CHAPTER ONE: INTRODUCTION

1.1 Background

Primary Health Care (PHC) constitutes the foundation of the healthcare delivery system and serves as the first point of contact for individuals, families, and communities seeking healthcare services. It is intended to provide accessible, affordable, equitable, and integrated preventive, promotive, curative, and rehabilitative healthcare services.

In furtherance of the objectives of the National Health Policy, the National Strategic Health Development Plan, and Sustainable Development Goal (SDG) 3 on Good Health and Well-being, the Ondo State Government has invested in the development of primary healthcare infrastructure, human resources, medical equipment, and essential health programmes. Despite these interventions, concerns remain regarding the adequacy, accessibility, quality, and sustainability of primary healthcare services across the State.

This Performance Audit was undertaken to assess whether resources allocated to the primary healthcare sector were managed economically, efficiently, effectively, equitably, and sustainably, and whether the intended service delivery outcomes were being achieved.

1.2 Description of the Primary Health Care System

The primary healthcare system in Ondo State operates through a decentralized structure comprising 575 public health facilities distributed across the eighteen (18) Local Government Areas (LGAs) of the State. The network includes Comprehensive Health Centres (CHCs), Basic Health Centres (BHCs), Model Primary Health Care Centres, Primary Health Clinics, and Health Posts.

The system is coordinated by the Ondo State Primary Health Care Development Agency (SPHCDA) under the oversight of the Ministry of Health, while day-to-day operations at the grassroots level are supported by the Local Government Health Authorities (LGHAs). Community participation is facilitated through Ward Development Committees (WDCs), which support health promotion, community mobilization, immunization activities, maternal and child health programmes, and other primary healthcare interventions.

1.3 Audit Objectives

The overall objective of the audit was to assess the economy, efficiency, effectiveness, equity, and sustainability of primary healthcare service delivery in Ondo State during the period 2023–2025.

Specifically, the audit sought to:

i. Assess the adequacy, functionality, accessibility, and geographical distribution of public primary healthcare facilities across the State.

ii. Evaluate the adequacy, deployment patterns, utilization, and management of Human Resources for Health (HRH) in relation to applicable national standards and relevant international benchmarks.

iii. Assess the availability, storage, distribution, and management of essential medicines, vaccines, and cold chain infrastructure required for effective service delivery.

iv. Evaluate the planning, implementation, quality, and value-for-money of primary healthcare infrastructure projects and facility upgrade programmes.

v. Examine the effectiveness of monitoring, supervision, information management, and accountability mechanisms supporting primary healthcare service delivery.

1.4 Audit Scope and Methodology

The audit covered the activities of the Ondo State Primary Health Care Development Agency (SPHCDA), Local Government Health Authorities (LGHAs), and selected public primary healthcare facilities across the State for the period 1 January 2023 to 31 December 2025. Physical verification and validation exercises were conducted up to June 2026 where necessary to confirm the status of projects, facilities, personnel deployment, and service delivery indicators.

The audit examined:

i. Healthcare infrastructure and capital projects;
ii. Human resource management and personnel deployment;
iii. Availability and management of medicines, vaccines, and medical supplies;
iv. Maternal and child healthcare services;
v. Monitoring, supervision, and information systems; and
vi. Governance, financing, and accountability arrangements.

The audit was conducted in accordance with the International Standards of Supreme Audit Institutions (ISSAI 3000) on Performance Auditing.

To obtain sufficient and appropriate audit evidence, the audit team adopted a combination of methodologies, including:

Review of relevant laws, policies, guidelines, plans, budgets, reports, and administrative records;

Analysis of personnel, infrastructure, financial, and service delivery data;

Physical inspection and verification of selected health facilities and projects

Interviews with management, health workers, community representatives, and other stakeholders; and

Validation of facility-level records against central databases and management reports.

A stratified sampling approach was adopted to ensure adequate representation of facilities across the three Senatorial Districts, different facility categories, and diverse geographical settings, including urban, rural, riverine, and hard-to-reach communities. The sampling framework was designed to facilitate assessment of service delivery conditions across varying operational environments and population characteristics.

Table 1.1: Statewide Sample of Health Facilities Selected for Physical Verification

Senatorial District	LGA	Facility	Category	Basis for Selection
Ondo North	Akoko North East	PHC Okeagbe	Rural PHC	Rural service coverage
		CHC Ikare	CHC	High patient volume
	Akoko North West	PHC Arigidi	Urban PHC	Population concentration
		PHC Ogbagi	Rural PHC	Rural outreach services
	Akoko South East	PHC Isua	Urban PHC	Service utilization
		PHC Epinmi	Rural PHC	Accessibility assessment
	Akoko South West	PHC Akungba	Urban PHC	Student and youth population
		CHC Oka	CHC	Maternal and child health services
	Ose	PHC Elegbeka	Rural PHC	Hard-to-reach community
		PHC Ifon	Urban PHC	Administrative centre
	Owo	CHC Emure-Ile	CHC	High-volume service centre
		PHC Isaipen	Rural PHC	Rural service coverage
Ondo Central	Akure South	Model PHC Oda Road	Model PHC	Largest population concentration
		PHC Isikan	Urban PHC	Urban service demand
	Akure North	PHC Ita-Ogbolu	Rural PHC	Rural service delivery
		PHC Oba-Ile	Urban Fringe PHC	Urban-rural interface

Senatorial District	LGA	Facility	Category	Basis for Selection
	Ondo West	Model PHC Fagun	Model PHC	Strategic referral centre
		CHC Yaba	CHC	High maternal service utilization
	Ondo East	PHC Bolorunduro	Rural PHC	Rural coverage assessment
		PHC Epe	Rural PHC	Accessibility evaluation
	Ifedore	PHC Igbara-Oke	Rural PHC	Service utilization assessment
		PHC Ilara-Mokin	Rural PHC	Rural health coverage
	Idanre	PHC Alade	Rural PHC	Infrastructure verification
		PHC Idanre	Urban PHC	Capital project assessment
Ondo South	Ilaje	Model PHC Igbokoda	Model PHC	Riverine flagship facility
		PHC Mahin	Riverine PHC	Coastal service delivery
	Ese-Odo	PHC Igbekebo	Riverine PHC	Riverine accessibility
		PHC Apoi	Hard-to-Reach PHC	Difficult terrain assessment
	Okitipupa	Model PHC Okitipupa	Model PHC	High service volume
		PHC Erinje	Rural PHC	Rural service coverage
	Irele	PHC Ode-Irele	Rural PHC	Service utilization assessment
		PHC Ajagba	Rural PHC	Geographic coverage
	Odigbo	PHC Ore	Urban PHC	Population concentration
		PHC Kajola	Rural PHC	Rural outreach assessment
	Ile-Oluji/Oke-Igbo	PHC Ile-Oluji	Urban PHC	Urban-rural service mix
		PHC Oke-Igbo	Rural PHC	Rural coverage assessment

Methodology: The audit methodology integrated **four primary verification pathways**:

Physical Asset and Ledger Inspections: On-site inspection of capital upgrades, buildings, water systems, energy tools, and inventory stock registers across the 12 sample stations.

- **On-Site Control Testing:** Physical headcounts of on-duty clinical staff conducted during active clinic hours to check the accuracy of central payroll records.

- **Clinical Record Verification:** Manual extraction of service data from facility logbooks to track patient progression through antenatal care and immunization.
- **Interviews with Local Leaders:** Structured discussions with Ward Development Committees (WDCs) to evaluate local health needs and facility functionality.

1.5 Audit Criteria

The operational and structural performance of the sector was evaluated against the following criteria:

WHO Minimum Health Workforce Standards: Prescribed doctor-to-population ratio of 1:300 and nurse-to-population ratio of 1:1,001.

NPHCDA Minimum Standards for Primary Health Care: Mandatory 1:1 pupil/patient resource parity, functional Water, Sanitation, and Hygiene (WASH) infrastructure, gender-segregated sanitation facilities, and continuous on-site cold chain security.

Ondo State Education & Quality Assurance Guidelines: Requirement for regular unannounced supervisory field inspections per academic/operational term and rigorous pre-payment verification of capital project locations.

Public Procurement Contractual Deliverables: Directives governing structural specifications, site integrity, and final-mile logistics execution for state-funded contracts.

1.6 Limitation of Audit

The audit findings were bounded by severe deficiencies in institutional memory and reporting data within the central registries. Columns dedicated to "Original Data" for fundamental clinical outcomes—including initial antenatal registration (ANC1), late-stage follow-ups (ANC4), facility-based deliveries, and antigen doses administered (BCG, OPV3, Pentavalent3, Measles)—were completely missing or flagged as "NA" (Not Available) in central databases.

Consequently, the Audit Team had to reconstruct baseline operational trends entirely through manual physical field verifications, store ledgers, and on-site clinical register sampling.

CHAPTER TWO: SYSTEM DESCRIPTION AND DATA ANALYSIS

SECTION 2.1: Health Facility Profile Analysis

Table 2.1: Profile of Primary Health Care Facilities in Ondo State

S/N	Local Government Area	Total PHCs	Urban	Rural	Functional PHCs	Functional PHC Rate (%)	Rural Share (%)	Facility Facility Rate (%)	Utilization
1	Akoko North East	25	6	19	25	100.0	76.0	100.0	
2	Akoko North West	25	10	15	25	100.0	60.0	100.0	
3	Akoko South East	20	5	15	20	100.0	75.0	100.0	
4	Akoko South West	34	10	24	34	100.0	70.6	100.0	
5	Akure North	34	6	28	34	100.0	82.4	100.0	
6	Akure South	38	33	5	38	100.0	13.2	100.0	
7	Ese-Odo	38	0	38	38	100.0	100.0	100.0	
8	Idanre	47	5	42	47	100.0	89.4	100.0	
9	Ifedore	29	5	24	29	100.0	82.8	100.0	
10	Ilaje	47	2	45	47	100.0	95.7	100.0	
11	Ileoluji/Okeigbo	37	5	32	37	100.0	86.5	100.0	
12	Irele	23	6	17	23	100.0	73.9	100.0	
13	Odigbo	42	8	34	42	100.0	81.0	100.0	
14	Okitipupa	35	9	26	35	100.0	74.3	100.0	
15	Ondo East	26	3	23	26	100.0	88.5	100.0	
16	Ondo West	43	30	13	43	100.0	30.2	100.0	
17	Ose	25	2	23	25	100.0	92.0	100.0	
18	Owo	34	15	19	34	100.0	55.9	100.0	
Total Ondo State		**637**	**165**	**472**	**637**	**100.0**	**74.1**	**100.0**	

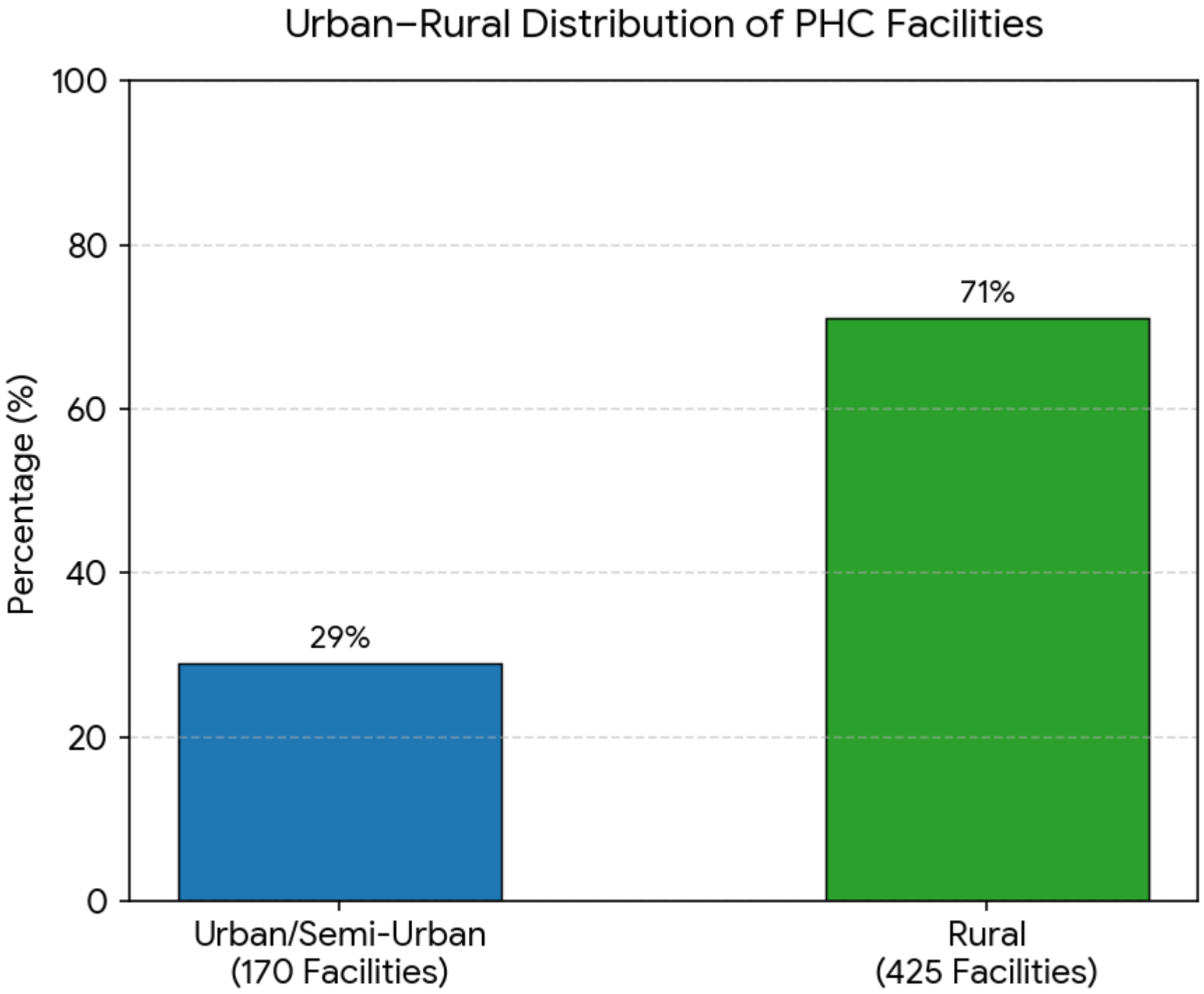
Audit Comments:

Table 2.1 presents the distribution and functional status of Primary Health Care (PHC) facilities across the eighteen (18) Local Government Areas of Ondo State.

Table 2.2: Summary of Urban–Rural Distribution of PHC Facilities

Location Category	Number of Facilities	Percentage
Urban/Semi-Urban	170	29%
Rural	425	71%
Total	**595**	**100%**

The distribution shows that approximately **three-quarters (74.1%)** of Primary Health Care facilities in Ondo State are located in **rural communities**, while only **25.9%** are situated in **urban centres**.


Urban–Rural Distribution of PHC Facilities
Percentage (%)
100
80
60
40
20
0
29%
71%
Urban/Semi-Urban
(170 Facilities)
Rural
(425 Facilities)

Observations

I. Predominant Distribution of Primary Health Care Facilities in Rural Communities

The audit examined the geographical distribution of the State's Primary Health Care (PHC) facilities to assess the equity of healthcare access and the extent to which the PHC network responds to the needs of rural, riverine, and underserved populations. Analysis of the PHC facility register revealed that Ondo State operates **637 PHC facilities**, comprising **472 (74.1%) rural facilities** and **165 (25.9%) urban facilities**. This distribution demonstrates that the State's PHC system is predominantly rural, reflecting its strategic role in extending essential healthcare services to communities with limited access to secondary and tertiary health facilities.

While the extensive rural network enhances the geographical reach of primary healthcare services, it also presents significant operational challenges relating to infrastructure maintenance, transportation logistics, electricity supply, cold-chain management, equitable deployment of health personnel, and routine monitoring and supervision. These contextual factors provide an important basis for understanding the performance issues and service delivery gaps identified in subsequent chapters of this report.

II. Senatorial District-Level Structural Distribution of Primary Health Care Facilities in Ondo State

Aggregating the 18 Local Government Areas into the three Senatorial Districts reveals significant geographical disparities in the distribution of Primary Health Care (PHC) facilities across Ondo State.

Table 2.3: Distribution of PHC Facilities by Senatorial District

Senatorial District	Total PHCs	Urban PHCs	Rural PHCs	Urban Share (%)	Rural Share (%)
Ondo North	194	54	140	27.84%	72.16%
Ondo Central	183	76	107	41.53%	58.47%
Ondo South	260	35	225	13.46%	86.54%
State Total	**637**	**165**	**472**	**25.90%**	**74.10%**

(Source: Planning, Research and Statistics Department of Ondo State Primary Health Care Development Agency)

III. iDistribution of Primary Health Care Facilities and Equity of Access

Key Findings

i. International and National Benchmarks

The **World Health Organization (WHO)** and the **National Primary Health Care Development Agency (NPHCDA)** emphasize that Primary Health Care (PHC) infrastructure should be geographically distributed to ensure equitable physical access to essential healthcare services. However, equitable access extends beyond the mere presence of facilities and requires adequate staffing, functional infrastructure, essential medicines, medical equipment, utilities, and effective referral systems to ensure quality service delivery.

ii. Statewide Distribution of PHC Infrastructure

Audit analysis shows that Ondo State maintains an extensive PHC network comprising **637 facilities**, of which **472 facilities (74.10%)** are located in rural communities, while **165 facilities (25.90%)** are situated in urban and semi-urban locations.

This distribution demonstrates a deliberate policy orientation towards extending physical healthcare infrastructure to rural communities. Nevertheless, field verification established that the existence of facilities alone does not guarantee effective access to healthcare services. Many rural facilities continue to experience significant operational constraints that limit their ability to provide comprehensive PHC services.

iii. Senatorial District Distribution

Analysis of PHC infrastructure across the three Senatorial Districts revealed marked geographical variations.

Ondo South Senatorial District possesses the largest PHC network, with 260 facilities, comprising 225 rural facilities (86.54%) and 35 urban facilities (13.46%). This reflects the district's dispersed settlement pattern and extensive riverine terrain, which necessitate a larger number of service points.

Ondo North Senatorial District operates 194 PHC facilities, consisting of 140 rural facilities (72.16%) and 54 urban facilities (27.84%), broadly reflecting the State's overall rural distribution.

Ondo Central Senatorial District has 183 PHC facilities, including 107 rural facilities (58.47%) and 76 urban facilities (41.53%), representing the highest proportion of urban facilities among the three districts due to greater urbanization around Akure and adjoining communities.

iv. Equity Assessment

While the physical distribution of PHC facilities generally supports geographical coverage, audit evidence indicates that **equity in healthcare access has not been fully achieved**.

Physical inspections, personnel verification, and service delivery analysis showed that many rural and riverine facilities experience substantially greater operational challenges than facilities located in urban centres.

The audit observed that rural facilities were more likely to experience:

- Critical shortages of skilled health personnel;
- Limited electricity and potable water supply;
- Weak laboratory and diagnostic capacity;
- Inadequate staff accommodation;
- Greater dependence on volunteer personnel;
- Longer supply cycles for medicines and consumables; and
- Limited supervisory and monitoring visits due to accessibility constraints.

Conversely, urban facilities generally demonstrated better staffing levels, stronger utility support, improved diagnostic capacity, and more frequent supervisory oversight. However, several urban facilities also experienced significantly higher patient workloads, placing considerable pressure on available personnel and infrastructure.

Accordingly, the principal equity challenge identified by the audit is **functional inequality rather than physical facility distribution**.

v. Operational Status of PHC Facilities

Administrative records supplied by the Ondo State Primary Health Care Development Agency indicate that all **575 designated functional PHC facilities** remained operational throughout the audit period, representing a reported operational rate of **100 percent**.

However, audit verification established that operational status should not be interpreted as synonymous with full functionality or service readiness.

Although facilities remained open and provided varying levels of healthcare services, numerous operational deficiencies were observed, including:

- shortages of critical healthcare personnel;
- inadequate diagnostic equipment;
- unreliable electricity and water supply;
- non-functional or incomplete infrastructure;
- inadequate staff accommodation;
- weak maintenance practices;
- insufficient security arrangements; and
- limited availability of essential medical equipment in some facilities.

Consequently, the audit concludes that the reported operational status reflects **facility availability** rather than **service capacity**.

Performance Audit Conclusion

Ondo State has established an extensive Primary Health Care network that provides broad geographical coverage, particularly across rural communities, with approximately three-quarters of all PHC facilities located outside urban centres.

However, the audit found that **physical infrastructure expansion has not been matched by commensurate investment in staffing, equipment, utilities, logistics, supervision, and maintenance**. As a result, significant disparities persist in the functionality and quality of healthcare services between urban and rural facilities.

The audit therefore concludes that, although the State has largely achieved geographical coverage of PHC infrastructure, **equitable access to quality primary healthcare services remains constrained by differences in operational capacity rather than by the number or location of facilities alone**.

Key Performance Audit Finding

Finding: Functional Inequity in Primary Health Care Service Delivery

Condition

Ondo State maintains an extensive network of **637 Primary Health Care facilities**, with **472 facilities (74.10%)** located in rural communities. While all **575 designated functional PHCs** were reported to be

operational, audit verification revealed substantial disparities in staffing levels, infrastructure quality, utility services, diagnostic capacity, equipment availability, and supervisory support between rural and urban facilities.

Criteria

The National Health Act, National Minimum Standards for Primary Health Care, WHO guidance, and Sustainable Development Goal 3 require equitable access to quality healthcare services through adequately staffed, equipped, functional, and accessible PHC facilities.

Cause

The observed disparities are attributable to:

- inadequate workforce planning and deployment;
- insufficient operational funding for rural facilities;
- historical infrastructure investment patterns;
- difficult terrain and accessibility challenges in riverine communities;
- weak maintenance culture; and
- limited supportive supervision.

Implication

The operational capacity of many rural facilities remains significantly below that of urban facilities, potentially reducing service utilization, delaying access to skilled care, increasing referral burdens, and limiting progress towards Universal Health Coverage. These disparities are particularly evident in maternal healthcare, emergency services, diagnostic services, and preventive healthcare programmes.

Recommendation

The Ondo State Primary Health Care Development Agency should shift from a **facility expansion strategy** to a **facility functionality strategy** by prioritizing investments in rural and riverine PHCs through equitable deployment of skilled personnel, rehabilitation of critical infrastructure, improved utility services, strengthened logistics systems, enhanced supervision, and routine service-readiness assessments to ensure that all operational facilities provide the minimum standard of primary healthcare services

SECTION 2.2: HUMAN RESOURCES FOR HEALTH (HRH)

2.2.1.Overview of the Health Workforce 2023–2024

The availability of qualified health personnel remains a critical determinant of the effectiveness, accessibility, and quality of primary healthcare service delivery. The audit assessed the adequacy, distribution, and deployment of Human Resources for Health (HRH) across the State's 575 Primary Health Care (PHC) facilities.

The analysis covered Medical Officers, Nurses/Midwives, Community Health Officers (CHOs), Community Health Extension Workers (CHEWs), Junior Community Health Extension Workers (JCHEWs), Laboratory Personnel, Pharmacy Personnel, and other support cadres.

2.2.2 .Human Resources for Health (HRH) Analysis

Ratio of Health workers (Doctors, Nurse/Midwives and Chews) in Ondo State to the Population of the entire State

2023

Table 2.4 Gaps/Surplus of HRH Disaggregated by Cadre Across Each LGA in Ondo State

Source: NPHCDA Primary Health Care Information System (PHCIS) | Format: Available Staff Count (Gap/Surplus)

2023

AKOKO NORTH EAST	1(--23)	3(--45)	22(--50)	2(--94)	2(--22)	2(--22)	2(--22)
AKOKO NORTH WEST	1(--18)	9(--29)	45(--22)	13(--75)	13(--6)	13(--6)	13(--6)
AKOKO SOUTH EAST	1(--15)	7(--25)	33(--21)	6(--66)	6(--10)	6(--10)	6(--10)
AKOKO SOUTH WEST	1(--17)	5(--31)	51(--17)	6(--98)	6(--12)	6(--12)	6(--12)
AKURE NORTH	1(--32)	16(--50)	122(+21)	13(--123)	13(--20)	13(--20)	13(--20)
AKURE SOUTH	2(--1)	21(+15)	160(+87)	26(--50)	26(+23)	26(+23)	26(+23)
ESE ODO	1(--32)	5(--61)	108(+1)	16(--124)	16(--17)	16(--17)	16(--17)
IDANRE	1(--43)	8(--80)	82(--52)	12(--166)	12(--32)	12(--32)	12(--32)
IFEDORE	2(--24)	28(--24)	78(--2)	15(--93)	15(--11)	15(--11)	15(--11)
ILAJE	1(--4)	3(--7)	56(--49)	15(--97)	15(+10)	15(+10)	15(+10)
ILEOLUJI/OKEIGBO	1(--4)	6(--4)	63(--16)	15(--71)	15(+10)	15(+10)	15(+10)
IRELE	1(--12)	4(--22)	41(--6)	7(--57)	7(--6)	7(--6)	7(--6)
ODIGBO	2(--33)	7(--63)	49(--64)	9(--139)	9(--26)	9(--26)	9(--26)
OKITIPUPA	1(--28)	6(--52)	62(--37)	10(--118)	10(--19)	10(--19)	10(--19)
ONDO EAST	1(--23)	4(--44)	61(--11)	13(--87)	13(--11)	13(--11)	13(--11)
ONDO WEST	2(--19)	7(--35)	79(--18)	17(--111)	17(--4)	17(--4)	17(--4)
OSE	1(--15)	2(--30)	31(--29)	9(--71)	9(--7)	9(--7)	9(--7)
OWO	1(--32)	12(--54)	77(--24)	13(--121)	13(--20)	13(--20)	13(--20)

i. Baseline Workforce Deficit in 2024

The workforce assessment conducted in 2024 revealed substantial shortages across nearly all critical PHC staffing categories.

2024

TABLE 2.5 BASELINE WORKFORCE (KEY STAFF) DEFICIT IN 2024

Cadre	Required	Actual	Gap	Gap %	Critical Shortages
Doctor	103	25	**78**	75.70%	76% facilities lack doctors.
Nurse/Midwife	412	72	**340**	82.50%	Only 17.5% of needs met.
CHEW	309	142	**167**	54.00%	54% shortage; uneven distribution.
JCHEW	618	13	**605**	97.90%	Near-total absence (98% gap).
CHO	103	51	**52**	50.50%	Half of facilities lack CHOs.
Lab Scientist/Tech	103	70	**33**	32.00%	Moderate gap in diagnostics.
Pharmacist/Tech	103	15	**88**	85.40%	Critical for drug management.
Health Assistant Health Information Management Personnel	206	198	**8**	3.90%	Nearly adequate.

The shortages translated into extremely unfavorable health-worker-to-population ratios based on the projected State population of **5,637, 395** persons:

TABLE 2.6 SUMMARY OF HEALTH-WORKER-TO-POPULATION RATIOS BASED ON THE PROJECTED STATE POPULATION

PROJECTED POPULATION (Bureau of Statistics)	**5,637, 395**	
Cadre	**STATE REALITY**	**WORLD HEALTH ORGANISATION'S RECOMMENDATION**
TOTAL DOCTOR:	22	
DOCTOR/PATIENT RATIO	**1 : 256,245**	WHO recommends 1:300
TOTAL NURSE:	153	
NURSE/ PATIENT RATIO	**1 : 36,846**	WHO recommends 1:1001
CHEW:	1220	
CHEW/ PATIENT RATIO	**1 : 4,620**	

From the summary table above Ondo state has **1 : 256,245** for Doctor to population ratio, Nurse as **1 : 36,846,** and CHEW **1 : 4,620** as against World Health Organization's recommendation of **1 : 300** for Doctors and **1 : 1001** for Nurses. Therefore, it can be concluded that the State health workforce (Primary Health Care) ratio to population fell below the required (World Health Organization) standard.

ii. Government Workforce Expansion Initiative in 2025

In response to the identified staffing deficits, the State Government implemented a major recruitment exercise in 2025, resulting in the engagement of 552 health personnel compared to the planned target of 490 personnel.

Table 2.7: DATA ON MAJOR RECRUITMENT EXERCISE IN 2025

Cadre	Original Year 1 Target (2025)	Actual Recruitment (2025)	Variance	Alignment with Plan
Doctors	20	17	-3	Close to target; initial hires focused on priority areas.
Nurses	150	151	1	Target met and slightly exceeded.
CHEWs	70	158	88	Significantly exceeded, boosting community health outreach.
JCHEWs	250	0	-250	Original target revised; focus shifted to CHEWs and other mid-level cadres.
Community Health Officers (CHOs)	0	16	16	Strategic recruitment to fill a critical leadership gap (50.5% gap in Type 3).
Laboratory Personnel	0	17	73	Proactive investment in diagnostics (Scientists, Technicians, Lab Techs).
Pharmacy Personnel	0	151	19	Direct response to critical absence of pharmacists in rural areas.
Medical Records Personnel	0	158	59	Strengthening data management and reporting capacity.
Health Educators	0	9	9	Enhancing community awareness programs in both urban and rural areas.
Nutrition Officers/Assistants	0	14	14	New cadre to address malnutrition and related health issues.
Dental Technicians	0	36	36	Expanding essential dental services across the state.
Total	**490**	**552**	**62**	**Recruitment exceeded the original plan by 12.6%.**

iii. Impact of Recruitment on Critical Staffing Gaps

Using the 2024 baseline workforce position and assuming the newly recruited personnel are deployed within the PHC system, the staffing situation improves substantially.

Table 2.8 GAP ANALYSIS AFTER 2025 RECRUITMENT

Cadre	2024 Actual	Recruited 2025	Estimated Workforce After Recruitment	Original Gap	Remaining Gap
Doctors	25	17	42	78	61
Nurses	72	151	223	340	189
CHEWs	142	158	300	167	9
CHOs	51	16	67	52	36
Laboratory Personnel	70	73	143	33	Surplus (+40)
Pharmacy Personnel	15	19	34	88	69
HIM Personnel					

iv. Key Observations

Table 2.9 Impact of Recruitment on Personnel Gap

Doctors	Gap reduced from 78 to 61.	Doctor shortage remains severe.	More than half of facilities are still likely to operate without a resident doctor.
Nurses	Workforce increased from 72 to 223	Gap reduced by approximately 44%.	Nevertheless, substantial shortages remain.
CHEWs	Workforce increased from 142 to approximately 300.	Gap virtually eliminated.	This represents one of the most significant workforce achievements
Laboratory Personnel	Improvement recorded,	shortages remain substantial.	Laboratory services will still be sub-optimal
Pharmacy Personnel	Improvement recorded	shortages still substantial.	Drug management and pharmaceutical oversight challenges may persist in many facilities.

v. Recalculated Workforce Ratios After Recruitment

Using the projected population of 5,801,532:

vi. Table 2.10: Summary of Recalculated Workforce Ratios After Recruitment

Cadre	Estimated Workforce (2025)	Population Ratio
Doctors	42	1:138,132
Nurses	223	1:26,016

Cadre	Estimated Workforce (2025)	Population Ratio
CHEWs	300	1:19,338

Although these ratios remain below international benchmarks, they represent substantial improvements over the 2024 position.

Table 2.11: Revised Workforce/Population Incators after Recruitment

Indicator	2024	Post-Recruitment 2025
Doctor Ratio	1:256,245	1:138,132
Nurse Ratio	1:36,846	1:26,016
CHEW Ratio	1:4,620	1:19,338

vii. Audit Comments

The Audit findings strongly validates PHCDA reports regarding workforce shortages.The audit found that the State's Primary Healthcare workforce was critically inadequate in 2024, with staffing gaps ranging from 32% to 98% across key professional cadres. These shortages contributed to poor health-worker-to-population ratios and constrained service delivery capacity across PHC facilities.

However, evidence further showed that the State Government initiated a significant workforce strengthening programme in 2025, recruiting 552 health personnel against a planned target of 490 personnel. The recruitment exercise substantially improved staffing levels, particularly among nurses, CHEWs, laboratory personnel, and other mid-level healthcare cadres. Notwithstanding these gains, significant shortages persist among doctors, nurses, pharmacists, and Community Health Officers, indicating that additional recruitment, equitable deployment, and retention strategies are necessary to achieve minimum staffing standards and ensure universal access to quality primary healthcare services across Ondo State.

Table 2.12: Additional Personnel-Related Issues that were discovered during project inspection

10	Igbotu PHC, Ese-Odo	75,613,615.05	Posted Laboratory Technician failed to report for duty.	Reduced diagnostic capacity and delays in patient management.
12	All Sampled Health Facilities Visited	N/A	Absence of security personnel.	Increased vulnerability of healthcare assets, personnel and patients to security threats.

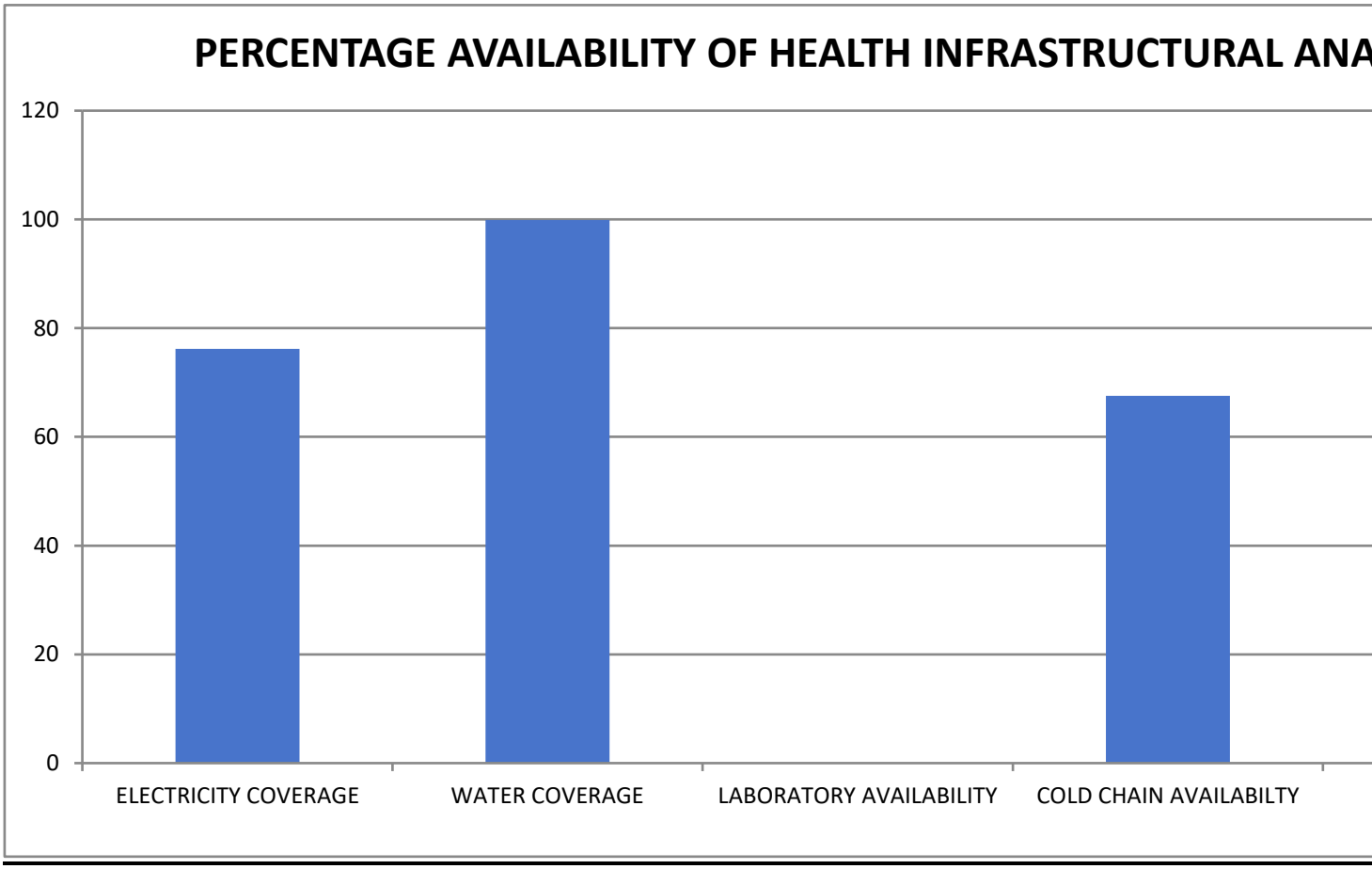
SECTION 2.3: INFRASTRUCTURE & COLD CHAIN ADEQUACY

Table 1.13 Health Infrastructure Analysis

S/N	LOCAL GOVERNMENT	TOTAL NUMBERS OF PHCs	Electricity Coverage %	Water Coverage %	Laboratory Availability %	Cold Chain Availability %	Facility Infrastructure Adequacy Index %
1	AKOKO NORTH EAST	22	59	73		1	
2	AKOKO NORTH WEST	25	64	88		56	
3	AKOKO SOUTH EAST	19	63	47		47	
4	AKOKO SOUTH WEST	33	61	82		45	
5	AKURE NORTH	33	64	73		48	
6	AKURE SOUTH	30	90	83		43	
7	ESE-ODO	34	18	62		56	
8	IDANRE	45	29	51		38	
9	IFEDORE	28	79	61		61	
10	ILAJE	47	13	51		53	
11	ILEOLUJI/OKEIGBO	38	34	58		47	
12	IRELE	21	19	67		38	
13	ODIGBO	40	55	60		40	
14	OKITIPUPA	35	43	60		43	
15	ONDO EAST	24	38	71		46	
16	ONDO WEST	42	36	60		48	
17	OSE	24	83	88		63	
18	OWO	35	69	66		37	
	TOTAL	**575**	**50.83**	**66.61**		**45**	

Table 2.14 Summary of Health Infrastructure Analysis

	HEALTH INFRASTRUCTURE ANALYSIS				
	ELECTRICITY COVERAGE	**WATER COVERAGE**	**LABORATORY AVAILABILITY**	**COLD CHAIN AVAILABILITY**	**INFRASTRUCTURE AVAILABILITY**
TOTAL	915	1199		810	
PERCENTAGE	76	100		68	



It can be concluded that 51% of health facility in the state have Electricity Coverage, while all the health facility have Water Coverage of **66.61%**and Cold Chain equipments are available in 45% of the facilities across the State.

2.3.1 Health Infrastructure Analysis

The assessment of health infrastructure focused on the availability of essential service-support facilities across the 575 Primary Health Care (PHC) facilities in Ondo State. Key indicators examined included electricity coverage, water supply, laboratory services, and cold chain infrastructure.

I. Analysis of Findings

The analysis revealed varying levels of infrastructure availability across the State's primary healthcare facilities.

i. Electricity Coverage

Out of the 575 PHC facilities assessed, 438 facilities (76%) had access to electricity from either the national grid, solar installations, generators, or alternative energy sources. However, 137 facilities (24%) operated without reliable electricity supply.

Significant disparities were observed across Local Government Areas. Electricity coverage was highest in Akure South (90%), Ose (83%), Ifedore (79%), and Owo (69%), while the lowest levels were recorded

in Ilaje (13%), Ese-Odo (18%), Irele (19%), and Idanre (29%). These deficiencies were particularly pronounced in riverine and hard-to-reach communities where electricity remains a major challenge.

The absence of reliable power supply adversely affects vaccine storage, laboratory operations, lighting for night-time services, and the overall quality of healthcare delivery.

ii. Cold Chain Availability

Cold chain equipment was available in 391 facilities, representing 68 percent of the total PHC network. Consequently, approximately one-third of health facilities lacked functional cold chain infrastructure for vaccine storage and temperature-sensitive medical supplies.

Coverage varied significantly across LGAs, ranging from 63 percent in Ose and 61 percent in Ifedore to as low as 37 percent in Owo and 38 percent in Idanre and Irele. In coastal LGAs such as Ilaje and Ese-Odo, cold chain functionality was further constrained by poor electricity supply.

The limited availability of cold chain infrastructure poses risks to immunization programmes and may affect vaccine potency, availability, and service continuity.

iii. Laboratory Services

Although laboratory availability data were not fully provided in the facility assessment records, field observations indicated that laboratory services were concentrated in Comprehensive Health Centres and selected Model PHCs, while many Basic Health Centres lacked diagnostic facilities. This limitation constrains the capacity of facilities to provide timely diagnosis and evidence-based treatment.

iv. Water Coverage

The assessment indicated that all 575 PHC facilities had access to at least one form of water source, resulting in a reported water coverage rate of 100 percent.

However, physical inspections revealed variations in the reliability, functionality, and quality of available water sources. While some facilities had access to functional boreholes and protected water systems, others depended on seasonal water sources or facilities requiring rehabilitation. Consequently, the reported coverage does not necessarily imply uninterrupted access to safe and potable water.

2.3.2 Key Audit Observations

The audit identified the following infrastructure-related concerns:

a. **Uneven distribution of critical infrastructure** across Local Government Areas, particularly in riverine and rural communities.
b. **Inadequate electricity coverage** in several LGAs, especially Ilaje, Ese-Odo, Irele, and Idanre, affecting service delivery and equipment functionality.
c. **Limited cold chain availability**, with only 68 percent of facilities equipped to safely store vaccines and other temperature-sensitive commodities.
d. **Variations in water source functionality**, despite reported universal water coverage.
e. **Insufficient diagnostic infrastructure** in many PHC facilities, limiting access to basic laboratory services.

iv. Audit Comments

The audit concludes that while the State has achieved substantial geographical coverage of primary healthcare facilities and universal access to basic water sources, significant infrastructure gaps remain. Electricity coverage and cold chain availability are inadequate in several Local Government Areas, particularly in rural and riverine communities. These deficiencies have implications for the quality, accessibility, effectiveness, and sustainability of primary healthcare service delivery and may undermine efforts to achieve Universal Health Coverage and improved health outcomes across the State.

SECTION 2.4: CHILD HEALTH OUTCOMES AND IMMUNIZATION PERFORMANCE

The audit assessed child health outcomes using key immunization and vaccine service indicators across the eighteen (18) Local Government Areas of Ondo State for the period 2023–2025. The assessment focused on immunization coverage, vaccine programme continuity, cold chain functionality, and vaccine availability, which collectively serve as proxies for the effectiveness of routine child health services.

Table 2.14: Child Health and Immunization Performance Indicators (2023–2025)

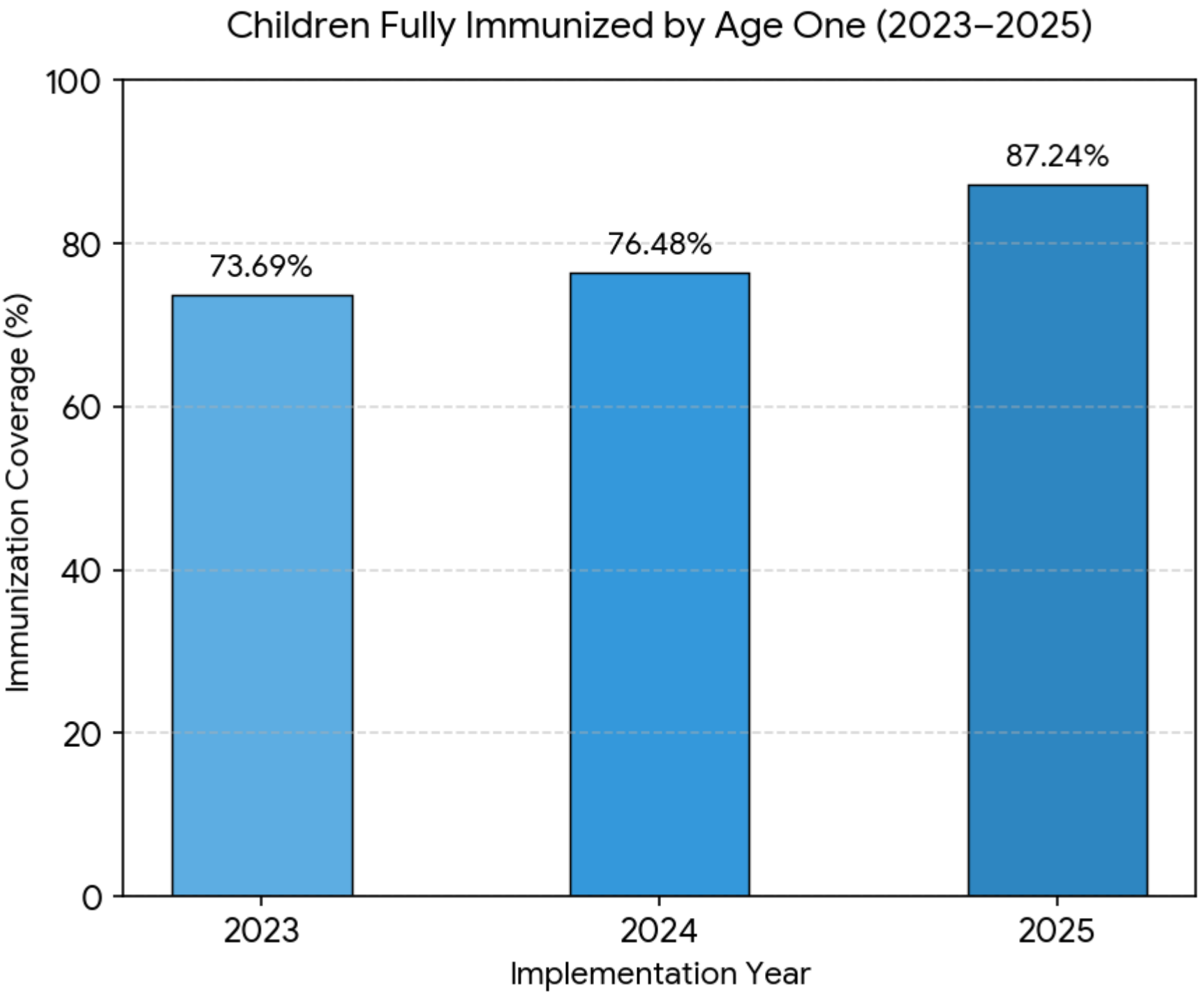
S/N	Local Government	Children Fully Immunized by Age One (%)	Penta Dropout Rate (%)	Cold Chain Functionality (%)	Vaccine Stock-out Rate (%)
		2023	2024	2025	2023
1	Akoko North East	47.33	61.54	75.96	-1.46
2	Akoko North West	66.00	53.66	84.65	2.53
3	Akoko South East	61.58	62.84	91.58	0.60
4	Akoko South West	0.34	3.22	15.81	2.72
5	Akure North	104.41	103.34	98.89	1.66
6	Akure South	109.00	88.35	92.84	3.22
7	Ese-Odo	83.82	82.33	95.54	2.91
8	Idanre	71.44	68.86	96.57	4.66
9	Ifedore	18.07	19.66	23.77	4.95
10	Ilaje	85.63	90.51	102.03	5.82
11	Ile-Oluji/Okeigbo	72.46	70.90	92.50	3.21
12	Irele	92.93	89.75	116.29	5.52
13	Odigbo	149.61	223.66	179.13	1.26
14	Okitipupa	96.89	86.92	81.28	5.47
15	Ondo East	75.85	70.66	86.17	1.11
16	Ondo West	71.79	74.32	87.49	3.81
17	Ose	40.00	38.25	67.34	1.20

S/N	Local Government	Children Fully Immunized by Age One (%)	Penta Dropout Rate (%)	Cold Chain Functionality (%)	Vaccine Stock-out Rate (%)
18	Owo	42.29	44.53	75.60	2.44
State Average	**Ondo State**	**73.69**	**76.48**	**87.24**	**3.07**

Table 2.15: Summary of State Child Health and Immunization Performance Indicators (2023–2025)

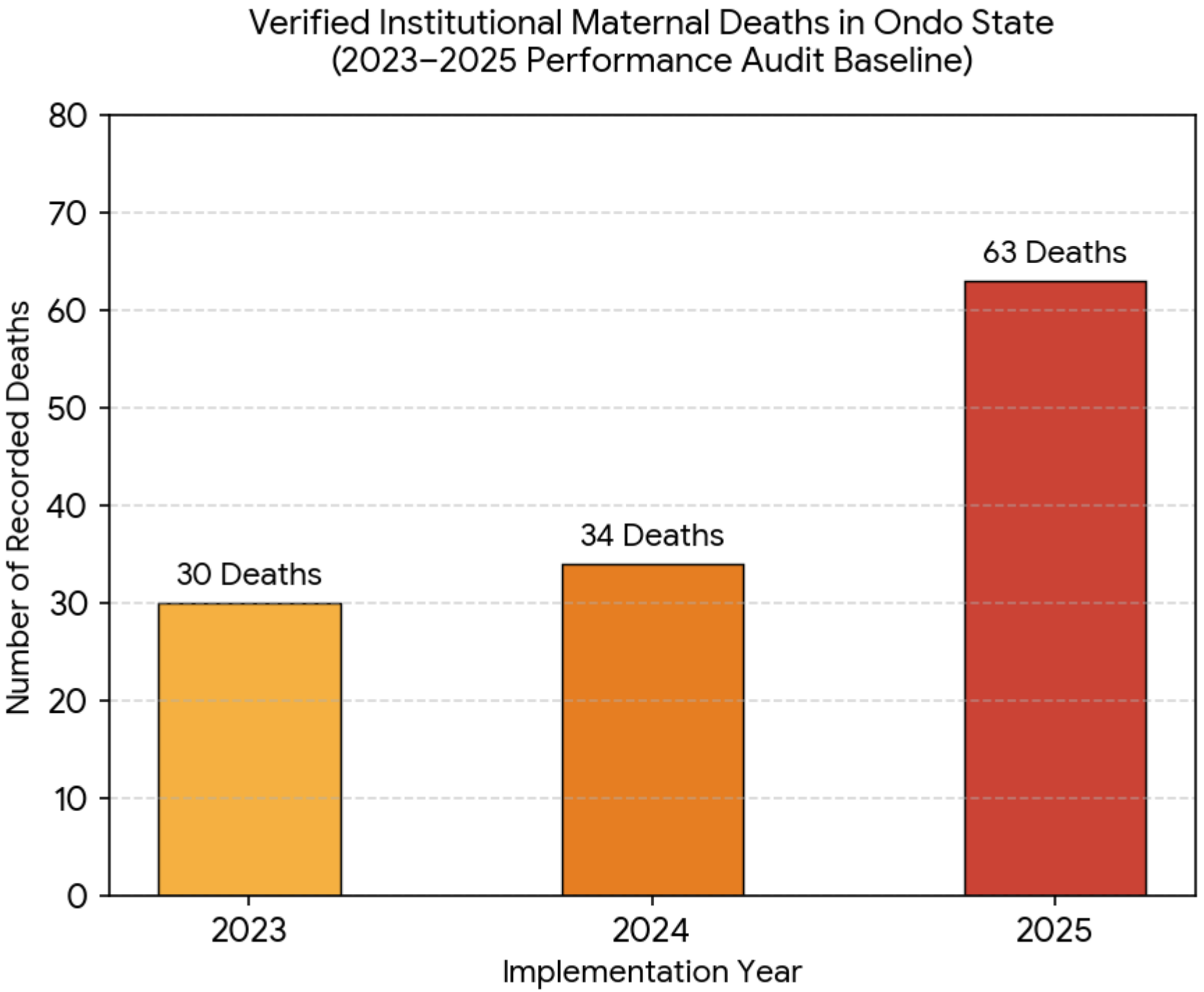
Indicator	2023	2024	2025
Children Fully Immunized by Age One (%)	**73.69**	**76.48**	**87.24**
Penta Dropout Rate (%)	**3.07**	**3.45**	**3.17**
Cold Chain Equipment Functionality Rate (%)	**97.56**	**95.43**	**93.57**
Vaccine Stock-out Rate (%)	**8.58**	**13.80**	**10.00**

Data was not made available in respect of Under-Five Consultation Rate and by the PHCDA.


Children Fully Immunized by Age One (2023–2025)
Immunization Coverage (%)
100
80
60
40
20
0
73.69%
76.48%
87.24%
2023
2024
2025
Implementation Year

Data Summary

- **2023 Baseline:** The proportion of children fully immunized before their first birthday stood at **73.69%** in 2023, providing the baseline for assessing improvements in routine immunization performance during the audit period.
- **2024 Performance:** Immunization coverage increased modestly to **76.48%** in 2024, representing a **2.79 percentage point** improvement over the 2023 baseline.
- **2025 Performance:** Coverage improved substantially to **87.24%** in 2025, representing an overall increase of **13.55 percentage points** compared with the 2023 baseline and **10.76 percentage points** over the 2024 level.


Verified Institutional Maternal Deaths in Ondo State
(2023–2025 Performance Audit Baseline)
Number of Recorded Deaths
0
10
20
30
40
50
60
70
80
30 Deaths
34 Deaths
63 Deaths
2023
2024
2025
Implementation Year

Data Summary

- **2023 Baseline:** The State recorded **30 institutional maternal deaths** in 2023, establishing the baseline for assessing maternal health outcomes during the audit period.
- **2024 Performance:** Institutional maternal deaths increased marginally to **34 deaths** in 2024, representing a **13.3% increase** over the 2023 baseline.
- **2025 Performance:** Institutional maternal deaths increased sharply to **63 deaths** in 2025, representing an **85.3% increase** over the 2024 figure and a **110.0% increase** compared with the 2023 baseline.

Audit Observation

The audit therefore confirms SPHCDA's position that substantial laboratory capacity gaps exist within the primary healthcare system.

SECTION 2.5: Child Health Performance

Table 2.16: Child Health Performance Indicators (2023–2025)

S/N	Local Government Area	Facility Utilisation Rate (<5 years)			Under-Five Mortality Rate (Facility)			Infant Mortality Rate		
		2023	2024	2025	2023	2024	2025	2023	2024	2025
1	Akoko North East	0.61	0.76	1.45	4.11	3.25	2.70	1.03	–	–
2	Akoko North West	0.86	0.76	1.94	4.18	6.37	4.80	3.13	2.55	1.20
3	Akoko South East	0.85	0.84	1.49	–	–	–	–	–	–
4	Akoko South West	0.61	0.54	1.24	–	1.47	1.27	–	–	1.27
5	Akure North	1.49	1.53	1.82	0.87	1.70	1.62	–	1.70	0.81
6	Akure South	1.49	1.65	1.78	20.31	23.80	19.48	16.01	18.21	16.14
7	Ese-Odo	1.01	0.91	2.06	4.05	–	1.35	2.02	–	–
8	Idanre	1.14	1.09	1.74	7.81	5.85	3.88	1.56	1.67	0.65
9	Ifedore	0.29	0.29	0.58	3.09	1.59	1.43	1.54	–	–
10	Ilaje	1.12	1.19	1.84	4.89	2.17	7.16	4.89	2.17	5.37
11	Ile-Oluji/Okeigbo	1.14	1.08	1.67	9.88	5.05	3.70	6.59	2.53	1.85
12	Irele	1.17	1.23	1.74	–	3.79	–	–	–	–
13	Odigbo	1.42	1.36	1.47	7.41	5.74	5.69	5.39	0.64	3.11
14	Okitipupa	1.10	1.00	1.51	2.65	3.66	3.07	2.12	3.05	1.54
15	Ondo East	1.19	1.15	1.73	3.64	–	1.34	1.82	–	–
16	Ondo West	1.09	1.18	1.43	13.62	53.55	61.09	8.51	44.38	56.81
17	Ose	0.57	0.58	1.47	–	–	–	–	–	–
18	Owo	0.74	0.68	1.27	8.01	1.43	30.14	2.67	1.43	28.31
State Average	**Ondo State**	**1.01**	**1.02**	**1.56**	**8.69**	**12.79**	**14.50**	**5.98**	**9.33**	**12.25**

Indicator	OSPHCDA Position	Audit Verification	Assessment
Laboratory Services	The Agency acknowledged gaps in laboratory diagnostic capacity across Primary Health Care facilities and indicated that many facilities depend on referral arrangements for diagnostic investigations.	Physical inspection of the sampled Primary Health Care facilities confirmed that laboratory diagnostic capacity remains inadequate. A significant proportion of facilities lacked functional laboratory equipment and basic diagnostic infrastructure, including microscopes and essential laboratory consumables. Consequently, many facilities relied on referrals to secondary or private health facilities for routine laboratory investigations, limiting timely diagnosis and continuity of care, particularly for maternal, neonatal and communicable disease services.	**Validated**

Note: "–" indicates that no value was reported in the HMIS dataset.

Audit Summary of Child Health Outcomes (Audit Tone)

Facility Utilisation

The analysis indicates a gradual improvement in the utilisation of primary health care services by children under five years of age. The State-wide facility utilisation rate increased from **1.01** in 2023 to **1.02** in 2024 before rising significantly to **1.56** in 2025. This trend suggests increased patronage of primary health care facilities for child health services, possibly reflecting improvements in service accessibility and community uptake of PHC interventions.

Under-Five Mortality

Despite improved utilisation of health services, facility-based under-five mortality worsened over the review period. The State average increased from **8.69** deaths per applicable reporting unit in 2023 to **12.79** in 2024 and **14.50** in 2025. Particularly high mortality rates were recorded in **Ondo West**, **Akure South**, and **Owo** in 2025, indicating persistent child survival challenges within these Local Government Areas.

Infant Mortality

Similarly, facility-based infant mortality increased steadily from **5.98** in 2023 to **9.33** in 2024 and **12.25** in 2025. The highest mortality burden was concentrated in **Ondo**

West, **Owo**, and **Akure South**, while relatively low infant mortality rates were recorded in **Akure North**, **Idanre**, and **Akoko North West**.

Overall Audit Assessment

The audit observed that although child health service utilisation and routine immunisation performance improved during the review period, these gains were not accompanied by corresponding improvements in child survival outcomes. The rising trend in facility-based infant and under-five mortality suggests that improvements in access to health services have yet to translate into better quality of care and improved clinical outcomes. This underscores the need for the State Primary Health Care Development Agency to strengthen neonatal and paediatric emergency care, improve referral systems, enhance case management protocols, and intensify routine mortality surveillance to identify and address the underlying causes of preventable child deaths.

4.2 Validation of Essential Medicines Availability

Table 2.17: Validation of Essential Medicines Availability

Indicator	SPHCDA Position	Audit Verification	Assessment
Essential Medicines Availability	Essential medicines were reported to be generally available across Primary Health Care facilities.	Physical verification conducted across the thirty-one (31) sampled Primary Health Care facilities confirmed that essential medicines were available in all facilities at the time of audit inspection, indicating a 100% point-in-time availability rate. However, audit interviews and stock records revealed that eleven (11) facilities (35.5%) experienced temporary stock-outs of one or more essential medicines during the review period. These stock-out episodes were generally short in duration, with none exceeding one day before replenishment. The findings suggest that while medicine supply chains were largely functional, occasional inventory disruptions occurred at facility level.	**Substantially Validated**

4.3 Validation of Maternal Health Services

Table 2.18 Validation of Maternal Health Services

Indicator	Audit Result
First Antenatal Care (ANC1) Registrations	30,960
Fourth Antenatal Care (ANC4) Attendance	836
ANC4 Completion Rate	2.7%
Skilled/Facility Deliveries	2,609
Live Births Recorded	53
Maternal Deaths Recorded	2

Assessment Parameter	Result
SPHCDA Position	Routine reporting systems are in place for key maternal health indicators, including antenatal care attendance, skilled birth attendance, live births, and maternal deaths. The Agency also reported continued implementation of maternal and newborn health interventions across Primary Health Care facilities.
Audit Verification	Physical inspection and review of facility registers across the thirty-one (31) sampled Primary Health Care facilities confirmed that maternal health services, including antenatal care, skilled delivery services, and postnatal care, were operational in all facilities visited. However, audit identified significant weaknesses in the continuity of maternal care, monitoring of pregnancy outcomes, and completeness and reliability of health records. While 30,960 women registered for their first antenatal visit (ANC1), only 836 completed the recommended fourth antenatal visit (ANC4), representing an overall completion rate of **2.7%**. Audit also observed inconsistencies between antenatal attendance records, delivery registers, and live birth documentation, indicating deficiencies in patient follow-up, referral tracking, and routine health information management.
Assessment	**Partially Validated**

Audit Observation

The audit confirmed that maternal health services are available and routinely delivered across sampled Primary Health Care facilities. Nevertheless, the extremely low ANC4 completion rate, coupled with inconsistencies in maternal outcome records, suggests significant challenges in continuity of care, patient retention, referral coordination, and data quality. These weaknesses reduce the reliability of maternal health performance reporting and may limit the effectiveness of interventions aimed at improving maternal and neonatal outcomes.

Recommendation

The State Primary Health Care Development Agency should strengthen maternal health service delivery by improving client follow-up mechanisms throughout the antenatal care continuum, enhancing referral and defaulter-tracking systems, and ensuring complete and accurate documentation of maternal health outcomes. The Agency should also strengthen supportive supervision and routine data quality assurance to improve the reliability of maternal health information for planning, monitoring, and evidence-based decision-making.

4.4 Validation of Child Health and Immunization Services

Table 2.19 Validation of Child Health and Immunization Services

Indicator	2023	2024	2025
Children Fully Immunized by Age One (%)	73.69	76.48	87.24
Facility Maternal Mortality Ratio (per 100,000 live births)	304.55	373.00	563.24
Reported Maternal Deaths	30	34	63
Penta Dropout Rate (%)	3.07	3.45	3.17
Cold Chain Equipment Functionality Rate (%)	97.56	95.43	93.57
Vaccine Stock-out Reports (%)	8.58	13.80	10.00

Validation Assessment

Table 2.20 Validation of Maternal Health Services- Assessment Result

Assessment Parameter	Result
SPHCDA Position	The Agency reported sustained improvements in routine immunization performance, expansion of child health services, and continued implementation of immunization outreach programmes across the State during the review period.
Audit Verification	Analysis of the State's routine health management information system (HMIS) data confirmed a steady improvement in full immunization coverage, increasing from **73.69% in 2023** to **76.48% in 2024**, and further to **87.24% in 2025**, indicating improved access to childhood immunization services. Audit also noted that Penta vaccine dropout rates remained consistently low (between **3.07% and 3.45%**), suggesting relatively good completion of routine immunization schedules. However, audit observed a gradual decline in cold chain equipment functionality from **97.56%** to **93.57%**, together with recurring vaccine stock-out reports ranging between **8.58% and 13.80%**, indicating operational weaknesses within the vaccine logistics and cold chain management system. Furthermore, despite improvements in immunization performance, facility-based maternal mortality indicators deteriorated over the review period, with reported maternal deaths increasing from **30** in 2023 to **63** in 2025 and the facility maternal mortality ratio rising correspondingly.
Assessment	**Substantially Validated**

Audit Observation

The audit confirmed substantial progress in routine childhood immunization services, as reflected by the sustained increase in full immunization coverage and consistently low vaccine dropout rates. These improvements demonstrate the effectiveness of immunization outreach and service delivery interventions. Nevertheless, declining cold chain functionality, recurring vaccine stock-outs, and worsening maternal mortality indicators highlight persistent health system challenges that may undermine the sustainability of service delivery and broader maternal and child health outcomes if not adequately addressed.

Recommendation

The State Primary Health Care Development Agency should consolidate the gains recorded in routine immunization by strengthening vaccine logistics and supply chain management, rehabilitating and replacing ageing cold chain equipment, and maintaining adequate buffer stocks to eliminate vaccine stock-outs. In addition, the Agency should intensify interventions aimed at reducing maternal mortality through improved emergency obstetric care, strengthened referral systems, enhanced supportive supervision, and continuous monitoring of maternal and child health performance indicators.

Table 2.21: Validation of Financial Management Arrangements

Indicator	**Result**
Facilities Receiving Direct Budget Allocations	0%
Facilities Receiving Operational Funds	83.3%
Facilities Maintaining Expenditure Records	77.8%
Facilities Maintaining IGR Records	100%

Assessment Parameter	**Result**
SPHCDA Position	Funding is provided through State Government appropriations and development partner interventions.
Audit Verification	Most facilities received operational funding and maintained financial records; however, direct budget allocations, especially for those facilities not receiving operational funding through decentralized facility financing approach, were absent; and record-keeping practices varied.
Assessment	Partially Validated

Audit Observation

The audit confirmed that the majority of sampled facilities received operational support funding and maintained records of internally generated revenue.

However:

- No sampled facility received direct budgetary allocations;
- Financial reporting practices varied considerably;
- Some facilities maintained incomplete expenditure documentation;
- Financial accountability arrangements remain largely manual and fragmented.

Although funding mechanisms exist and support service delivery, stronger financial management controls and expenditure documentation procedures are required to improve accountability and transparency.

4.6 Validation of the IMPACT Project: Upgrade of 102 Primary Health Care Facilities

Audit review of the IMPACT Project revealed that a total investment of **₦7,482,724,620.87** was committed to the rehabilitation and upgrading of **102 Primary Health Care Centres** across the eighteen Local Government Areas of Ondo State.

Table 2.22: Summary of PHC Upgrade Projects under the IMPACT Project

Lot	No. of PHCs	Contract Sum (₦)
Lot 1	16	1,169,999,937.40
Lot 2	24	1,747,587,861.74
Lot 3	19	1,473,269,897.58
Lot 4	20	1,399,694,471.93
Lot 5	23	1,692,172,452.22
Total	**102**	**7,482,724,620.87**

Table 2.23: Distribution of Investment by Senatorial District

Senatorial District	LGAs Covered	No. of PHCs	Investment Value (₦ Billion)
Northern	Akoko North East, Akoko North West, Akoko South East, Akoko South West, Ose, Owo	40	**2.92**
Central	Akure North, Akure South, Idanre, Ifedore, Ondo East, Ondo West	19	**1.75**
Southern	Ese-Odo, Irele, Ilaje, Okitipupa, Odigbo, Ile-Oluji/Okeigbo	43	**2.81**
Total	18 LGAs	**102**	**7.48**

Source: Ondo State Primary Health Care Development Agency (SPHCDA)

Audit Observation

The audit confirmed that substantial investments were made in PHC infrastructure under the IMPACT Project. Physical verification established that many facilities had benefitted from upgrades and rehabilitation works.

However, field inspections also identified significant implementation weaknesses, including:

- Project diversion from approved locations;
- Structural defects and poor workmanship;
- Incomplete and abandoned staff quarters;
- Defective roofing and ceiling installations;
- Damaged solar infrastructure;
- Weak post-construction quality assurance;
- Persistent service delivery constraints despite infrastructure investments.

Furthermore, the audit observed that infrastructure investments were not always aligned with:

- Population density;
- Healthcare utilization patterns;
- Workforce availability;
- Accessibility challenges;
- Operational readiness requirements.

Notwithstanding substantial investments in riverine areas, significant deficits remain in staffing, electricity supply, transport logistics, equipment availability, and service accessibility.

Assessment

Partially Validated

While the audit confirms that substantial capital investments were executed under the IMPACT Project, the effectiveness, sustainability, and value-for-money of some investments were reduced by weaknesses in planning, project monitoring, quality assurance, and integration with broader health system requirements.

4.7 Validation of Health Information Management Systems

Data Quality Issues Identified

The audit identified several anomalies and inconsistencies within reported health information datasets, including:

- Inconsistent laboratory data;
- Incomplete child health indicators- Missing under-five mortality records;

Assessment

Not Fully Validated

Audit Observation

The audit found that weaknesses in data collection, validation, aggregation, and reporting processes continue to affect the reliability of management information used for planning and decision-making.

The absence of robust electronic reporting systems and automated validation controls increases the risk of reporting errors, omissions, duplication, and inaccurate performance reporting.

Consequently, the reliability of several key health outcome indicators could not be independently verified with a high degree of assurance.

Overall Audit Conclusion

The audit found that the majority of primary healthcare services reported by the Ondo State Primary Health Care Development Agency (SPHCDA) are operational and being delivered at facility level. Physical verification confirmed the existence and functionality of health facilities, immunization services, maternal health interventions, essential medicine availability, and ongoing infrastructure investments.

The audit also noted positive developments, including improvements in immunization coverage, expansion of the health workforce through the 2025 recruitment exercise, and significant capital investment in primary healthcare infrastructure under the IMPACT Project.

However, the audit identified significant weaknesses in health information management, project oversight, workforce distribution, maternal care continuity, infrastructure maintenance, and performance reporting systems.

Accordingly, while the audit provides reasonable assurance that primary healthcare services are operational and generally accessible across the State, it concludes that substantial improvements are required in governance, monitoring, data quality, accountability, and service integration before reported performance outcomes can be relied upon fully for planning, resource allocation, performance assessment, and measurement of progress towards Universal Health Coverage (UHC) and Sustainable Development Goal 3 (SDG 3).

CHAPTER THREE

PERFORMANCE AUDIT FINDINGS

3.1 Areas of Positive Performance

The audit acknowledges that despite the systemic weaknesses identified, the Ondo State Primary Health Care Development Agency (OSPHCDA) recorded notable achievements during the period under review. These provide evidence of continued government commitment towards strengthening primary healthcare service delivery.

3.1.1 Sustained Functionality of the PHC Network

The audit confirmed that all **575 Primary Health Care facilities** reported by the Agency remained operational throughout the audit period, thereby maintaining a statewide primary healthcare delivery platform. This demonstrates sustained government commitment to ensuring the availability of basic health services across the State.

3.1.2 Improvement in Health Workforce Recruitment

The audit confirmed that **552 health personnel** were recruited during 2025 against a target of **490 personnel**, representing **112.6% achievement**. The recruitment covered critical professional cadres including:Nurses, Community Health Extension Workers (CHEWs), Community Health Officers, Laboratory Personnel, Medical Records Officers, Nutrition Officers, and Dental Technicians

The recruitment has contributed towards reducing workforce shortages across primary healthcare facilities.

3.1.3 Progressive Improvement in Childhood Immunization Coverage

Analysis of State HMIS records revealed sustained improvement in childhood immunization coverage during the review period.

Table 3.1Analysis of State HMIS

Year	Fully Immunized Children (%)
2023	73.69
2024	76.48
2025	87.24

Overall immunization coverage increased by **13.55 percentage points** over the three-year period, indicating improvements in vaccine logistics, outreach activities and routine immunization services.

3.1.4 Expansion of Primary Healthcare Infrastructure

Government continued substantial investments in PHC infrastructure through construction, rehabilitation and upgrading of facilities under various intervention programmes.Investments covered:, Health facility rehabilitation,Solar electrification, Water supply systems, Staff accommodation, Medical equipment, and Cold-chain infrastructure

Although quality deficiencies were observed in several projects, these investments have expanded service delivery capacity across the State.

3.1.5 High Availability of Essential Medicines

Physical verification conducted across the sampled facilities confirmed that essential medicines were available in virtually all facilities visited during the audit.

Although temporary stock-outs were reported in a number of facilities, these were generally resolved within short periods, indicating that the State's medicine supply chain remains reasonably functional.

3.1.6 Strong Cold Chain Functionality

HMIS records showed that refrigerator functionality remained consistently high:

Table 3.2: Cold Chain Functionality Rate

Year	Cold Chain Functionality (%)
2023	97.56
2024	95.43
2025	93.57

These performance levels demonstrate that the State has largely maintained the integrity of vaccine storage systems.

3.2 Areas Requiring Improvement

The audit identified several systemi weaknesses affecting the economy, efficiency, effectiveness and sustainability of primary healthcare service delivery.

Table 3.3 Summary of Major Audit Findings

Finding	Condition	Criteria	Cause	Implications	Recommendations
3.2.1 Inequitable Access to PHC Services	Geographical disparities remain in access to PHC services, particularly in riverine and	National Health Policy, SDG 3.	Weak needs-based planning.	Unequal access and delayed treatment.	Adopt GIS-based needs assessment and equitable facility planning.

Finding	Condition	Criteria	Cause	Implications	Recommendations
	difficult-to-reach communities.				
3.2.2 Human Resource Shortages and Maldistribution	Critical shortages and uneven deployment of skilled personnel across LGAs.	WHO staffing benchmarks.	Weak workforce planning.	Overworked staff and poor service quality.	Redistribute staff and strengthen rural retention incentives.
3.2.3 Weak Maternal Health Outcomes	Although ANC attendance increased substantially, continuity of maternal care remains weak while maternal deaths increased from **30 (2023)** to **63 (2025)**.	National Safe Motherhood Guidelines.	Weak referral systems, inadequate follow-up, poor emergency obstetric care.	Increased maternal mortality.	Strengthen referral systems, emergency obstetric care and ANC follow-up.
3.2.4 Child Health Service Gaps	Despite improved immunization coverage, infant mortality increased from **5.98** to **12.25 per 1,000 live births**, while under-five mortality rose from **8.69** to **14.50**.	SDG 3.	Quality-of-care deficiencies.	Reduced child survival outcomes.	Strengthen integrated child health services.
3.2.5 Infrastructure Quality Deficiencies	Numerous facilities exhibited structural defects, unfinished projects and	National PHC Infrastructure Standards.	Weak contract supervision.	Reduced service quality.	Strengthen project monitoring and maintenance.

Finding	Condition	Criteria	Cause	Implications	Recommendations
	inadequate maintenance.				
3.2.6 Laboratory Capacity Deficits	Only a small proportion of sampled facilities possessed functional laboratory diagnostic equipment, compelling most facilities to rely on external referrals.	National PHC Minimum Service Package.	Inadequate equipment and investment.	Delayed diagnosis and treatment.	Provide laboratory equipment and deploy qualified personnel.
3.2.7 Essential Equipment and Cold Chain Gaps	Although cold-chain functionality remained above 90%, declining performance and localized equipment failures pose risks to vaccine quality.	National Immunization Policy.	Ageing equipment and maintenance gaps.	Potential compromise of vaccine potency.	Strengthen preventive maintenance and equipment replacement.
3.2.8 Weak Health Information Management	Data inconsistencies, missing values and reporting anomalies were identified in HMIS datasets.	NHMIS Guidelines.	Weak validation controls.	Poor planning and monitoring.	Strengthen HMIS data quality assurance.
3.2.9 Weak Governance and Supervision	Supervisory visits and project monitoring remain inadequate.	National PHC Governance Framework.	Funding and coordination constraints.	Reduced accountability.	Institutionalize risk-based supervision.

Finding	Condition	Criteria	Cause	Implications	Recommendations
3.2.10 Weak Facility Security	Many facilities lacked perimeter fencing, guards and security infrastructure.	Government Asset Management Standards.	Poor security planning.	Asset loss and vandalism.	Develop facility security framework.

3.3 Overall Performance Assessment

The audit concludes that although the Ondo State Government made appreciable investments in primary healthcare infrastructure, workforce recruitment, vaccine logistics, and routine immunization during the period 2023–2025, these investments have not translated proportionately into improved health outcomes.

Key outcome indicators reveal persistent systemic weaknesses:

i. Childhood immunization coverage improved from **73.69%** in 2023 to **87.24%** in 2025.
ii. Skilled birth attendance increased modestly from **82.8%** to **84.1%**.
iii. Maternal mortality increased from **30** to **63** facility-reported deaths.
iv. Infant mortality increased from **5.98** to **12.25**.
v. Under-five mortality increased from **8.69** to **14.50**.
vi. Vaccine cold-chain functionality declined slightly from **97.56%** to **93.57%**.
vii. Vaccine stock-out reporting remained unstable, increasing from **8.58%** in 2023 to **13.8%** in 2024 before improving marginally to **10.0%** in 2025.

Overall, while significant progress was recorded in expanding service availability and immunization coverage, the persistence of rising maternal and child mortality, inequitable workforce distribution, infrastructure deficiencies, laboratory capacity constraints, and weaknesses in health information management indicates that the efficiency, effectiveness, equity, and value-for-money of primary healthcare investments remain below expected standards.

Table 3.4: Summary of Deficiencies Identified During Physical Inspection of Selected Primary Health Care Facilities

S/N	Health Facility	Contract Sum (₦)	Audit Observation	Audit Implication
1	PHC Supare II Akowonjo, Akoko South West	66,576,579.65	The approved PHC Upgrade Project was not executed at the designated facility. Audit verification	Indicates weak contract administration, inadequate project monitoring, deviation from approved project

S/N	Health Facility	Contract Sum (₦)	Audit Observation	Audit Implication
			established that the project was instead implemented at PHC Supare I.	scope, and potential misapplication of public resources. The intended beneficiary community was deprived of the planned investment.
2	PHC Oba I, Araromi Oba, Akoko	71,116,507.83	Recently completed structures exhibited leaking roofs, broken floor tiles, falling ceiling finishes and absence of lighting at the security post.	Evidence of poor workmanship and weak quality assurance during project execution, exposing government assets to premature deterioration and increasing future maintenance costs.
3	PHC Epinmi, Akoko South East	64,638,421.30	The ceiling of the newly constructed staff quarters had partially collapsed, while installed solar panels had been displaced by wind shortly after completion.	Reflects substandard construction quality, inadequate structural design and poor contractor supervision, thereby compromising the sustainability and value-for-money of the investment.
4	PHC Okeagbe, Akoko North West	N/A	Perimeter fencing was partially collapsed and no functional security post was available.	Weak facility security exposes public assets, medicines and equipment to theft, vandalism and unauthorized access, thereby increasing operational risks.
5	PHC Ifon I, Ose LGA	N/A	The facility lacked a functional solar power system and had no public electricity supply for over seven years. The borehole was non-functional, while the delivery couch and neonatal equipment were badly deteriorated.	Critical deficiencies in essential infrastructure adversely affect maternal and newborn healthcare, reduce infection prevention standards, discourage skilled staff retention and weaken service delivery capacity.
6	PHC Elegbeka, Ose LGA	76,944,145.75	No pharmacist or pharmacy technician was available to manage	Weak medicines management increases the risk of poor inventory control, irrational drug use, stock management

S/N	Health Facility	Contract Sum (₦)	Audit Observation	Audit Implication
			pharmaceutical services.	failures and compromised pharmaceutical service delivery.
7	PHC Owena Bridge, Ondo East	80,134,282.62	Construction of staff quarters remained approximately 60% completed, with major internal finishing works outstanding at the time of audit inspection.	Delayed project completion postpones realization of intended benefits, exposes incomplete works to deterioration and reduces the expected return on public investment.
8	Italurowo PHC, Ondo East	N/A	Existing staff quarters were incomplete, dilapidated and unsuitable for occupation.	Poor residential accommodation discourages staff residency, weakens emergency response capability and negatively affects continuity of healthcare service delivery.
9	Arakale Comprehensive Health Centre, Akure South	N/A	Installed solar power system and vaccine refrigerator were non-functional during audit inspection.	Compromises vaccine cold-chain integrity, increases the risk of vaccine spoilage, interrupts immunization services and undermines previous public investments in immunization infrastructure.
10	Igbokoda Comprehensive Health Centre, Igbobini PHC and Igbotu PHC	Various	Roof leakages were observed in multiple facilities during physical inspection.	Persistent roof defects accelerate structural deterioration, expose medical equipment and medicines to water damage, disrupt clinical operations and increase maintenance liabilities.
11	Multiple Sampled PHCs Across the State	Various	Laboratory diagnostic capacity remained inadequate. Only a limited proportion of sampled facilities possessed functional laboratory equipment,	Weak diagnostic capacity delays clinical decision-making, increases patient referrals, raises out-of-pocket expenditure and limits the comprehensiveness of

S/N	Health Facility	Contract Sum (₦)	Audit Observation	Audit Implication
			compelling most facilities to rely on external referrals for basic investigations.	primary healthcare services.
12	Statewide PHC Network	N/A	Audit analysis identified significant geographical disparities in access to PHC services, with infrastructure, skilled personnel and specialised services unevenly distributed across Local Government Areas, particularly in difficult-to-reach rural and riverine communities.	Unequal distribution of healthcare resources reduces equitable access to essential services, contributes to service congestion in some locations and limits progress towards Universal Health Coverage and equitable health outcomes across the State.

3.4 Overall Audit Conclusion

The performance audit concludes that although the Ondo State Government has made substantial investments in primary healthcare infrastructure, workforce recruitment, vaccine logistics and service expansion during the period 2023–2025, significant systemic weaknesses continue to undermine the economy, efficiency, effectiveness, equity and value-for-money of these investments.

Physical inspections and analysis of administrative and HMIS data revealed deficiencies in project execution, infrastructure quality, laboratory capacity, maintenance culture, workforce distribution, maternal and child health outcomes, health information management, governance and facility security. While childhood immunization coverage improved significantly during the review period, the increase in maternal, infant and under-five mortality indicators, coupled with persistent infrastructure and service delivery deficiencies, indicates that improved service availability has not translated into commensurate improvements in health outcomes.

The audit therefore concludes that sustained improvements in primary healthcare delivery will require stronger governance arrangements, risk-based project supervision, evidence-based resource allocation, strengthened quality assurance, improved maintenance systems, enhanced workforce planning, and more robust performance monitoring to ensure that future public investments deliver measurable health benefits and achieve value for money.

CHAPTER FOUR

ROOT CAUSES AND CROSS-CUTTING ISSUES

The findings presented in Chapter Three indicate that the observed weaknesses within the Primary Health Care (PHC) system are largely systemic rather than isolated operational failures. While the State has made considerable investments in PHC infrastructure, workforce recruitment, immunization services and digital health reporting, the audit established that these investments have not consistently translated into proportional improvements in service delivery and health outcomes.

The underlying causes cut across governance, strategic planning, human resource management, infrastructure management, financial sustainability, health information systems, and service delivery arrangements. The table below summarizes the major root causes identified during the audit.

Table 4.1: Summary of Root Causes and Cross-Cutting Issues

Root Cause Area	Condition Observed	Audit Criteria	Root Cause	Implications	Strategic Recommendation
4.1 Weak Health Workforce Planning and Deployment	Significant shortages of doctors, nurses, midwives, pharmacists, laboratory personnel and Community Health Extension Workers persist, while wide disparities exist in staff distribution between urban and rural facilities.	National Health Act, WHO workforce benchmarks, National Minimum Standards for PHC.	Inadequate workforce planning, retirements without timely replacement, weak deployment policy, and absence of workload-based allocation.	Reduced service availability, staff burnout, long patient waiting time, and inequitable access to healthcare.	Develop a comprehensive Human Resource for Health Strategy supported by periodic workload analysis, equitable deployment, recruitment and rural retention incentives.
4.2 Geographic Inequity in	Although PHC facilities	SDG 3, National Health	Historical concentration of	Reduced utilization of PHC	Implement a Rural and Riverine Health

Root Cause Area	Condition Observed	Audit Criteria	Root Cause	Implications	Strategic Recommendation
Access to PHC Services	exist across all LGAs, several rural and riverine communities continue to experience limited access to quality healthcare owing to difficult terrain, transportation constraints and inadequate staffing.	Policy, PHC Minimum Service Package.	investments in accessible locations without sufficient consideration of geographical barriers and service demand.	services, delayed access to maternal and child healthcare, and widening rural health inequalities.	Equity Framework incorporating outreach services, mobile clinics, transport support and targeted infrastructure investment.
4.3 Weak Infrastructure Maintenance and Asset Management	Physical inspection revealed leaking roofs, damaged ceilings, incomplete staff quarters, failed solar systems, defective water facilities, deteriorating perimeter fencing and other infrastructure defects in several sampled facilities.	Public Asset Management Principles; National PHC Infrastructure Standards.	Weak preventive maintenance culture, inadequate maintenance funding, poor contractor supervision and delayed corrective maintenance.	Premature deterioration of public assets, reduced service quality, safety risks and increased future rehabilitation costs.	Institutionalize preventive maintenance planning, annual facility condition assessments and dedicated maintenance budgets supported by digital asset management systems.
4.4 Weak Contract Managemen	Audit identified cases of	Ondo State Public Procuremen	Weak project monitoring,	Reduced value for money,	Strengthen project monitoring,

Root Cause Area	Condition Observed	Audit Criteria	Root Cause	Implications	Strategic Recommendation
t and Project Supervision	incomplete projects, project diversion, poor workmanship and delayed completion of infrastructure projects.	t Law; Contract Specifications.	inadequate technical supervision and insufficient post-completion quality assurance.	delayed realization of project benefits and increased exposure to contractual disputes.	independent quality assurance inspections and contractor performance evaluation before final certification.
4.5 Weak Maternal Health Continuum of Care	Statewide maternal service utilization improved during the audit period; however, institutional maternal deaths increased from **30 in 2023** to **63 in 2025**, despite increased skilled birth attendance and antenatal attendance.	WHO Safe Motherhood Guidelines; National Reproductive Health Policy.	Delays in referral systems, inadequate emergency obstetric care capacity, workforce shortages in high-volume facilities and quality-of-care gaps.	Increased maternal mortality, preventable obstetric complications and reduced effectiveness of maternal health investments.	Strengthen Comprehensive Emergency Obstetric and Newborn Care (CEmONC), referral networks, maternal death surveillance and quality improvement programmes.
4.6 Weak Child Health Service Delivery and Monitoring	Immunization coverage improved substantially from **73.69% (2023)** to **87.24% (2025)**; however, under-five mortality increased from **8.69** to **14.50 per 1,000**, while	SDG 3; National Child Survival Strategy; Expanded Programme on Immunization Guidelines.	Improvements in preventive services have not been matched by corresponding improvements in curative services, nutrition, referral care and neonatal	Persistent preventable childhood mortality despite increased immunization coverage.	Strengthen Integrated Management of Childhood Illness (IMCI), neonatal care, nutrition interventions, referral systems and mortality surveillance.

Root Cause Area	Condition Observed	Audit Criteria	Root Cause	Implications	Strategic Recommendation
	infant mortality rose from **5.98** to **12.25 per 1,000** over the same period.		management.		
4.7 Weak Health Information and Data Governance	Audit identified inconsistencies, missing indicators, reporting anomalies and incomplete facility records. Significant variations were observed between facility registers and electronic reports in some locations.	NHMIS Guidelines; ISSAI 3000 evidence requirements.	Continued dependence on manual data capture, weak validation controls and inadequate data quality assurance mechanisms.	Reduced reliability of performance reporting, inaccurate planning and weakened accountability.	Deploy an integrated electronic Health Management Information System (e-HMIS) with automated validation, periodic data quality assessments and supervisory verification.
4.8 Weak Cold Chain and Logistics Management	Although overall cold-chain functionality remained above 93%, functionality declined progressively from **97.56% (2023)** to **93.57% (2025)**, while vaccine stock-out reports increased in	National EPI Guidelines; WHO Vaccine Management Standards.	Ageing cold-chain equipment, inadequate preventive maintenance and logistics constraints.	Increased risk of vaccine wastage and interruption of immunization services.	Strengthen preventive maintenance, equipment replacement planning and integrated logistics management systems.

Root Cause Area	Condition Observed	Audit Criteria	Root Cause	Implications	Strategic Recommendation
	several LGAs.				
4.9 Weak Operational Funding and Service Sustainability	Delays in operational funding affected supervision, outreach activities, transportation, equipment maintenance and routine service delivery in several facilities.	Public Financial Management Framework; Budget Execution Guidelines.	Administrative bottlenecks, inadequate operational budgeting and competing expenditure priorities.	Reduced effectiveness of health programmes and delayed implementation of corrective actions.	Improve budget execution, prioritize frontline operational expenditures and establish protected funding for maintenance and outreach services.
4.10 Weak Governance, Monitoring and Accountability Frameworks	Supervisory visits, contractor monitoring, facility inspections and implementation follow-up remain inconsistent across LGAs.	ISSAI 3000; Public Sector Governance Principles.	Limited supervisory resources, weak performance monitoring systems and insufficient accountability mechanisms.	Delayed detection of operational deficiencies, infrastructure deterioration and reduced value for money.	Institutionalize risk-based supervision, digital monitoring dashboards, performance scorecards and periodic independent performance audits.
4.11 Weak Facility Security and Asset Protection	Several facilities lacked perimeter fencing, security posts, functional lighting and adequate physical security arrangements.	Public Asset Protection Principles.	Security planning has not been fully integrated into facility design, budgeting and operations.	Increased exposure to theft, vandalism, equipment losses and unauthorized access.	Develop a comprehensive PHC Facility Security Framework incorporating perimeter protection, security personnel, lighting and routine security assessments.

CHAPTER FIVE

CONCLUSIONS

5.1 Overall Conclusion

This Performance Audit assessed whether investments in the Primary Health Care (PHC) system in Ondo State during the period 2023–2025 were managed with due regard to economy, efficiency, effectiveness, equity and value for money, and whether these investments improved access to quality primary healthcare services and health outcomes.

The audit concludes that Ondo State has demonstrated a sustained commitment to strengthening the Primary Health Care system through continued investment in health infrastructure, recruitment of healthcare personnel, expansion of immunization services, procurement of medical equipment, and implementation of several health sector interventions. The State also maintained an extensive network of approximately 575 functional Primary Health Care facilities providing essential health services across the eighteen Local Government Areas.

Notwithstanding these achievements, the audit established that significant systemic weaknesses continue to limit the overall performance of the Primary Health Care system.

Although childhood immunization coverage improved significantly from 73.69 percent in 2023 to 87.24 percent in 2025, corresponding improvements were not observed in several critical health outcomes. Facility-based maternal deaths increased from 30 deaths in 2023 to 63 deaths in 2025, while facility-based infant mortality increased from 5.98 to 12.25 per 1,000 live births, and under-five mortality increased from 8.69 to 14.50 per 1,000 during the same period. These trends indicate that improvements in preventive health interventions have not been matched by equivalent improvements in the quality, continuity and effectiveness of maternal and child healthcare services.

The audit further established that inequitable distribution of healthcare personnel, persistent shortages of critical clinical cadres, inadequate referral systems, infrastructure maintenance deficiencies, incomplete capital projects, weak contract supervision, inconsistent health information, and operational challenges in rural and riverine communities continue to undermine the efficiency and effectiveness of service delivery.

Physical verification further revealed instances of defective construction works, deteriorating healthcare infrastructure, non-functional utility systems, inadequate staff accommodation, incomplete projects and weak preventive maintenance practices, thereby reducing the long-term value derived from substantial public investments in the health sector.

The audit also identified weaknesses in health information management, including incomplete records, reporting inconsistencies and data quality challenges that reduce

the reliability of performance information required for planning, budgeting, monitoring and evidence-based decision-making.

Overall, the audit concludes that while substantial public resources have been committed to strengthening Primary Health Care in Ondo State, the expected improvements in service quality, equitable access and health outcomes have not been fully realized due to persistent institutional, operational and governance weaknesses.

5.2 Conclusions by Audit Objective

5.2.1 Objective One: Adequacy and Distribution of Human Resources for Health

The audit concludes that the State has made measurable progress in recruiting additional healthcare personnel during the review period. Nevertheless, workforce availability remains inadequate relative to service demand, while significant disparities persist in the deployment of doctors, nurses, midwives, pharmacists, laboratory personnel and Community Health Extension Workers across Local Government Areas. Rural and riverine facilities continue to experience critical staffing shortages, thereby limiting equitable access to essential healthcare services.

5.2.2 Objective Two: Accessibility and Equity of Primary Healthcare Services

The audit concludes that the geographical distribution of healthcare facilities and health personnel does not adequately reflect population distribution, disease burden and the unique accessibility challenges of rural and riverine communities. Consequently, significant inequalities remain in physical access to healthcare services, particularly within difficult-to-reach communities.

5.2.3 Objective Three: Maternal and Child Health Outcomes

The audit concludes that maternal and child healthcare services have not achieved the expected level of effectiveness. While skilled birth attendance and immunization coverage improved during the review period, maternal mortality, infant mortality and under-five mortality increased, indicating persistent weaknesses in continuity of care, referral systems, emergency obstetric care, neonatal management and quality of clinical services.

5.2.4 Objective Four: Infrastructure, Equipment and Service Readiness

The audit concludes that considerable investments have been made in healthcare infrastructure; however, weaknesses in contract management, project supervision, preventive maintenance and utility support have reduced the functionality, sustainability and value for money of several completed projects. Physical inspection confirmed defects, incomplete works and infrastructure deterioration in a number of sampled facilities.

5.2.5 Objective Five: Medicines, Vaccines and Logistics Management

The audit concludes that the State has maintained generally satisfactory availability of essential medicines and achieved high cold-chain functionality throughout the review

period. Nevertheless, declining cold-chain functionality, intermittent vaccine stock-outs in some Local Government Areas, inadequate pharmaceutical staffing and logistics management weaknesses continue to pose operational risks.

5.2.6 Objective Six: Health Information Management and Governance

The audit concludes that existing health information systems require significant strengthening. Data inconsistencies, incomplete reporting, weak validation processes and continued reliance on manual data management reduce the reliability of information used for planning, performance monitoring and resource allocation.

5.2.7 Objective Seven: Governance, Monitoring and Accountability

The audit concludes that governance arrangements require substantial strengthening. Weak supervision, inconsistent project monitoring, inadequate contractor oversight and limited accountability mechanisms have contributed to delayed corrective actions, inefficient resource utilization and declining infrastructure quality.

5.3 Overall Performance Assessment Against the Five Audit Criteria

Economy

The State demonstrated commitment to financing Primary Health Care programmes and infrastructure. However, defects in completed projects, incomplete infrastructure, weak maintenance culture and instances of poor contract administration reduced the economic use of public resources.

Assessment:Moderately Satisfactory

Efficiency

Although considerable investments were made in infrastructure, workforce recruitment and immunization services, inefficiencies in personnel deployment, referral systems, maintenance planning, project implementation and health information management limited the conversion of resources into optimal service outputs.

Assessment:Partially Efficient

Effectiveness

Preventive health interventions, particularly immunization services, recorded notable improvement. However, increasing maternal mortality, infant mortality and under-five mortality indicate that overall health interventions did not consistently achieve their intended outcomes.

Assessment:Partially Effective

Equity

Significant inequalities remain in access to healthcare services across rural, urban and riverine communities owing to disparities in facility accessibility, workforce deployment and infrastructure availability.

Assessment:Requires Significant Improvement

Value for Money

The audit concludes that although substantial public investments have strengthened aspects of Primary Health Care delivery, weaknesses in project quality, infrastructure maintenance, workforce deployment, governance and outcome achievement have reduced the overall value obtained from these investments.

Overall Value-for-Money Assessment:Moderately Satisfactory with Significant Scope for Improvement

5.4 Audit Opinion

Based on the audit evidence obtained and evaluated, the Office of the Auditor-General concludes that the Primary Health Care system in Ondo State was **Partially Effective** during the period 2023–2025.

The State achieved commendable progress in expanding immunization coverage, maintaining widespread PHC infrastructure and strengthening the health workforce. However, these achievements were offset by persistent systemic weaknesses in workforce distribution, maternal and child health outcomes, infrastructure maintenance, contract management, health information systems, governance arrangements and equitable access to healthcare services.

Accordingly, the audit opinion is that the Primary Health Care system **partially achieved its intended objectives**, but requires substantial institutional reforms to improve economy, efficiency, effectiveness, equity and value for money.

5.5 Matters Requiring Priority Management Attention

The audit recommends that Government accords immediate priority to the following strategic reform areas:

viii. Develop and implement a comprehensive Health Workforce Strategy focusing on equitable deployment, rural retention and succession planning.
ix. Strengthen maternal, newborn and child health services, particularly referral systems, emergency obstetric care and quality-of-care improvement initiatives.
x. Institutionalize preventive maintenance programmes and strengthen contractor supervision to protect public infrastructure investments.
xi. Expand resilient utility infrastructure, including solar power systems, potable water supply, staff accommodation and cold-chain facilities.

xii. Strengthen medicines, vaccine logistics and pharmaceutical management systems.
xiii. Deploy an integrated electronic Health Management Information System with automated validation and regular data quality audits.
xiv. Strengthen governance, risk management, internal controls and performance monitoring across the Primary Health Care system.
xv. Improve healthcare access within underserved rural and riverine communities through targeted infrastructure, workforce deployment and outreach services.
xvi. Strengthen facility security and public asset protection through improved perimeter fencing, lighting, security personnel and routine security assessments.
xvii. Establish a comprehensive performance management framework linking resource allocation to measurable health outcomes to ensure greater accountability and value for money.

Implementation of these recommendations will significantly improve the economy, efficiency, effectiveness, equity and sustainability of Primary Health Care service delivery in Ondo State while accelerating progress towards Universal Health Coverage and Sustainable Development Goal 3.

CHAPTER SIX

RECOMMENDATIONS AND ACTION PLAN

Table 6.1 SUMMARY OF RECOMMENDATIONS AND ACTION PLAN

S/N	Audit Finding (Condition)	Audit Criteria	Root Cause	Audit Implication	Recommendation / Action Plan
1	**Persistent inequitable geographical distribution of PHC facilities and services**, with urban facilities experiencing significantly higher utilisation rates while many rural and riverine facilities remain under-utilised and difficult to access.	National Health Act; National Policy on Health; SDG 3; National Minimum Standards for PHC require equitable access to quality healthcare.	Facility planning has historically been based on administrative boundaries rather than population density, disease burden and geographical accessibility.	Geographic inequity in service delivery, congestion in urban PHCs, reduced utilisation in remote areas and unequal health outcomes.	**The Ondo State Primary Health Care Development Agency (OSPHCDA)** should develop a Geographic Health Service Rationalisation Plan using GIS mapping, population projections, disease burden and travel-time analysis to guide future infrastructure investments and outreach services.
2	**Large disparities exist in utilisation of maternal health services across LGAs**, with skilled birth attendance remaining below optimal levels despite increasing antenatal registrations. Maternal deaths increased from **30 (2023)** to **63 (2025)**.	National Reproductive Health Policy; WHO Safe Motherhood Guidelines.	Weak referral systems, inadequate emergency obstetric care, poor continuity of maternal care and delayed presentation to facilities.	Increased maternal mortality and reduced effectiveness of maternal health interventions.	OSPHCDA should strengthen the continuum of maternal care by implementing electronic ANC tracking, emergency referral networks, maternal death surveillance and response (MDSR), and community follow-up systems for high-risk pregnancies.
3	**Although childhood**	SDG 3; National	Improvements in	Child survival	Government should undertake a

S/N	Audit Finding (Condition)	Audit Criteria	Root Cause	Audit Implication	Recommendation / Action Plan
	immunisation coverage improved significantly from 73.69% (2023) to 87.24% (2025), infant mortality increased from 5.98 to 12.25 per 1,000 live births while under-five mortality rose from 8.69 to 14.50.	Child Health Policy.	immunisation have not been matched by corresponding improvements in neonatal care, nutrition, early diagnosis and postnatal care.	outcomes remain poor despite increased programme investments.	comprehensive review of neonatal and child survival programmes, strengthen Integrated Management of Childhood Illnesses (IMCI), improve newborn care services and prioritise high-burden LGAs for targeted interventions.
4	**Significant disparities exist in health workforce distribution**, with rural and riverine facilities continuing to experience shortages of skilled personnel.	WHO Human Resources for Health Standards; National HRH Policy.	Weak workforce planning, inadequate rural incentives and limited evidence-based deployment.	Reduced service quality, staff burnout and inequitable access to skilled healthcare.	Government should institutionalise an evidence-based Human Resource Planning Framework supported by an integrated Human Resource Information System (HRIS), workload analysis and rural retention incentives.
5	**Critical infrastructure defects, incomplete projects, defective construction works and utility failures were observed during physical inspection of sampled PHCs.**	Public Procurement Law; National PHC Infrastructure Standards.	Weak project supervision, inadequate quality assurance and poor maintenance planning.	Reduced value for money, accelerated asset deterioration and compromised service delivery.	OSPHCDA, in collaboration with the Ministry of Works, should establish an Infrastructure Asset Management Framework incorporating independent quality assurance, geo-tagged monitoring, preventive maintenance schedules and

S/N	Audit Finding (Condition)	Audit Criteria	Root Cause	Audit Implication	Recommendation / Action Plan
					contractor performance evaluation.
6	**Cold-chain functionality declined from 97.56% in 2023 to 93.57% in 2025 while vaccine stock-out reports increased from 8.58% to 10.0%.**	National Immunisation Policy; WHO Cold Chain Standards.	Weak preventive maintenance, ageing equipment and supply chain challenges.	Increased risk of vaccine spoilage and interruption of immunisation services.	OSPHCDA should establish a preventive maintenance programme for cold-chain equipment, replace obsolete refrigerators, deploy remote temperature monitoring systems and strengthen vaccine logistics management.
7	**Laboratory diagnostic capacity remains inadequate in many PHCs,** with several facilities relying entirely on referrals for basic diagnostic services.	National Minimum Service Package for PHC.	Limited investment in laboratory infrastructure and shortage of laboratory personnel.	Delayed diagnosis, increased referrals and reduced quality of patient management.	Government should progressively equip PHCs with basic diagnostic equipment, deploy laboratory personnel to strategic facilities and introduce point-of-care diagnostic technologies in underserved communities.
8	**Although essential medicines were generally available during the audit, temporary stock-outs and uneven pharmaceutical staffing continue to**	National Essential Medicines Policy.	Weak pharmaceutical workforce planning and supply chain forecasting.	Risk of interrupted treatment, irrational drug use and reduced patient confidence.	OSPHCDA should strengthen logistics management information systems (LMIS), improve demand forecasting and deploy additional pharmacy personnel to high-volume facilities.

S/N	Audit Finding (Condition)	Audit Criteria	Root Cause	Audit Implication	Recommendation / Action Plan
	affect service delivery.				
9	**Significant weaknesses were observed in health information management**, including inconsistencies between facility records and reported performance indicators, incomplete datasets and data quality anomalies.	NHMIS Guidelines; ISSAI 300.	Continued reliance on manual reporting, weak validation controls and inadequate data governance.	Reduced reliability of management information and weakened evidence-based planning.	Government should fully digitise the Health Management Information System (HMIS), introduce automated validation protocols, strengthen routine data quality assessments and establish quarterly data verification exercises.
10	**Facility utilisation rates vary considerably across LGAs**, indicating uneven demand and possible inefficiencies in resource allocation.	National PHC Planning Framework.	Historical allocation of resources without periodic workload analysis.	Under-utilisation of some facilities and excessive pressure on others.	OSPHCDA should institutionalise annual workload assessments and adopt performance-based resource allocation to optimise staffing, equipment and infrastructure deployment.
11	**Several facilities continue to experience unreliable electricity supply, inadequate water systems and poor staff accommodation.**	National PHC Infrastructure Standards.	Inadequate investment in resilient infrastructure and weak maintenance arrangements.	Reduced service availability, compromised emergency care and poor staff retention.	Government should expand renewable energy infrastructure, rehabilitate water systems, improve staff accommodation and establish dedicated maintenance funding for utility infrastructure.
12	**Weak monitoring,**	Public Sector Governance	Insufficient supervisory	Reduced effectiveness	OSPHCDA should

S/N	Audit Finding (Condition)	Audit Criteria	Root Cause	Audit Implication	Recommendation / Action Plan
	supervision and contract management systems contributed to delayed identification of defects and inconsistent implementation quality.	Framework; ISSAI 3000.	logistics, limited risk-based inspections and weak accountability mechanisms.	of investments and diminished value for money.	institutionalise risk-based supportive supervision, deploy digital inspection tools, strengthen internal audit functions and implement periodic independent performance reviews.
13	**Security arrangements remain inadequate in several PHCs**, exposing infrastructure, medicines and equipment to theft and vandalism.	Public Asset Management Principles.	Security considerations are not fully integrated into facility planning and budgeting.	Increased risk of asset losses and service disruption.	Government should develop a comprehensive PHC Security Management Framework incorporating perimeter fencing, solar-powered security lighting, security personnel deployment and periodic security risk assessments.
14	**The audit identified systemic weaknesses in governance, planning, monitoring and accountability that collectively reduce the effectiveness and sustainability of PHC investments.**	ISSAI 3000; National Health Policy; Public Financial Management Framework.	Fragmented planning processes, weak institutional coordination and inadequate performance monitoring.	Reduced economy, efficiency, effectiveness and value for money from public investments.	The State Government should develop and implement a comprehensive **Primary Health Care Performance Improvement Strategy (2027–2031)** with measurable performance indicators, annual performance audits, digital monitoring dashboards and regular public

S/N	Audit Finding (Condition)	Audit Criteria	Root Cause	Audit Implication	Recommendation / Action Plan
					reporting of health sector outcomes.

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APPENDICES

Appendix I: List of Primary Health Care Facilities in Ondo State

Appendix II: Summary of Sampled PHCs Selected for Physical Verification

Appendix III: Primary Health Care Infrastructure Assessment