Policy Brief by

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Infrastructure and PHC Services in Nigeria: *The Case of Delta State*

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Introduction

The emphasis of this policy brief is on the principle of accessibility. Accessibility emphasizes that health care services must be equally shared by all the people of the community irrespective of their race, creed or economic status. It shifts the accessibility of healthcare from the cities to the rural areas, where the most needy and vulnerable groups of the population live. Inaccessibility is, therefore a disadvantage. In this study the object of distribution are primary health care facilities between and among rural communities, in Delta State. While accessibility implies locational proximity, this study also makes a distinction in the quality of what is distributed. Thus, there could be the disadvantage of physical inaccessibility, when the health seekers does not get enough where they are located. There could also be the disadvantage of 'infrastructural' inaccessibility, when what gets to the seekers is of poor quality because of the facilities available. There could also be an accentuated disadvantage of 'double inaccessibility', where what seekers get is of insufficient quantity and poor quality. Thus, infrastructure of a health centre is a surrogate indicator of the quality of the health care services that can be geographically accessed.
This policy brief will examine the state of infrastructure available in the primary health care centres in the Niger Delta region of Nigeria, using Delta State as a case study.

Preface

This policy brief is based on the findings of CPED in the concluded health research project titled *"Strengthening the Health System in Nigeria through Improved Access to Primary Health Care (PHC): The Case Study of Delta State, Niger Delta Region"* funded by IDRC and WAHO. This policy brief is designed to draw attention to key findings their policy implications after the execution of the project.

Background

One of the spin-off effects of the urban-based medical services established by the colonial administration was the total neglect of rural communities. Those that existed lacked infrastructure. Even fifty years after independence, this dichotomy has persisted and become more pronounced. The objective of this study is to examine the state of infrastructure in the primary health care centres in Delta State, Nigeria.

Infrastructure is, collectively, the underlying foundation that supports a larger structure; the intrinsic framework of a system or organization and the 'substructure' that underpins the 'superstructure'. They determine the capacity and capability of the system to carry out its core functions and deliver on their core mandates and the corresponding quality of the care and accessibility to health care delivery in a society. To ensure quality service delivery, the World Health Organization (WHO) has recommended that health care infrastructure should be 'formal and enduring', requiring a mandated strategic focus that is maintained over time on a sustainable basis. The expectation of formal and enduring infrastructure is that their sustenance and maintenance should be endorsed as the statutory and systematic responsibility of government; rather than being ad hoc or disjointed. This policy brief considers four (4) physical amenities, namely: sources of water supply, sources of electricity, number of functional hospital beds and type of communication facilities.

Methodology

Information gathering adopted the multi-stage sampling procedure. Accordingly, nine local government areas were selected; three each from the three senatorial districts, as follows: Ndokwa East, Aniocha North and Ika South from Delta North senatorial district; Ughelli South, Udu and Okpe from Delta Central; and Isoko North, Bomadi and Warri North from Delta South.

In addition to the quantitative data, there was also a qualitative component; implemented through focus group discussions (FGDs) and key informant interviews (KIIs). The participants in the qualitative survey were PHC staff, and randomly selected key stakeholders in the localities, such as community opinion leaders, users of primary health services, women and youths.

Findings

Table 1: Percentage Distribution of Main Sources of Water Supply in PHC Facilities

LGAs	Piped Water	Open Well	Covered Well or Borehole	Surface Water	Rain Water	Tanker Truck Supply	Total
Aniocha North	88	0	0	4	4	4	100
Bomadi	0	0	67	33	0	0	100
Ika South	0	48	35	0	9	8	100
Isoko North	32	21	47	0	0	0	100
Ndokwa East	7	10	24	21	35	3	100
Okpe	18	18	64	0	0	0	100
Udu	19	5	76	0	0	0	100
Ughelli South	17	24	48	0	4	7	100
Warri North	25	38	25	0	12	0	100
Average	**22.89**	**18.22**	**42.89**	**6.44**	**7.11**	**2.44**	**100**

Source: Fieldwork, 2014

Table 2: Percentage Distribution of Main Sources of Power Supply in PHC Facilities

LGAs	National Grid	Back-up Generators	Solar Panels	Others: Rechargeable Light, Torch, Candle, Lantern	Total
Aniocha North	33	67	0	0	100
Bomadi	0	89	0	11	100
Ika South	66	22	4	8	100
Isoko North	79	11	0	10	100
Ndokwa East	17	7	4	72	100
Okpe	94	6	0	0	100
Udu	62	29	0	9	100
Ughelli South	62	21	3	14	100
Warri North	25	12	0	63	100
Average	**48.67**	**29.33**	**1.22**	**20.78**	**100**

Source: Fieldwork, 2014

Table 4: Percentage Distribution of Communication Facilities in PHC Centres

LGAs	None	Landline Phone	Cellular Phone (GSM)	Short-wave Radio	Computer Facilities	Internet Facilities	Total
Aniocha North	92	0	8	0	0	0	100
Bomadi	56	0	22	0	11	11	100
Ika South	17	0	83	0	0	0	100
Isoko North	36	5	21	11	11	16	100
Ndokwa East	100	0	0	0	0	0	100
Okpe	11	12	35	6	12	24	100
Udu	47	0	29	0	14	10	100
Ughelli South	73	3	21	0	3	0	100
Warri North	100	0	0	0	0	0	100
Average	**59.11**	**2.22**	**24.33**	**1.89**	**5.67**	**6.78**	**100**

Source: Fieldwork, 2014

Table 3: Number and Percentage Distribution of Functional and Non-Functional Beds in PHCs

LGAs	Population (Projected from 2006 Census)	Total Number of Beds	Number of Functional Beds	Number of non-functional Beds	Percentage of Functional Beds	Percentage of non-functional Beds	Number of Functional Beds per population
Aniocha North	114,989	228	186	42	82	18	1:618
Bomadi	89,023	85	54	31	64	36	1:1,648
Ika South	110,807	154	111	43	72	28	1:998
Isoko North	148,584	128	77	51	60	40	1:1,930
Ndokwa East	100,837	279	105	174	38	62	1:960
Okpe	132,892	153	103	50	67	33	1:1,290
Udu	147,469	213	125	88	59	41	1:1,180
Ughelli South	220,080	445	259	186	58	42	1:850
Warri North	140,914	140	129	11	92	8	1:1,092

Source: Fieldwork, 2014

Policy Implications

In consonance with the participatory methodology of the study, the policy implications of the distribution of facilities and amenities in the PHCs in Delta State were derived by supplementing the inventory with the qualitative outcomes of focus group discussions and key informant interviews. During these discussions and interviews, the broad picture that emerged from the quantitative findings was subjected to community scrutiny and evaluation. International best practices for the optimal operation of PHC centres, require that adequate provision be made for safe water, constant power supply and effective communication. However, the survey showed that the situation on ground was different, in various combinations, from centre to centre. This was reflected in the various ways health care seekers, communities and stakeholders expressed their concerns. For instance, some were concerned about situations where babies were sometimes delivered in the night with candles lights and kerosene lanterns, because of lack of power. Similarly, others were worried about the inconveniences to new mothers who have had to wait for family members to bring water from home before they could clean up and take a bath, after child delivery. Furthermore, stakeholders in focus group discussions and key informant interviews noted that communities, in general, and health care seekers, in particular, underutilized PHC facilities partly because they perceived their environments to be uncomfortable and uninviting, as a result of various combinations of infrastructural deficits. Correspondingly, they were of the opinion that many of the centres needed infrastructural upgrading, by providing new floors, comfortable seats for waiting patients, and window shutters with mosquito nets (particularly for the protection of new-borns), among others, as may be needed in specific centres.

Based on this background, the following major policy implications flow from the quantitative and qualitative findings of the study.

1. Increased and sustained funding of the health care system
2. Prioritization allocation of resources among the tiers of health care providers.
3. Targeted upgrading of facilities

Conclusion and Policy Recommendation

Infrastructure constitutes the back bone of the primary health care system, like any other. However, it is one thing for the primary health care centre to be physically present in a community, but quite another for it to rest on a solid foundation. PHC centres must have the requisite facilities for the delivery of quality service and timely interventions. The findings indicated that there were varying degrees of deficiencies in the physical amenities at the PHC centres. Consequently, the centres were unable to render some essential but basic services, such as the proper examining of pregnant women. As a result users were frustrated and discouraged from utilizing their services. The explanation for the weak infrastructural base of the facilities was inadequate funding. The logical policy implication that flows from the study, therefore, is the urgent need to increase the level of funding of the primary health care system in the state. Improved funding would enable the centres to have equipment and facilities that are currently inadequate, such as: supply of safe water and constant power and hospital beds which will widen the scope of health care services that they can offer.

Reference

1. Gideon E.D. Omuta, "Infrastructure and Health Care Services in the Niger Delta Region of Nigeria: A Case Study of Physical Amenities in the Primary Health Care System in Delta State", *Online Journal of Health and Allied Sciences*, 2015:14(4):2
2. Ademiluyi IAA, Aluko-Arowolo SO. Infrastructural Distribution of Health Care Services in Nigeria: An Overview. Journal of Geography and Regional Planning. 2009;2(5):105-106.
3. Stephenson P. Health Promotion Infrastructure: A Think piece, An Occasional Paper, Commissioned by the Health Promotion Forum (HPF) of New Zealand.
4. Erinosho O. A. Health Sociology for Universities, Colleges and Health-Related Institutions. Bulwark Consult, Abuja, 2006
5. Powles J, Comim F. Public Health Infrastructure and Knowledge. In WHO, Trade, foreign policy, diplomacy and health Available at www.who.int/trade/distance_learning/ gpgh/gpgh6.en.index1.html. Accessed 23/09/2015

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