

# **Community-Based Perception Survey on Primary Health Care Services in Nigeria**

Nigeria Health Watch

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## Acronyms

BHCPF - Basic Healthcare Provision Fund

PHC - Primary Health Care

LGAs - Local Government Areas

HHS - Household Survey

FGD - Focus Group Discussions

KII - Key Informant Interviews

KNSPHCMB - Kano State Primary Healthcare Management Board

NSMPHC - Niger State Ministry of Primary Health Care

UN - United Nations

EMR - Electronic Medical Records

WHO - World Health Organization

SARA - Service Availability and Readiness Assessment

WDC - Ward Development Committee

# Executive Summary

## Overview

The Community-Based Perception Survey, conducted by Nigeria Health Watch, aimed to evaluate and improve Primary Health Care (PHC) services in six states across the six geopolitical zones in Nigeria: Kano (Northwest), Akwa-Ibom (Southsouth), Lagos (Southwest), Borno (Northeast), Niger (Northcentral), and Enugu (Southeast). The survey targeted residents who primarily use government PHC facilities to enhance community accountability mechanisms, revive social accountability efforts, and amplify citizens' voices in healthcare delivery. The study also focused on understanding perceptions of quality, accessibility, and accountability within these facilities, providing essential insights to drive improvements in PHC services.

The survey employed a mixed methods approach in Niger and Kano States, combining quantitative household surveys with qualitative Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) to capture a deeper, more nuanced understanding of healthcare experiences. This approach enabled the collection of both broad quantitative insights and in-depth qualitative perspectives on specific PHC issues, such as service accessibility, responsiveness to community needs, and overall effectiveness. Data from Akwa-Ibom, Lagos, Borno, and Enugu States was collected solely through quantitative surveys.

In general, perceptions of PHCs across the surveyed states reflected both positive recognition of PHC importance and concerns about specific areas for improvement. Respondents widely acknowledged PHCs as essential healthcare access points, especially in underserved communities. However, issues such as inconsistent care, limited-service availability, and occasional shortages of essential supplies were commonly reported, highlighting areas where enhanced investment and management are needed to fully meet community expectations.

## Key Findings

**High Utilization of Government PHC Facilities:** The survey confirmed that government PHCs are a critical resource, with nearly all respondents indicating they primarily rely on these facilities for healthcare services. This dependency stresses the importance of strengthening PHC infrastructure and service quality to effectively meet local health needs.

**Satisfaction with Service Quality:** Approximately 68% of respondents were satisfied with the quality of care received at PHC facilities. Satisfaction varied by state, with higher satisfaction reported in urban areas compared to rural areas, where respondents noted challenges related to overcrowding, limited medical supplies, and inadequate infrastructure.

**Barriers to Access:** While 89% of respondents faced no significant discrimination or barriers, some challenges, such as long waiting times and the unavailability of certain services, were mentioned. These issues were particularly noted in rural areas, where distance to facilities and inconsistent availability of healthcare providers affected timely access.

**Provider-Patient Continuity and Care Coordination:** Around 32% of respondents reported "always" seeing the same healthcare provider, a factor important for continuity of care. However, frequent changes in providers or the absence of designated primary care providers were a common concern, impacting patients' overall experience and continuity of care.

**Comprehensive and Patient-Centered Care:** Almost 83% of respondents felt their PHC services addressed physical, mental, and social health needs comprehensively, and 91% felt that providers listened to and involved them in healthcare decisions. However, some respondents expressed needing more tailored care, especially for specific demographic groups like mothers and children.

**Community Feedback and Accountability:** Although 47% of respondents observed mechanisms for community feedback, only 46% rated PHC facility management as "Very Transparent and Accountable." Respondents suggested the need for more consistent community engagement to foster trust and transparency in facility management.

## Recommendations

- **Strengthening Health Infrastructure:** Invest in equipping PHC facilities with essential medical equipment and ensure equitable distribution across Local Government Areas (LGAs). This will help address issues of resource shortages and enhance the quality of services provided.
- **Improve Health Workforce Capacity:** Develop policies prioritizing staffing in rural and underserved LGAs through targeted recruitment drives and incentives for healthcare professionals. Increasing the health workforce in these areas is critical to meeting patient demands and improving the consistency of care.
- **Enhance Accountability and Transparency:** Introduce governance frameworks that include community oversight, regular performance audits, and citizen participation in healthcare decisions. This would foster trust and ensure that PHC facilities are managed transparently, aligning with the community's expectations and needs.
- **Expand Community Engagement Efforts:** Strengthen community outreach programs and feedback mechanisms to promote widespread awareness of government healthcare interventions and ensure that community voices are represented in healthcare policies. Enhanced community engagement will improve service responsiveness and accountability.

These recommendations provide actionable steps to address the common challenges identified in the survey, aiming to strengthen healthcare delivery across the states surveyed.

## Introduction

### Background

Primary Health Care (PHC) services are essential to achieving universal health coverage and addressing the basic health needs of communities across Nigeria. These services are critical in delivering preventive, curative, and rehabilitative healthcare at the grassroots level, especially for underserved populations. However, despite various government efforts, challenges such as inadequate infrastructure, limited healthcare workforce, and gaps in accountability continue to hinder the effectiveness of PHC services in Nigeria.

Nigeria Health Watch initiated this Community-Based Perception Survey to gain insights into the perceptions and experiences of communities regarding the quality, accessibility, and responsiveness of PHC facilities across the geopolitical zones in Nigeria in six states: *Kano, Akwa-Ibom, Lagos, Borno, Niger, and Enugu.*

### Objectives of the Survey

The primary objectives of this survey were to:

1. Assess community perceptions of PHC service quality, accessibility, and accountability.
2. Identify specific barriers and challenges that communities face when accessing PHC services.
3. Strengthen community accountability mechanisms by amplifying citizens' voices in healthcare delivery.
4. Provide actionable insights to inform policy and drive improvements in PHC services, with a particular focus on areas that require urgent attention and intervention.

### Scope of the Survey

The survey was conducted across six states, capturing the views of respondents who primarily rely on government PHC facilities. A mixed-method approach was used in two states, Niger and Kano, involving both quantitative household surveys and qualitative methods such as Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs). This comprehensive approach provided a well-rounded perspective by allowing the collection of both quantitative data and nuanced qualitative insights. In Akwa-Ibom, Lagos, Borno, and Enugu, data was collected through quantitative household surveys alone, giving a broad overview of community experiences and perceptions.

## Focus Areas

The survey explored several key aspects of PHC service delivery, including:

- **Service Quality:** Assessing satisfaction with care quality, the availability of essential services, and the adequacy of infrastructure and medical supplies.
- **Access to Care:** Understanding barriers to access, such as travel distance, waiting times, and potential discrimination.
- **Continuity of Care:** Examining whether respondents consistently receive care from the same providers, which is essential for building trust and ensuring coordinated care.
- **Community Engagement and Accountability:** Evaluating the extent to which community feedback mechanisms exist and how effectively they promote transparency and accountability in PHC management.

## Methodology

### Study Design

The Community-Based Perception Survey utilized a mixed-method approach to capture insights into Primary Health Care (PHC) services across six Nigerian states: Kano, Akwa-Ibom, Lagos, Borno, Niger, and Enugu. The design integrated both quantitative household surveys and qualitative methods (FGDs and KIIs) to assess community perceptions of PHC service quality, accessibility, and accountability. The study targeted six Local Government Areas (LGAs) per state, with a deliberate selection of three rural and three urban LGAs in each state to ensure a balanced representation of urban and rural healthcare experiences.

### Research Questions

The survey was guided by three primary research questions:

1. **Community Accountability:** How effective are the community accountability mechanisms in improving the delivery of PHC services in the selected LGAs?
2. **Citizen Perception:** How do citizens perceive the quality and accessibility of PHC services, and what are their main concerns and suggestions for improvement?
3. **PHC Readiness:** What is the current state of PHC readiness in the selected LGAs regarding the implementation of the Basic Health Care Provision Fund (BHCPF) 2.0, and how do community perceptions align with the actual readiness and performance of PHC facilities?

### Sample Size Determination – Household Survey (HHS)

The sample size was calculated to ensure statistical robustness. The following formula was used to determine the sample size for each state:

$$SS = Z^2 \times P \times (1-p) / MOE^2$$

SS = Is the sample size

Z = Z-score (1.96 for 96% confidence level)

P = estimated proportion of the population (if unknown, use 0.5 to maximize the sample size) for the States

MOE = Margin of error (expressed as a decimal, e.g., 0.05 for ±5%)

$$SS = 1.962 \times 0.5 \times (1 - 0.5) / (0.05)^2$$

$$SS = 3.84 \times 0.5 \times (0.5) / 0.0025$$

$$SS = 0.96 / 0.0025$$

$$SS = 384$$

Attrition = 20%

$$384 \times 1/1-0.20 = 384 \times 1.25 = 480$$

Design Effect (Deff = 2):  $Deff^2 = 480 \times 2 = 960$  (per State)

$$SS = 960 \times 6$$

$$SS = 5,760 \text{ (6 States)}$$

## Sampling Method

A multi-stage cluster sampling technique was employed to select respondents within the six targeted LGAs in each state. The selection of three rural and three urban LGAs per state was based on specific criteria, including:

- **Population Density:** Ensuring that dense and sparsely populated areas were represented.
- **Geographic Diversity:** Covering different regions within each state to reflect healthcare access and infrastructure variations.
- **Socio-Economic Status:** Including LGAs with varied socio-economic backgrounds to capture a wide range of community perspectives on PHC services.
- **PHC Service Performance:** Based on existing health data, LGAs with both high-performing and under-resourced PHC facilities were selected to better understand disparities in service delivery.

Within each selected LGA, clusters (wards or communities) were identified, and households within these clusters were randomly sampled to provide a representative cross-section of PHC users.

## Participants and Selection

**Quantitative Survey:** Households were sampled across the six LGAs per state to reflect both urban and rural experiences with PHC services.

**Focus Group Discussions (FGDs):** In Kano and Niger, FGDs were conducted with participants from diverse subgroups in both rural and urban settings, ensuring balanced insights from different community segments.

**Key Informant Interviews (KIIs):** Key informants in each selected LGA were chosen based on their roles in healthcare delivery and management, representing both urban and rural perspectives.

## Data Collection Tools

The survey employed structured questionnaires for the household surveys, incorporating both closed and open-ended questions. These were adapted from internationally recognized frameworks, including the WHO Primary Health Care Monitoring and Evaluation Toolkit and the Service Availability and Readiness Assessment (SARA).

Semi-structured guides were used for FGDs and KIIs, allowing for flexibility in discussions and deeper exploration of issues.

## Data Collection Process

The data collection process was organized into four key phases, conducted over four weeks in each state, with Kano and Niger running individually, while the remaining four states (Akwa-Ibom, Lagos, Borno, and Enugu) were conducted simultaneously:

**Secondary Data Review:** An initial phase reviewing government reports, international publications, statistical databases, and previous studies to provide a contextual background.

**Focus Group Discussions (FGDs):** Conducted only in Kano and Niger, with six FGDs in each state, capturing qualitative insights on PHC service quality and community engagement.

**Key Informant Interviews (KIIs):** Also conducted in Kano and Niger, with 12 KIIs in each state targeting key stakeholders to provide context on PHC management, accountability, and community responsiveness.

**Household Surveys:** Administered across all six states, gathering quantitative data on healthcare access, service quality, and satisfaction.

## Quality Assurance and Data Quality

To ensure data accuracy and reliability, several quality control measures were implemented:

**Spot Checks:** Supervisors conducted regular spot checks on data collection to monitor protocol adherence.

**Daily Debriefs:** Field teams participated in daily debrief sessions to address issues and reinforce quality practices.

**Data Security:** Data was collected on encrypted devices, transferred to a secure cloud storage system with end-to-end encryption, and deleted from devices post-upload to minimize security risks.

## Pretest and Public Involvement Procedure

A pretest was conducted before the main data collection to refine survey instruments:

**Methodology Review with Government Officials:** The survey methodology was presented to government officials for validation, ensuring alignment with local strategies.

**Community Pretesting:** Approximately Ten (10) community representatives participated in a pretest, allowing feedback on question clarity, cultural sensitivity, and relevance. Insights from this pretest informed final adjustments to survey instruments.

## Ethical Considerations

Ethical standards were strictly followed to protect participant rights:

**Informed Consent:** Participants received information about the study's purpose, procedures, risks, and benefits, with voluntary consent obtained before participation.

**Confidentiality and Anonymity:** Personal information was kept confidential, and data was anonymized during analysis by replacing identifiers with pseudonyms or codes.

**Cultural Sensitivity:** The research team respected local customs and norms, engaging with community leaders and aligning research protocols with cultural expectations.

**Ethical Approval:** The National Research Ethics Committee (NREC) in Nigeria and relevant ethical bodies in each state reviewed and approved the study protocol.

## Limitations

While the survey provided valuable insights, certain limitations were considered:

**Sampling Bias:** The focus on government PHC users limited the generalisability of findings to those relying on private healthcare.

**Geographic Limitations:** Qualitative data was collected only in Kano and Niger, potentially limiting the depth of insights from other states.

## Timeline

The survey was conducted over a nine-month period, from April 2024 to October 2024, covering all phases from preparation, stakeholder engagement, and data collection to analysis and reporting. This structured timeline ensured a thorough evaluation of PHC services, identifying strengths, challenges, and areas for improvement across the six states.

# Data Analysis and Key Findings – Household Survey (HHS)

## Household Survey Overview

The data set comprises 9,176 household responses from six states, providing detailed insights into healthcare access, satisfaction levels, and demographic profiles. The gender distribution reveals a slight male majority, with males representing 53.26% (4,887 respondents) and females 46.74% (4,289 respondents). This nearly balanced gender ratio offers an inclusive perspective on healthcare needs and satisfaction levels from both male and female-headed households, which may influence decision-making and healthcare priorities differently.

State-level satisfaction data varies significantly. States like Lagos and Akwa Ibom, with a younger demographic, show higher satisfaction with accessibility and preventive care, suggesting a strong demand for maternal and wellness services. Conversely, in states with a higher proportion of older household heads, such as Borno and Enugu, there is a noticeable preference for chronic disease management and age-related healthcare services. This data highlights the need for regionally tailored healthcare strategies to address the unique preventive and chronic care requirements of each state and demographic group.

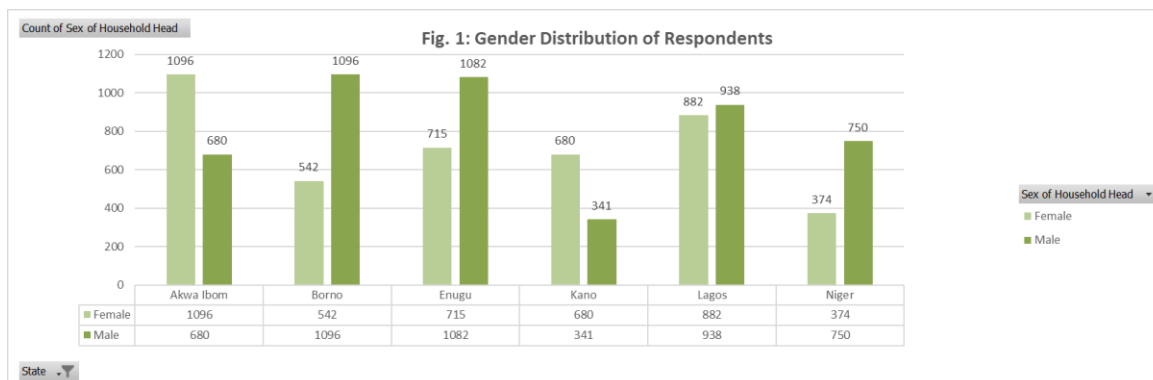
## Demographics Household Survey Respondents

**Gender of Household Head:** In the surveyed states, there is a noticeable variation in the gender distribution of household heads, which may influence healthcare decision-making dynamics.

- **Niger and Borno:** These states show a higher prevalence of male household heads, with 67% in Niger and 67% in Borno, suggesting that men are more commonly responsible for household decisions, including healthcare expenditures and access. Traditional gender roles may, therefore, play a significant role in healthcare decision-making in these states (UN Women, 2021).
- **Lagos and Enugu:** In Lagos, the distribution is more balanced, with males representing 52% of household heads, while in Enugu, males make up 60% of household heads. This balance could reflect more shared decision-making in households compared to Niger and Borno.
- **Kano:** Kano stands out as the only state with the most female household heads, with 67% of household heads being women. This female prevalence could indicate a unique dynamic in which women hold more responsibility for healthcare-related decisions, potentially leading to different healthcare priorities than male-dominant households.
- **Akwa Ibom:** Akwa Ibom has a higher proportion of female household heads (62%), suggesting that women are more actively involved in decision-making in this state as well.

These variations across states indicate that household decision-making around healthcare may be influenced by gender dynamics, with traditional male-dominant roles in some states and a greater involvement of women in others, as seen in Kano and Akwa Ibom (UN Women, 2021).

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**Age Distribution of Heads of Households:** The age distribution among household heads across the six states reveals diverse demographic profiles, which can inform tailored healthcare strategies for each state.

**Akwa Ibom:** With 1,776 household heads, the largest group falls within the 31–40 years range (41.7%), followed by the 18–30 years range (21.2%), totalling 62.9% under 40. This youthful demographic suggests a need for healthcare services focused on preventive care, maternal and child health, and health education on lifestyle-related conditions. Programs leveraging mobile health (mHealth) platforms and community-based outreach may be particularly effective, as Murray et al. (2021) highlight the benefits of mHealth in enhancing healthcare accessibility and engagement in younger populations.

**Borno:** Out of 1,638 household heads in Borno, the largest age group is 41–50 (40.2%), followed by 31–40 (27.3%) and 18–30 (16.3%). This older demographic highlights the need for services targeting chronic disease management and preventive care. According to Banerjee et al. (2021), older adults are more susceptible to chronic health issues, and integrating chronic disease management within primary healthcare can significantly address age-related health concerns.

**Enugu:** With 1,797 household heads, Enugu shows a balanced distribution between the 31–40 years (33.8%) and 41–50 years (36.2%) age groups. A considerable number also fall within the 61–70 years range (16.5%), and 2.4% are above 70. This balanced profile suggests a need for a mix of healthcare services, from reproductive health for younger adults to chronic disease management for older adults. Kabudula et al. (2021) highlights the importance of age-specific interventions within primary healthcare systems to address the diverse needs of such populations effectively.

**Kano:** Kano has 1,021 household heads, predominantly younger, with 42.0% in the 31–40 years range and 22.6% in the 18–30 range. This youthful demographic calls for preventive care, maternal health services, and early intervention programs. Fewer

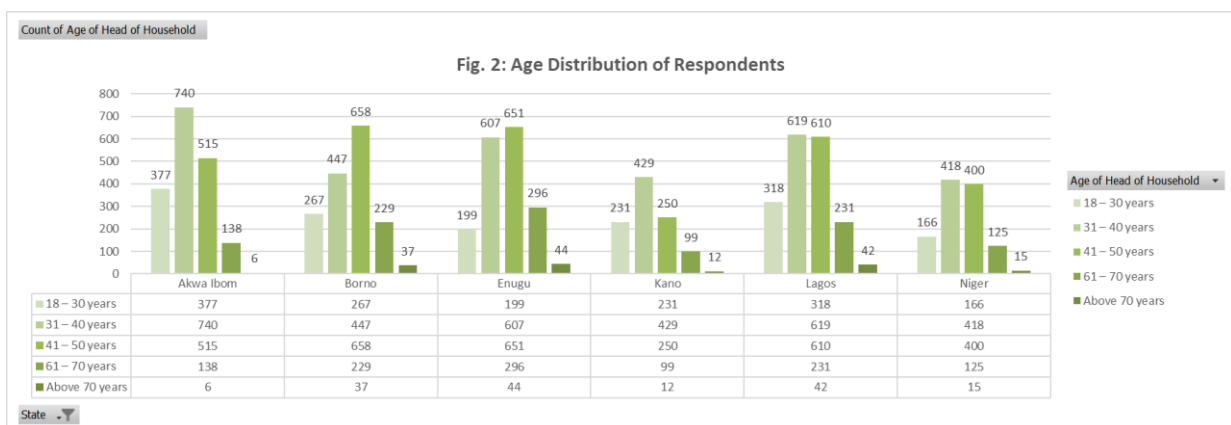
respondents fall into older age groups, which may indicate less immediate demand for chronic disease services but highlights the potential for investment in long-term preventive health measures. James et al. (2021) advocate for preventive health education and wellness programs to reduce the future burden of chronic diseases in young populations.

**Lagos:** Lagos, with 1,820 household heads, has the youngest profile, with 34.0% in the 31–40 years group and 17.5% in the 18–30 years group, totalling 86.7% under 40. This young adult majority suggests a strong need for health initiatives that focus on reproductive health, family planning, and wellness programs. Leveraging digital platforms and mHealth could be beneficial, as younger adults are more likely to engage in technology-based health solutions, as noted by Murray et al. (2021) in their study on digital health engagement.

**Niger:** Among Niger’s 1,124 household heads, the 31–40 years group (37.2%) and 41–50 years group (35.6%) are predominant, with a relatively balanced distribution across other age ranges. The state’s demographic calls for comprehensive healthcare services addressing both maternal and child health for younger adults and chronic disease management for older adults. Ameh et al. (2021) emphasize the importance of preventive screenings and maternal health services in regions with a diverse age profile to effectively meet these age groups’ varying needs.

This analysis suggests tailored healthcare strategies based on age distribution. Younger populations in states like Lagos and Akwa Ibom would benefit from digital engagement, maternal health, and preventive programs, while older demographics in Borno, Enugu, and Niger highlight the importance of chronic disease management alongside preventive care. Recent studies support these tailored approaches, emphasizing the effectiveness of targeted interventions in improving health outcomes across different age groups.

The diverse age profiles across these states highlight the need for tailored healthcare strategies. Younger populations in Lagos and Akwa Ibom would benefit from digital engagement and wellness programs, while Borno, Enugu, and Kano’s older demographics indicate a greater need for chronic disease management alongside preventive care.



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**Educational Attainment of Respondents:** The educational attainment data reveals significant variation among household heads in different states, which can affect healthcare engagement, awareness, and service utilization.

**Akwa Ibom:** With a total of 1,776 household heads, the majority have secondary education (50.1%), and a substantial portion hold an Ordinary National Diploma (12.7%). A smaller percentage of respondents have no formal education (2.3%) or only primary education (23.6%). This educational profile suggests that healthcare messaging could be moderately advanced, leveraging written materials and community health programs to improve understanding and engagement.

**Borno:** Borno, with 1,638 respondents, has a notable proportion of household heads with no formal education (22.3%) or only secondary education (32.6%). This low level of formal education may indicate a need for health communication strategies that utilize visual aids and oral communication, particularly to address awareness and preventive healthcare.

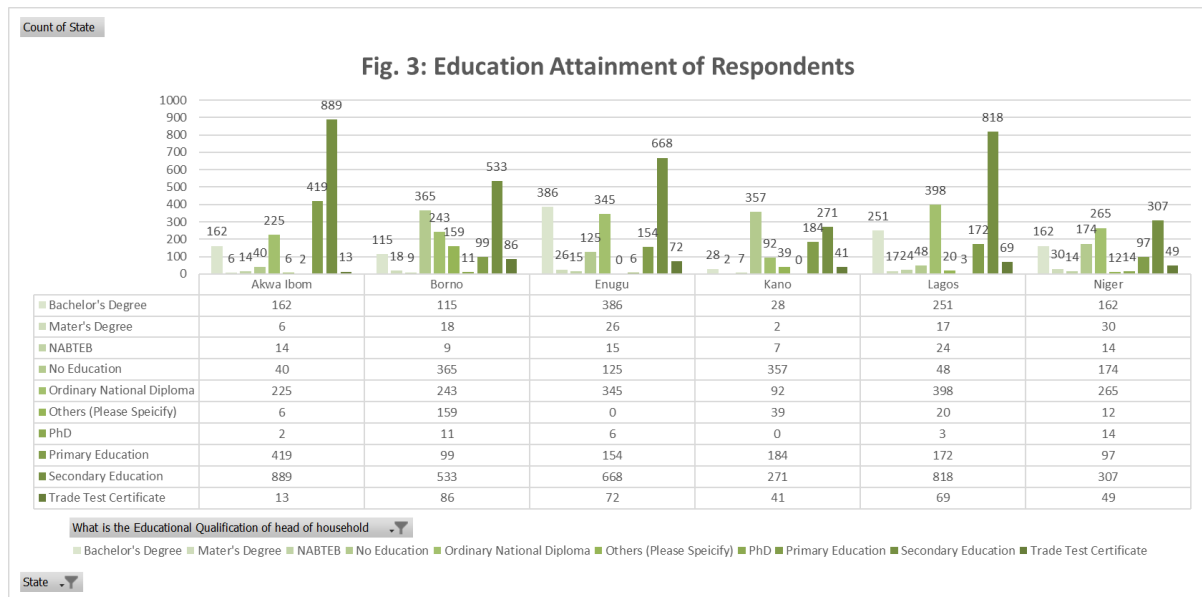
**Enugu:** Of the 1,797 household heads, a high percentage (37.2%) have at least a Bachelor's degree, with 18.9% holding an Ordinary National Diploma and 37.2% completing secondary education. This highly educated population could be more receptive to advanced health initiatives, digital health tools, and community education programs that provide in-depth health information.

**Kano:** Kano's household heads (1,021 in total) show a diverse educational spread, with the majority completing secondary education (26.5%) and a significant portion (35%) having no formal education. Given the high rate of lower educational attainment, healthcare providers might consider culturally appropriate, simple, and easily accessible health information to ensure inclusivity.

**Lagos:** In Lagos, 34.7% of household heads have completed secondary education, and 21.9% hold an Ordinary National Diploma. This state also has a relatively high number of respondents with a Bachelor's degree (13.8%). The higher educational levels suggest an openness to digital health interventions, health literacy programs, and preventive care campaigns.

**Niger:** Of the 1,124 respondents in Niger, secondary education (27.3%) and Ordinary National Diploma (23.6%) are the most common qualifications. The diverse educational profile, with some respondents holding advanced degrees (such as PhDs at 1.2%), suggests that healthcare strategies could vary between community outreach programs and more formalized healthcare education sessions.

The educational attainment analysis highlights the importance of tailoring healthcare communication strategies to the literacy levels in each state. For states with higher education levels, such as Enugu and Lagos, digital health platforms and detailed health information may be effective. Conversely, states with lower levels of formal education, like Borno and Kano, would benefit from simplified and culturally sensitive health communication, possibly through radio or community outreach. This approach would ensure inclusivity and enhance the effectiveness of health interventions across diverse populations.



## Factors Influencing Respondents' Choice of PHC Facilities

The survey data reveals various factors that respondents consider when choosing a PHC facility across the six surveyed states. Key factors include *quality of care, recommendations from others, cost of services, availability of specific services, proximity to home, and other unspecified factors.*

**Proximity to Home:** Proximity is the most frequently cited factor, with 6,069 mentions, emphasizing the importance of accessibility in healthcare choices. Akwa Ibom leads with 1,433 mentions, suggesting that residents may prioritize facilities close to their homes, potentially due to transportation limitations or a preference for convenience.

**Availability of Specific Services:** Availability of specific healthcare services is an influential factor with 4,183 mentions overall. This factor is particularly prioritized in Borno (1,104) and Enugu (911), indicating that these states may have unique healthcare needs or gaps in service provision, prompting residents to seek out facilities based on available treatments or specialties.

**Quality of Care:** Quality of care is a prominent factor, with 4,047 mentions across the states. Enugu shows the highest emphasis on quality, with 1,068 mentions, followed by Lagos with 656. This trend suggests that quality remains a critical priority for most residents when selecting healthcare facilities, indicating a general demand for reliable and effective health services.

**Cost of Services:** Cost considerations are mentioned 3,124 times, with the highest emphasis in Enugu (1,101) and Borno (687). This focus suggests that affordability is a significant factor in healthcare access, particularly in Enugu and Borno, where economic constraints may influence healthcare choices more heavily.

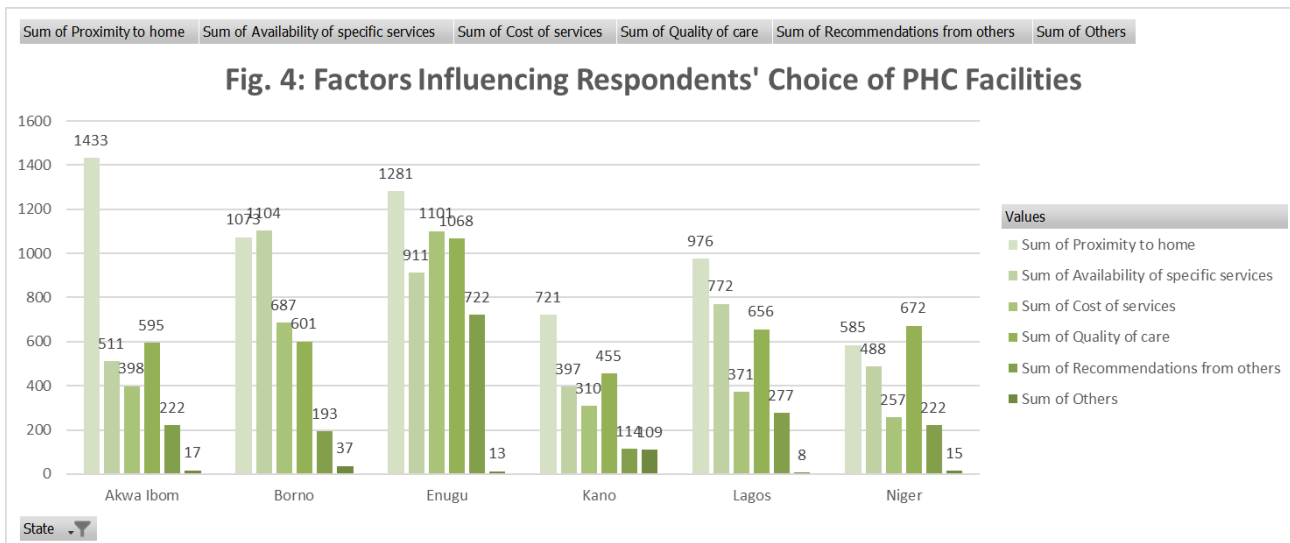
**Recommendations from Others:** A total of 1,750 mentions indicate that word-of-mouth recommendations play a moderate role in influencing PHC choices. Enugu (722) and Lagos (277) have a notable reliance on recommendations, potentially indicating strong community networks where personal endorsements significantly impact healthcare decisions.

**Other Factors:** While less frequently mentioned, 199 responses indicate additional factors influencing PHC selection. Kano (109) has the highest number of these unspecified factors, which could include unique community or cultural considerations not captured in the main categories.

Among the 199 *additional factors* mentioned, key themes identified include;

- **Insurance Considerations:** A number of respondents highlighted the availability of insurance plans and coverage options as influencing factors. This indicates that for some households, insurance plays a role in determining which PHC facility they choose, underscoring the importance of financial risk protection in healthcare access.
- **Limited Options:** Many respondents pointed out that the facility chosen was "the only one available" or that they had "no other choice," which highlights gaps in healthcare infrastructure and facility availability in some communities.
- **Interpersonal Relationships and Staff Behavior:** Comments frequently mentioned the friendliness, reliability, and interpersonal skills of healthcare staff, emphasizing the importance of positive provider-patient interactions.
- **Timeliness and Accessibility of Care:** Several responses emphasized proximity, waiting times, and availability of staff, reflecting accessibility concerns that are vital to patients.
- **Cultural and Community-Based Preferences:** A few responses noted that staff members were "neighbors" or familiar to the community, showing that cultural or community relationships can influence healthcare choices.

This analysis indicates that while quality of care and proximity to home are major factors in PHC selection, economic considerations (cost and insurance availability) and service accessibility also play critical roles, especially in states like Enugu and Borno. The "Other" factors reveal deeper insights, including limited facility options, interpersonal considerations, and insurance coverage, suggesting that financial protection and accessible, community-sensitive healthcare services could improve PHC utilization across these states.



## Respondents' Frequency of Accessing Primary Health Care Services

The survey data reveals varying levels of PHC service utilization among household heads across the six states. Here's a breakdown of access frequency by category:

**Frequently:** A total of 3,509 respondents across the states reported frequent access to PHC services, representing approximately 38.2% of the total respondents. Borno has the highest number of frequent users (956), suggesting a strong reliance on PHC services in the area, possibly due to the need for consistent healthcare support. Niger follows with 644 frequent users, while Kano and Akwa Ibom have 469 and 466, respectively.

**Occasionally:** The majority of respondents (4,369 or 47.6%) reported occasional visits to PHCs. Akwa Ibom had the highest number of occasional users (1,249), followed closely by Enugu (1,127) and Lagos (831). This occasional access might indicate a population that utilizes healthcare services as needed rather than on a regular basis, possibly reflecting barriers such as accessibility, cost, or perceived necessity.

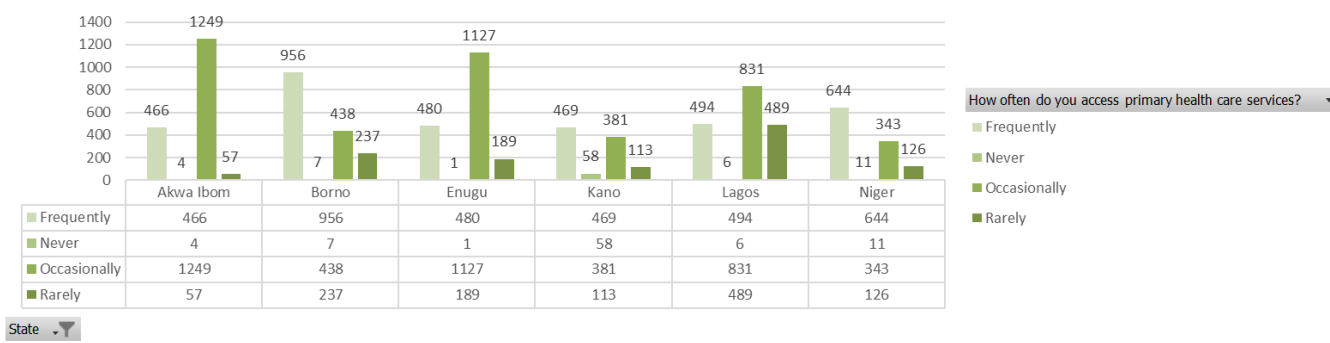
**Rarely:** A smaller segment, 1,211 respondents (13.2%), indicated they rarely visit PHC facilities. Lagos (489) and Borno (237) show the highest counts in this category. This may point to obstacles in accessing PHC services, including long distances, financial constraints, or a preference for alternative healthcare options.

**Never:** Only 87 respondents (less than 1%) stated they never access PHC services. Kano has the highest number of respondents in this category (58), which could highlight issues of availability, cultural beliefs, or dissatisfaction with the services provided.

This analysis shows that while a significant proportion of the population frequently access PHC services, a majority still use them only occasionally. The reasons for occasional or rare use could range from logistical barriers and service costs to alternative health practices or lack of perceived need. The data suggests a potential need to improve PHC accessibility, affordability, and public awareness about the benefits of regular healthcare utilization to encourage more consistent engagement, particularly in states with higher occasional and rare users.

Count of How often do you access primary health care services?

Fig. 5: Respondents Frequency of Accessing Primary Health Care Services



## Respondents' Experience of Long Wait Times or Delays in PHC Service

The survey data reveals varying responses across the six states regarding whether households experience long waiting times or delays when accessing primary healthcare services:

**Akwa Ibom:** Among 1,776 respondents, a significant majority (91.5%) reported "No," indicating that they do not experience long wait times or delays, while only 8.5% indicated "Yes." This suggests that PHC facilities in Akwa Ibom may generally have efficient processes in place to manage patient flow.

**Borno:** In Borno, the responses are more balanced, with 919 respondents (56.1%) reporting "No" and 719 (43.9%) reporting "Yes." This indicates that a considerable portion of the population experiences delays or extended wait times, which may point to a need for improved service efficiency in the state's healthcare facilities.

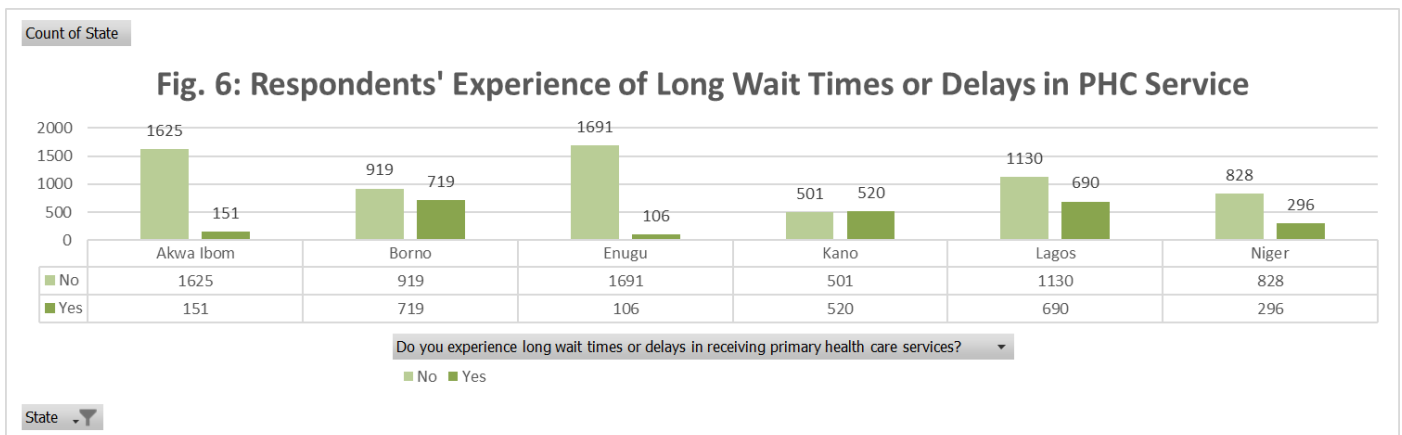
**Enugu:** Enugu shows a notably high percentage (94.1%) of respondents answering "No," meaning they do not experience long wait times, with only 5.9% saying "Yes." This reflects efficient patient processing in primary healthcare facilities in Enugu.

**Kano:** In Kano, the responses are almost evenly split, with 501 respondents (49.1%) saying "No" and 520 (50.9%) reporting "Yes." This indicates that a significant portion of the population faces delays in receiving care, suggesting room for improvement in managing patient flow and reducing wait times.

**Lagos:** In Lagos, out of 1,820 respondents, 62.1% reported "No" while 37.9% reported "Yes." Although the majority do not experience long wait times, a notable proportion still faces delays, which may be due to the high population density and demand on healthcare resources in Lagos.

**Niger:** Among 1,124 respondents in Niger, 73.7% indicated "No," while 26.3% indicated "Yes." This shows that while the majority of respondents do not experience delays, a quarter of the population still faces issues with waiting times.

The data suggests that Akwa Ibom, Enugu, and Niger generally have shorter wait times in their primary healthcare facilities, as reflected by the majority of respondents indicating "No" to



experiencing delays. However, in states like Borno, Kano, and Lagos, a substantial portion of respondents experience long waiting times or delays. This could indicate capacity issues, resource constraints, or higher patient demand in these areas, highlighting a need for targeted interventions to improve service delivery efficiency and reduce waiting times in the primary healthcare facilities of these states.

## Respondents' Barriers to Accessing Primary Healthcare Services

The survey data reveals significant barriers experienced by households in accessing primary healthcare (PHC) services, highlighting both systemic and logistical issues that impact healthcare access:

**Experience of Barriers:** A substantial portion of respondents across the states reported facing barriers or discrimination when accessing PHC services, with 1,035 respondents (11.3% of total) indicating "Yes." Borno (15.8%) and Kano (23.8%) showed the highest rates of reported barriers, while Enugu (4.3%) reported the lowest, suggesting potential regional differences in healthcare accessibility and service quality.

### Key Barriers:

**Long Wait Times and Delays:** Long waiting times and delays in attending to patients were frequently mentioned across multiple states, indicating a need for better management of patient flow and more healthcare staff to reduce congestion.

**Lack of Transportation and Distance from Facilities:** Many respondents, especially those in rural areas, highlighted transportation challenges and long distances to reach healthcare facilities. This barrier emphasizes the need for improved healthcare infrastructure and transportation support for remote areas.

**Shortage of Healthcare Workforce and Staff Absence:** A recurring issue was the inadequate number of healthcare workers, with reports of staff absenteeism and late arrival to facilities. This shortage leads to increased wait times and insufficient care, impacting the overall patient experience.

**High Cost of Services and Medication:** Affordability is a significant concern, with many respondents noting the high cost of services, medication, and transportation as a barrier. This

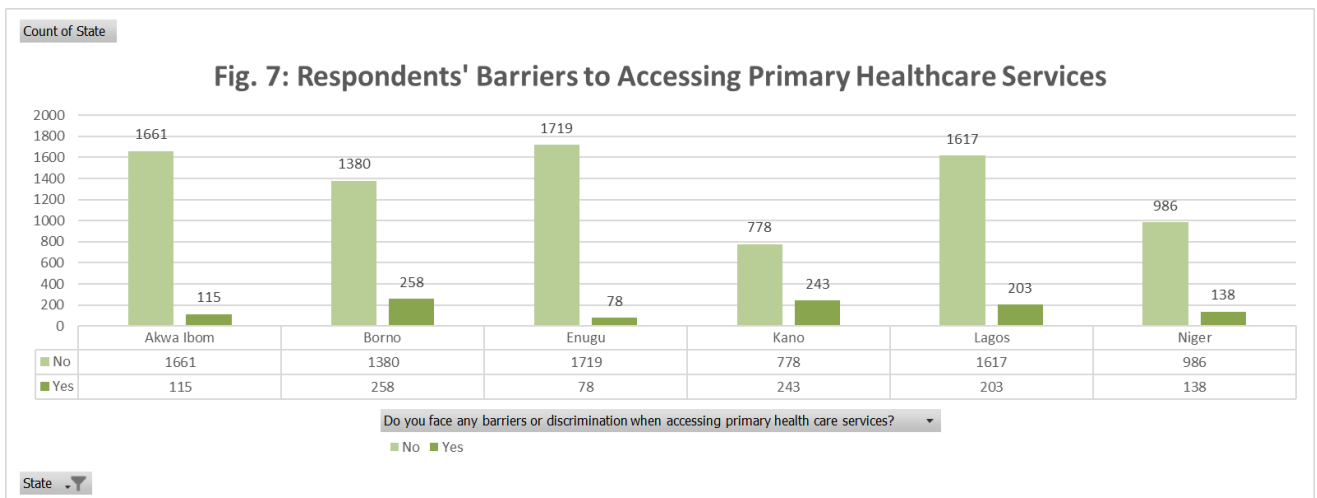
points to a need for subsidized healthcare options, especially for economically disadvantaged households.

**Lack of Essential Drugs and Equipment:** The unavailability of essential drugs and outdated or inadequate healthcare equipment were reported, particularly affecting respondents in Borno, Kano, and Niger. This shortage undermines the quality of care available at PHC facilities and highlights the need for improved supply chains and resource allocation.

**Discrimination and Staff Attitudes:** Instances of discrimination, tribalism, and negative staff attitudes were mentioned, with some respondents feeling ignored or treated poorly. This points to the importance of training healthcare providers in cultural sensitivity and patient-centered care practices.

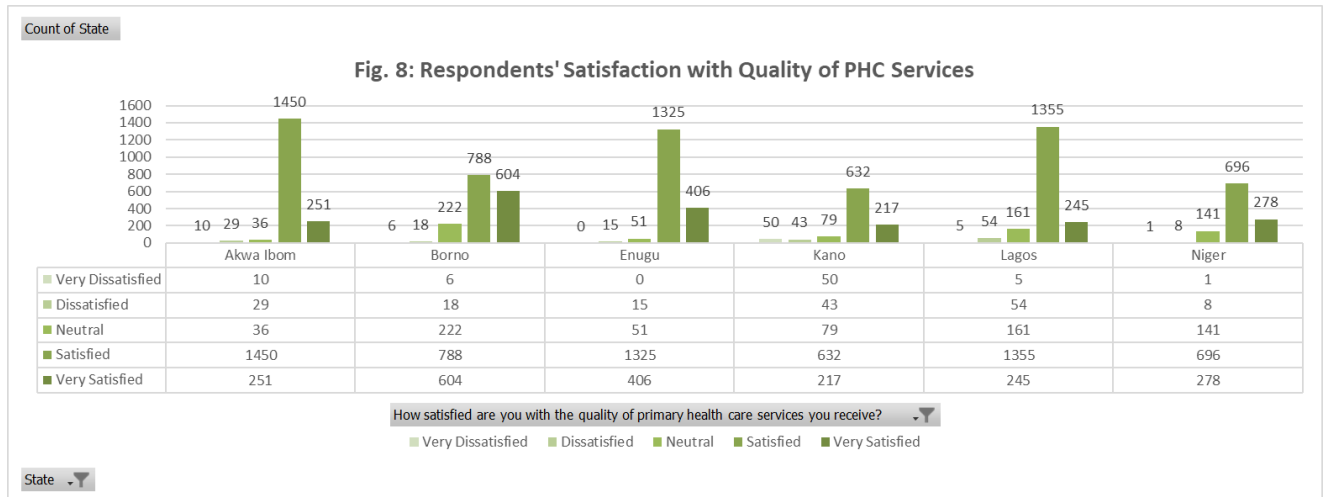
**Poor Facility Conditions and Lack of Security:** Some respondents mentioned concerns about facility conditions, including a lack of cleanliness, water, and essential infrastructure like secure fencing and lighting, especially at night. Ensuring safe, well-maintained, and well-equipped facilities could address some of these concerns.

This analysis highlights the multifaceted barriers to accessing healthcare services, ranging from logistical issues like distance and cost to systemic issues like staff shortages and discrimination. Addressing these barriers will require coordinated efforts to improve healthcare infrastructure, enhance service delivery efficiency, ensure equitable resource distribution, and promote respectful and inclusive patient care across all states.



## Respondents' Satisfaction with Quality of PHC Services Received

The survey data on satisfaction levels across the six states reveals a high level of satisfaction among respondents, with 6,246 indicating they were "Satisfied" and 2,001 indicating they were "Very Satisfied." Despite this, there are still some dissatisfaction levels, with 167 respondents "Dissatisfied" and 72 "Very Dissatisfied." The high levels of satisfaction, particularly in Enugu and Lagos, suggest that these states may have better healthcare services compared to others. However, the dissatisfaction noted in Kano and Lagos indicates areas for potential improvement, especially regarding staff responsiveness and service availability.

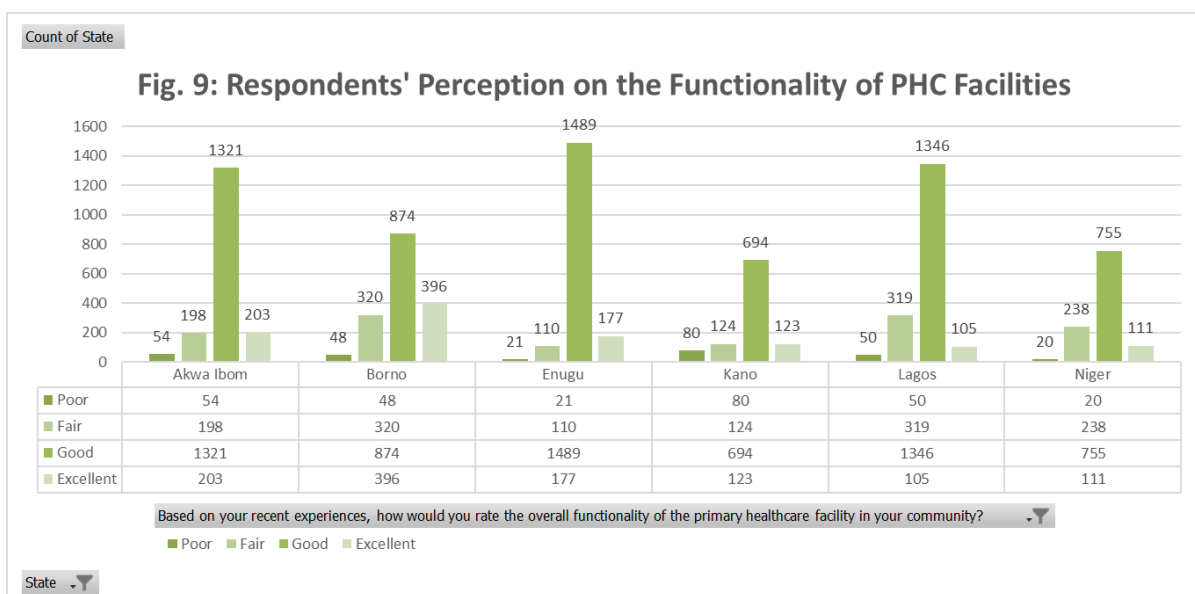


## Respondents' Perception of the Functionality of PHC Facilities

The functionality of PHC facilities, as perceived by respondents, shows that "Good" and "Excellent" ratings dominate, with 6,479 and 1,115 respondents selecting these options, respectively. Poor functionality ratings were minimal, though Kano had a notably higher rate of "Poor" responses compared to other states, suggesting infrastructure or resource challenges specific to that region.

### Factors Influencing Ratings

Respondents provided various reasons for their ratings, including positive remarks on attentive and honest healthcare workers and quality service for higher ratings. In



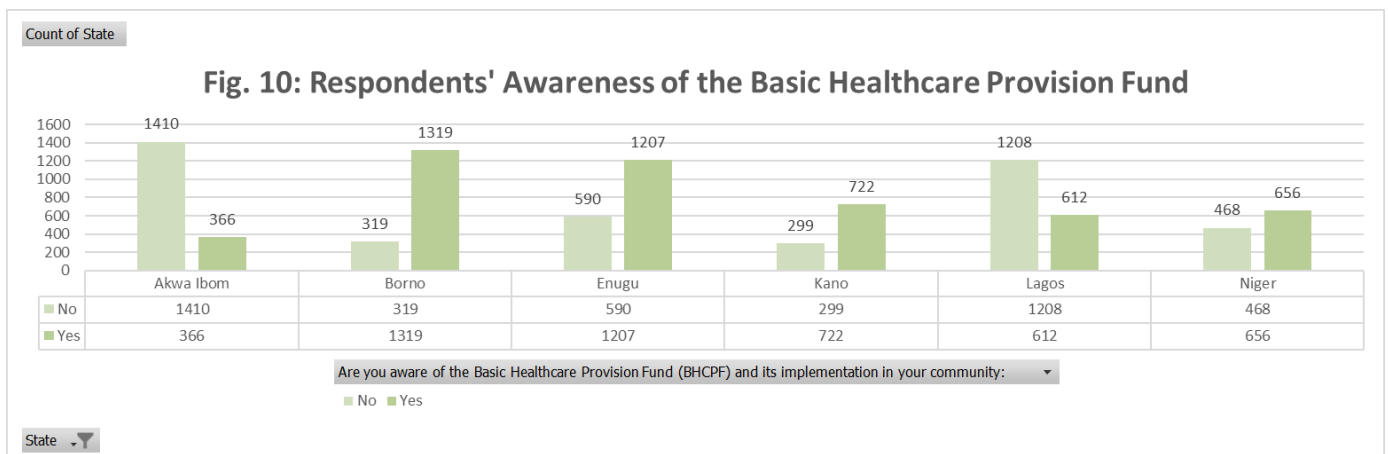
contrast, negative feedback centered on issues like lack of available drugs, inadequate staff, long wait times, and poor handling of emergencies. These insights underline the importance of addressing resource shortages and staffing in underperforming facilities to enhance the overall healthcare experience.

The overall findings indicate high satisfaction and positive functionality ratings in many areas, though with clear room for improvement in specific regions, particularly concerning availability of staff and timely service delivery.

## Respondents' Awareness and Perceived Impact of the Basic Healthcare Provision Fund

The survey data presents insights into the awareness and perceived impact of the BHCPF on healthcare access among respondents across six states.

**Awareness of BHCPF:** Across the six states, 53.2% of respondents reported awareness of the BHCPF, totaling 4,882 individuals, while 46.8% (4,294 respondents) were unaware of the fund. Borno and Enugu showed relatively high awareness with 1,319 and 1,207 respondents respectively acknowledging the fund, whereas Akwa Ibom (366) and Kano (722) had lower levels of awareness. This distribution indicates varying levels of exposure to information about the BHCPF across the states.



**Impact of BHCPF on Healthcare Access:** For those who were aware of the fund, perceptions of its impact were as follows:

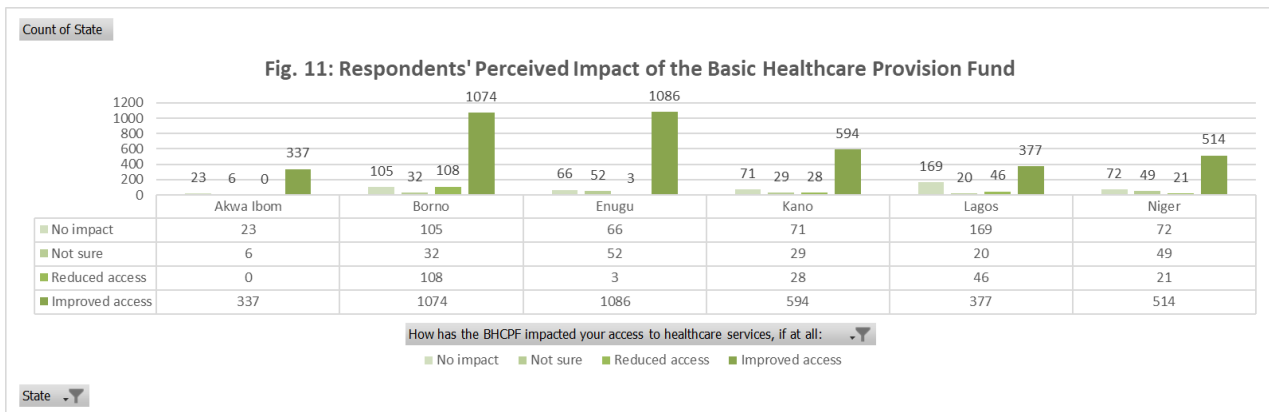
**Improved Access:** The majority, 3,982 respondents, indicated that the BHCPF has improved their access to healthcare. This was particularly pronounced in Borno (1,074) and Enugu (1,086), suggesting effective implementation and outreach in these states.

**No Impact:** A total of 506 respondents felt the BHCPF did not impact their access to healthcare services, with Lagos (169) and Niger (72) showing relatively higher counts in this category. This could indicate gaps in fund benefits or awareness in these areas.

**Reduced Access:** A smaller group of 206 respondents reported a perceived reduction in healthcare access due to the fund, with Borno showing the highest count in this category (108), which might point to specific challenges in the fund's local implementation.

**Uncertainty:** A total of 188 respondents were unsure about the impact of the BHCPF on their healthcare access, highlighting potential areas for improvement in public communication and clarity about the fund’s purpose and benefits.

This analysis points out the importance of targeted communication strategies to increase awareness of the BHCPF and to ensure its intended impact reaches all communities equitably. Addressing areas with reported reduced access or uncertainty can further enhance the fund’s effectiveness in improving healthcare accessibility across states.



## Respondents' Perceptions of Transparency and Accountability in PHC Management

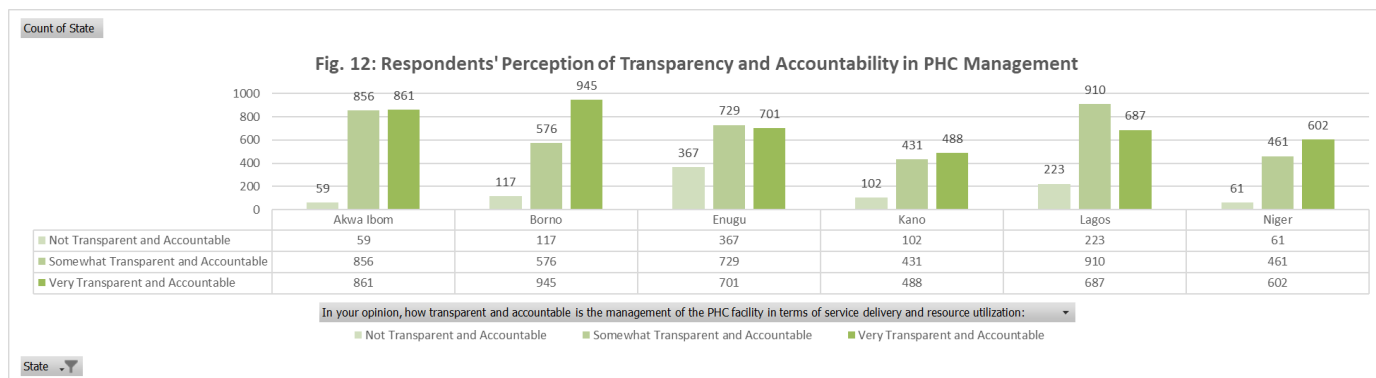
The survey data reveals respondents' perceptions of the transparency and accountability in the management of Primary Health Care (PHC) facilities across six states, specifically regarding service delivery and resource utilization.

**Very Transparent and Accountable:** A majority of 46.7% (4,284 respondents) rated their PHC facilities as very transparent and accountable. Borno (945) and Akwa Ibom (861) had the highest levels of perceived transparency and accountability, indicating that respondents in these states generally trust the management of their PHC facilities.

**Somewhat Transparent and Accountable:** About 43.2% (3,963 respondents) indicated that their PHC facilities were somewhat transparent and accountable. Lagos (910) and Enugu (729) had substantial proportions in this category, suggesting that while respondents perceive some level of accountability, there may be areas for improvement in terms of openness and resource management.

**Not Transparent and Accountable:** Only 10.1% (929 respondents) reported that their PHC facilities lacked transparency and accountability. Enugu (367) and Lagos (223) showed the highest counts in this category, highlighting potential challenges in these states related to trust in PHC management and transparency practices.

This analysis suggests that while there is a strong perception of transparency and accountability in PHC management across most states, specific areas may require targeted interventions to enhance public trust, especially in states like Enugu and Lagos. Improvements in communication and visible accountability measures could further build confidence in PHC services and resource management.



## Respondents' Perceptions of the Presence of Mechanisms for Community Feedback in Healthcare

The data reveals respondents' perceptions of the presence of mechanisms that ensure community feedback is considered and acted upon by healthcare authorities in six states.

**Yes:** Approximately 48.7% (4,469 respondents) believe that mechanisms for community feedback are indeed in place. Akwa Ibom (1,042) and Borno (929) had the highest counts of positive responses, suggesting that respondents in these states feel confident that their feedback is valued and addressed by healthcare authorities.

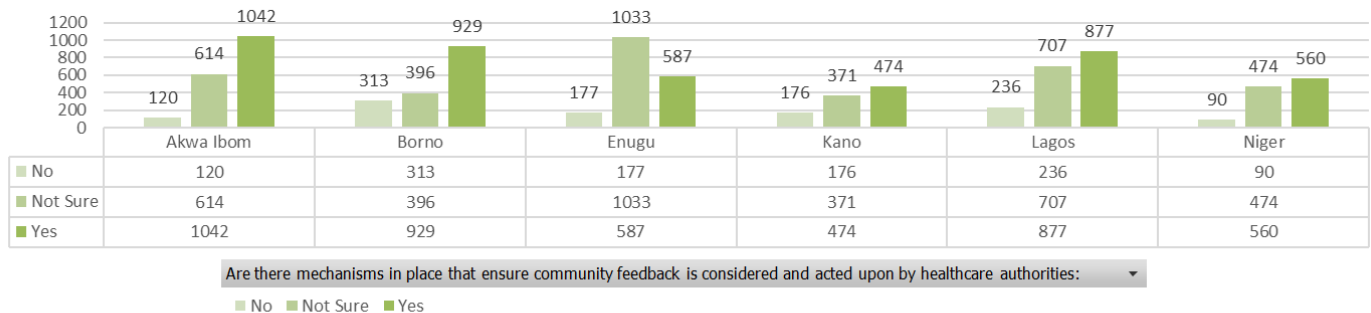
**Not Sure:** Around 39.2% (3,595 respondents) were uncertain about the presence of such mechanisms. Enugu (1,033) and Lagos (707) had significant proportions of respondents who were unsure, indicating a potential gap in awareness about community feedback mechanisms in these states. This uncertainty suggests the need for more visibility or communication around existing feedback systems to ensure the community knows how to provide input and sees evidence of follow-up actions.

**No:** A smaller portion, 12.1% (1,112 respondents), reported that no mechanisms are in place to ensure their feedback is considered. Borno (313) and Lagos (236) showed notable counts in this category, highlighting areas where respondents perceive a lack of feedback systems or responsiveness from healthcare authorities.

This analysis indicates a mixed perception of feedback mechanisms across the states. While nearly half of the respondents feel that feedback systems are in place, a substantial portion remains unsure, which points to the importance of enhancing transparency and communication about these mechanisms. Efforts to increase awareness and demonstrate accountability in feedback could improve community engagement and trust in healthcare services.

Count of State

**Fig. 13: Respondents' Perception of the Presence of Mechanisms for Community Feedback in Healthcare**



State ▾

## Respondents' Perspectives on Enhancing Primary Healthcare Facility Preparedness

The responses from communities across six states highlight critical gaps in the capacity of primary healthcare facilities to effectively meet local healthcare needs. The narrative reveals widespread concerns around inadequate staffing, insufficient medical equipment, and poor infrastructure. Many facilities lack qualified healthcare personnel, resulting in limited-service availability, especially for emergencies and specialized care. Communities consistently emphasize the need for modern medical equipment, affordable medicines, and well-stocked pharmacies to improve diagnostic and treatment capabilities locally.

Infrastructure issues are a recurrent theme, with calls for expansion, renovations, and basic utilities like clean water and stable electricity to ensure hygienic and reliable services. Security improvements, such as perimeter fencing, are also suggested to create safer environments for both patients and staff. Funding remains a pivotal challenge, as communities seek government and external support to subsidize the cost of medicines, fund facility improvements, and maintain service affordability.

Additionally, the need for enhanced community engagement is clear, with suggestions for increased health education, preventive health talks, and awareness campaigns to foster a stronger relationship between facilities and the public. Respondents call for better accountability and regular monitoring of facilities to ensure that funds are used efficiently and that healthcare services meet the expected standards.

Overall, this narrative underlines a pressing need for investment in staffing, equipment, infrastructure, and community-centred approaches to strengthen primary healthcare facilities' role in delivering accessible, affordable, and quality healthcare at the community level.

## Respondents' Understanding of the Role of Community Members in Accountability for Healthcare Service Delivery

The survey data illustrates the roles that community members believe they should play in ensuring healthcare providers and authorities are accountable for service delivery across six states. Key roles identified include reporting issues, supporting healthcare workers, monitoring service delivery, advocating for transparency, and participating in feedback forums.

**Reporting Issues or Concerns:** This is the most frequently mentioned role, with 5,901 responses overall. Enugu (1,444) and Borno (1,134) have the highest responses, indicating a strong belief among residents in these states that reporting issues to healthcare authorities is essential in holding the system accountable.

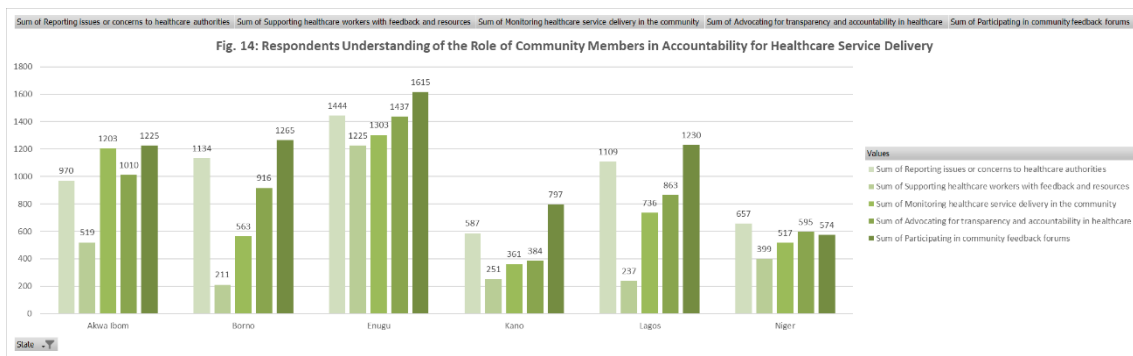
**Supporting Healthcare Workers:** Although less frequently cited, 2,842 respondents believe that providing feedback and resources to healthcare workers is crucial. Enugu again leads with 1,225 responses, followed by Akwa Ibom with 519. This suggests recognising the value of constructive support for healthcare providers to improve service quality.

**Monitoring Healthcare Service Delivery:** Monitoring service delivery is valued by 4,683 respondents, with Enugu (1,303) and Akwa Ibom (1,203) showing the highest engagement in this role. This reflects a proactive approach where community members see themselves as overseers of service standards in healthcare.

**Advocating for Transparency and Accountability:** Advocacy is highlighted by 5,205 respondents, indicating that many community members believe they should actively call for transparency and accountability in healthcare. Enugu (1,437) and Akwa Ibom (1,010) lead in responses, pointing to an awareness of the importance of transparent healthcare administration.

**Participating in Community Feedback Forums:** This role has the highest overall response (6,706), with Enugu (1,615) and Akwa Ibom (1,225) at the forefront, indicating a strong willingness to engage in organized forums. This shows that many community members view structured feedback forums as an effective way to contribute to healthcare improvements.

Community members across the states recognize various roles in supporting and holding healthcare authorities accountable, with an emphasis on reporting issues, advocating for transparency, and participating in feedback forums. These insights highlight a community-driven approach to enhancing healthcare service accountability.



## Key Findings – Focused Group Discussions (FGD) and Key Informants Interviews (KIIs)

### Overview

The qualitative component of this mixed-method survey report complements the quantitative findings by providing in-depth insights from community and healthcare stakeholders on primary healthcare (PHC) services across 12 Local Government Areas (LGAs) in Niger and Kano States. Through Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs), participants shared experiences, identified challenges, and provided recommendations to improve healthcare delivery. This qualitative data adds depth to the survey results, highlighting specific community needs and the perspectives of key informants directly involved in PHC management and implementation.

To capture a diverse range of perspectives, the FGDs included various stakeholders, such as community leaders, health educators, Ward Development Committee (WDC) members, women representatives, religious leaders, and other key community figures. Each discussion was guided by a set of thematic questions, with participants encouraged to share their personal experiences and insights. The data was subsequently analyzed using thematic coding, allowing key themes to emerge, including facility preference, service quality, awareness and impact of the Basic Healthcare Provision Fund (BHCPF), barriers to healthcare access, and group-specific insights.

In addition, the KIIs offered in-depth perspectives from key informants within the Kano State Primary Healthcare Management Board (KNSPHCMB) and Niger State Ministry of Primary Health Care (NSMPHC). This approach provided a comprehensive understanding of both community-level challenges and systemic issues influencing PHC service delivery. Key themes from the KIIs included resource allocation, workforce capacity, infrastructure needs, and strategies for improving healthcare accessibility and responsiveness across urban and rural settings. Together, these qualitative insights complement the quantitative findings, offering a detailed view of healthcare delivery challenges and potential solutions in the surveyed LGAs.

## Qualitative Findings (FGD)

The findings from the FGDs are organized by key themes. For each theme, similarities and differences between the two states (Niger and Kano) are noted to provide a comprehensive view of the qualitative insights.

### Facility Preference

**General Trends:** Across LGAs in both Niger and Kano states, participants preferred facilities that were accessible, provided essential services, and had healthcare workers who treated patients with respect and attentiveness. The choice of facility was often influenced by proximity and the availability of specific services, particularly maternal and child health services.

### Service Quality

**Positive Aspects:** Participants generally expressed satisfaction with the dedication of healthcare workers, particularly in providing maternal and child health services. Many facilities were praised for their attentiveness and the respectful treatment of patients, which fostered community trust in PHC services.

**Challenges Noted:** While service quality was viewed positively, significant issues emerged regarding staffing shortages, limited operational hours, and inadequate infrastructure (e.g., lack of running water and electricity).

### Observations:

**Niger LGAs:** In areas like Wushishi and Tafa, participants valued the professionalism of staff but emphasized the need for infrastructure improvements, such as clean water and a reliable power supply.

**Kano LGAs:** In Bunkure and KMC, participants appreciated early opening hours but cited the absence of 24-hour services, which limited access to emergency care.

### Awareness and Experiences with BHCPF

**Awareness Levels:** There was widespread awareness of the Basic Healthcare Provision Fund (BHCPF) across all LGAs, with many participants expressing satisfaction with the fund's role in facilitating access to free or subsidized healthcare.

**Impact:** In both States, BHCPF was noted to positively impact vulnerable groups, such as pregnant women and children, by providing essential medications and services. However, gaps were reported in medication availability, and some participants noted that while they were aware of the fund, they had not directly benefited from it.

### Observations:

**Niger LGAs:** Participants in Agaie and Lapai highlighted the judicious use of BHCPF funds and the transparency in management, particularly with the involvement of WDC members.

**Kano LGAs:** In Gwarzo and Kura, BHCPF awareness was high, but participants mentioned a need for expanded coverage of essential drugs to address all community health needs.

## Barriers to Healthcare Access

**Key Challenges:** Common barriers across both states included staff shortages, financial constraints, cultural beliefs, and infrastructure limitations (e.g., lack of toilets, limited water supply). Socioeconomic factors, such as poverty and transportation costs, were also significant obstacles in accessing timely care.

### Observations:

**Niger LGAs:** Participants in Wushishi and Kotangora noted that lack of transportation and financial limitations impacted healthcare access, especially for the most vulnerable groups.

**Kano LGAs:** In Bunkure and Kunchi, participants expressed concerns about facility maintenance and environmental factors like nearby rivers, contributing to health issues like malaria.

### Group-Specific Insights

**WDC Representatives:** Advocated for infrastructure upgrades and supported fund transparency in both states.

**Community Leaders:** Emphasized the need for better management, accountability, and access to essential drugs, reflecting community priorities for reliable healthcare services.

**Women Leaders:** In both Niger and Kano states, women leaders highlighted the importance of accessible maternal services, continuous power supply, and respectful treatment, which they viewed as crucial during childbirth and emergency cases.

**Youth and Religious Leaders:** In Kano LGAs, youth leaders emphasized the need for 24-hour service, while religious leaders emphasized the importance of health education to counter misconceptions and encourage healthcare utilization.

## Qualitative Findings (KII)

The Key Informant Interviews (KIIs) conducted in selected LGAs across Kano and Niger States provided in-depth insights into the operational strengths, challenges, and areas for improvement within Primary Healthcare Centers (PHCs).

### PHC Facility Functionality and Resource Allocation

**Strengths:** Many key informants commended PHC facilities for their responsiveness and dedication to providing essential services despite resource limitations. The Basic Healthcare Provision Fund (BHCPF) was noted as a significant contributor to facility improvements, with funds often allocated for security, minor renovations, and medical supplies.

**Challenges:** A persistent issue highlighted was the inadequate availability of key medical equipment and infrastructure. Informants reported shortages of beds, laboratory equipment, and medicines, which hinder the quality and efficiency of service delivery. The lack of space within facilities was also mentioned as a barrier to accommodating an increasing patient load, particularly in growing communities like Tafa (Niger State).

### Recommendations:

- Increase government funding and support to expand existing PHC facilities.

- Allocate resources for critical equipment such as beds, diagnostic tools, and emergency supplies.

### **Staffing and Workforce Capacity**

**Strengths:** Healthcare workers in many PHCs were praised for their commitment, empathy, and proactive approach to patient care. Informants emphasized that despite limited numbers, the staff demonstrate a high level of dedication and responsiveness to patient needs.

**Challenges:** A common theme across both states was the shortage of skilled healthcare workers, especially in specialized roles such as maternity care. Informants noted that the current workforce struggles to meet the demands of the population, particularly in rural LGAs, where access to general and specialized care is limited. This shortage is exacerbated by the absence of a structured support system for training and capacity-building.

#### **Recommendations:**

- Increase recruitment of healthcare personnel, particularly in underserved rural areas.
- Invest in continuous training programs to enhance healthcare workers' skills, especially in maternal and emergency care.

### **Community Engagement and Trust**

**Strengths:** Informants emphasized the importance of community trust in PHC services, with many PHCs receiving strong support from local leaders. In Tafa, for example, the WHDC Chairman highlighted the community's reliance on PHC services and the positive relationship between healthcare providers and community members.

**Challenges:** Despite general trust, informants in some areas mentioned that youth and certain groups in the community are sometimes skeptical about PHC services. A lack of targeted health awareness programs was identified as a contributing factor to this mistrust.

#### **Recommendations:**

- Implement community health awareness campaigns to address misconceptions about PHC services.
- Engage community leaders as advocates for PHCs to enhance local support and encourage healthcare-seeking behaviors.

### **Access and Geographic Barriers**

**Strengths:** In urban areas and more accessible LGAs, PHCs have become a reliable source of healthcare, reducing the need for residents to travel long distances for basic services.

**Challenges:** In rural and remote LGAs, informants highlighted the significant challenges posed by geographic barriers. The absence of nearby secondary healthcare facilities means that patients requiring advanced care must travel long distances. This issue is particularly acute in developing communities where general hospitals are located far from PHCs, delaying access to emergency services.

### Recommendations:

- Introduce mobile health units or outreach services to bridge the access gap in remote areas.
- Improve referral systems and coordinate with secondary healthcare facilities to streamline emergency responses.

### Impact of the Basic Healthcare Provision Fund (BHCPF)

**Strengths:** Informants across both states noted the positive impact of BHCPF on improving facility conditions and maintaining essential services. The fund has supported the payment of security personnel, minor facility renovations, and the provision of basic medicines.

**Challenges:** While BHCPF funds have helped, the participants noted that the allocations are often insufficient to address more significant infrastructural needs. Additionally, in some cases, delays in the disbursement of BHCPF funds were reported, impacting service continuity.

### Recommendations:

- Increase the allocation of BHCPF to cover more extensive facility needs, such as infrastructure expansion and equipment procurement.
- Ensure timely disbursement of BHCPF funds to maintain uninterrupted service delivery.

The Key Informant Interviews from Kano and Niger States highlight both strengths and areas for improvement within the PHC system. While PHCs are widely regarded as essential to community health, especially in rural areas, key challenges such as workforce shortages, limited equipment, and infrastructural gaps persist. Leveraging BHCPF more effectively, strengthening community engagement, and addressing geographic barriers can enhance healthcare accessibility and quality across both states.

## Key Insights from Quantitative and Qualitative Analysis of PHC Services

**Community Perception of Quality and Respect as Indicators of Trust:** In both Kano and Niger, trust in healthcare services is significantly influenced by the interpersonal interactions between healthcare workers and patients. Community members value respectful and attentive care as much as clinical expertise, viewing these interactions as service quality indicators. This emphasizes the importance of patient-centered care, suggesting that training healthcare providers in empathetic communication and respect could improve patient trust and increase PHC utilization.

**BHCPF Awareness and Access Disparities:** While there is general awareness of the Basic Healthcare Provision Fund (BHCPF) in both regions, actual access and benefits vary significantly. In Niger, the active involvement of Ward Development Committee (WDC) members contributes to transparent fund management, which has led to higher satisfaction among community members. Conversely, in Kano, limited awareness of fund access suggests that community engagement mechanisms are either underutilized or inconsistent, impacting equitable healthcare access. Strengthening community involvement and increasing transparency through similar WDC initiatives could address these gaps, particularly involving local health advocates and influencers.

**Healthcare Workforce Motivation and its Impact on Service Quality:** Mentions of "motivation" and "support" for healthcare workers reveal underlying issues with workforce morale that directly affect the quality of service provided at PHCs. An unmotivated or unsupported workforce may result in suboptimal patient experiences, further undermining community trust in healthcare services. Structured support systems, regular feedback mechanisms, and localized incentive programs could significantly enhance workforce satisfaction, improving service delivery and community satisfaction with PHC services.

**Community Role in Accountability and PHC Management:** The role of community leaders and WDC representatives in advocating for better healthcare accountability varies by region. In Niger, the active involvement of community members in PHC management has positively impacted transparency and service quality. However, in Kano, the absence of such structured accountability mechanisms could contribute to service delivery inconsistencies. Establishing feedback loops, perhaps through regular community meetings or local health forums, could strengthen accountability in Kano, fostering a collaborative approach to PHC management and community health improvement.

**Emerging Demand for Specialized Services Beyond Basic PHC:** The repeated requests for specialized diagnostic equipment (e.g., ultrasound, scanning machines) indicate that community members expect PHCs to serve a broader role in healthcare provision beyond basic services. This unmet demand suggests the potential for expanding PHC capacities or establishing partnerships with higher-level facilities to offer referrals and mobile diagnostic units. Meeting these needs could enhance PHCs' functionality, making them more comprehensive care hubs aligned with community health expectations.

## Recommendations for Improving PHC Services

From the data, it is evident that PHCs are often constrained by resource limitations, insufficient medical equipment, and infrastructural inadequacies, affecting service quality and accessibility. Furthermore, issues such as long wait times, cost of services, and limited awareness around health initiatives like the Basic Healthcare Provision Fund (BHCPF) present obstacles to healthcare utilization and trust in the healthcare system. Variances in regional demographics and socio-economic factors also influence healthcare needs, further accentuating the importance of state-specific healthcare approaches.

The following recommendations are designed to address these core challenges by improving facility infrastructure, expanding workforce capacity, fostering community engagement, and enhancing resource availability. By focusing on tailored interventions, these recommendations aim to strengthen PHCs, improve healthcare accessibility, and ultimately elevate the standard of care across the surveyed states.

### 1. Enhance Resource Allocation and Infrastructure Improvements

- **Increased Funding:** Given the frequent reports of inadequate infrastructure and equipment, it is important to prioritize allocating funds to expanding facilities, especially in areas with high patient loads. Key focus areas should include constructing additional wards, upgrading essential diagnostic tools, and ensuring all PHCs have basic utilities like water and electricity.

- **Prioritize Modern Medical Equipment:** Equip PHCs with essential diagnostic and emergency response tools, such as ultrasound scanners, X-ray machines, and lab facilities, to address high demand and improve service delivery quality. This is critical in rural and remote areas with limited access to advanced facilities.
- 2. Increase Staffing Levels and Build Workforce Capacity**
    - **Recruit Additional Healthcare Staff:** Address staffing shortages by recruiting more healthcare workers, especially in under-resourced and rural areas. Emphasis should be placed on hiring specialized personnel, such as midwives and nurses trained in maternal and emergency care, to meet the specific needs of diverse populations across states.
    - **Provide Continuous Training and Development:** Implement regular training programs to strengthen healthcare workers' capacity. This could include cultural sensitivity training, customer service skills, and technical skill upgrades, ensuring workers are well-prepared to deliver high-quality, patient-centered care.
  - 3. Strengthening Community Engagement and Awareness Campaigns**
    - **Launch Health Awareness Initiatives:** Increase health education and preventive care awareness at the community level, focusing on topics like maternal and child health, hygiene practices, and disease prevention. Utilize local leaders, religious figures, and youth representatives as community health ambassadors to foster trust and encourage engagement.
    - **Enhance Transparency Around the BHCPF:** Given the mixed awareness and impact perceptions of the BHCPF, implement more communication efforts that clearly outline how the fund benefits local communities. Regular updates on fund allocation, availability of free services, and eligibility criteria can enhance trust and utilization.
  - 4. Improve Access to PHC Services through Structural and Policy Interventions**
    - **Expand Operating Hours and Emergency Response Services:** Given the demand for 24-hour services noted in both FGDs and KIs, extend operating hours in high-demand facilities, especially those in urban centers and areas with high emergency care needs. Establish dedicated emergency response units to manage after-hours care for critical cases.
    - **Address Geographic Barriers with Mobile Health Units:** In rural and remote LGAs, where travel to PHCs presents a barrier, introduce mobile health units to bridge access gaps. Mobile units can provide basic healthcare, routine immunizations, and maternal services, reducing travel burdens for isolated communities.
  - 5. Implement Accountability Mechanisms and Improve Feedback Systems**
    - **Establish Clear Feedback Channels:** Ensure every PHC has accessible channels for patient feedback, such as suggestion boxes, community forums, and direct contact points for reporting issues. Regularly review and address this feedback to demonstrate commitment to community needs and service improvements.
    - **Promote Community Participation in Oversight:** Empower community members to monitor PHC services actively. Form local health committees involving community leaders, women's groups, and youth representatives to oversee resource utilization and advocate for service quality for their communities.

## **6. Ensure Availability and Affordability of Essential Medicines**

- **Enhance Drug Supply Chains:** Improve supply chain mechanisms to ensure essential medicines are available consistently across PHCs. Partner with state health authorities to streamline stock management, with a particular focus on chronic illness medications, antibiotics, and emergency supplies.
- **Introducing Subsidies for Essential Medicines:** In areas where cost is a significant barrier, consider implementing subsidy programs to reduce patients' financial burdens. This could involve partnerships with local governments, NGOs, and international health organizations to maintain affordable pricing.

## **7. Leverage Technology for Efficiency and Data-Driven Decision-Making**

- **Implement Digital Health Solutions for Patient Management:** Use electronic medical records (EMRs) and patient management systems to streamline processes and reduce wait times, especially in PHCs with high patient volumes. EMRs can improve continuity of care and enable efficient resource allocation.
- **Use Data Analytics for Service Planning:** Analyze patient demographics and health trends to tailor service offerings within each state. This approach ensures that PHCs are equipped to meet their local communities' most pressing health needs, from maternal health in younger populations to chronic disease management for older age groups.

These recommendations aim to address the key challenges identified in the survey, FGDs, and KIIs by enhancing resource allocation, fostering community trust, and improving service accessibility. Through targeted interventions in staffing, infrastructure, accountability, and community engagement, PHCs can more effectively meet the diverse healthcare needs of Nigerian communities and support the country's broader health goals.

## Conclusion

This report highlights the critical role of Primary Healthcare Centers (PHCs) in meeting community healthcare needs across the surveyed states, emphasizing the strengths and challenges inherent in current PHC service delivery. The insights gathered through both quantitative and qualitative analyses reflect a complex yet actionable view of healthcare accessibility, quality, and equity within local communities.

The findings underscore a strong community reliance on PHCs for essential healthcare services, especially in rural and underserved areas with limited alternatives. Despite challenges such as shortages in medical equipment, inadequate staffing, and infrastructure limitations, PHCs remain a vital health resource due to the dedication of healthcare workers and the support of local community leaders. Introducing the Basic Healthcare Provision Fund (BHCPF) has brought notable improvements in facility resources and community trust, though gaps persist in comprehensive implementation and access.

Recommendations focused on strengthening health infrastructure, expanding the healthcare workforce, enhancing transparency, and bolstering community engagement reflect a strategy to address the unique needs identified in each state. By prioritizing resource distribution, workforce policies, accountability, and community feedback mechanisms, state and local governments can work alongside communities to improve the responsiveness and quality of PHC services.

A continuous collaborative approach involving government agencies, local stakeholders, healthcare providers, and community members is essential to bridge existing gaps and build a more resilient, accessible primary healthcare system. Effectively addressing these recommendations could lead to a substantial improvement in healthcare delivery, ensuring that PHCs are well-positioned to provide equitable, quality care for all citizens.

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KANO STATE OF NIGERIA  
**MINISTRY OF HEALTH**

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**Ref:** SHREC/2024 /5138

*29<sup>th</sup> May, 2024*  
**Date:** \_\_\_\_\_

NHREC Approval Number; NHREC/17/03//2018

Dr. Kemisola Agbaoye  
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Nigerian Health Watch,  
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Central Business District,  
Abuja.

**RE: APPLICATION FOR ETHICAL APPROVAL**

Reference to your letter dated 7<sup>th</sup> May, 2024 on the above request addressed to the Chairman Health Research Ethics Committee of the Ministry requesting for ethical approval to conduct a Research work in Kano Municipal, Kura, Gwarzo, Ghari, Wudil and Bunkure Local Government Areas, Kano State.

2. The research entitled "*Community-Based Perception Survey to Enhance Accountability and Amplify Citizens' Voices in Primary Health Care Delivery in Kano State, Nigeria*"

3. In view of the foregoing, I wish to convey the Ministry's approval for you to conduct the research at the above mentioned LGAs.

4. You are also requested to share your findings with the Ministry of Health, Kano state.

5. Best Regards

Muhammad Murtala Abubakar

Secretary

Health Research Ethics Committee



# NIGER STATE GOVERNMENT

## MINISTRY OF PRIMARY HEALTH CARE (MPHC)



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NSMPHC/SUB/638/Vol. 01/017

Date: 3<sup>rd</sup> March 2024.

NSMPHC ERC Protocol Number-ERC/PN/2023/11/002

NSMPHC ERC Protocol Approval Number - ERC/PAN/2023/11/002

### CONDUCT COMMUNITY-BASED PERCEPTION SURVEY TO ENHANCE ACCOUNTABILITY AND AMPLIFY CITIZENS VOICES IN PRIMARY HEALTH CARE DELIVERY

**Name of Principal Investigator:** Dr. Kemisola Agbaoye

**Address of Principal Investigator:** Nigeria Health Watch 7<sup>th</sup> Floor, Plateau House, Plot 79 Ralph Shodeinde  
St CBD, 900103, Abuja Nigeria

**Date of Receipt of valid Application:** 10/06/2024

**Type of Review:** Committee Review

**Date of Committee Evaluation of the Research:** 19/03/2024

**Date of Committee Approval on the Research:** 22/03/2024

#### Notice of Committee Approval

This to inform you that the research described in your submitted protocol and other relevant information materials have been reviewed by the Niger State Ministry of Primary Healthcare Ethical Review Committee and given approval. The approved research period is from 01/04/2024 to 1/12/2024. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the MPHC/DHPRS assigned number and duration of approval of the study. If there is delay in starting the research, please inform the Department of Health Planning Research and Statistics so that the dates of approval can be adjusted accordingly.

#### Subject Description:

No changes are permitted in the research without prior approval by this committee. This committee reserves the right to conduct compliance visits without notification, to evaluate research compliance with approved protocol. You are required to submit periodic research updates and the final documentation of the study (hard copy and soft copy) to this committee on completion of the study. The committee should be duly informed on commencement of the study; and final documentation of the study sent to the committee before the research findings are published.

Congratulation and best wishes.

**Dr. Abdullahi U. Imam**

Permanent Secretary