. However, we have also included in a separate section, some recommendations which run through the entire health care system, from the independent community-self-provided health service, with or without government participation in the mean time. We have included recommendations for the secondary and tertiary health services, in relation with PHC, as the WHO calls "the PHC-support system through a 2-way referral system and without which PHC itself provided by the LGAs will not succeed"[39]. We have also made suggestions in this section regarding how the entire PHC system may be entirely revised so as to truly get out of the old quagmires. With the **rather low level of success of the PHC programme so far**, as packaged and re-packaged, to positively affect the health status in the country all this while, it is obvious that we need to look at the programme more thoroughly rather than regurgitating and remodelling all the past methods, styles, terminologies, staffing and systems, which have still so far failed to work well.

5.1.1 Lessons learnt that need restating.

The lessons that need to be reiterated before making or alongside with the recommendations on the minimum standards include the following:

1. Career opportunity for all health workers

There should be career opportunities for all health workers.in the LGA system. The LGA, according to the Riga Conference of 1988[39], is the practice level of all PHC. Therefore it is important to allow all categories of health workers (as the veritable PHC workers anywhere) to attain their maximum achievement and professional fulfilment within the LG service system, rather than be taken away to the state government and its secondary health services.

2 Development of appropriate working relationships between the health care levels

The two-way referral system not only needs to be revitalized and insisted upon but also the teaching and enforcement of the healthy working relationship which enables all health workers in the three government levels to see themselves as people working in one unified system meant to provide health to all their different people who are not properties of the state, local or national government but of all the three governments at the one and same time and who only patronize any particular level of the health services merely because that where such need is best efficiently taken care of in a reasonable health system. Regular meetings and workshops at which health workers of both the state and LGAs would attend together will go a long way in reducing these unhealthy behaviours.

3. Streamlining the roles of the PHC workers

With the continuing wrangling and rivalry among the various health workers in the PHC System, it is high time **properly trained and supported** community physicians (as members of the apex health profession) are properly involved in the Nigerian PHC system.

States that will be unable to employ one medical officer of health for each LGA may group such LGAs into contiguous groups and appoint group MOHs for them, as long as they are willing to give such MOHs what it takes to cover the LGAs as such – particularly, transportation facilities and supplies as well as the field/rural tour allowance for doing so. In that way, he will be able to visit all the physical health facilities in those LGAs within reasonable times for an effective health service.. The range of populations that make up a community nursing and midwifery zone or district ranges from 3,000 to 7,000 depending in the scatter or density of accommodation in the different areas of the LGA[40]. This has been since William Rathbone recommended 2,000 as the ideal number at the birth of community nursing and midwifery in 1859 in Liverpool under his humanitarian genius[41].

4. Appropriate training and use of nurses and midwives in PHC

Nurses and midwives who wish to be or remain part of the community/PHC delivery professionals should proceed and develop themselves into proper community nurses and midwives or both. They should not remain the mere clinical workers that they had been all this while in Nigeria, even when they got involved with PHC.

5. Redesignation and use of SCHEWs as auxiliary community nurses

The new categories of health workers - CHEWs and CHOs should be redesignated as auxiliary community nurses and auxiliary community medical officers respectively. Provision should be made for those who wish and can develop themselves to be full provessional nurses or medical officers.

6 Refining the names of the physical facilities used for PHC

The names, service levels and contents for each type of physical health facility should be as recommended in Chapter 4 above.

7 Involvement of all NYSC health workers in PHC

All the health workers mobilized every year for the National Youth Service Corps should no longer be allowed to go on wasting as they are currently doing in all kinds of unproductive service postings, especially the doctors. On the contrary, these young people constitute a formidable workforce that if properly re-oriented, organized, equipped and motivated can be used for effectively boosting the PHC services in the country. In this regard, the most essential organizationsl issues apart from an orientation programme in effective PHC service are local accommodation, transportation for the rural services and essential drug supply for the mobile and other health services that they can engage upon as in the NYSC-doctor-on-wheels of the mid and late-1970s.

Annex 1

Table 4.1a: Recommended furnishings and equipments at the health post

S/N	Item description	Qty required
	Furnishings	
1.	Writing table	1
2.	Chairs	2
3.	Examination couch	1
4.	Screen	1
5.	Benches	2
6.	Cupboards	2
7.	Wash hand basin	1
8.	Stove	1
	Equipments	
1.	Weighing scale	1
2.	Stadiometer	1
3.	Tape rule	1
4.	Dressing forceps	2
5.	Scissors	2
6.	Kidney dish	2
7.	Sphygmomanometer	2
8.	Stethoscope	2
	Other items	
	Bicycle	

Table 4.1b: Recommended essential drugs for the health post

S/N	Drugs
1.	Paracetamol syrup and tablets
2.	Arthemeter/Lumenfantrine tablets
3.	Folic acid tabs
4.	Ferrous sulphate tabs
5.	Vitamin B complex tabs and syrup
6.	Vitamin C tabs and syrup
7.	Multivitamin tabs and syrup
8.	ORS
9.	Cotton wool & gauze bandage,
10.	Adhesive plasters
11.	TBC, savlon, Eusol, methylated spirit
12.	Pyrantel pamoate
13.	Condoms
14.	Benzyl benzoate, calamine lotion
15.	Methylsalicylate ointment, zinc oxide

Annex 2

Table 4.2a: Recommended furnishings and equipment for community health centre (health clinic)

S/N	Item description	Qty required
	Furnishings	
1.	Writing table	3
2.	Chairs	10
3.	Examination couch	2
4.	Screen	2
5.	Delivery table	1
6.	Cupboards	2
7.	Wash hand basin	2
8.	Benches	4
9.	Beds	4
	Equipments	
1.	Sphygmomanometer	2
2.	Stethoscope	2
3.	Foetal stethoscope	2
4.	Adult weighing scale	2
5.	Baby weighing scale	1
6.	Bed pan	4
7.	Dressing trolley	1
8.	Instrument tray	2
9.	Kidney dishes	4
10.	Sponge holding Forceps	1
11.	Artery forceps	2
12.	Sims speculum	4
13.	Coscos speculum	2
14.	Stadiometer	2
15.	Tape rule	2
16.	Dressing forceps	2
17.	Scissors	1
18.	Kidney dish	1
19.	Mucus extractors	2
20.	Clinical thermometers	2
21.	Cord clamp	2
22.	Episiotomy scissors	2
23.	Refrigerator	2
24.	Urinary catheter	1
25.	Enema kits	2
26.	***Other items***	
	GSM	1
1.	Motorcycle	1
2.	Bicycle	1
3.	Stove	1
4.	Lanterns	4
5.	Rechargeable lamps	2
6.	Buckets	4

Table 4.2b: Recommended essential drugs for community health centre (health clinic)

S/N	Drugs
1.	**Analgesics/antipyretics** Paracetamol syrup and tablets Aspirin (use with care)
2.	**Antimalarials** Arthemeter/Lumefantrine, amodiaquine, quinine
3.	**Hematinics/Vitamins** Folic acid tabs, ferrous sulphate tabs, Vitamin B complex tabs and syrup, Vitamin C tabs & syrup, multivitamin tabs and syrup
4.	**Rehydration salts** ORS
5.	**Wound dressing** Cotton wool, gauze bandage, adhesive plasters, TBC, savlon, Eusol, methylated spirit
6.	**Anti-helminthics** Pyrantel pamoate, mebendazole
7.	**Antibiotics** Ampicillin + cloxacillin, co-trimoxazole, metronidazole, erythromycin
8.	**Contraceptives** Condoms, oral contraceptive pills, foaming tablets
9.	**Oxytocics** Limited ergot preparations
10.	**Others** Benzyl benzoate, Whitfield ointment, calamine lotion, methylsalicylate ointment, zinc oxide

Annex 3

Table 4.3a: Recommended furnishings and equipment for ward primary health centre

S/N	Item description	Qty required
	Female ward	
1.	Angle poised lamp	1
2.	Artery forceps (Medium)	4
3.	Bed pan (stainless steel)	2
4.	Bowls stainless steel with stand	2
5.	Ceiling fan	2
6.	Plastic chair (President)	2
7.	Stainless covered bowl for cotton wool	2
8.	Graduated medicine, cup	2
9.	Dissecting forceps	2
10.	Dressing scissors	2
11.	Dressing trolley	1
12.	Drinking mug	2
13.	Dust bin (Pedal)	2
14.	Galipot (median)	1
15.	Gloves, disposable pack of 100	2
16.	Hospital bed and mattress coved with Macintosh	6
17.	Stainless Instrument tray	1
18.	Forceps Jar	1
19.	Kerosene pressure lamp	1
20.	Kidney dishes (large)	4
21.	Length measure for babies	1
22.	Long benches	1
23.	Mackintosh sheet	6
24.	Pump, breast, hand rubber bulb	4
25.	Refrigerator (kerosene)	1
26.	Screen	1
27.	Sphygmomanometer mercurial (Accossons) Table top	1
28.	Stethoscope (Littman)	1
29.	Stitch removal/suture scissors	1
30.	Writing Table	1
31	Tape measure	1
32	Thermometer, oral	2
33	Thermometer rectal	2
34	Tongue depressor	2
35	Vaginal speculum, Sims, set of 3	2
	LABOUR	
1.	Artery forceps (Medium)	4
2.	Bed pan, adult stainless steel	2
3.	Stainless Bowls with stand	1
4.	Ceiling fan	1
5.	Plastic Chairs (president)	1
6.	Covered bowl for cotton wool	1
7.	Delivery couch	2
8.	Dissecting forceps	1
9.	Dressing trolley	1

10.	Dust bin (Pedal)	1
11.	Enema can	2
12.	Episiotomy scissors	2
13.	Foetal stethoscope (Aluminium)	2
14.	Stainless Galipot	1
15.	Gloves, disposable pack, pack of 100	4
16.	Instrument tray	1
17.	Forceps jar	1
18.	Kerosene pressure lamp	1
19.	Kidney dish	2
20.	Length measure for babies	1
21.	Mackintosh sheet	2
22.	Nail scrubbing brush, box of 12	1
23.	Needle holder	2
24.	Scalpel blade, pack of 100, 4 sizes	3
25.	Scalpel handle, set of 2	2
26.	Catheter tray with cover	1
27.	Sphygmomanometer, mercurial (Accosons) Table top	1
28.	Sponge holding forceps	4
29.	Stethoscope (Littman)	1
30.	Suture needle	1
31	Syringes & Needles (100)2cc,	5
32	Syringes & Needles (100) 5cc,	5
33	Syringes & Needles (100) 10cc,	1
34	Thermometer, oral	1
35	Vaginal speculum, Sims set of 3	2
36	Wall clock	1
37	Water container with tap	1
38	Screen	2
39	Soap/disinfectant dispenser	1
40	Scrub brush dispenser	1
41	Nursery costs	1
42	Angle poised lamp	1
43	Vacuum extractor, manual	1
44	Suction pump	1
45	Weighting scale, baby	1
46	Instrument cabinet	1
47	Tape measure	1
48	Thermometer jar	1
49	Urinary catheter	3
50	Umbilical cord clamp, pack of 100	1
51	Drip stand	2
52	Suture kit	1
53	Oro-pharyngeal airway, set of 7	1
54	Plastic apron	10
55	Anvard's speculum	1
1.	**LABORATORY** Kidney dish (medium)	1
2.	Box, microscope slide (x100)	1
3.	Centrifuge, manual	1

4.	Clam, test tube	1
5.	Container, sputum screw capped	50
6.	Container, sputum, snapped on lid	50
7.	Microscope, binocular	1
8.	Refrigerator, kerosene	1
9.	Scalpel handle	1
10.	Slides rack	3
11.	Spirit lamp	1
12.	Stop watch	1
13.	Test tube rack	1
14.	Tray test tube	2
15.	Tray test tube	2
16.	Waste receptacle	1
17.	Microscope cover slides pack of 1000	1
18.	Bunsen burner	1
19.	Tripod stand	1
20.	Wire gauze	1
21.	Laboratory glass ware	1
22.	Blood lancets, pack of 200	1
23.	Tourniquet	1
24	Urine dipstick (multistix)	10
26	Stool specimen bottles, pack of 100	1
27	Urine specimen bottles, pack of 100	1
28	Wall Clock	1
29	Door name plate	1
30	Haemoglobinometer (sliding type)	1
	DRESSING AND INJECTION ROOMS	
1.	Artery forceps (medium size)	2
2.	Stainless Bowl with stand	1
3.	Ceiling fan	2
4.	Plastic chairs	2
5.	Stainless covered bowl for cotton wool	1
6.	Dissecting forceps (medium)	2
7.	Dressing scissors	2
8.	Dust bin (pedal bin)	1
9.	Stainless Instrument tray	2
10.	Latex gloves (size 71/2) pack of 100	1
11.	Stainless instrument tray	1
12.	Jar, forceps	1
13.	Kidney dish (medium)	2
14.	Long benches	1
15.	Needle holder	2
16.	Plastic bowls	1
17.	Scalpel blade, pack of 100, 4 sizes	3
18.	Scalpel handle	2
19.	Stainless catheter tray with cover	1
20.	Spencer wells artery forceps	2
21.	Sphygmomanometer, mercurial (Accosons, Table Top)	1
22.	Sponge holding forceps	4
23.	Small sterilizer	1

24.	Stethoscope	1
25.	Stitch removal/suture	2
26.	Stretcher trolley	2
27.	Suture needles	1
28.	Syringes & needles (100) 2cc,	5
	5cc	5
	10cc	1
29.	Table	1
30.	Tape measure	1
31	Thermometer, oral	2
32	Thermometer, rectal	2
33	Tongue depressor	4
34	Scrub brush dispenser	2
35	Weighting scale, adult	1
36	Height measuring stick	1
37	Stainless dressing trolley	2
38	Tourniquet	1
39	Pen torch	1
40	Instrument cabinet	2
41	Medicine cupboard	1
42	Wheel chair	1
43	Angle poised lamp	2
44.	Filling cabinet	1
45.	Suction pump	1
46.	Filling cabinet	1
47.	Refrigerator, kerosene	1
48	Tissue forceps	4
49	Dressing forceps	4
50	Sterilizing forceps	4
51	Bandage scissors	2
52	Soap/disinfectant dispenser	2
53	Examination couch	1
54	Foot step	1
55	Swivel stool	1
56	Incision and Drainage kit	10
57	Suture kit	4
58	Stainless ear syringe	2
59	Wall clock	5
	FAMILY PLANNING	
1.	Ceiling fan	1
2.	Plastic chairs (president)	2
3.	Stainless covered bowl for cotton wool	1
4.	Dissecting forceps	1
5.	Stainless gallipot (medium)	1
6.	Gloves, disposable pack, box of 100	1
7.	Instrument tray	1
8.	Stainless kidney dish (medium)	1
9.	Sphygmomanometer, mercurial (Accosons, Table Top)	1
10.	Small size sterilizer	1
11.	Syringes & needles	100

12.	Table	1
13.	Thermometer, oral	1
16.	Swivel stool	1
17.	Foot step	1
18.	Screen	1
19.	Stethoscope (Littman)	1
20.	Angle poised lamp	1
21.	IUD Kit	1
22.	Pedal bin	1
23.	Thermometer jar	1
24.	Bowls stainless steel with stand	1
25.	Stainless instrument trolley	1
26.	Gynae couch	1
27.	Auvards speculum	1
28.	Tenaculum forceps	1
29.	Kick about	1
30.	Wall clock	1
31	Door name plate	1
	INFANT AND CHILD WELFARE	
1.	Basket with lid for ORS	2
2.	Ceiling fan	1
3.	Plastic Chairs	2
4.	Stainless covered bowl for cotton wool	1
5.	Dressing Trolley	1
6.	Cup, medicine, graduated	4
7.	Dust bin (pedal)	2
8.	Stainless Gallipot (medium size)	1
9.	Table infant weighing scale (Seward)	3
10.	Stainless instrument tray	1
11.	Stainless kidney dish (medium size)	1
12.	Wooden long benches	1
13.	Plastic bowls	1
14.	Refrigerator, gas/kerosene	1
15.	Spoon measure	3
16.	Wooden tables	2
17.	Thermometer, rectal	4
18.	Tongue depressor	2
19.	Vaccine cold box	5
20.	Length measure for babies	3
21.	Bowls stainless steel with stand	1
22.	Wall clock	1
23.	Door name plate	1
	FIRST STAGE ROOM	
1.	Stainless bedpan	3
2.	Bowls stainless steel with stand	1
3.	Ceiling fan	1
4.	Plastic chairs	3
5.	Stainless covered bowls for cotton wool	2
6.	Dressing trolley	1
7.	Stainless steel drinking mug	2

8.	Pedal dust bin	1
9.	Foetal stethoscope	1
10.	Stainless gallipot (median)	1
11.	Latex gloves, disposable pack, pack of 100	2
12.	Hospital bed with mattress covered with mackintosh	2
13.	Stainless instrument tray with stand	1
14.	Jar, forceps	2
15.	Kerosene pressure lamp	1
16.	Stainless kidney dish (median)	2
17.	Mackintosh sheet	4
18.	Nail scrubbing brush, box of 12	1
19.	Sphygmomanometer, mercurial	1
20.	Sponge holding forceps	2
21.	Stethoscope (Littman)	1
22.	Office table	1
23.	Thermometer, oral	2
24.	Tongue depressor	2
25.	Weighing scale (Seward)	1
26.	Chart holder	4
27.	Bedside cabinet	2
28.	Overbed cabinet	2
29.	Thermometer jar	4
30.	Soap/disinfectant dispenser	1
31	Urinal, female	2
32	Drip stand	1
33	Oro-pharyngeal airway (set of 7)	2
34	Wall clock	1
35	Door name plate	1
	ANTENATAL ROOM/INTERVIEW ROOM	
1.	Ceiling fan	2
2.	Plastic chairs	3
3.	Stainless covered bowl for cotton wool	2
4.	Dust bin	2
5.	Examination couch	1
6.	Foetal stethoscope	2
7.	Stainless gallipot (medium)	1
8.	Latex gloves, disposable pack, pack of 100	20
9.	Hammer, reflex	1
10.	Height measuring stick	1
11.	Wooden long benches	3
12.	Mackintosh sheet	2
13.	Nail scrubbing brush, pack of 12	1
14.	Pen torch	1
15.	Sphygmomanometer, mercurial (Accosons, table top)	1
16.	Stethoscope	1
17.	Tables	2
18.	Thermometer, oral	2
19.	Tongue depressor	6
20.	Soap/disinfectant dispenser	1
21.	Thermometer jar	1

22.	Angle poised lamp	1
23.	Bowls stainless steel with stand	1
24.	Dressing trolley	1
25.	Urine dipstick for sugar and albumin, pack of 100	20
26.	ANC gowns for patients	50
27.	Wall clock	1
28.	Door name plate	1
	NUTRITION	
1.	Spoon	10
2.	Stainless drinking mugs	10
3.	Gas cylinders	2
4.	Knives	4
5.	Gas cookers	1
6.	Weighing scale (Seward)	1
7.	Blender and mill	2
8.	Stainless tray	1
9.	Plates	10
10.	Water container	4
11.	Bucket wit lid	4
12.	Chopping board	2
13.	Cooking spoons	6
14.	Kerosene stove	2
15.	Utility table	2
16.	Cooking pot (A set of 6)	1
	STERILIZATION	
1.	Bucket autoclave	1
2.	Tape dispenser	1
3.	Srub brush dispenser	1
4.	Autoclave tape	1
5.	Storage cabinet	2
6.	Sterilizing drums, set of 3	6
7.	Soap/disinfectant dispenser	1
8.	Nail scrubbing brush, pack of 12	1
9.	Wall clock	1
10.	Door name plate	1
	Cleaning and utilization	
1.	Brooms	10
2.	Mops	10
3.	Mop buckets	3
4.	Dusters	20
5.	Buckets	10
6.	Aprons	10
7.	Wellington boots	3
8.	Latex gloves	10
9.	Kerosene pressure lamp	2
10.	Hurricane lamp	4
11.	Apron, utility	8
12.	Flash light – 24 box batteries	4
13.	Nail scrubbing brush, pack of 12	1
14.	Fire extinguishers	2

15.	Soap box	5
	Linen store	
1.	Linen cupboard	2
2.	Pedal dust bin	1
3.	Table	1
4.	Plastic chair (President)	2
5.	Bed sheet	32
6.	Draw sheet	16
7.	Pillow case	32
8.	Bath towel	24
9.	Hand towel	24
10.	Theatre gown	10
11.	Lithotomy leggings	10
12.	Perineal sheet	1
13.	Standing fan	1
14.	Wall clock	1
	Consulting cubicle	
1.	Ceiling fan (Newclime)	2
2.	Plastic Chairs	3
3.	Stainless covered bowl for cotton wool	2
4.	Dust bin	2
5.	Examination couch	1
6.	Hammer, reflex	1
7.	Height measuring stick	1
8.	Macintosh	2
9.	Pen torch	1
10.	Sphygmomanometer, mercurial (accosons, table top)	1
11.	Stethoscope	1
12.	Snellen's chart	1
13.	Tables	2
14.	Thermometer, oral	2
15.	Tongue depressor	6
16.	Weighing scale (child)	2
17.	Bowls stainless steel with stand	1
18.	Wall clock	1
19.	Diagnostic set (Gowland)	1
	Staff room	
1.	Examination couch	1
2.	Chair	5
3.	Table	5
4.	Dust bin	2
5.	Filling cabinet	2
6.	Standing fan	1
7.	Refrigerator, kerosene	1
8.	Wall clock	1
	Records	
1.	Table	2
2.	Plastic chairs (president)	2
3.	Safe (daily cash sales)	1
4.	Standing fan (Newclime)	2

5.	Dust bin (KDK)	1
6.	Filling cabinet	2
7.	Wall clock	1
1.	**Male ward** Angle poised lamp	1
2.	Artery forceps (medium)	2
3.	Stainless bedpan	2
4.	Bowls stainless steel with stand	2
5.	Ceiling fan (Newclime)	2
6.	Plastic chairs (president)	6
7.	Covered bowl for cotton wool	2
8.	Cup, medicine, graduated	2
9.	Dissecting forceps (medium)"	2
10.	Dressing scissors	2
11.	Stainless drinking mug	2
12.	Pedal dust bin	2
13.	Stainless gallipot (medium)	2
14.	Latex glove, disposal pack of 100	2
15.	Hospital bed and mattress covered with mackintosh	6
16.	Stainless instrument tray	1
17.	Jar forceps	1
18.	Kerosene pressure lamp	1
19.	Kidney dishes (medium)	4
20.	Length measure for babies	1
21.	Mackintosh sheet	6
22.	Nursery cots	4
23.	Pump, breast, hand rubber bulb	2
24.	Refrigerator	1
25.	Screen	1
26.	Sphygmomanometer, mercurial, (Accosons, table top)	1
27.	Spoon, measure	2
28.	Standing fan (KDK)	1
29.	Littman stethoscope	1
30.	Stitch removal/suture scissors	1
31	Syringes & needles (100) 2cc,	5
32	5cc	5
33	10cc	1
34	Tables	1
35	Tape measure	1
36	Thermometer, oral	2
37	Thermometer, rectal	2
38	Tongue depressor	2
39	Tourniquet	1
40	Vaginal speculum, Sims, set of 3	2
41	Weighing scale	1
1.	**Others** Communication facility; e.g., GSM	1
2.	Motorcycle	1

3.	Bicycle	6

Annex 4

Table 4.3b: Recommended essential drugs for ward PHC

S/N	

1.	**Infections**
1.1	***Antibacterial drugs*** • Benzathine benzyl penicillin • Benzyl penicillin • Chloramphenicol • Co-trimoxazole • Fortified procaine penicillin • Amoxicillin • Ampicillin + cloxacillin • Doxycycline • Ampicillin • Tetracycline •
1.2	***Antituberculous drugs*** • Isoniazid • Rifampicin • Thiacetazone + isoniazid • Ethambutol • Streptomycin
1.3	***Antileprosy drugs*** • Clofazimine • Dapsone
1.4	***Antimalarial drugs*** • Pyrimethamine + Sulphadoxine • *Amodiaquine • *Artesunate • Lumenfantrine + Artemether (to be used only as combination therapies and never singly)
1.5	***Anthelminthics*** • Levamisole • Niclosamide • Pyrantel • Mebendazole
1.6	***Amoebicides and Antiflagellates*** • Metronidazole
1.7	***Antifilarial drugs*** • Ivermectin
1.8	***Antschistosomal drugs*** • Praziquantel
1.9	***Antiseptics and disinfectants*** • Iodine • Methylated spirit • Sapponated cresol • Sodium hypochlorite

Annex 5

Table 4.4a: Recommended equipment and furnishing list for the Apex PHC centre

S/N	Item description	Qty required
	Female ward	
1.	Angle poised lamp	1
2.	Artery forceps (Medium)	4
3.	Bed pan (stainless steel)	2
4.	Bowls stainless steel with stand	2
5.	Ceiling fan	2
6.	Plastic chair (President)	2
7.	Stainless covered bowl for cotton wool	2
8.	Graduated medicine, cup	2
9.	Dissecting forceps	2
10.	Dressing scissors	2
11.	Dressing trolley	1
12.	Drinking mug	2
13.	Dust bin (Pedal)	2
14.	Galipot (median)	1
15.	Gloves, disposable pack of 100	2
16.	Hospital bed and mattress coved with Macintosh	6
17.	Stainless Instrument tray	1
18.	Forceps Jar	1
19.	Kerosene pressure lamp	1
20.	Kidney dishes (large)	4
21.	Length measure for babies	1
22.	Long benches	1
23.	Mackintosh sheet	6
24.	Pump, breast, hand rubber bulb	4
25.	Refrigerator (kerosene)	1
26.	Screen	1
27.	Sphygmomanometer mercurial (Accossons) Table top	1
28.	Stethoscope (Littman)	1
29.	Stitch removal/suture scissors	1
30.	Writing Table	1
31	Tape measure	1
32	Thermometer, oral	2
33	Thermometer rectal	2
34	Tongue depressor	2
35	Vaginal speculum, Sims, set of 3	2
	LABOUR	
1.	Artery forceps (Medium)	4
2.	Bed pan, adult stainless steel	2
3.	Stainless Bowls with stand	1
4.	Ceiling fan	1
5.	Plastic Chairs (president)	1

6.	Covered bowl for cotton wool	1
7.	Delivery couch	2
8.	Dissecting forceps	1
9.	Dressing trolley	1
10.	Dust bin (Pedal)	1
11.	Enema can	2
12.	Episiotomy scissors	2
13.	Foetal stethoscope (Aluminium)	2
14.	Stainless Galipot	1
15.	Gloves, disposable pack, pack of 100	4
16.	Instrument tray	1
17.	Forceps jar	1
18.	Kerosene pressure lamp	1
19.	Kidney dish	2
20.	Length measure for babies	1
21.	Mackintosh sheet	2
22.	Nail scrubbing brush, box of 12	1
23.	Needle holder	2
24.	Scalpel blade, pack of 100, 4 sizes	3
25.	Scalpel handle, set of 2	2
26.	Catheter tray with cover	1
27.	Sphygmomanometer, mercurial (Accosons) Table top	1
28.	Sponge holding forceps	4
29.	Stethoscope (Littman)	1
30.	Suture needle	1
31	Syringes & Needles (100)2cc,	5
32	Syringes & Needles (100) 5cc,	5
33	Syringes & Needles (100) 10cc,	1
34	Thermometer, oral	1
35	Vaginal speculum, Sims set of 3	2
36	Wall clock	1
37	Water container with tap	1
38	Screen	2
39	Soap/disinfectant dispenser	1
40	Scrub brush dispenser	1
41	Nursery costs	1
42	Angle poised lamp	1
43	Vacuum extractor, manual	1
44	Suction pump	1
45	Weighting scale, baby	1
46	Instrument cabinet	1
47	Tape measure	1
48	Thermometer jar	1
49	Urinary catheter	3
50	Umbilical cord clamp, pack of 100	1
51	Drip stand	2
52	Suture kit	1
53	Oro-pharyngeal airway, set of 7	1
54	Plastic apron	10
55	Anvard’s speculum	1

1.	**LABORATORY** Kidney dish (medium)	1
2.	Box, microscope slide (x100)	1
3.	Centrifuge, manual	1
4.	Clam, test tube	1
5.	Container, sputum screw capped	50
6.	Container, sputum, snapped on lid	50
7.	Microscope, binocular	1
8.	Refrigerator, kerosene	1
9.	Scalpel handle	1
10.	Slides rack	3
11.	Spirit lamp	1
12.	Stop watch	1
13.	Test tube rack	1
14.	Tray test tube	2
15.	Tray test tube	2
16.	Waste receptacle	1
17.	Microscope cover slides pack of 1000	1
18.	Bunsen burner	1
19.	Tripod stand	1
20.	Wire gauze	1
21.	Laboratory glass ware	1
22.	Blood lancets, pack of 200	1
23.	Tourniquet	1
24	Urine dipstick (multistix)	10
26	Stool specimen bottles, pack of 100	1
27	Urine specimen bottles, pack of 100	1
28	Wall Clock	1
29	Door name plate	1
30	Haematocrit centrifuge with reader	1
31	Differential counter	1
32	Basic haematological and microbiological reagents	
1.	**DRESSING AND INJECTION ROOMS** Artery forceps (medium size)	2
2.	Stainless Bowl with stand	1
3.	Ceiling fan	2
4.	Plastic chairs	2
5.	Stainless covered bowl for cotton wool	1
6.	Dissecting forceps (medium)	2
7.	Dressing scissors	2
8.	Dust bin (pedal bin)	1
9.	Stainless Instrument tray	2
10.	Latex gloves (size 71/2) pack of 100	1
11.	Stainless instrument tray	1
12.	Jar, forceps	1
13.	Kidney dish (medium)	2
14.	Long benches	1
15.	Needle holder	2
16.	Plastic bowls	1
17.	Scalpel blade, pack of 100, 4 sizes	3
18.	Scalpel handle	2
19.	Stainless catheter tray with cover	1
20.	Spencer wells artery forceps	2

21.	Sphygmomanometer, mercurial (Accosons, Table Top)	1
22.	Sponge holding forceps	4
23.	Small sterilizer	1
24.	Stethoscope	1
25.	Stitch removal/suture	2
26.	Stretcher trolley	2
27.	Suture needles	1
28.	Syringes & needles (100) 2cc,	5
	5cc	5
	10cc	1
29.	Table	1
30.	Tape measure	1
31	Thermometer, oral	2
32	Thermometer, rectal	2
33	Tongue depressor	4
34	Scrub brush dispenser	2
35	Weighting scale, adult	1
36	Height measuring stick	1
37	Stainless dressing trolley	2
38	Tourniquet	1
39	Pen torch	1
40	Instrument cabinet	2
41	Medicine cupboard	1
42	Wheel chair	1
43	Angle poised lamp	2
44.	Filling cabinet	1
45.	Suction pump	1
46.	Filling cabinet	1
47.	Refrigerator, kerosene	1
48	Tissue forceps	4
49	Dressing forceps	4
50	Sterilizing forceps	4
51	Bandage scissors	2
52	Soap/disinfectant dispenser	2
53	Examination couch	1
54	Foot step	1
55	Swivel stool	1
56	Incision and Drainage kit	10
57	Suture kit	4
58	Stainless ear syringe	2
59	Wall clock	5
	FAMILY PLANNING	
1.	Newclime ceiling fan	1
2.	Plastic chairs (president)	2
3.	Stainless covered bowl for cotton wool	1
4.	Dissecting forceps	1
5.	Stainless gallipot (medium)	1
6.	Gloves, disposable pack, box of 100	1
7.	Instrument tray	1
8.	Stainless kidney dish (medium)	1
9.	Sphygmomanometer, mercurial (Accosons, Table Top)	1
10.	Small size sterilizer	1
11.	Syringes & needles	100
12.	Table	1
13.	Thermometer, oral	1
16.	Swivel stool	1
17.	Foot step	1
18.	Screen	1
19.	Stethoscope (Littman)	1

20.	Angle poised lamp	1
21.	IUD Kit	1
22.	Pedal bin	1
23.	Thermometer jar	1
24.	Bowls stainless steel with stand	1
25.	Stainless instrument trolley	1
26.	Gynae couch	1
27.	Auvards speculum	1
28.	Tenaculum forceps	1
29.	Kick about	1
30.	Wall clock	1
31	Door name plate	1
	INFANT AND CHILD WELFARE	
1.	Basket with lid for ORS	2
2.	Ceiling fan	1
3.	Plastic Chairs	2
4.	Stainless covered bowl for cotton wool	1
5.	Dressing Trolley	1
6.	Cup, medicine, graduated	4
7.	Dust bin (pedal)	2
8.	Stainless Gallipot (medium size)	1
9.	Table infant weighing scale (Seward)	3
10.	Stainless instrument tray	1
11.	Stainless kidney dish (medium size)	1
12.	Wooden long benches	1
13.	Plastic bowls	1
14.	Refrigerator, gas/kerosene	1
15.	Spoon measure	3
16.	Wooden tables	2
17.	Thermometer, rectal	4
18.	Tongue depressor	2
19.	Vaccine cold box	5
20.	Length measure for babies	3
21.	Bowls stainless steel with stand	1
22.	Wall clock	1
23.	Door name plate	1
	FIRST STAGE ROOM	
1.	Stainless bedpan	3
2.	Bowls stainless steel with stand	1
3.	Ceiling fan	1
4.	Plastic chairs	3
5.	Stainless covered bowls for cotton wool	2
6.	Dressing trolley	1
7.	Stainless steel drinking mug	2
8.	Pedal dust bin	1
9.	Foetal stethoscope	1
10.	Stainless gallipot (median)	1
11.	Latex gloves, disposable pack, pack of 100	2
12.	Hospital bed with mattress covered with mackintosh	2
13.	Stainless instrument tray with stand	1
14.	Jar, forceps	2
15.	Kerosene pressure lamp	1
16.	Stainless kidney dish (median)	2
17.	Mackintosh sheet	4
18.	Nail scrubbing brush, box of 12	1
19.	Sphygmomanometer, mercurial	1
20.	Sponge holding forceps	2
21.	Stethoscope (Littman)	1
22.	Office table	1

23.	Thermometer, oral	2
24.	Tongue depressor	2
25.	Weighing scale (Seward)	1
26.	Chart holder	4
27.	Bedside cabinet	2
28.	Overbed cabinet	2
29.	Thermometer jar	4
30.	Soap/disinfectant dispenser	1
31	Urinal, female	2
32	Drip stand	1
33	Oro-pharyngeal airway (set of 7)	2
34	Wall clock	1
35	Door name plate	1
	ANTENATAL ROOM/INTERVIEW ROOM	
1.	Ceiling fan (Newclime)	2
2.	Plastic chairs	3
3.	Stainless covered bowl for cotton wool	2
4.	Dust bin	2
5.	Examination couch	1
6.	Foetal stethoscope	2
7.	Stainless gallipot (medium)	1
8.	Latex gloves, disposable pack, pack of 100	20
9.	Hammer, reflex	1
10.	Height measuring stick	1
11.	Wooden long benches	3
12.	Mackintosh sheet	2
13.	Nail scrubbing brush, pack of 12	1
14.	Pen torch	1
15.	Sphygmomanometer, mercurial (Accosons, table top)	1
16.	Stethoscope	1
17.	Tables	2
18.	Thermometer, oral	2
19.	Tongue depressor	6
20.	Soap/disinfectant dispenser	1
21.	Thermometer jar	1
22.	Angle poised lamp	1
23.	Bowls stainless steel with stand	1
24.	Dressing trolley	1
25.	Urine dipstick for sugar and albumin, pack of 100	20
26.	ANC gowns for patients	50
27.	Wall clock	1
28.	Door name plate	1
	NUTRITION	
1.	Spoon	10
2.	Stainless drinking mugs	10
3.	Gas cylinders	2
4.	Knives	4
5.	Gas cookers	1
6.	Weighing scale (Seward)	1
7.	Blender and mill	2
8.	Stainless tray	1
9.	Plates	10
10.	Water container	4
11.	Bucket wit lid	4
12.	Chopping board	2
13.	Cooking spoons	6
14.	Kerosene stove	2
15.	Utility table	2
16.	Cooking pot (A set of 6)	1

	STERILIZATION	
1.	Bucket autoclave	1
2.	Tape dispenser	1
3.	Srub brush dispenser	1
4.	Autoclave tape	1
5.	Storage cabinet	2
6.	Sterilizing drums, set of 3	6
7.	Soap/disinfectant dispenser	1
8.	Nail scrubbing brush, pack of 12	1
9.	Wall clock	1
10.	Door name plate	1
	Cleaning and utilization	
1.	Brooms	10
2.	Mops	10
3.	Mop buckets	3
4.	Dusters	20
5.	Buckets	10
6.	Aprons	10
7.	Wellington boots	3
8.	Latex gloves	10
9.	Kerosene pressure lamp	2
10.	Hurricane lamp	4
11.	Apron, utility	8
12.	Flash light – 24 box batteries	4
13.	Nail scrubbing brush, pack of 12	1
14.	Fire extinguishers	2
15.	Soap box	5
	Linen store	
1.	Linen cupboard	2
2.	Pedal dust bin	1
3.	Table	1
4.	Plastic chair (President)	2
5.	Bed sheet	32
6.	Draw sheet	16
7.	Pillow case	32
8.	Bath towel	24
9.	Hand towel	24
10.	Theatre gown	10
11.	Lithotomy leggings	10
12.	Perineal sheet	1
13.	Standing fan	1
14.	Wall clock	1
	Consulting cubicle	
1.	Ceiling fan (Newclime)	2
2.	Plastic Chairs	3
3.	Stainless covered bowl for cotton wool	2
4.	Dust bin	2
5.	Examination couch	1
6.	Hammer, reflex	1
7.	Height measuring stick	1
8.	Macintosh	2
9.	Pen torch	1
10.	Sphygmomanometer, mercurial (Accosons, table top)	1
11.	Stethoscope	1
12.	Snellen's chart	1
13.	Tables	2
14.	Thermometer, oral	2
15.	Tongue depressor	6
16.	Weighing scale (child)	2
17.	Bowls stainless steel with stand	1

18.	Wall clock	1
19.	Diagnostic set (Gowland)	1
	Staff room	
1.	Examination couch	1
2.	Chair	5
3.	Table	5
4.	Dust bin	2
5.	Filling cabinet	2
6.	Standing fan	1
7.	Refrigerator, kerosene	1
8.	Wall clock	1
	Records	
1.	Table	2
2.	Plastic chairs (president)	2
3.	Safe (daily cash sales)	1
4.	Standing fan (Newclime)	2
5.	Dust bin (KDK)	1
6.	Filling cabinet	2
7.	Wall clock	1
	Male ward	
1.	Angle poised lamp	1
2.	Artery forceps (medium)	2
3.	Stainless bedpan	2
4.	Bowls stainless steel with stand	2
5.	Ceiling fan (Newclime)	2
6.	Plastic chairs (president)	6
7.	Covered bowl for cotton wool	2
8.	Cup, medicine, graduated	2
9.	Dissecting forceps (medium)”	2
10.	Dressing scissors	2
11.	Stainless drinking mug	2
12.	Pedal dust bin	2
13.	Stainless gallipot (medium)	2
14.	Latex glove, disposal pack of 100	2
15.	Hospital bed and mattress covered with mackintosh	6
16.	Stainless instrument tray	1
17.	Jar forceps	1
18.	Kerosene pressure lamp	1
19.	Kidney dishes (medium)	4
20.	Length measure for babies	1
21.	Mackintosh sheet	6
22.	Nursery cots	4
23.	Pump, breast, hand rubber bulb	2
24.	Refrigerator	1
25.	Screen	1
26.	Sphygmomanometer, mercurial, (Accosons, table top)	1
27.	Spoon, measure	2
28.	Standing fan (KDK)	1
29.	Littman stethoscope	1
30.	Stitch removal/suture scissors	1
31	Syringes & needles (100) 2cc,	5
32	5cc	5
33	10cc	1
34	Tables	1
35	Tape measure	1
36	Thermometer, oral	2
37	Thermometer, rectal	2
38	Tongue depressor	2
39	Tourniquet	1
40	Vaginal speculum, Sims, set of 3	2

41	Weighing scale	1
1.	**Emergency obstetric services** Suction machine (manual and Electric)	2
2.	Oxygen concentrator with accessories	2
3.	Face mask different sizes	1
4.	Anaesthetic Machine	1
5.	Minor procedures instrument Sets	2
6.	Caesarean section set	2
7.	Minor gynae surgery set	2
8.	Manual vacuum aspirator	1
9.	Operating table	1
10.	Manual vacuum extractor	1
1	**Others** Generator	1
2	Communication facility; e.g., GSM	1
3	Electric typewriter	1
4	Complete computer set	1
5	Ambulance	1
6	Motor cycle	2
7	Bicycles	6

Annex 6

Table 4.4b: Recommended essential drug list for the Apex PHC

S/N	

1.	**Infections**
1.1	***Antibacterial drugs*** • Benzathine benzyl penicillin • Benzyl penicillin • Chloramphenical • Co-trimoxazole • Fortified procaine penicillin • Amoxicillin • Ampicillin + cloxacillin • Doxycycline • Ampicillin • Tetracycline • ***Complimentary list –*** Ciprofloxacin, Azithromycin
1.2	***Antituberculous drugs*** • Isoniazid • Rifampicin • Thiacetazone + isoniazid • Ethambutol • Streptomycin
1.3	***Antileprosy drugs*** • Clofazimine • Dapsone
1.4	***Antimalarial drugs*** • Pyrimethamine + Sulphadoxine • *Amodiaquine • *Artesunate • Lumenfantrine + Artemether (to be used only as combination therapies and never singly)
1.5	***Anthelminthics*** • Levamisole • Niclosamide • Pyrantel • Mebendazole
1.6	***Amoebicides and Antiflagellates*** • Metronidazole
1.7	***Antifilarial drugs*** • Ivermectin
1.8	***Antschistosomal drugs*** Praziquantel
1.9	***Antiseptics and disinfectants*** • Iodine • Methylated spirit • Sapponated cresol

Annex 7

Table 5.1a: Recommended minimum standards for PHC services and providers.

TYPE OF SERVICES	HEALTH FACILITY TYPE AND STAFF														
	HP			HC			PHC/LGA Hq								
	VHW	CBA	JCHEW	CHEW	MW	CHO1	MRO	PT	LT	NMW	PHN	EHO	PHNMW	CHO2	MOH
(A) HEALTH EDUCATION AND COMMUNITY MOBILIZATION[1]															
(i) Identify and inform individuals and the community about the prevalent health problems, and educate them on how to prevent and control such health problems.	X	X	X	X	X	X				X	X	X	X	X	X
(ii) Identify the prevalent personal and community practices that which affect health and seek to promote health enhancing practices while educating against the harmful practices.			X	X	X	X				X	X	X	X	X	X

(iii) Identify and provide through appropriate channels, the information, education and communication (IEC) needs of individuals, families and the community for health.					X	X					X		X	X	X
(iv) Community mobilization for health – to take responsibility for the health and well being of the members and the environment and thus mobilize community resources to support health actions and utilize services.						X					X		X	X	X
(v) Community capacity building for sustenance of health education activities through training of CHWs, school teachers, traditional, religious and other community leaders.											X	X	X	X	X
(B) MATERNAL AND CHILD CARE INCLUDING FAMILY PLANNING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
(i) Identify and mobilize pregnant women for antenatal care (ANC).															
(ii) Provide services for safe motherhood including basic obstetric services appropriate to the personnel skill and level of care for normal		X			X					X	X		X	X	X

pregnancy and identify the at-risk pregnancies for prompt referral to higher level of care.															
(iii) Provide emergency obstertric services					X					X			X	X	X
(iii) Maintain a pregnancy and birth outcome register for the community.	X	X	X	X	X	X				X	X		X	X	X
(iv) Provide services for child survival including IMCI, growth monitoring and immunization services	X	X	X	X	X	X				X	X		X	X	X
(v) Provide family planning education and services and mobilize adolescents and couples to support and utilize the services.	X	X	X	X	X	X				X	X		X	X	X
(C) PROMOTION OF FOOD AND PROPER NUTRITION	X	X	X	X	X	X				X	X		X	X	X
(i) Mobilize the community for identification of the problems and solutions to food security and nutrition in the community															
(ii) Carry out nutritional education and demonstration on locally available food stuff including correct preservation and processing	X	X	X	X	X	X				X	X		X	X	X

(iii) Maintain community nutritional surveillance and assessment and management of identified nutritional disorders					X	X				X	X		X	X	X
(D). WATER AND SANITATION			X	X	X	X				X	X	X	X	X	X
(i) Mobilize community to identify, protect and use community water sources including education on household and community methods of water purification.	X	X	X	X	X	X				X	X	X	X	X	X
(ii) Promotion of personal and community hygiene including waste disposal.				X		X					X	X	X	X	X
(iii) Pest control services.															
(E) PROVISION OF ESSENTIAL DRUGS															
(i) Compile, procure, store and rational use of essential drugs, vaccines and supplies as needed by individuals, community and the PHC facility.	X	X	X	X	X	X		X	X	X	X	X	X	X	X

(F) TREATMENT OF COMMON MINIOR AILMENTS AND INJURIES	X	X	X	X	X	X	X			X	X		X	X	X
(i) Correctly identify and treat the common diseases and injuries frequently seen in the community according to the personnel skill and level of care	X	X	X	X	X	X		X	X	X	X	X	X	X	X
(ii) Identify serious health conditions and refer promptly to higher level of care.															
(G) PREVENTION AND CONTROL OF LOCALLY ENDEMIC COMMUNICABLE AND NON-COMMUNICABL DISEASES	X	X	X	X	X	X		X		X	X	X	X	X	X
(i) Community education, mobilization and empowerment for malaria prevention and control including environmental sanitation activities and use of insecticide treated nets (ITNs)															

(ii) Promotion of correct diagnosis and effective management of malaria in the community and health facilities including provision of artemisinine combined therapy (ACT), training of health workers, CHW and community members laboratory diagnosis in the health facilities.	X	X	X	X	X	X		X		X	X		X	X	X
(iii) Creation of public awareness and preventive measures against tuberculosis, HIV/AIDS and other locally endemic diseases through appropriate IEC strategies.	X	X	X	X	X	X		X	X	X	X	X	X	X	X
(iv) Capacity building of health workers for early detection and appropriate management of TB with the DOTS strategy, including promotion of contact and defaulter tracing.	X	X	X	X	X	X		X	X	X	X		X	X	X
(v) Provision of HIV counseling and testing centers and services									X	X	X		X	X	X
(vi) Provide and promote the distribution and use of condom	X	X	X	X	X	X		X	X	X	X		X	X	X
(vii) Capacity building of health workers on syndromic management of STIs and opportunistic infections					X	X				X	X		X	X	X

(viii) Establish and facilitate the functioning of community support groups for PLWHA and PABA.	X	X	X	X	X	X				X	X		X	X	X
(ix) Maintain register of, and follow up community members with specific disease and other health conditions requiring supervised management including rehabilitation.				X	X	X					X		X	X	X
(H) ORAL HEALTH	X	X	X	X	X	X				X	X		X	X	X
(i) Educate individuals and the community on the common oral diseases and the various measures to prevent them including oral hygiene education.															
(ii) Identify and treat the minor oral ailments											X		X	X	X
(iii) Identify and refer serious oral diseases.	X	X	X	X	X	X				X	X		X	X	X
(I) MENTAL HEALTH															
(i) Educate individuals and the community about the causes of mental health problems and how to prevent them			X	X	X	X				X	X	X	X	X	X
(ii) Mobilize the community for collective actions to promote good physical and mental health including	X	X	X	X	X	X	X			X	X		X	X	X

recreation facilities/activities.															
(ii) Identify, manage and follow up individuals with minor mental health problems											X		X	X	X
(iii) Identify and refer persons requiring specialist mental health services accordingly.	X	X	X	X	X	X				X	X	X	X	X	X
(J) PHC MANAGEMENT INFORMATION SYSTEM. (i) Collection, storage, analysis and use of PHC information.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

HP- Health post, HC – Health centre, PHC/LGAHq – Primary Health Centre/ Local Government Headquarters
VHW – Voluntary health worker, CBA – Community birth attendant (retrained traditional birth attendant),
JCHEW – Junior community health extension worker, CHEW – Community health extension worker (same as senior CHEW), MW – Midwife,
CHO1 – Community health officer without midwifery qualification, MRO – Medical records officer, PT – Pharmacy technician,
LT – Laboratory technician, NMW – Nurse/midwife, PHN – Public health nurse, EHO – Environmental health officer,
PHNMW – Public health nurse midwife, CHO2 – Community health officer with midwifery qualification, MOH – Medical officer of health

Annex 8

Table 5.1b. Types of health services and their providers: Recommended optimum service package and providers.

TYPE OF SERVICES	HEALTH FACILITY TYPE AND STAFF										
	HP	HC	PHC/LGAHq								
	CHW*	CM	MRO	LabT	PT	CHEd	PHNutr	EHO	NMW	MA	MOH
(A) HEALTH EDUCATION AND COMMUNITY MOBILIZATION[1]											
(i) Identify and inform individuals and the community about the prevalent health problems, and educate them on how to prevent and control such health problems.	X	X				X	X	X	X	X	X
(ii) Identify the prevalent personal and community practices that which affect health and seek to promote health enhancing practices while educating against the harmful practices.		X				X	X	X	X	X	X
(iii) Identify and provide through appropriate channels, the information, education and communication (IEC) needs of individuals, families and the community for health.		X				X	X	X		X	X
(iv) Community mobilization for health – to take responsibility for the health and wellbeing of the members and the environment and thus mobilize community resources to support		X				X	X	X		X	X

health actions and utilize services.											
(v) Community capacity building for sustenance of health education activities through training of CHWs, school teachers, traditional, religious and other community leaders.		X				X	X	X		X	X
(B) MATERNAL AND CHILD CARE INCLUDING FAMILY PLANNING											
(i) Identify and mobilize pregnant women for antenatal care (ANC).	X	X	X	X		X			X	X	X
(ii) Provide services for safe motherhood including basic obstetric services appropriate to the personnel skill and level of care for normal pregnancy and identify the at-risk pregnancies for prompt referral to higher level of care.		X							X	X	X
(iii) Provide emergency obstetric services		X							X	X	X
(iii) Maintain a pregnancy and birth outcome register for the community.	X	X							X	X	X
(iv) Provide services for child survival including IMCI, growth monitoring and immunization services	X	X					X		X	X	X
(v) Provide family planning education and services and mobilize adolescents and couples to support and utilize the services.	X	X				X			X	X	X
(C) PROMOTION OF FOOD AND PROPER NUTRITION											
(i) Mobilize the community for identification of the problems											

and solutions to food security and nutrition in the community	X	X				X	X		X	X	X
(ii) Carry out nutritional education and demonstration on locally available food stuff including correct preservation and processing	X	X				X	X			X	X
(iii) Maintain community nutritional surveillance and assessment and management of identified nutritional disorders		X					X			X	X
(D). WATER AND SANITATION											
(i) Mobilize community to identify, protect and use community water sources including education on household and community methods of water purification.	X	X				X		X		X	X
(ii) Promotion of personal and community hygiene including waste disposal	X	X						X		X	X
(iii) Pest control services.								X		X	X
(E). PROVISION OF ESSENTIAL DRUGS											
(i) Compilation, procurement, storage and rational use of essential drugs, vaccines and supplies as needed by individuals, community and the PHC facility.	X	X			X					X	X
(F) TREATMENT OF COMMON MINIOR AILMENTS AND INJURIES											
(i) Correctly identify and treat the common diseases and injuries frequently seen in the community according to the appropriate to the personnel skill and level of care	X	X					X		X	X	X

(ii) Identify serious health conditions and refer promptly to higher level of care.	X	X					X		X	X	X
(G) PREVENTION AND CONTROL OF LOCALLY ENDEMIC COMMUNICABLE AND NON-COMMUNICABL DISEASES											
(i) Community education, mobilization and empowerment for malaria prevention and control including environmental sanitation activities and use of insecticide treated nets (ITNs)	X	X			X	X	X	X	X	X	X
(ii) Promotion of correct diagnosis and effective management of malaria in the community and health facilities including provision of artemisinine combined therapy (ACT), training of health workers, CHW and community members laboratory diagnosis in the health facilities.	X	X		X	X	X		X	X	X	X
(iii) Creation of public awareness and preventive measures against tuberculosis, HIV/AIDS and other locally endemic diseases through appropriate IEC strategies.	X	X		X		X			X	X	X
(iv) Capacity building of health workers for early detection and appropriate management of TB with the DOTS strategy, including promotion of contact and defaulter tracing.	X	X		X	X	X		X	X	X	X
(v) Provision of HIV counseling and testing centers and services		X		X		X		X	X	X	X
(vi) Provide and promote the distribution and use of condom											
(vii) Capacity building of health workers on syndromic management of STIs and opportunistic infections	X	X			X	X			X	X	X
(viii) Establishment and facilitate the functioning of community support groups for PLWHA and PABA.									X	X	X

	X	X				X			X	X	X
(ix) Maintain register of, and follow up community members with specific disease and other health conditions requiring supervised management including rehabilitation.		X								X	X
(H) ORAL HEALTH											
(i) Educate individuals and the community on the common oral diseases and the various measures to prevent them including oral hygiene education.	X	X				X	X		X	X	X
(ii) Identify and treat the minor oral ailments											
(iii) Identify and refer serious oral diseases.		X							X	X	X
	X	X				X	X			X	X
(I) MENTAL HEALTH											
(i) Educate individuals and the community about the causes of mental health problems and how to prevent them		X				X			X	X	X
(ii) Mobilize the community for collective actions to promote good physical and mental health including recreation facilities/activities.	X	X				X		X	X	X	X
(ii) Identify, manage and follow up individuals with minor mental health problems		X								X	X
(iii) Identify and refer persons requiring specialist mental health services accordingly.	X	X	X			X		X	X	X	X
(J) PHC MANAGEMENT INFORMATION SYSTEM.											
(i) Collection, storage, analysis and use of PHC information.		X									

	X			X	X	X	X	X	X	X	X

HP – Health post, HC – Health centre, PHC/LGAHq – Primary Health Centre/Local Government Headquarters
CHW – Community health worker (transformed and retrained TBA/CBA), CM – Community midwife (retrained CHEW/freshly trained)
MRO – Medical records officer, Lab T – Laboratory technician, PT – Pharmacy technician, CHEd – Community health educator,
PHNutr – Public health nutritionist, EHO – Environmental health officer, NMW – Nurse Midwife,
MA – Medical assistant (retrained CHO with midwifery qualification), MOH – Medical officer of health

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1 A logistic vehicle or motorcycle with public address system should be added to the equipments for LGA level

HEALTH FACILITIES

1. HEALTH POST – 1 per settlement to serve 500 or less
2. HEALTH CLINIC – 1 per group of settlement to serve about 3,000 – 5,000 population
3. PRIMARY HEALTH CENTRE - 1/ward to serve 10,000 – 30,000 population

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Appendix 1.

Table 1. Participants at meetings at the Department of Planning, Research and Statistics, NPHCDA Headquarters, Abuja

S/N	Names	Designation	Email /Telephone
1.	Prof. C.O Akpala	DPRS	coakpala@yahoo.co.uk 08036270750
2.	Prof. M.C Asuzu	Consultant	mcasuzu@comui.edu.ng, mcasuzu2003@yahoo.com, 08033467670
3.	Dr. M.O. Ogundeji	Consultant	prihemac@yahoo.com , 08033256644
4.	Dr. I.A. Lewis	Consultant SPGI	iyabolewrs@yahoo.com 08034037577
5.	Egahi, Ada	AD (PRS)	08060958248
6.	Tanimu Morafa	TAIED	marafatanimu@yahoo.com 08033144676
7.	S.A Adelakun	ACHPO	adesinaadelakun@yahoo.co.uk 08023068714
8.	Dr O. Ogbe	SMOI	Weyimo@yahoo.com 08036252533
9.	Onasoga E.O	ACHPO	Kkkolaonasanyaonasagakola, 08037877429
10.	Dr. Amina Aimad-Shehu	SMO,II	aminahmadshehu@yahoo.com 08037879870

Table 2. Participants at the Directorate of PHC, Lagos State meeting with stakeholders

1.	Dr. Detoun Agbe-Davis	DPHC/DC	08034078144 08023338214
2.	Dr. (Mrs,) Ajayi	Nutr. Officer	
3.	Mrs. O.A.Adebanjo	MCH/FP Off.	08037187100
4.	Dr. M.O. Ogundeji	Consultant	prihemac@yahoo.com, 08033256644
5.	Pro. M.C Asuzu	PHC consult.	08033467670

Table 3. Participants at the Directorate of PHC, Oyo State meeting with stakeholders

1.	Dr. A.D. Osofowora	Coordinator	Bioduntutu@yahoo.com, 08037866613
2.	Mr. G.O Akinwunmi	Zonal coordi.	08033335151
3.	Mr. A.R Adewolu	M & E Offi.	08028210525
4.	Mr. O.O Olaleye	ACNO	08023677324
5.	Pro. J.D Adeniyi	PHC consult.	08033187182
6.	Pro. M.C Asuzu	PHC consult.	08033467670
7.	Dr. M.O Ogundeji	PHC consult.	prihemac@yahoo.com, 08033256644

Table 4 Participants at the Directorate of PHC, Plateau State meeting with stakeholders

1.	Dr. Pede Elias	D.PHC/DC	
2.	Mrs. Zipperah Mafuyai Adamu	Dep. D. M &E PHC Dept.	
3.	Mrs. Asabe Balami	Asst./DZC NPHCDA	
4.	Dr. M.O. Ogundeji	Ex. Director	prihemac@yahoo.com, 08033256644
5.	Ibrahim Gonton	DDD Mini. of Health	

6.	Hajara N.L. Nibeile	DDN. Nursing	
7.	Prof. M.C Asuzu	Consult. UCH Ib.	
8.	Peter A. Uchi	DDPHC	
9.	Henry S. Fildan	ADDC	

Table 5. Participants at the Directorate of PHC, Kano State meeting with stakeholders

S/N	Names	Designation	Email /Telephone
1.	Dr. M.O. Ogundeji	Consultant	prihemac@yahoo.com,08033256644
2.	Mr. Adamu Aliyu Sumaila	DDYMD	08028545085
3.	Pro. M.C Asuzu	Consultant	08033467670
4.	Mr. Garba B. Bebeji	Coordinator	08033498348
5.	Mr. Auwadu Bello	Coordinator	08024264774
6.	Mrs. Aishatu Lawani		08034509554
7.	Mr. Sani Nahambo		08023576368
8.	Mr. Saidu Alhassan Tango		08065460484
9.	Mr. Aniw Mulchta		08065460484
10.	Mr. Daiali Tanko		08028438548
11.	Mr. Abitul Magaji		08025561121
12.	Mr. Lamidi T. Sanusi	M & E Cordi.	08036208633
13.	Mr. Salisu Abubakar	Zonal officer	08023052730
14.	Mr. Sani Haruna Rano	Principal	08033478899
15.	Dr. M.N Mahusud	SE,MOH	08037022026
16.	Mr. Ahmed Fufai,	Dep. PHCC	