budgIT

Primary Health Care (PHC) Accountability Report

About BudgIT

BudgIT is a civic organisation that uses creative technology to simplify public information, stimulating a community of active citizens and enabling their right to demand accountability, institutional reforms, efficient service delivery and an equitable society.

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Report Insights

93%

of PHCs have CHEWs

That makes the CHEW cadre the only one approaching full coverage at the national level

49.6%

of PHCs have NO nurse or midwife

No skilled support for:

- ☒ Childbirth
- ☒ Emergencies
- ☒ Routine care

Only 51%

of PHCs have electricity

No power means:

- ☒ No night-time care
- ☒ No proper storage for vaccines
- ☒ Limited emergency response

38%

of PHCs have NO access to water. And about 31% lack proper toilets

This affects:

- ☒ Hygiene
- ☒ Infection control
- ☒ Patient safety

Report Insights

Only 13.9% of PHCs have an ambulance

In emergencies, getting to proper care becomes a challenge on its own.

Only 53% of PHCs operate 24 hours

Nearly half are not open when you need them most.

40% of PHCs have NO functional laboratory

This means patients are sometimes treated without proper diagnosis.

Many PHCs have buildings but lack the basics

A centre might have structure but no staff, equipment or power.So it exists, but it doesn't function.

Executive Summary

The Primary Health Care (PHC) Accountability Tracka has revealed a critical dichotomy in Nigeria's primary health sector: while there is a strong framework for community engagement and rising citizen demand for quality care, the physical and operational state of facilities lags significantly behind national standards. Data from over 5,099 facilities assessed and tracked in 2025 indicate that staffing shortages, energy poverty, ambulance service shortages, and drug unavailability remain the most pervasive barriers to effective healthcare delivery.

Since the 1978 Alma-Ata Declaration, the PHC has been recognised as the foundational, low-cost, first-contact healthcare service critical to the functioning of global health systems. Yet, most PHC facilities in focus are significantly under-resourced and some are borderline non-functional. In BudgIT's 2025 PHC systems survey, a comprehensive analysis of infrastructure, amenities and staffing conditions was conducted across 5,099 PHC facilities spanning all 36 states and the Federal Capital Territory (FCT). The dataset covers twelve infrastructure and service indicators from electricity and water supply to functional laboratories and waste management as well as staffing profiles for doctors, nurses/midwives and Community Health Extension Workers (CHEWs).

Assessment of 5,099 PHC facilities across Nigeria's 36 states and FCT reveals a system under profound structural stress and the findings reveal a healthcare system under significant strain. While some indicators such as drug dispensing (76.2%) and waste management (71.1%) show relatively adequate coverage, others notably ambulance availability (13.9%), electricity supply (51.4%) and operational time compliance (53.5%) expose deep and widespread deficiencies. Perhaps most alarming is the staffing crisis: 86.2% of all PHC facilities under review have no doctor on site and 49.6% have no nurse or midwife. These gaps compound the infrastructure shortfalls and collectively undermine the capacity of Nigeria's primary health system to deliver essential services to its citizens.

Pronounced geographic disparities persist across geopolitical zones. The South-West zone led by Lagos State consistently outperforms other regions across infrastructure indicators, while the North-West and North-Central zones record the weakest electricity coverage. Composite infrastructure scoring reveals Lagos, Ondo, Borno, Jigawa and Yobe as the strongest performers, while Ebonyi, Niger, Benue, and Edo are the most underserved.

Compounding deficits, where states like Ebonyi, Benue and Kogi rank poorly across multiple indicators simultaneously mean the effective healthcare access gap is far greater than any single metric suggests. Operational reliability is a hidden crisis, with only 53.5% of facilities meeting expected service hours and data completeness gaps in states like Edo, Zamfara and the FCT further obscure the true scale of the challenge. Nonetheless, bright spots exist: Ondo's 91.2% ambulance coverage, Cross River's near-universal waste management, Lagos's consistent infrastructure leadership, and some northern states' adaptive solar power investments demonstrate what sustained political will and targeted investment can achieve.

Closing these gaps requires multi-indicator facility rescue programmes, a national ambulance fleet initiative, mandatory nurse deployment tied to Basic Health Care Provision Funding, an operational time accountability framework and a national PHC solar electrification programme.

According to previously documented assessments, Nigeria has over 34,000 PHCs (which account for 85% of the hospital facilities) distributed across the 774 local government areas, with at least one functional PHC per ward. Despite the large numbers, only 20%-25% are functional, with many requiring infrastructural renovation, lacking basic equipment and suffering from a gross human resource deficit. Hence, there is an urgent need for action.

1.0 Introduction/Background

The PHC system in Nigeria forms the bedrock of the healthcare system and is the foundation of Universal Health Coverage (UHC). Despite increased investments through initiatives such as the Basic Health Care Provision Fund (BHCPF), donors and state-level health reforms, gaps persist in service delivery, including accountability gaps in financing, infrastructure, human resources and citizen participation.

"To achieve progress towards Universal Health Coverage (UHC), the World Health Organisation recommends adopting the Primary Health Care (PHC) approach to health systems, as it is the most inclusive, equitable, cost-effective, and efficient way to enhance people's health and well-being".[1]

According to previously documented assessments, Nigeria has over 34,000 PHCs (which account for 85% of the hospital facilities) distributed across the 774 local government areas, with at least one functional PHC per ward. Despite the large numbers, only 20%-25% are functional, with many requiring infrastructural renovation, lacking basic equipment and suffering from a gross human resource deficit. Hence, there is an urgent need for action.

In the last 13 years, the BudgIT Foundation has focused on transforming citizens' experiences, breaking down information asymmetry, providing access to public finance information and showing the path to public accountability. However, our interest in health service delivery expanded in 2019 when we led a campaign on #FixPHC through our Tracka platform, which discovered the disheartening state of most Primary Healthcare centres across Nigeria, given the poor services they offered.

In 2022, BudgIT developed the Primary Health Care Accountability Tracka[2] (PHC Tracka), a digital public accountability tool that tracks the implementation of the Basic Health Care Provision Fund (BHCPF) and monitors facility conditions. This tool was launched in 2023 to enable citizens to share their experiences after receiving care, promote transparency and assess the facility's current status. With improvement and contextualization, the PHC Tracka has been adapted to consistently monitor the quality of care delivered across PHCs while providing the insights needed to strengthen health care services at the subnational level.

Scope: The platform utilises a "bottom-up" approach, empowering citizens in over 260 communities across focus states (including Kano, Kaduna, Gombe, Niger and Yobe) to report directly on facility conditions with a wide national representation of PHCs profiled on the platform.

Mechanism: Through Ward Development Committees (WDCs), Community-Based Organisations (CBOs), Community members (patients and concerned citizens) and desk officers in some states, the platform collects real-time data on infrastructure, personnel and service quality, creating a feedback loop between patients and policymakers.

The over 5,000 PHC challenge is a follow-up to the earlier piloted PHC survey conducted across 75 PHCs in five pilot states (Gombe, Niger, Kaduna, Kano and Yobe; 15 PHCs per state), which was later expanded to 200 facilities in Kaduna state. The survey is based on the modified Service Availability and Readiness Assessment (SARA), a standard health facility assessment methodology promoted by the World Health Organisation (WHO), in keeping with the Revised Ward Health System Strategy (RWHSS) minimum standards.[3] The SARA is a systematic health facility assessment tool designed to assist countries in assessing health system progress and monitoring service availability, as well as the readiness of health facilities to provide services. This survey covered the availability of basic inputs, including infrastructure, basic amenities/utilities, equipment and human resources/staff strength, which are key variables for assessing service delivery at health facilities.

1. World Health Organisation (WHO). (December 5 2025). Universal health coverage (UHC). Fact Sheets. Available at: https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-%28uhc%29
2. BudgIT Foundation. (2026). PHC Accountability Tracka (Online). Available at: https://www.phctracka.org/
3. Service availability and readiness assessment (SARA), National Primary Health Care Development Agency (NPHCDA). The Revised Ward Health System Strategy: A Harmonised Framework. Abuja; 2022.

1.1 Country Context

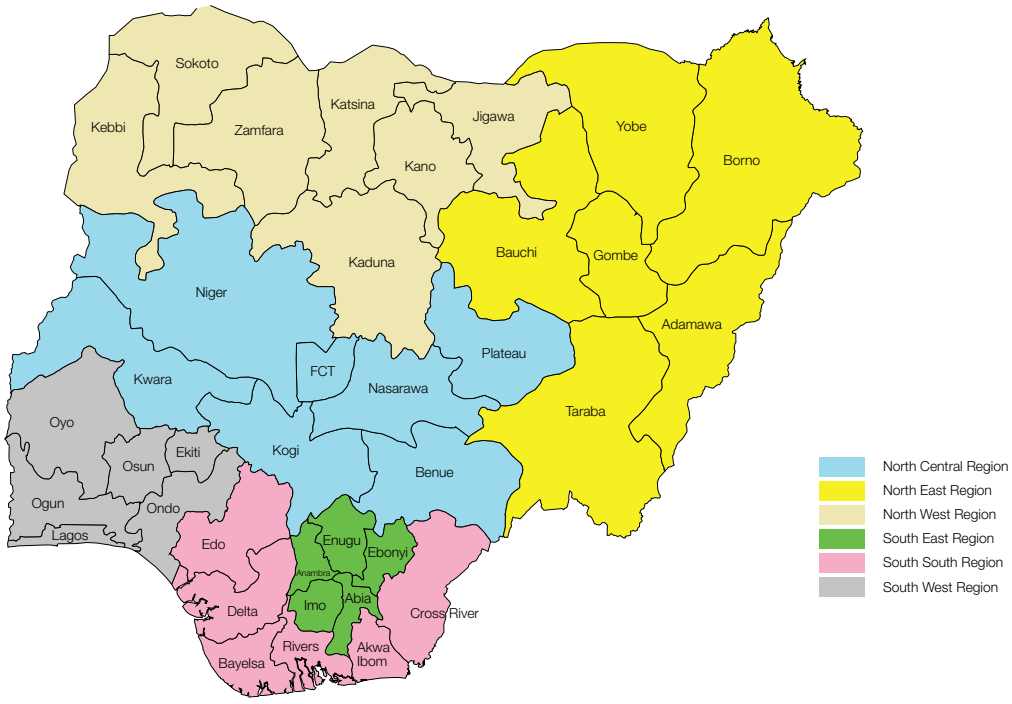
Nigeria is a Federal Republic with power distributed among 3 arms: the executive, legislative and judicial. The country is divided into thirty-six states (36) and a Federal Capital Territory (FCT), which are further subdivided into seven hundred and sixty-eight (768) Local Government Areas (LGAs) and six Area Councils (in the FCT). These LGAs are further structured into an estimated 9,410 council/political Wards. At the state and FCT level, there is further conventional aggregation into six geopolitical zones: North-Central, North-East, North-West, South-East, South-South and South-West.

As the most populous nation in Africa, with an estimated population of over 244 million people,[4] with more than 300 ethnic groups and well over 500 languages/dialects: Nigeria faces a complex cascade of challenges in achieving its desired health outcomes for its citizens.

Despite numerous policies and interventions, it has been reported that 114 out of every 1000 children under five years old die,[5] in addition to 8,200 maternal deaths and a maternal mortality ratio of 1,047 per 100,000 livebirths.[6]

As a nation, Nigeria accounts for 10% to 16% of the global burden of maternal and child mortality[7] with a significant proportion of maternal deaths resulting from poor care during critical periods (Antenatal care) of pregnancy, from poorly controlled diseases in pregnancy (such as hypertension, diabetes to pre-eclampsia and eclampsia and hemorrhages) and complications from unsafe abortions-especially in rural communities. These contextual factors make it increasingly challenging to meet the health needs of the populace and, perhaps even more so, to improve service quality.

Image 1



Source: Researchgate.net

4. First Schedule 1, Part 1, Constitution of the Federal Republic of Nigeria, 1999.
5. Okoroiwu, H.U., Edet, U.O., Uchendu, I.K., Echieh, C.P., Nneoyi-Egbe, A.F., Anyanwu, S.O., Umoh, E.A., Nwaiwu, N.P., and Mbabuike, I.U. (2024). Causes of infant and under-five (under-5) morbidity and mortality among hospitalized patients in Southern Nigeria: A hospital based study. J Public Health Res. Feb 24;13(1):22799036241231787. doi: 10.1177/22799036241231787.
6. Dogbanya, G. (2025). Maternal Mortality in Nigeria: Holding the Line in Uncertain Times. Ann Glob Health. Mar 25;91(1):16. doi: 10.5334/aogh.4710.
7. UNICEF. (2025). Nigeria: Demographics, Health & Infant Mortality. Country Profiles. Available at: https://data.unicef.org/country/nga/

1.2 The Health Sectoral Context

Nigeria's National Health Act, 2014,[8] provides a framework for standards and regulations of the health sector.

The health sector encompasses the Federal and State ministries of health, Local Government health authorities, village and ward health authorities, private healthcare providers and alternative and traditional healthcare providers.

The provision of healthcare services is the responsibility of the three tiers of Government: Federal, State and Local Government Authorities. The primary function of the federal government is to coordinate the National Health System (NHS) through the formulation of national policies and standards and the establishment of regulatory mechanisms. In addition, it manages service delivery at the federal Tertiary Health Institutions in the country, namely: Teaching Hospitals, Federal Medical Centres and Specialist Hospitals. On the other hand, the State Government manages secondary health care facilities (general hospitals), while Local Government Authorities (LGAs) are responsible for primary healthcare, with support from the National Primary Health Care Development Agency (NPHCDA).

1.3 Survey Justification

There is a wide array of problems associated with citizens' access to care in health facilities in Nigeria. These challenges range from the poor state of PHC infrastructure to the non-availability of health facilities in some communities, an inadequate number of health care personnel, obsolete or non-functional equipment, poor standards and quality of service delivery at some facilities and a poor referral system, amongst others. With studies showing alarming records in the number of cases of under-five mortality, infant mortality and maternal mortality figures across the nation (due to poor quality of care at the health facilities) there is a need for evidence-based information on the current status of health facilities.[9] This information ought to detail their availability, readiness and service delivery quality; hence, the goal to conduct the 5,099 PHC assessment/survey.

Between Q3 and Q4, 2025, an independent survey was conducted by BudgIT Foundation to map out facilities nationwide. 20,986 facilities were mapped and 5,099 PHC facilities were assessed in phase one of the survey to determine their level of functionality.

This initiative was timely, given the government's ongoing revitalisation efforts under the Renewed Hope Intervention Agenda, which aims at revitalising two PHCs per political ward, supported by the Basic Health Care Provision Fund (BHCPF).[10] It is estimated that 2,700 facilities were upgraded by the end of 2025, aiming to increase the number of functional PHCs from 8,406 to 17,600 over four years.[11] The NPHCDA, on the other hand, recently launched its live dashboard to track PHC upgrades nationwide, providing an update that, out of the 26,711 PHC facilities highlighted on its platform at the time of this report, 8,309 are BHCPF-funded, 2,582 have been revitalised and 2,926 have been upgraded to Level 2 PHCs.

For Nigeria to tackle the various challenges in the health care system across the country while advancing Universal Health Coverage, all health stakeholders, including government and non-government actors, must collaborate to review, plan and implement effective policies that promote the well-being of all citizens, irrespective of age, gender, ethnicity or religious orientation. The survey will provide high-quality data to policymakers, researchers and partners to coordinate necessary interventions in Nigeria's health sector.

8. National Health Act, 2014. Federal Republic of Nigeria. Available at: The-Official-Gazette-of-the-National-Health-Act.pdf
9. Okoroiwu, H.U., Edet, U.O., Uchendu, I.K., Echieh, C.P., Nneoyi-Egbe, A.F., Anyanwu, S.O., Umoh, E.A., Nwaiwu, N.P., and Mbabuike, I.U. (2024) Causes of infant and under-five (under-5) morbidity and mortality among hospitalized patients in Southern Nigeria: A hospital based study. J Public Health Res. Feb 24;13(1):22799036241231787. doi: 10.1177/22799036241231787.
10. Federal Ministry of Health. (2023). Renewed Hope Agenda: Health sector priorities and implementation framework. Abuja: Federal Ministry of Health, National Primary Health Care Development Agency. (2023). Basic Health Care Provision Fund operational guidelines. Abuja: NPHCDA.
11. Adejoro, L. (April 22 2025). Nigeria upgrades 901 health centres, targets 2,700 more by 2025. In the Punch Newspapers (Online). Available at: https://punchng.com/nigeria-upgrades-901-health-centres-targets-2700-more-by-2025/
12. National Primary Healthcare Development Agency. (2026). PHC Dashboard-Home Page. Federal Republic of Nigeria. Available at: https://nphcda.gov.ng/

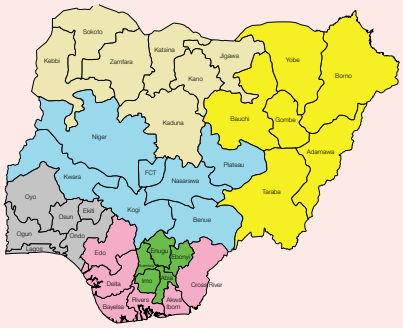
1.4 Survey Objectives

The survey objectives of the 5,099 PHC assessment are to:

- Provide evidence-based information that would strengthen health service delivery.
- Collect health facility data to serve as benchmarks for measuring progress.
- Assess the service availability and readiness in Primary Health Care facilities.
- Actively track and monitor progress across the Primary Health Care facilities.
- Provide an independent/unbiased report that would serve as a verification report for the government and citizens to assess the efforts of the ongoing revitalisation exercise.

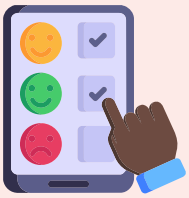
1.5 Coverage

The survey assessed 5,099 public primary health facilities selected from the 36 States and the Federal Capital Territory (FCT). This approach ensured a mix of urban and rural settings, reflecting the varied local contexts. The target respondent was the facility's Officer-in-Charge (OIC).



5,099

public primary health facilities were surveyed across 36 states & FCT



2.0 Methodology

To understand the structure and functionality of PHCs, the survey mapped PHCs across the 36 states and the FCT and evaluated the compliance of public PHC facilities in Nigeria with the Revised Ward Health System Strategy (RWHSS) minimum standards.[13]

This was to ensure that at least 1 facility is captured per ward with a representation across the 774 LGAs. The evaluation mapped 20,986 facilities and a sample of 5,099 facilities were profiled in line with the NPHCDA minimum standard for Primary Health Care in Nigeria.[14] The primary health care accountability report was also supported by review of secondary literature and global set standards, such as journal articles, media reports, health regulations and legislation such as; the Abuja Declaration and the National Health Act of 2014, to ensure policy foundation.

2.1 Study Design and Sampling Technique

The survey employed a cross-sectional descriptive design to evaluate the compliance of public primary healthcare (PHC) facilities in Nigeria with the Service Availability and Readiness Assessment (SARA) and the RWHSS minimum standards. The evaluation was conducted across all 5,099 public PHC facilities in Nigeria, spanning the six geopolitical zones: North-east, North-Central, North-west, South-east, South-South and South-west. The study aimed to assess adherence to these standards, identify gaps in service delivery and provide insights to enhance the quality of PHC services nationwide.

A multi-stage stratified sampling technique was utilised to ensure representation across Nigeria's diverse geopolitical zones. In the first stage, the country was stratified into six geopolitical zones and states were randomly selected within each zone. Local government areas (LGAs) were selected within each state, followed by sampling PHC facilities within these LGAs. This approach ensured a mix of urban and rural settings, reflecting the varied local contexts.

The sampling was purposive in its stratification, deliberately structured to achieve minimum ward-level representation and LGA coverage and random at the facility selection stage within each LGA stratum, thereby combining the strengths of both approaches to maximise geographic coverage while minimising selection bias.

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13. National Primary Health Care Development Agency (NPHCDA). The Revised Ward Health System Strategy: A Harmonised Framework. Abuja; 2022.
14. National Primary Health Care Development Agency. National Guidelines for Development of Primary Health Care System in Nigeria. Abuja; 2012.

2.2 Data Collection

Data was collected through a comprehensive national survey using a standardised assessment tool designed to evaluate compliance with the harmonised tool. This tool covered several domains, including infrastructure (building condition, signpost), basic amenities (water, electricity, sanitary facilities), staffing/human resources, service readiness (lab, drugs, 24-hour service), access systems (ambulance, security), resilience (alternative power) and hygiene (waste management).

The data collection process included three phases: pre-assessment training across the six geopolitical zones; facility visits; and data recording.

- **Pre-assessment training**: Data collectors, including community health champions and state officers, underwent comprehensive training on the use of the assessment tool and survey protocols to ensure data accuracy and consistency.
- **Facility visits**: After obtaining a letter of acknowledgement to participate in the exercise from the respective authorities, the trained teams visited each selected PHC facility, conducted structured interviews with facility managers and performed direct observations using checklists to verify the availability and condition of infrastructure, equipment and essential medicines.
- **Data recording**: Information collected at the facility was entered using the computer-assisted personal interview (CAPI) method via the Open Data Kit (ODK) software to facilitate real-time data entry and minimise errors.

2.3 Limitations

Notwithstanding the rigour of the study design, several limitations should be acknowledged when interpreting the findings:

- **Incomplete portal registration**: The PHC portal survey from which the facility was drawn did not capture the full complement of operational PHC facilities in every state. States such as Edo (20 facilities), Zamfara (60), Ekiti (61), Taraba (63) and the FCT (58) reported facility counts which were inconsistent with their population sizes and known health system footprints.
- **Access constraints**: In Edo State, assessors encountered limited physical access to a number of facilities due to lack of cooperation from the facility OIC's, constraining the completeness of data collection within that state.
- **Geographical spread limitations**: The geographic distribution of data collectors was not uniform across some states, potentially resulting in underrepresentation of facilities in more remote or difficult-to-reach areas.
- **Security restrictions**: Active banditry and insecurity in the North East and some Eastern States restricted assessors' access to several facilities, limiting the comprehensiveness of coverage in that state.
- **Facility operational disruptions**: At the time of data collection, PHC facilities in the FCT had recently resumed operations following an industrial strike action by health workers, which may have affected the accuracy of operational status and staffing data recorded for those facilities.

- **Cross-sectional design constraints**: As a cross-sectional study, the assessment captures a snapshot of facility conditions at a single point in time and cannot account for seasonal variations, post-survey improvements, or deterioration in facility status. As such, causal inferences cannot be drawn from the findings.

- **Self-reporting and observer bias**: Some data points, particularly those relating to operational time compliance, staff availability and facility security relied on assessor observation and facility records at the time of visit, which may not fully reflect day-to-day operational realities.

3.0 PHC Infrastructure and Amenities Indicator Analysis

Health facilities are static or mobile structures that provide various types of health services by different cadres of health workers. 5,099 facilities across the six geopolitical zones (the 36 states and the FCT) were assessed using various indicators and each state scored on these core dimensions:

1. Infrastructure (building condition, signpost)
2. Basic amenities (water, electricity, sanitary facilities) and resilience (alternative power)
3. Human Resource/ Staffing
4. Service readiness (lab, drugs, 24-hour service)
5. Access systems (ambulance, security)
6. Hygiene (waste management)

3.1 Infrastructure (signpost, building condition)

A Primary Health Care (PHC) centre in Nigeria is defined not only by the services it provides but also by its basic infrastructure, which signals its presence and functionality to the community. Two key elements used to assess the state of infrastructure are building condition and signposts. According to the NPHCDA's minimum standards for PHC, the latter are classified into three recognised facility types using the Ward Health Systems into the following:

For the purpose of this analysis, our core focus is on the Primary Health Care Centres (Level 2 Facilities).

3.1.1 Signpost:

Of the 5,099 PHCs surveyed, only 3,434 (67%) of their facilities had visible signposts, affecting facility visibility, community access, and utilisation.

67%
of facilities had visible signposts

In Ondo State, of the 113 facilities surveyed, only 104 had visible signposts, accounting for 98% of the facilities that did. This is the highest proportion of facilities with signposts; it is closely followed by Plateau (89%), Rivers (87%), Ogun (86%), Anambra (85%), Delta (83%), Borno (82%), Yobe (82%) and Akwa Ibom (81%).

While the lowest proportion of facilities with signposts (based on the number of facilities surveyed) was recorded in states such as Zamafra (58%), FCT (55%), Kano (54%), Ebonyi (48%), Edo (45%), Niger (42%) and Kwara (40%).

Southern states, with the exception of Borno and Yobe (Northern States), accounted for the majority of facilities with visible signposts, indicating stronger facility standardisation and supervision.

3.1.2 Building Condition:[15]

Leveraging the NPHCDA's minimum infrastructure standards, the survey found that 63% (3,213 out of 5,099) of facilities were in good condition.

63%
of facilities were in good condition

During the survey, we observed a clear divide in infrastructure across the states. Poor building conditions in low-performing states suggest under-investment and weak maintenance systems.

Following the survey, we identified Yobe (85.9%), Borno (85.5%), Ogun (79.7%), Ondo (77.8%), Kano (76%), Edo state (75%), Kebbi (74.7%), Katsina (74%), Anambra (72%) and Bayelsa (71.6%) as the top ten (10) states with the highest proportion of facilities in good condition.

Other states with building conditions higher than the average of 63% are: Sokoto (71.43%), Lagos (68.42%), Bauchi (67.92%), Kaduna (67.58%), Adamawa (66.67%), Rivers (65.77%), Cross River (65.12%), Akwa Ibom (65.00%) and Osun (64.10%) respectively.

We identified that facilities in some states had percentages of buildings in good condition above the 50% mark but below the 63% average benchmark. The facilities include: FCT (50%), Abia (50.7%), Ekiti (50.8%), Imo (51.2%), Taraba (53.97%) and Zamfara (56.6%).

Some states had the majority of their facilities in poor condition. During the survey, we identified that Benue state tops the list from the bottom, with only 37 out of the 111 facilities in good condition (33.3%); this is closely followed by Jigawa (41.1%) and Ebonyi (47%).

15. Building condition: refers to the recommended infrastructural dimensions, furniture and equipment in alignment with the NPHCDA minimum standards for PHCs.

3.2 Basic Amenities (water, electricity, sanitary facility) and Resilience (alternative power)

3.2.1 Access to Water:

When assessed for water availability, 3,165 of the 5,099 (62%) facilities had access to water (running water or stored water reservoirs).

62%
had access to water

Access to water is one of the most fundamental determinants of quality service delivery in PHC facilities, especially in maternal, newborn and child health (MNCH). Its impact spans clinical quality, optimising infection prevention and control, patient safety, staff performance and overall health outcomes. At the community level, access to water affects utilisation of services at the facility (PHC attendance), which, in turn, affects public health outcomes and disease control.

Lagos state tops the list, with 88.8% of the facilities profiled having access to water; this is followed closely by Kaduna (86.2%), Ondo (85.8%), Jigawa (85%) and Bauchi (81.7%).

Other facilities identified as having a high proportion of water availability were: Ogun (79.7%), Delta (77.2%), Yobe (75.6%), Rivers (72.9%), Borno (72.4%), Anambra (68.4%), Ekiti (67.2%), Taraba (66.6%), Kwara (64.1%), Katsina (62.5%), Osun (62.3%) and FCT (62.0%).

States with facilities with access to water at 50% or below, compared to the total number of facilities identified and profiled, were: Benue (36.9%), Kogi (42.4%), Niger (44.6%), Ebonyi (48.3%), Gombe (48.5%), Edo (50.0%), Plateau (50.3%) and Bayelsa (50.6%).

3.2.2 Electricity and Alternate power supply:

Nationally, 2,621 out of 5,099 facilities (51.4%) are connected to an electricity supply. This leaves a substantial 48.6% of PHC facilities without reliable grid electricity, a situation that poses serious risks to service delivery, patient safety and staff efficiency.

51.4%
are connected to electricity supply

Access to reliable electricity is a critical enabler of effective service delivery in PHC facilities. Like water, it directly shapes the quality, availability and safety of care: especially for MNCH services. Electricity availability improves health services by enabling a safe environment, reducing errors due to poor visibility and improving emergency response and timely care. Lack of electricity has been found to be a major determinant in delayed or unsafe care at night, often leading to referrals or avoidable deaths.

Another critical area where electricity is crucial is in the maintenance of the cold chain system (refrigerators for vaccines and temperature monitoring devices among other things), which in turn ensures vaccine potency and continuous immunisation services. Unreliable electricity is a major cause of vaccine spoilage, stock-outs and missed immunisation opportunities, especially in rural and hard-to-reach areas.

Lagos State stands out as the top performer on a proportional basis, with 137 of its 152 facilities (90.1%) connected: the highest percentage in the country. This reflects the state's relatively advanced urban infrastructure. Kwara and Anambra are notable for combining both high counts and high rates of 72.4% each, suggesting relatively strong grid infrastructure relative to facility needs. Kaduna and Kano rank 3rd and 4th with 135 and 132 facilities, respectively, though their coverage rates (37.1% and 51.8%) indicate room for improvement given the large number of facilities in each state. Niger State leads in absolute numbers, with 174 facilities connected to electricity, largely reflecting its high total facility count (325). However, this translates to only 53.5% coverage, suggesting that, despite the large volume, more than half of Niger's facilities still lack grid power.

Among states with the fewest facilities recorded with electricity connections, Edo State has the lowest absolute count (9 facilities), though this is partly explained by its small total of only 20 registered facilities. Zamfara and Borno are more concerning; both have very low coverage rates of 31.7% and 36.2%, respectively, meaning the majority of facilities in these states lack electricity.

Ebonyi State records the lowest coverage rate among states with a substantial facility count, with only 42 of 147 facilities (28.6%) electrified, the worst performance on a proportional basis in the country. Plateau State (not in the bottom 10 by count but with a 33.3% rate) similarly reflects infrastructure challenges in the North-Central zone.

States such as Bayelsa, Taraba, FCT and Borno each have 25–30 facilities with electricity, with rates ranging from 36–52%. The FCT's relatively low absolute number (30), despite its urban status, is notable and may reflect gaps in newer or peri-urban health facilities.

Given the unreliability of grid electricity in many parts of Nigeria, alternative power sources, including solar panels, generators and inverter systems, play a critical complementary role in health facility operations. Nationally, 3,103 facilities (60.9%) have access to an alternate power supply, which is higher than the grid electricity rate (51.4%). This suggests that some states have invested in off-grid or backup solutions to compensate for poor grid access.

Interestingly, in several states, the number of facilities with alternate power exceeds those with grid electricity, particularly in northern states like Bauchi (85.5% alternate vs. 54.7% on grid), Jigawa (94.1% alternate vs. 55.9% on grid), and Borno (79.7% alternate vs 36.2% on grid). This points to deliberate policy and/or donor investment in solar and generator-based backup systems in regions with poor grid reliability. Kaduna and Kano jointly lead with 154 facilities each: the highest counts nationally. Bauchi follows with 136 facilities, representing an impressive 85.5% coverage rate, the second-highest proportion in the country. Anambra again demonstrates strong performance with an alternate power rate of 82.9%, consistent with its high electricity coverage. Nasarawa appears in the top 5 for alternate power (130 facilities, 68.8%) despite not featuring as prominently in the electricity rankings, suggesting proactive investment in backup power solutions. Lagos maintains its position among the top performers in alternate power (120 facilities, 78.9%). Its high scores across both power indicators reflect the advantage of its urban infrastructure and funding base.

On the contrary, states like Zamfara are the most concerning among states with a meaningful facility count, with only 28 of 60 facilities (46.7%) having alternate power, the lowest rate among those with 50+ facilities. Imo State (43.7%) and Gombe (45.8%) stand out as underperformers given their facility sizes. Abia State also features here with an alternate power rate of 47.7% across 130 facilities, indicating limited backup power investment in the South-East zone.

3.2.3 Access to Sanitary Facilities:

Access to sanitary facilities within health centres is a fundamental component of infection prevention and patient dignity. The national average of 69.0% (3,517 out of 5,099 facilities) indicates that nearly one-third of PHC facilities lack adequate toilet access, an unacceptable situation from both a public health and patient rights perspective.

69%
of PHC facilities lack adequate toilet access

Kaduna leads nationally with an exceptional 323 of 364 facilities (88.7%) equipped with toilets, the highest absolute count and one of the highest rates. Lagos achieves the highest coverage rate at 90.8% (138 of 152 facilities), maintaining its consistent top-tier performance across all indicators. Kano, Katsina, Oyo, Bauchi and Anambra all appear among the top 10 for both count and coverage rate. This cluster of states represents the more infrastructure-advanced segment of Nigerian PHC facilities.

Benue State has the lowest toilet coverage rate among states with a substantial number of facilities, only 44.1% (49 of 111 facilities). This is particularly concerning, given that Benue has more facilities than many bottom-ranking states, suggesting a systemic rather than volume-driven gap. This is closely followed by Ebonyi (46.9%).

3.3 Human Resources/Staffing

The National Primary Health Care Development Agency (NPHCDA) Minimum Service Package (MSP)[16] establishes clear human resource standards that every Primary Health Care (PHC) facility in Nigeria must meet to deliver safe, effective, and equitable health services. Central to the MSP are three cadres of health workers: Medical Doctors, Nurses and Midwives, and Community Health Extension Workers (CHEWs). Each plays a distinct and non-substitutable role in delivering Basic Health Care Provision Fund (BHCPF) services, the Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH+N) package, and the broader Universal Health Coverage (UHC) agenda. Nigeria's primary healthcare system relies on three critical cadres of health workers each plays a distinct and irreplaceable role and the absence of any one of them weakens the entire system. Together, their functions define whether a PHC facility can genuinely serve its community or merely exist as a physical structure.

Under the NPHCDA MSP, each PHCC facility is expected to have at minimum: at least one Medical Officer-if available or Community Health Officer (CHO)(working with standing order) for clinical oversight and management of complex cases; at least one Nurse or Midwife to ensure safe maternal and neonatal care, immunization, and general nursing services; and at least one CHEW or Junior CHEW (JCHEW-at health post) as the frontline community health worker responsible for health promotion, disease prevention, and routine community outreach. Additionally, PHCs classified as Primary Health Care Centres (PHCCs); the higher tier are expected to maintain at least two nurses and additional CHEWs to support 24-hour service delivery.

National Overview: Human Resource Summary

Across the 5,099 PHC facilities assessed nationally (a mix of PHC and PHCC), the distribution of the three key human resource cadres is markedly uneven and, in several categories, critically below the MSP threshold. The aggregate data, presented in the table below, reveal a system structurally dependent on CHEWs while experiencing severe deficits in medical and nursing personnel.

Table: National Human Resource Coverage across 5,099 PHC Facilities

Human Resource Cadre	PHCs with Staff	Coverage (%)	PHCs without Staff	Gap (%)
Medical Doctors	703	13.8%	4,396	86.2%
Nurses/Mudwives	2,568	50.4%	2,531	49.6%
CHEWs/JCHEWs	4,744	93.0%	355	7.0%

3.3.1 Doctors

Doctors are the apex clinical decision-makers at the PHC level. They diagnose complex conditions, initiate and oversee treatment, make referral decisions and provide clinical supervision to other staff. In a system where malaria, tuberculosis, hypertension, diabetes, and obstetric complications are among the leading causes of death, the doctor's ability to distinguish between conditions that look alike, prescribe appropriately, and recognise when a patient needs higher-level care is fundamental.

Under the NPHCDA MSP, each PHCC facility is expected to have at minimum: at least one Medical Officer-if available or Community Health Officer (CHO)(working with standing order) for clinical oversight and management of complex cases.

Of the 5,099 facilities surveyed, only 703 (13.8%) have a medical doctor present. This means that 4,396 PHCs, representing 86.2% of the sampled facilities, operate without a doctor. The NPHCDA MSP envisages at least one qualified Medical Officer at the PHCC level to supervise clinical care, manage complications, provide emergency obstetric first aid, and ensure appropriate referrals.

State level variation: The distribution of doctors across states is highly inequitable, reflecting both population distribution and urban-rural disparities. Lagos State leads all states with 91 of 152 facilities (59.9%) having doctors, more than four times the national average, and the only state approaching a functional level of medical coverage. Rivers State (43.2%), Anambra (34.2%), Ekiti (31.1%), and Osun (28.2%) are the only other states with coverage above 25%, reflecting relatively stronger health investments in these southern states.

States with critically low doctor presence: Bauchi (1.9%), Benue (2.7%), Nasarawa (3.7%), Kogi (3.9%), Cross River (4.1%), Plateau (5.0%), and Kebbi (4.7%) record near-total absence of doctors in their PHC networks, with some managing over 150 facilities with fewer than 5 doctors.

The North-East and North-West zones, including Borno (7.2%), Gombe (14.8%), Adamawa (20.2%), Jigawa (7.4%), Kebbi (4.7%), and Zamfara (6.7%), collectively reflect a northern PHC system that is structurally doctor-free.

3.3.2 Nurses and midwives are the operational backbone of PHC delivery.

Nurses and midwives constitute the clinical backbone of PHC service delivery in Nigeria, particularly for Maternal, Newborn, and Child Health (MNCH) services. The MSP mandates the presence of at least one Registered Nurse or Registered Midwife at every PHC facility for: antenatal care (ANC), skilled birth attendance, postnatal care (PNC), immunisation, family planning, wound management, and emergency triage.

The survey reveals that only 2,568 of 5,099 facilities (50.4%) have at least one nurse or midwife. This means that 2,531 facilities, exactly half the national PHC network, have no nursing staff whatsoever. In these facilities, all nursing functions are being performed by CHEWs, whose scope of practice under law and the MSP is defined as health promotion, disease prevention, and basic curative care, not skilled nursing or midwifery.

This is particularly alarming in the context of Nigeria's maternal mortality ratio of over 1,000 deaths per 100,000 live births, one of the highest in the world. Deliveries conducted without a skilled birth attendant (SBA) significantly increase the risk of preventable maternal and neonatal deaths.

Wide variation exists across states in nursing and midwifery coverage: Jigawa (98.5%), Katsina (98.3%), Kano (95.7%), and Adamawa (84.5%) lead with near-complete nursing coverage, reflecting the relatively more structured deployment of nurses in these northern states, particularly for maternal health programmes. Lagos (78.3%), Borno (72.5%), Anambra (71.1%), Delta (79.7%), and Imo (66.4%) maintain coverage above 60%, suggesting relatively more functional health workforce deployment in these states.

The most critical nursing deficits are recorded in Kebbi (5.6%), where only 6 of 107 facilities have a nurse. Ebonyi (17.7%), Kogi (17.9%), Plateau (18.2%), and Bauchi (21.4%). These states represent zones of almost complete absence of skilled nursing at the PHC level.

Enugu (24.0%), Niger (20.0%), Gombe (27.5%), and Ekiti (21.3%) also record nursing coverage below 30%, meaning the vast majority of deliveries and nursing-dependent services in these states occur outside the reach of a qualified nurse or midwife.

3.3.3 Community Health Extension Workers (CHEW) represent Nigeria's deliberate policy response to its chronic shortage of health workers.

They are the bridge between the formal health system and the community, conducting house-to-house visits, mobilising communities for health services, delivering outreach immunisation and family planning, managing uncomplicated childhood illnesses and serving as the grassroots layer of Nigeria's disease surveillance network. CHEWs and Junior CHEWs (JCHEWs) are the most widely deployed cadre of health workers at the PHC level in Nigeria, and the backbone of community-based health services. The MSP assigns them responsibility for health education and promotion, growth monitoring, community outreach, immunisation support, distribution of preventive commodities (such as Vitamin A, deworming interventions, etc), and basic

curative care for minor ailments within their competency while working on standing order.

The survey shows that 4,744 of 5,099 facilities (93.0%) have at least one CHEW, making the CHEW cadre the only one approaching full coverage at the national level. Only 355 facilities (7.0%) lack a CHEW entirely.

Five states; Adamawa, Ekiti, Bauchi, Katsina, and Plateau record near-complete CHEW coverage at or above 99%. This near universal CHEW deployment is a significant achievement. However, a critical concern emerges when this is analysed alongside the severe deficits in doctors and nurses: in the majority of PHC facilities across Nigeria, the CHEW is the only health worker present. This places a burden on CHEWs that far exceeds their defined scope of practice under the NPHCDA MSP.

Across the 2,531 facilities without nurses and the 4,396 without doctors, CHEWs are, in fact, primary clinical providers performing functions that the MSP explicitly assigns to higher cadres. This includes conducting deliveries, managing obstetric complications, initiating treatment for conditions beyond their competence, and making clinical decisions with limited/without supervision. This constitutes systemic task-shifting without the corresponding training, supervision, or legal authorisation, creating serious safety risks for patients.

State-by-State Human Resource Coverage Across 5,099 PHC Facilities

State	Total PHCs	Doctors	Nurses/ Midwives	CHEWs
Abia	130	15 (11.5%)	97 (74.6%)	107 (82.3%)
Adamawa	129	26 (20.2%)	109 (84.5%)	129 (100.0%)
Akwa Ibom	180	11 (6.1%)	98 (54.4%)	158 (87.8%)
Anambra	152	52 (34.2%)	108 (71.1%)	116 (76.3%)
Bauchi	159	3 (1.9%)	34 (21.4%)	158 (99.4%)
Bayelsa	81	12 (14.8%)	36 (44.4%)	79 (97.5%)
Benue	111	3 (2.7%)	34 (30.6%)	108 (97.3%)
Borno	69	5 (7.2%)	50 (72.5%)	68 (98.6%)
Cross River	172	7 (4.1%)	84 (48.8%)	159 (92.4%)
Delta	79	10 (12.7%)	63 (79.7%)	58 (73.4%)
Ebonyi	147	19 (12.9%)	26 (17.7%)	141 (95.9%)
Edo	20	3 (15.0%)	14 (70.0%)	13 (65.0%)
Ekiti	61	19 (31.1%)	13 (21.3%)	61 (100.0%)
Enugu	96	16 (16.7%)	23 (24.0%)	94 (97.9%)
FCT	58	5 (8.6%)	26 (44.8%)	57 (98.3%)
Gombe	142	21 (14.8%)	39 (27.5%)	133 (93.7%)
Imo	119	18 (15.1%)	79 (66.4%)	111 (93.3%)
Jigawa	68	5 (7.4%)	67 (98.5%)	63 (92.6%)
Kaduna	364	37 (10.2%)	234 (64.3%)	287 (78.8%)
Kano	255	29 (11.4%)	244 (95.7%)	244 (95.7%)
Katsina	232	29 (12.5%)	228 (98.3%)	231 (99.6%)
Kebbi	107	5 (4.7%)	6 (5.6%)	104 (97.2%)
Kogi	179	7 (3.9%)	32 (17.9%)	165 (92.2%)
Kwara	170	22 (12.9%)	105 (61.8%)	158 (92.9%)
Lagos	152	91 (59.9%)	119 (78.3%)	149 (98.0%)
Nasarawa	189	7 (3.7%)	71 (37.6%)	181 (95.8%)
Niger	325	29 (8.9%)	65 (20.0%)	311 (95.7%)
Ogun	74	9 (12.2%)	25 (33.8%)	69 (93.2%)
Ondo	113	7 (6.2%)	43 (38.1%)	111 (98.2%)
Osun	117	33 (28.2%)	53 (45.3%)	110 (94.0%)
Oyo	189	33 (17.5%)	75 (39.7%)	176 (93.1%)
Plateau	159	8 (5.0%)	29 (18.2%)	158 (99.4%)
Rivers	111	48 (43.2%)	57 (51.4%)	103 (92.8%)
Sokoto	189	40 (21.2%)	84 (44.4%)	180 (95.2%)
Taraba	63	5 (7.9%)	39 (61.9%)	62 (98.4%)
Yobe	78	10 (12.8%)	40 (51.3%)	76 (97.4%)
Zamfara	60	4 (6.7%)	19 (31.7%)	56 (93.3%)
AGGREGATE	5,099	703 (13.8%)	2,568 (50.4%)	4,744 (93.0%)

Alignment with the NPHCDA Minimum Service Package: A Scorecard

The NPHCDA MSP defines three tiers of PHC: Health Posts, Primary Health Clinics, and Primary Health Care Centres (PHCCs). Alignment of the Human Resource across the 5,099 PHCs surveyed against the human resource requirements escalate across tiers:

State	MSP Human Resource Requirement	National Status (5,099 PHCs surveyed)	Compliance
Health Post	1 CHEW or JCHEW	93.0% of facilities have CHEWs	Partially met
Primary Health Clinic	1 Nurse/Midwife + 1 CHEW	50.4% Nurse; 93.0% CHEW	Not Met
PHCC	1 Doctor/CHO +1 Nurse/Midwife +2 CHEWs (24-hr)	13.8% Doctor; 50.4% Nurse	Not Met

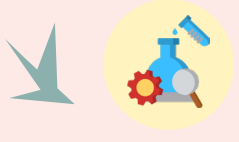
Source: MSP Human Resource Compliance Scorecard (2012)

3.4 Service Readiness

The service readiness of PHCs is measured by three indicators: Functional Laboratory, Functional Drug dispensing and Operational time, collectively defining whether a primary healthcare facility can fulfil its core purpose of diagnosing, treating, and being available when needed. A functional laboratory ensures that clinical decisions are grounded in evidence rather than guesswork. Without it, conditions like malaria, tuberculosis and anaemia go undetected or are mismanaged, fuelling drug resistance and preventable deaths. Functional drug dispensing closes the gap between diagnosis and treatment. When medicines are unavailable at the point of care, patients, most of whom cannot afford private alternatives, simply go without treatment. For children under five, pregnant women and those managing chronic conditions, this gap is frequently fatal.

Operational time determines whether the other two indicators ever reach a patient. Emergencies do not respect working hours. Maternal deaths, severe childhood malaria and obstetric complications occur at night and on weekends. A facility that is closed during these critical moments offers nothing, regardless of how well equipped it is. Together, these three indicators measure the difference between a facility that merely exists and one that genuinely functions, a central challenge in primary healthcare delivery in Nigeria.

Our analysis revealed that only 3,044 of 5,099 facilities have a functional laboratory, representing roughly 60% nationwide. 3,885 out of 5,099 have functional drug dispensing, approximately 76% nationally. Only 2,728 out of 5,099 are open 24 hours a day (operationally active at the time of assessment), just about 53% across the 36 states and the FCT.



60%

of PHC facilities have a functional laboratory

3.4.1 Laboratory Availability

The best-performing states are Jigawa: 62 out of 68 (over 91%), Taraba: 54 out of 63 (86%), Bauchi: 135 out of 159 (85%), Kaduna: 306 out of 364 (84%), Lagos: 124 out of 152 (82%). The worst performing states are Delta: only 17 out of 79 (22%), meaning nearly 4 in 5 Delta facilities cannot run a basic lab test, Enugu: 28 out of 96 (29%), Edo: 6 out of 20 (30%), Anambra: 50 out of 152 (33%), Oyo: 63 out of 189 (33%). The gap between Jigawa (91%) and Delta (22%) is stark. Patients in Delta are far more likely to receive treatment without any laboratory confirmation of diagnosis.

3.4.2 Functional Drug Dispensing

Drug dispensing is the best-performing indicator nationally, but several states still lag. The best-performing states are: Jigawa: 67 out of 68 (99%); Ondo: 109 out of 113 (96%); Lagos: 142 out of 152 (93%); Ekiti: 55 out of 61 (90%); Anambra: 136 out of 152 (89%). The worst-performing states: Edo: 9 out of 20 (45%), less than half of Edo facilities lack a drug dispensary unit. Meanwhile, Kogi: 103 out of 179 (58%), Imo: 71 out of 119 (60%), Niger: 194 out of 325 (60%), Delta: 48 out of 79 (61%).

3.4.3 Operational Time

This is where the data reveals the deepest systemic failure. Many facilities are simply not open for 24 hours or are not functional when patients need them. The best-performing states are Plateau: 158 out of 159 (nearly 99%), almost every facility is operationally active, Ondo: 106 out of 113 (94%), Benue: 96 out of 111 (86%), Ogun: 57 out of 74 (77%), yet still mid-range and Cross River: 132 out of 172 (77%). Worst performing states are catastrophically low, such as: Kano: 35 out of 255 (14%) the second largest facility base in the country, yet only 1 in 7 is reliably operational, Zamfara state - critically low: only 12 out of 60 (just 20%) with 8 out of every 10 facilities are not reliably operational, Akwa Ibom: 37 out of 180 (21%) despite having the most facilities after Kaduna, Lagos and Kano, fewer than 1 in 4 are operationally active, Sokoto: 54 out of 189 (29%) and finally Katsina: 72 out of 232 (31%).

This analysis further reveals the average for the three indicators (Lab-Drug-Operations Triangle), highlighting the best 5 performing states (representing Operational reliability) and the worst 5 performing states(representing the greatest risk to patients) - in terms of Service Readiness. These states performs consistently well across the three indicators: Jigawa (91% lab, 99% drug, 68% operations) outstanding on the first two, Ondo (59% lab, 96% drug, 94% operations) excellent operational reliability, Bauchi (85% lab, 88% drug, 75% operations) strong operational reliability, Taraba (86% lab, 89% drug, 73% operations) one of the most balanced performers, Plateau (69% lab, 77% drug, 99% operations) near-perfect operational time.

The worst performing states on the average are: Edo, critically weak on lab (30%), weak on drug dispensing (45%), moderate on operations (40%); Oyo, weak on lab (33%), moderate on drug dispensing (61%), moderate on operations (51%); Delta, critically weak on lab (22%), weak on drug dispensing (61%), moderate on operations (63%); Kogi, weak on lab (39%), moderate drug (58%) and moderate on operations (52%); Niger, moderate lab (47%), moderate drug (59%) and moderate on operations (47%).

3.5 Access System

Access System is measured by two indicators, namely; Facility Security and Ambulance Availability.

An unsecured PHC facility creates cascading failures across the entire system. It simultaneously undermines staffing, utilisation, supplies, and operational availability. At the aggregate level, from our survey, 2,809 out of 5,099 facilities are recorded as secure: a national average of 55.09%. Only 708 out of 5,099 facilities have an ambulance, a national average of just 13.89%. These two figures alone tell a powerful story. Just over half of Nigeria's PHC facilities are physically secure, and fewer than 1 in 7 have an ambulance. The gap between facility security and ambulance availability is enormous, 55.09% versus 13.89%, meaning that even in facilities that are safely accessible, the capacity to transfer emergency cases to higher-level care is almost universally absent.

Average overall performance for Access System shows these five states as top performers: Ondo leads the country convincingly by a wide margin, 71.68% (Security 52.21% and Ambulance 92.15%), Lagos: second place 55.92% (Security 84.87% and Ambulance 53.97%), Borno with an average of 53.62%, Sokoto: 50.79%, Yobe: 49.36%.

The bottom-performing states on average are as follows: Bayelsa is the single worst performer nationally with a combined average of just 16.05% (Security 23.46%, Ambulance 8.64%). Plateau: 16.35% (Security 28.30%, Ambulance 4.40%), Benue 20.27%, Cross Rivers: 20.64%, Niger has the second largest facility network in the country with 325 facilities, yet ranks in the bottom five, recording only 37.23% security and 4.31% ambulance; a compound failure of access in a state with enormous geographic spread and dispersed population.

3.6 Waste Management

Effective waste management within PHC facilities is a critical but often overlooked component of healthcare delivery. Improper disposal of medical and general waste poses significant risks to patients, healthcare workers and surrounding communities, including the spread of infections, environmental contamination and injury from sharp needles and other instruments.

Nationally, 3,625 out of 5,099 facilities (71.1%) are recorded as having waste management services. However, the remaining 28.9% of facilities without waste management-representing over 1,400 health centres-still pose an unacceptable public health risk. Cross River tops the list with 165 facilities out of the 175 profiled (95.9%), recording the presence of a waste management system at the facility. This is followed by Kaduna with 325 out of the 364 facilities (89.3%), Lagos with 127 facilities out of the 152 (83.6%), Katsina with 187 out of the 232 (80.6%) and Bauchi at (80.5%) with 128 facilities out of the 159 recorded facilities. Other states include Akwa-Ibom and Sokoto at 79.4% and 76.7% respectively.

For states with the fewest facilities with waste management services, Edo State has 20.0% representing only 4 of 20 facilities that have waste management. Benue and Ogun (both 43.2%) are the highest-risk larger states (i.e., states with high risk for infection spread due to the majority of their facilities lacking waste management) with no waste management system.

4.0 Cross-Cutting Themes & Critical Observations

The following insights are drawn from our primary data on aggregated facility assessments.

1. The Compounding Gap Problem

The most alarming finding of this analysis is not any single indicator in isolation but the co-occurrence of multiple deficits within the same states. States like Ebonyi, Benue, Niger, Kogi and Edo consistently rank at the bottom across electricity, water, sanitary facilities, building condition, laboratories and staffing categories. A facility without electricity, water, sanitary facilities, a functional laboratory and a qualified clinician is not a health facility. The compounding effect of overlapping deficits means that the effective healthcare access gap is far larger than any single indicator suggests.

2. The Ondo State: A Model for Emergency Referral

Ondo State's 91.2% ambulance coverage rate, compared with the national average of 13.9%, is one of the most striking data points in the entire dataset. No other state exceeds 43% ambulance coverage. This represents a deliberate policy choice by the Ondo State Government to invest in emergency referral infrastructure at scale and its impact on maternal mortality, emergency response times and overall health outcomes deserves structured documentation and can form the basis of national replication.

3. Operational Time: The Looming Crisis

A facility that exists but is not open is functionally equivalent to no facility at all. The finding that only 53.5% of facilities meet operational time standards, with Kano at just 13.7% and Zamfara at 20.0% represents a hidden but severe service access crisis that does not appear in infrastructure counts. Improving this indicator requires attention to human resource management, accountability systems and incentive structures rather than capital investment, making it a potentially high-return target for low-cost policy intervention.

4. Alternate Power Adaptation

Several northern states, particularly Jigawa (94.1%), Bauchi (85.5%) and Borno (79.7%) have developed alternative power infrastructure that substantially exceeds their grid electricity rates. This suggests an adaptive investment strategy in response to chronic grid unreliability, often supported by donor programmes and state government solar energy initiatives. This model of complementary infrastructure investment should be recognised, supported and scaled.

5. The FCT Paradox

The Federal Capital Territory, the seat of federal government, records below-national-average performance across electricity (51.7%), waste management (50.0%) and operational time (43.1%), while having only 58 facilities registered on the portal (due to the health workers' strike at the time of the assessment). The FCT's PHC underperformance is a governance paradox: the same government responsible for national health policy oversight is failing to meet minimum standards in the facilities within its direct administrative purview. This demands immediate federal government accountability.

6. Data Completeness and Accessibility Challenges

Several states, Edo (20 facilities), Ekiti (61), Taraba (63), Zamfara (60) and FCT (58), have strikingly low facility counts that are inconsistent with their population sizes and known health system footprints. Some states limit access to their facilities (Edo state), while others, such as Ekiti and Taraba, had some peculiarity of limited geographical spread of the data collectors. Zamfara state had high security concerns due to the repeated banditry attacks, and PHCs in the FCT had just resumed operations following the strike undertaken by its health workers. A national PHC facility and portal verification exercise from partners is a prerequisite for evidence-based health system planning.


PGL
75

5.0 Recommendations

1. Emergency Infrastructure Intervention

Majority of the PHCs across the states require an urgent intervention but Ebonyi, Benue, Niger, Kogi and Edo states require immediate, multi-indicator PHC infrastructure rescue programmes. Federal and state governments should jointly develop time-bound Facility Improvement Plans (FIPs) targeting electricity, water, toilet and building condition deficits, simultaneously recognising that piecemeal indicator-by-indicator investment is insufficient for states with compounding gaps.

2. National Ambulance Fleet Initiative

The near-universal absence of ambulances (86.1% of facilities uncovered) demands a dedicated National PHC Emergency Referral Programme utilising the BHCPF through the National Emergency Medical Services and Ambulance Systems (NEMSAS) gateway. Ondo State's model, which achieves 91.2% ambulance coverage, should be formally documented, evaluated and used as the blueprint for a federal fleet procurement and deployment strategy, with BHCPF funding ring-fenced for this purpose. The ODEMSA initiative expanded its coverage by the utilization of tricycle ambulances that are cost-effective and can access remote areas thereby not limiting their services to road traffic accidents but also facility based referrals.

3. Physician and Nurse Deployment Reform

The staffing data reveals that 86.2% of facilities are without a doctor and 49.6% are without a nurse. This findings demands a fundamental rethinking of PHC staffing norms. **Recommendations include the adoption of a tiered PHC workforce model that reflects Nigeria's current labour market realities as opposed to seeking universal doctor deployment. Further, what ought to be prioritised is the placement of at least one skilled nurse or midwife in every high-volume PHC; financed through the BHCPF and state counterpart funding. This is in addition to deploying doctors through a hub-and-spoke system, where one medical officer (or family physician team) supports a cluster of PHCs via scheduled outreach and supervision.** Also, what is needed is to scale up task-shifting by strengthening the clinical capacity of CHEWs and nurses through structured training, clear protocols and active supervision. Lastly, improvements should include attaching credible retention incentives to rural postings, including hardship allowances, accommodation, security and accelerated career progression.

4. Operational Time Accountability Framework

Facility operational time compliance should be incorporated into the National Health Facility Assessment and linked to monthly facility funding disbursements. These disbursements should be predicated on independent verification of operational time by 3rd parties and uploaded on portals created for review and confirmation. This evidence can then be evaluated at the end of the month and disbursements appropriately provided for those facilities that meet targets. States with operational time rates below 50%, particularly Kano (13.7%), Zamfara (20.0%) and Akwa Ibom (20.6%), should be subject to quarterly performance reviews with facility-level supervisory visits and sanctions for persistent non-compliance.

5. Reliable and Recyclable Energy Scale-Up

Building on the proven model of states like Jigawa, Bauchi and Borno, where significant investments in alternative power supply were provided, the National Primary Healthcare Centre (PHC) Solar Electrification Programme should target all 2,478 facilities currently without electricity supply, prioritising states in the North-West and North-Central zones with the lowest grid coverage rates. Empirical studies have shown that "on average, health facilities with solar [powered systems] treated 50% more out-patients each month, conducted 50% higher institutional deliveries, admitted a higher number of in-patients as well as provided round the clock services" (Heinrich Boell Stiftung Nigeria, 2018).[17] Public-private partnerships and climate finance mechanisms should be explored to fund this at scale for the procurement of solar panels, inverters and batteries for PHCs. Where energy provision can be scaled up, this will have a direct impact on cooling systems, heating, lab work and minor emergencies. This will also enable PHCs to operate around the clock.

6. Prioritization of medical supplies and commodities

This will happen by strengthening essential medicine availability at PHCs by instituting a state-led, end-to-end supply chain accountability system that links procurement, distribution and facility-level stock monitoring. **State Primary Health Care Boards, working with State Medical Stores, should deploy a simple, standardized stock reporting tool (digital where feasible, offline-compatible where not) that mandates PHCs to submit weekly stock status on a defined list of medicines. This data can then feed into a central dashboard at the state level to enable real-time visibility of stock levels, prompt timely restocking and flag persistent stockouts for corrective action.** In urban areas, this can be integrated into existing digital logistics systems, while in hard-to-reach areas, WDC should be formally engaged to verify deliveries, monitor stock levels and report discrepancies through structured community feedback channels. Clear accountability lines should be established, with named officers responsible for stock management at facility and LGA levels, and routine supervisory checks to validate reported data. Performance on medicine availability should be tracked and published periodically to incentivise compliance and improve transparency. The objective is to move from reactive restocking to a predictable, monitored supply system where stockouts are quickly identified, explained and resolved.

16. See Heinrich Boell Stiftung Nigeria. (2018). Improving Access to Clean Reliable Energy for Primary Health Care Centres in Nigeria: Situation Analysis of PHCs in the Federal Capital Territory. Available at: https://ng.boell.org/sites/default/files/solar_for_phcs.pdf

6.0 Conclusion

The 5,099 PHC assessments and the PHC Tracka platform demonstrate that, while physical structures exist, the functionality of Nigeria's primary health care system, which represents the foundation of the national health system and the first and often only point of care for the majority of the population, is compromised by a triad of challenges. The data analysed in this report reveal a system under profound structural stress: half of all facilities lack grid electricity, nearly two-thirds have no doctor and the gap between facility security and ambulance availability is enormous, with fewer than one in seven able to provide ambulance services for emergency referral. Meaning that even in facilities that are safely accessed by patients, the capacity to transfer emergency cases to higher-level care is almost universally absent.

Similarly, the data identifies bright spots of genuine achievement, including Lagos's consistent leadership in infrastructure, Ondo's exceptional emergency referral model, Jigawa and Borno's adaptive power solutions, Cross River's near-universal waste management, and Plateau's extraordinary operational time compliance. These are not accidents. They reflect the impact of sustained political will, targeted investment, and evidence-based prioritisation at the state level.

The path to a functional PHC system in Nigeria is not mysterious. It requires political commitment matched by financial investment, accountability mechanisms that link performance to resource allocation, and data systems robust enough to track progress and expose failure. This report provides the evidence base for that journey. The question is whether decision-makers at the federal and state levels will act on it with the urgency that 200 million Nigerians deserve.

The path to a functional PHC system in Nigeria is not mysterious. It requires political commitment matched by financial investment, accountability mechanisms that link performance to resource allocation, and data systems robust enough to track progress and expose failure.

Appendix

Table 1: Total number of facilities profiled by state in 2025.

State	Total Facilities on the portal
Abia	130
Adamawa	129
Akwa Ibom	180
Anambra	152
Bauchi	159
Bayelsa	81
Benue	111
Borno	69
Cross River	172
Delta	79
Ebonyi	147
Edo	20
Ekiti	61
Enugu	96
FCT	58
Gombe	142
Imo	119
Jigawa	68
Kaduna	364
Kano	255
Katsina	232
Kebbi	107
Kogi	179
Kwara	170
Lagos	152
Nasarawa	189
Niger	325
Ogun	74
Ondo	113
Osun	117
Oyo	189
Plateau	159
Rivers	111
Sokoto	189
Taraba	63
Yobe	78
Zamfara	60
	5099

Source: BudgIT 5,099 PHC Assessment Survey

Table 1.1 National infrastructural coverage summary; 5,099 PHC Facilities

Infrastructure Indicator	Facilities Covered	National Coverage (%
Drug Dispensing	3,885	76.20%
Waste Management	3,625	71.10%
Toilet Facilities	3,517	69.00%
Signpost	3,434	67.30%
Good Building Cond.	3,213	63.00%
Water Supply	3,165	62.10%
Alt. Power Supply	3,103	60.90%
Functional Lab	3,045	59.70%
Facility Security	2,809	55.10%
Operational Time	2,728	53.50%
Electricity Supply	2,621	51.40%
Ambulance	708	13.90%

Source: BudgIT 5,099 PHC Assessment Survey

Table 2.1 Facilities with Water Supply: Top 5 States

State	With Water Supply	Total Facilities	Coverage %
Lagos	152	135	88.8
Kaduna	364	314	86.3
Kwara	170	109	64.1
Katsina	232	145	62.5
Kano	255	154	60.4

Table 2.2 Facilities with Water Supply: Bottom 5 States

State	With Water Supply	Total Facilities	Coverage %
Benue	41	111	36.9
Kogi	76	179	42.5
Niger	145	325	44.6
Ebonyi	71	147	48.3
Gombe	69	142	48.6

Table 3.1 Electricity Supply: Top 5 States connected to the national grid

State	Connected Facilities	Total Facilities	Coverage %
Lagos	137	152	90.1
Kwara	123	170	72.4
Anambra	110	152	72.4
Oyo	116	189	61.4
Akwa Ibom	107	180	59.4

Table 3.2 Electricity Supply: Bottom 5 States with connection to the national grid

State	With Water Supply	Total Facilities	Coverage %
Ebonyi	42	147	28.6
Zamfara	19	60	31.7
Sokoto	60	189	31.7
Plateau	53	159	33.3
Borno	25	69	36.2

Table 4. Top 5 States - Alternate Power Supply

State	Connected Facilities - Alternate power supply	Total Facilities	Coverage %
Jigawa	64	68	94.1
Ondo	104	113	92.4
Bauchi	136	151	85.5
Anambra	126	152	82.8
Kebbi	86	107	80.3

Table 5. Human Resource/National Staffing Summary

Human Resource Cadre	PHCs with Staff	Coverage (%)	PHCs without Staff	Gap (%)
Medical Doctors	703	13.8%	4,396	86.2%
Nurses/Mudwives	2,568	50.4%	2,531	49.6%
CHEWs/JCHEWs	4,744	93.0%	355	7.0%

Service Readiness

Table 6.1 Facilities with Functional Laboratory - Top 5 States

State	Total Facilities	With a Functional Laboratory	Coverage (%)
Jigawa	68	62	91.2
Bauchi	159	135	84.9
Kaduna	364	306	84.1
Taraba	63	54	85.7
Kano	255	196	76.9

Table 6.2 Facilities with Functional Laboratory - Bottom 5 States

State	Total Facilities	With a Functional Laboratory	Coverage (%)
Delta	79	17	21.5
Anambra	152	50	32.9
Ogun	74	27	36.5
Enugu	96	28	29.2
Kogi	179	69	3

Table 6.3 Facilities with Drug Dispensary - Top 5 States

State	Total Facilities	With a Drug Dispensary	Coverage (%)
Jigawa	68	67	99
Ondo	113	109	96
Lagos	152	142	93
Ekiti	61	55	90
Anambra	152	136	89

Facilities with Operational time meeting set standards (24 hours)

Table 6.4 Operational Time (24 Hours) Top - 5 States

State	Total Facilities	Meeting standards (24 hours)	Coverage (%)
Plateau	159	158	99.4
Ondo	113	106	93.8
Benue	111	96	86.5
Ogun	74	57	77.0
Cross River	172	132	76.7

Table 6.5 Operational Time (24 Hours) Bottom - 5 States

State	Total Facilities	Meeting standards (24 hours)	Coverage (%)
Kano	225	35	13.7
Zamfara	60	12	20.0
Akwa Ibom	180	37	20.6
Sokoto	189	54	28.6
Katsina	232	72	31.0

Access System

Table 6.6 Facility Security — Top 5 States

State	Total Facilities	Secured Facility	Coverage (%)
Borno	69	59	85.5
Lagos	152	129	84.9
Jigawa	68	57	83.8
Kebbi	107	79	73.8
Kwara	170	99	58.2

Table 6.7 Facility Security — Bottom 5 States

State	Total Facilities	Secured Facility	Coverage (%)
Bayelsa	81	19	23.5
Plateau	159	45	28.3
Cross River	172	49	28.5
Ebonyi	147	52	35.4
Niger	325	121	37.2

Ambulance Availability

Table 6.8 Ambulance Coverage - Top 5 States

State	Total Facilities	With Ambulance	Coverage (%)
Ondo	113	103	91.2
Sokoto	189	80	42.3
Yobe	78	27	36.4
Ogun	74	22	29.7
Zamfara	60	17	28.3

Table 6.9 Ambulance Coverage - Bottom 5 States

State	Total Facilities	With Ambulance	Coverage (%)
Edo	20	0	0
Delta	79	1	1.3
Benue	111	2	1.8
Abia	130	2	1.5
Enugu	96	2	2.1

Waste Management

Table 6.10 Waste Management - Top 5 states

State	Total Facilities	With Waste Management System	Coverage (%)
Cross River	172	165	95.9
Ondo	113	104	92.0
Borno	69	63	91.3
Kaduna	364	325	89.2
Bayelsa	81	71	87.6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