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**PERSPECTIVES ON  
PRIMARY HEALTH CARE  
IN NIGERIA:  
PAST, PRESENT  
AND FUTURE**

**By Primary Health Care in Delta State  
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This Publication is supported by the *Think Tank Initiative* Programme initiated and managed by the *International Development and Research Centre (IDRC)*

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## PREFACE

This policy research monograph is the second publication of the on-going research of the *Centre for Population and Environmental Development (CPED)* on the research project titled “*Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region*” funded by *IDRC and WAHO*.

Primary Health Care (PHC) is driven by a political philosophy that emphasizes a radical change in both the design and content of conventional health care services. It also advocates an approach to health care principles that allow people to receive health care that enables them to lead socially and economically productive lives. The year 2008 celebrated 30 years of Primary Health Care (PHC) policy that emerged from the *Alma Ata Declaration* with publication of two key reports, the *World Health Report 2008* (WHO, 2008) and the *Report of the Commission on the Social Determinants of Health* (WHO, 2008). Both reports reaffirmed the relevance of PHC in terms of its vision and values in today's world. However, it was noted that important challenges in terms of defining PHC, equity and empowerment need to be addressed. In many countries including Nigeria, progress towards the MDGs has stalled. Weak health systems have restricted the success of efforts to improve maternal, newborn, and child health, and to reduce the disease burden from malaria and tuberculosis. New epidemics of chronic disease threaten to reverse what small gains have been achieved. To get back on track, and to meet the MDGs, countries need to strengthen their health systems through the implementation of effective primary health care. The continuing relevance of this 37-year-old Declaration is remarkable.

The paper examines the place of PHCs in the enhancement of health care delivery in Nigeria over the last four decades. Specifically, the study examines the evolution and the structure of the Primary Health Care delivery system in Nigeria. It also finds out the PHC programs and assesses the performance and functioning of the activities. Similarly, the study examines the extent of community participation in the program and the contributions of the government in sustaining the system.

We are particularly grateful to IDRC and WAHO as well as the *Think Tank Initiative* for the support to CPED which has enabled the Centre to carry out the study and the publication of this policy paper. We also appreciate the corporation of the Delta State Government in collaborating with CPED in the execution of the on-going research project.

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Principal Investigator

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# **Perspectives on Primary Health Care in Nigeria: Past, Present and Future**

## **Introduction**

The importance of health to national development and poverty reduction has been appreciated over the centuries, in that improving health status and increasing life expectancy contribute to long term economic development. The legitimacy of any national health system depends on how best it serves the interest of the poorest and most vulnerable people, for which improvements in their health status contributes significantly to the attainment of poverty reduction goals. Consequently, the key purpose of any health care system is to provide universal access to appropriate, efficient, effective and quality health services, in order to improve on, and promote people's health. Many developing countries, especially those in sub-Saharan Africa, in the 1970s experienced remarkable and unacceptable inequalities in the provision and distribution of health services. This contributed to and explained the exploration of different approaches to improve health care delivery by international health organizations in the 1970s. Before this period, China had made the most remarkable contribution to improving health care for all by promoting a community-based framework for health care delivery to its population. This bottom-up approach, which focused on prevention and management of health problems in their social setting, turned out to be a better option to the typical top-down, technological approach and rekindled hope about the possibility of addressing inequality to improve universal health. It was against this background that in 1978, 'health for all' was introduced and endorsed at an international conference on Primary Health Care (PHC) in Alma Ata, Kazakhstan.

Primary Health Care (PHC) is driven by a political philosophy that emphasizes a radical change in both the design and content of conventional health care services. It also advocates an approach to health care principles that allow people to receive health care that enables them to lead socially and economically productive lives. The Alma-Ata declaration of September 1978 defined the concept of PHC as essential care based on



practical, scientifically sound and socially acceptable health care methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of any country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact for individuals, the family and the community within the national health system, bringing health care as close as possible to where people live and work, and constitutes health care services (WHO 1998: 15).

The year 2008 celebrated 30 years of Primary Health Care (PHC) policy that emerged from the *Alma Ata Declaration* with publication of two key reports: the *World Health Report 2008* (WHO, 2008) and the *Report of the Commission on the Social Determinants of Health* (WHO, 2008). Both reports reaffirmed the relevance of PHC in terms of its vision and values in today's world. However, it was noted that important challenges in terms of defining PHC, equity and empowerment need to be addressed. In many countries including Nigeria, progress towards the MDGs has stalled. Weak health systems have restricted the success of efforts to improve maternal, newborn, and child health, and to reduce the disease burden from malaria and tuberculosis. New epidemics of chronic disease threaten to reverse what small gains have been achieved. To get back on track, and to meet the MDGs, countries need to strengthen their health systems through the implementation of effective primary health care. The continuing relevance of this 37-year-old Declaration is remarkable. Many of the challenges faced in 1978 remain, including infectious diseases such as HIV/AIDS, political instability and conflict, and the worsening of the poverty situation. It has been a renewed approach therefore been suggested that there should be to improving health care systems through revigourated PHC systems. There are several reasons for adopting a renewed approach to PHC, which include: the rise of new epidemiologic challenges that PHC must be empowered to address; the need to correct weaknesses and inconsistencies present in some of the widely divergent approaches to PHC; the development of new tools and knowledge of best practices that PHC can

capitalize on to be more effective; a growing recognition that PHC is an approach to strengthen society's ability to reduce inequities in health; and a growing consensus that PHC represents a powerful approach to addressing the causes of poor health and inequality.

A renewed approach to PHC is viewed as an essential condition for meeting internationally agreed-upon development goals such as those contained in the United Nations Millennium Declaration (the Millennium Development Goals or MDGs), as well as the need to address the fundamental causes of health as articulated by the WHO Commission on Social Determinants of Health, and to codify health as a human right which is well as articulated in some national constitutions and by civil society groups, among others. Renewing PHC will require building upon the legacy of Alma Ata and the PHC movement, taking full advantage of lessons learned and the best practices resulting from more than a quarter-century of experience, and renewing and reinterpreting the approach and practice of primary health care to address the challenges of the twenty-first century. Three key challenges in the revitalization of PHC are often mentioned in the literature (i) the challenge of moving away from a narrow technical bio-medical paradigm of health to a broader social determinants approach and the need to differentiate primary care from primary health care; (ii) The challenge of tackling the equity implications of the market oriented reforms and ensuring that the role of the State in the provision of welfare services is not further weakened; and (iii) the challenge of finding ways to develop local community commitments especially in terms of empowerment. These challenges need to be addressed if PHC is to remain relevant in today's context.

It is in this context that this study examines the place of PHCs in the enhancement of health care delivery in Nigeria over the last four decades. Specifically the study examines the evolution and the structure of the Primary Health Care delivery system in Nigeria. It also finds out the PHC programs and assesses the performance and functioning of the activities. Similarly, the study examines the extent of community participation in the program and the contributions of the government in sustaining the system. The remaining part of this monograph is divided into seven parts. The first part outlines a brief conceptual framework against which the examination

of the PHC system in Nigeria is carried out while the second part presents an overview of the emergence of orthodox health care in Nigeria. The third part reviews the emergence of a Centralized Health Care Services in Nigeria while the fourth part outlines the emergence of the PHC system with specific reference to the Nigerian situation. The fifth section examines the performance of the PHC system in Nigeria over the years with specific reference to the Delta State situation based on qualitative data collected recently in the state. The sixth section outlines some policy issues emerging from the findings as articulated largely from participants in the qualitative data collected in Delta State. Finally the seventh section concludes the paper.

### **Theoretical Framework**

Primary Health Care system does not exist in isolation from other relevant care giving systems in the society. It is perceived as just an integral part of a network of interrelated system with definite functions and roles towards maintaining the whole. Against this background this review utilises the structural functionalism theory developed by Radcliff-Brown (1952) to explicate Primary Health Care in society (Obioha and Molale, 2011). This theory explores how particular social forms function from day to day in order to reproduce the structure of the society (Schultz and Lavenda, 1995:396) so as to maintain the whole system. Thus, in a society there are different structures which function interdependently in order to maintain organic solidarity (Durkheim 1893) equilibrium and social stability (Malinowski, 1922, 1944) which the society strives to maintain (Obioha and Molale, 2011).

Functionalism is a sociological paradigm that originally attempted to explain social institutions as collective means to fill individual needs especially social stability. Functionalists perceive society as a whole which fulfils the functions necessary for its survival as an organic entity. People are socialized into roles and behaviours which fulfil their needs. They believe rules and regulations help organize relationships between and among members of the society. Values provide general guidelines for behaviour in terms of roles and norms. There are institutions which are major aspects of the social structure. Primary Health Care in this case is

viewed as a structure that interrelates and is interdependent on other structures in society such as political and economic structures to bring harmony but specifically within the context of the whole health care system. This health system caters for the health of the people so that they can stay healthy or active in order to produce goods and services (Obioha and Molale, 2011).

With reference to the functionalist perspective, Primary Health Care as an essential component of the health care system in Nigeria which must be made to function effectively because of its inalienable contributions to the improvement of health services in different parts of the country. The internal functionality of Primary Health Care as a structure is made up of interdependent sections such as community health workers, non-governmental organizations (NGOs), nurses, support groups, users and members of the community in general which work together to fulfil the functions necessary for meeting the health needs of the society as a whole (Obioha and Molale, 2011).

In terms of the key principles for assessing quality of PHC the framework developed by Donabedian (1988) is still of major relevance. Donabedian's conceptual framework consists of three main perspectives. In the first place, there is the *structure* which entails the assessment of the adequacy of facilities and equipment, administrative process, quality and quantity of health personnel in terms of their professional training. Secondly, there is the analysis of the *process* which includes the appraisal of the adherence to good medical care: clinical history, physical examination, diagnostic tests, justifications of diagnosis and therapy, technical competence, evidence of preventative management, co-ordination and continuity of care, acceptability of care to the recipient. At community level, this includes the quality of performance of health personnel with regards to managing acute problems such as acute respiratory infections and diarrhoea in children. Finally, Donabedian identified *outcome* as the third perspective and this considers whether a change in a person's current and future health status can be attributed to health care received. Measuring of infant mortality and maternal mortality or quality of health are other means of reflecting the impact of the health system on community health is an example of such

perspective. In 1995, the World Bank attempted to operationalise Donabedian's concept in developing countries.(WHO, 1995). Indicators that have been frequently used to assess the quality of primary health care in developing countries are structural aspects of the health care infrastructure and improved availability and access to drugs. Technical quality is assessed by evaluating the health workers performance skills and ability to correctly diagnose and treat illnesses. Donabedian (1988) argues that the interpersonal process is a vehicle by which technical care is implemented and on which its success depends and therefore, interpersonal quality of service provision is an essential part of the process of health care provision. A review of the literature indicates that limited attention has been paid to the analysis of the importance of attitudes and behaviour of health professionals in the provision of health care in sub-Saharan African countries. There is a general perception of the inability of consumers to assess the technical quality of services and their acceptance of quality of care is based on service availability, waiting times and accessibility.

### **Overview of the Emergence of Orthodox Health Care in Nigeria**

In Nigeria's pre-colonial period, traditional medicine was the dominant system of health care delivery. Traditional medical care comprised practitioners such as herbalists, divine healers, soothsayers, midwives, spiritualists, bone-setters, mental health therapists and surgeons. Although this traditional system of health care evolved separately in different micro-cultures in different parts of Nigeria, there are a great deal of philosophical and conceptual similarities which can be delineated in the system. Health care begins with a perception of illness, either by the patient or his associates, and reactions to symptomologies are culturally influenced. The traditional concept of disease causation in most cultural areas in Nigeria incorporates beliefs in natural or God-given illness and in supernatural forces. These include witchcraft, ghosts, spirit disturbance, the breach of a taboo, and failure to observe kinship rules or religious obligations. This concept of the causes of illness influences the mode of treatment applied. Diagnosis was based on one or more of several procedures, including: observation of the patient's attitude, gestures and ability to perform basic tasks as a test of logical reasoning; divination and possession, which may lead beyond diagnosis to prognosis and prescribed

treatment; and case history, which may be intensive and cover a patient's family and social milieu. The sick had three chances: to recover from illness, to remain ill or to die. In any case, the healer was seen as a helping medium trying to intervene between the hidden forces and the patient. Some practitioners accepted payment in kind, often only after the outcome of the treatment was known. Often the client could decide what to pay to the healer. It was possible for the payment to be postponed through mutual agreement until the following agricultural season or when fortunes improve. Payment could, take the form of a gift of a chicken or goat, foodstuffs or some assistance in the farm labour. The amount of payment varied with the severity of illness and time required for full recovery. In contemporary times traditional medicine still provides the only source of medical care in many rural areas owing to the scarcity and low accessibility of modern medical services. In such circumstances the rural population's use of traditional care will vary with the nature and gravity of the case, the type of specialist customarily sought, the acculturation of the client, the proximity of a preferred or reputable specialist and transportation (Onokerhoraye, 1984).

Although the Arabs have had the distinction of early-organized medical services, there is no recorded evidence of the introduction of such services to Nigeria despite the long period of interactions between some parts of present day northern Nigeria and the Arabs during the fifteenth century. The situation was essentially the same with respect to the trade relations between the southern parts of Nigeria and some European nations, especially the Portuguese and Great Britain during the later part of the fifteenth century. The first record of modern medical services in Nigeria was during the period of the various European expeditions in the early-to mid-nineteenth century. The earlier explorations of Mungo Park and Richard Lander were seriously hampered by disease. In the expedition of 1854, Dr. Baikie introduced the use of quinine, which greatly decreased mortality and morbidity among the explorers. It is still a subject of considerable debate whether the use of quinine by Dr. Baikie was his original discovery or whether he borrowed the idea from traditional herbalists with whom he had interacted in the course of his expeditions. Whatever is the true situation, the use of quinine both as prophylaxis

against and as therapy for malaria fever, expanded exploration and trade between Nigeria and European countries during the late nineteenth and early twentieth centuries.

However, the earliest form of Western-style health care in Nigeria was provided by doctors brought by explorers and traders to cater for their own well being. During this period the services were not available to the indigenes of the various localities which they visited. It was the church missionaries that first established health care services for the people. The first health care facility in the county was a dispensary opened in 1880 by the Church Missionary Society in Obosi, followed by others in Onitsha and Ibadan in 1886. However, the first hospital in Nigeria was the Sacred Heart Hospital in Abeokuta, built by the Roman Catholic Mission in 1885.

It should be stated that these missionary health care facilities were primarily used as tools for winning converts and expanding their followership. Consequently, these facilities were competitive rather than complementary. In spite of this fact, they were of high quality in terms of the services provided. This high quality is also evidenced by the fact that the Seventh Day Adventist Hospital in Ilesha as well as the Wesley Guild Hospital in Ile-Ife became the nucleus of the teaching hospital complex of a major university in Nigeria in latter years. Even today in Nigeria, the Baptist Hospitals in Ogbomsho and Eku function as referral centres in the health care delivery matrix. Because of the evangelical functions of these health care facilities, it was left for the government to organize and develop policies for general health care (Schram, 1971).

The establishment of colonial rule in Nigeria was associated with the establishment of medical services. The British colonial administration started to show interest in the provision of health facilities towards the end of the nineteenth century. Apart from military health services, civilian health services were also established and it is known that the first government hospital for civilians, the St. Margaret's Hospital, was built in Calabar in 1898. From 1900, building of hospitals was carried on in earnest throughout Nigeria. Some of them, such as the military hospitals at Jebba and Lokoja and the temporary hospital at Baro on the railway, closed down after a few years' service. Others were hardly hospitals at all by

today's standards - merely shelters constructed of grass, thatch, bamboo and mud. These 'bush' hospitals sprang up particularly rapidly at the commencement of the First World War, being required again, partly for military needs. Of these, the hospitals at Abakaliki, Afikpo, Okwoga, Ogoja, Okigwi, Owerri, Ikom and Ikot Ekpene were built in 1915. Most of these were later rebuilt with brick and timber and they today form the nuclei of the hospitals in those towns. Other hospitals were built initially as small isolation hospitals for epidemic febrile conditions, and later expanded to include general beds. Some of these hospitals had prison wards. In other cases, beds were provided at or near the prison. The true general hospitals were for a long time classified as European and African, and only gradually did this change to nursing home and general hospital. A number of hospitals were also built between 1900 and 1930 in the northern part of the country. These include those at Lokoja, Kaduna, Zungeru, Ilorin, Ibi and Offa (Onokerhoraye, 1984).

The combined activities of the Christian missions and the British colonial government in Nigeria led to a rapid rise in the number of hospitals in Nigeria before the end of the First World War. The end of the First World War (1914-1918) coincided with the amalgamation of the Northern and Southern regions. This war produced a lot of military activities in Nigeria, leading to the establishment of several military health care facilities, some of which were left to function as civilian hospitals after the war. In 1930 there were 71 hospitals in Nigeria; of these, 47 were established by the government, while 23 were owned by Christian missions. The remaining one was privately owned. By 1945 the number of hospitals in the country had risen to 116. The Christian missions established 46 while the government owned 69. There was still only one which had been privately established.

**The Emergence of a Centralized Health Care Services**  
Between 1952 and 1954, the control of medical services was transferred to the Regional governments, as was the control of other services. Consequently, each of the three regions (eastern, western and northern) set up their own Ministries of Health, in addition to the Federal Ministry of Health. Although the federal government was responsible for most of the health budget of the regions, the regional governments were free to allocate



the health care budget as they deemed fit. Over the years of development planning in Nigeria, health care services have been characterized by short-term planning as reflected in the various national development plans between 1945 and 2008. The first remarkable national policy statement on health care services delivery in Nigeria was in 1954 as reflected in the then Eastern Nigeria Government report titled "Policy for Medical and Health Services". This report stated that the aim of health care was to provide national health services for all irrespective of the location or place of residence. The report emphasized that "since urban services were well developed, the government intended to expand rural services. These rural services would be in the form of rural hospitals of 20- 24 beds, supervised by a medical officer, who would also supervise dispensaries, maternal and child welfare clinics and preventive work. The policy made local governments contribute to the cost of developing and maintaining such rural services, with grants-in-aid from the regional government. The policy document was extensive and detailed in its description of the services envisaged. This was therefore the major health policy statement in Nigeria before and during Independence. After independence in 1960, the same basic health care policy was pursued (Scott-Emuakpor, 2010).

By the time the *Third National Development Plan* was produced in 1975, more than 20 years after the report mentioned above was articulated, not much had been done to achieve the goals of the Nationwide Health Care Services policy. The *Third National Development Plan*, which was described by General Yakubu Gowon, the then Head of the Military Government, as "A Monument to Progress", stated, "Development trends in the health sector have not been marked by any spectacular achievement during the past decade". This development plan appeared to have focused attention on trying to improve the numerical strength of existing facilities rather than evolving a clear health care policy. The *Fourth National Development Plan* (1981- 1985) addressed the issue of preventive health services for the first time. The policy statement contained in this plan called for the implementation of the *Basic Health Services Scheme* (BHSS), which provides for the establishment of three levels of health care facilities; namely 1) Comprehensive Health Centres (CHC) to serve communities of more than 20, 000 people; 2) Primary Health Centres (PHC) to serve communities of

5000 to 20, 000 persons; and 3) Health Clinics (HC) to serve 2000 to 5000 persons. Thus, a CHC would have at least 1 PHC in its catchment area (ideally 4) and a PHC would have at least 1 HC in its catchment area (ideally 2). These institutions were to be built and operated by state and local governments with financial aid from the federal government. By this policy, the provision of health services would be the joint responsibility of the federal, state and local governments. In its outlook, this policy is not different from the one published in 1954 by the Eastern Nigerian Government previously mentioned. On the last day of 1983, a new Military Government came into being in Nigeria and one of the reasons it gave for the Military intervention was the state of health services, declaring "our teaching hospitals have been reduced to mere consulting clinics." One of the government's first efforts was to revise the Fourth National Development Plan. The health strategy under this revised plan gradually shifted emphasis to primary health care. Although this has always been the ultimate goal of the plan, the political will did not seem to exist for its implementation (Onokerhoraye, 1997).

Closely associated with the emergence of a centralized health care system in Nigeria was the training of indigenous health manpower. The need for manpower training and for the development of indigenous skills in health care services was recognized quite early, first by the missionaries and later by the colonial government. The main reason for this was the fact that the missionary physicians, as is true for other missionaries, had a high rate of morbidity and mortality among their ranks resulting from the inclement weather and previously unfamiliar tropical diseases. Since health care services had become a major part of evangelism, it became obvious that Nigerians needed to be trained in all aspects of evangelical work, including health care delivery, in order to expand the missionary activities to the hinterland.

The nearest place where this training was available was Britain. Several Africans were thus sponsored by missionary agencies to study in Britain. The first was John Macaulay Wilson, a Sierra Leonean, who became the first native African to become a physician. The first two Nigerian physicians were James Africanus Beal-Horton and William Broughton

Davis, and they were similarly trained in Britain. World War I brought the need for indigenous trained health care personnel home to the Colonial Government, which had hitherto mostly excluded Nigerian physicians from government medical services. The war led to the deployment of physicians and other health care workers in the army and there was an acute shortage of health personnel. Also, the influenza and plague epidemics had brought about the need for more hands. This led to the establishment in 1939 of the first medical school in Nigeria, the Yaba Medical College. At first, it trained medical assistants, but was later upgraded to train assistant medical officers. By special arrangement between the Colonial Office and The Royal Colleges of Surgeons and Physicians of Great Britain, most of the assistant medical officers were granted Licentiate Diplomas, after a short exposure in Britain. Because the Yaba College trained only half doctors, it became quite unpopular with the emergence of political activism among Nigerians. It eventually disappeared with the establishment of the University College, Ibadan. Although the Yaba College was closed due to its unpopularity, another school for training incomplete doctors evolved in Kano in 1955. This was also short-lived and its graduates were mostly converted to full-fledged doctors by a political declaration ( Fendal, 1967).

Medical training in Nigeria's premier university, University College, Ibadan, was fashioned after the British system as would be expected. The pre-clinical work was done in Ibadan, the clinical work was done in Teaching Hospitals in England, and the degrees awarded were London University degrees. By 1957, all aspects of the training were done in Ibadan, but the degrees were still those of London University, whose officials conducted the examinations in Ibadan. It was not until 1967 that the University of Ibadan granted its own degrees. By this time, the University of Lagos had also started awarding its own medical degrees. This was followed in quick succession by Ahmadu Bello University, University of Ife (now Obafemi Awolowo University), and the University of Benin. Other institutions followed, including the University of Nigeria, the University of Ilorin, the University of Calabar, the University of Port Harcourt, the University of Maiduguri, the University of Jos, and the University of Sokoto.

The training of other health care professionals followed the same developmental process as that described for doctors with the early ones being trained in England, until the development of local schools. The training of nurses in Nigeria started after the establishment of the Nursing Council of Nigeria. The Preliminary Training School (PTS) for nurses, which was based in Lagos, was transferred to Ibadan as one of three (3) such schools in the country. The others were in Kano and Aba. Whereas the two (2) schools in the South (Ibadan and Aba) had only a 6-month program, that in North (Kano) had two (2) courses, one of them admitted students with lesser qualifications and the programme lasted for one (1) year, while the other program of 6 months duration was for students with a higher entry qualification. By 1954, 23 (all men) graduated from the Kano School, 40 (16 women and 24 men) graduated from the Aba School and 71 (42 women and 29 men) graduated from the Ibadan School. As was the case with doctors, there was displeasure expressed over the incomplete training of nurses who received local training. This subsequently led to the establishment of 3-year nursing schools at designated government hospitals, seven (7) in the North, six (6) in the East and eight (8) in the West. In addition, the Nursing Council granted recognition to 17 missionary built programs for training of full-fledged nurses and PTS nurses. By 1955 there were 100 female student nurses at the University College Hospital in Ibadan receiving British-type State Registered Nurse's (SRN) training.

There were two (2) cadres of midwifery schools in Nigeria. One trained Grade I Midwives and the other trained Grade II Midwives, the latter being a lower standard of entry qualifications and training. Grade I Midwives were trained in designated government centres and by 1954, 12 women had graduated from the Northern School in Kaduna, 23 from the Eastern School in Aba, 10 women from the other Eastern school in Calabar, and 20 women from both Massey Street, Lagos and Ade-Oyo Hospital, Ibadan in the West. Grade II midwives were trained in missionary hospitals or Native Authority facilities. These individuals worked mostly in rural areas and in 1954, five (5) were trained in the North, 21 in the East and 103 in the West. Public Health Attendants (known as Sanitary Inspectors) were

trained in four (4) schools of hygiene across the country. One school, operated by the Lagos Town Council Public Health Department, graduated four (4) by 1954, while those operated by the government in Kano, Aba and Ibadan graduated a total of 128. The only schools for training Dispensary Attendants were in the North (Kano and Zaria). They became the centres for training Dispensary Attendants for the whole country, until the establishment of a similar training facility at the University College Hospital, Ibadan in 1957. The Field Unit School at Makurdi began training of Sleeping Sickness Assistants in 1933 and later trained Medical Field Unit Assistants for the entire country. At the Oji River Settlement in the East, a 6-month course was established for training Leprosy Inspectors and Attendants. By 1954, four (4) Leprosy Inspectors and 21 Attendants had been trained. Pharmacists were trained in the defunct Yaba Medical College site, and by 1954, 31 had graduated. The dispensers, trained at Zaria and Kano, were subsequently licensed to practice in Northern Nigeria only.

The only places that trained laboratory technicians were the Lagos Hospital and Kano Hospital and by 1954, 29 had graduated from Lagos and 2 from Kano. At the same time, three (3) Dental Technical Assistants were trained in Lagos Hospital. The only school for Radiography was in Lagos and it trained x-ray assistants for the whole country. By 1957, a total of 10 had graduated from this school five (5) from the West, three (3) from the East and two (2) from the North). The Orthopaedic Hospital in Igbobi, Lagos, trained six (6) Assistant Physiotherapists by 1957. This represented the training situation for personnel of the various aspects of health care services just before and around independence in 1960. After independence, the improvements were modest for the next 10 years, when judged against the background of population growth. For example, whereas there were 1354 physicians and 58 dentists in 1962, the corresponding figures for physicians and dentists in 1972 were 3112 and 124 respectively. However, the population growth from 54,000,000 in 1962 to 68,000,000 in 1972 makes the numerical improvement less meaningful.

## **Contributions from International Organizations to the Development of the Health System**

Several international organizations have played phenomenal roles in the development and maintenance of health services in Nigeria. Unfortunately most of these contributions pass through government (mostly federal government), which has kept very little record of the impact these contributions have made. Also, records of the exact cash amount of these contributions are sketchy, partly because of poor government record-keeping and partly because a lot of the contributions are in services, and in equipment and training, whose cash amount is normally difficult to establish. These organizations include the World Bank, United States Agency for International Development (USAID), WHO, UNICEF, and British Technical Assistance (BTA).

In a collaborative effort between the Nigerian government, USAID, and WHO, a very successful programme was launched against smallpox and measles in 1967 and 1968. Whereas USAID financed the cost of technical immunization expense, the Nigerian government and WHO provided medical personnel and local costs. This program was so successful in Lagos that in 1968, a 97 per cent efficiency was estimated for it, with more than 90 per cent of the target population immunized. The success of this program against smallpox was so remarkable that by mid-1968, smallpox incidence had dropped to only two (2) cases a month in Western Nigeria, mostly among immigrants. In the 1960's several projects aimed at controlling malaria (that accounted for about 11 per cent of all mortality) were launched by WHO and UNICEF. The Expanded Program on Immunization (EPI), Oral Rehydration Therapy (ORT), and bore-hole projects for drinking water are all areas in which UNICEF's contributions are immense. There are several investigative projects, such as the Guinea worm project in Anambra State, in which WHO and, later the Jimmy Carter Foundation, had invested substantial amounts of money. During the cholera epidemic in Nigeria in 1970-71, WHO established cholera diagnosis and treatment centres throughout the country. But without this timely intervention by the world body, it is generally agreed that the losses to human life would have been catastrophic. Today these agencies, along with the United States government, through the President's Emergency

Plan for AIDS Relief (PEPFAR), as well as private philanthropic organizations, such as the Jimmy Carter Foundation, the Bill Gates Foundation, the Bill Clinton Foundation, etc., have contributed to support efforts in various sectors of the Nigerian health scene, particularly HIV/AIDS. Once again the exact monetary contributions are impossible to estimate.

### **The Emergence and Structure of the Primary Health Care System in Nigeria**

Up to the 1960s and early 1970s, the health care approach in Nigeria consisted mainly of so-called vertical programmes, on which all efforts were concentrated on eliminating specific diseases, specially smallpox and malaria. The only access to health care for most people living in poor areas of the country consisted of vaccines and spray guns loaded with DDT to kill mosquitoes as prevention against malaria. Consequently, the history of primary health care (PHC) is steeped in politics (Pemberton and Cameron, 2010). During the Cold War, the vertical approach to the eradication of malaria, which had been in use since the 1950s, was heavily criticised. Among the fiercest critics of the approach was Bryant (1969) who faulted the effectiveness of the hospital-based health care delivery system, largely on the ground of its limited access to the vast majority of health care seekers and its lack of emphasis on prevention, particularly in developing countries.

Taylor (1976), founder of the *Department of International Health, Johns Hopkins University*, and founding chairman of what is now the *Global Health Council*, had also been advocating Indian rural medicine as a template for developing countries, as an alternative to the vertical approach. Cueto's (2004) survey of the early literature on the subject "challenged the assumption that health resulted from the transference of technology or more doctors and more services". Particularly noteworthy in moving away from this faulted approach, were the strong observations attributed to:

- ♣ Mc-Keown, that "the overall health of the population was less related to medical advances than to standard of living and nutrition",
- ♣ Illich, that "medicine was not only irrelevant but even detrimental, because medical doctors expropriated health from the public" and

- ♣ Newell, that “a strict health sectoral approach is ineffective” (Cueto, 2004: 1, 2).

In addition, there was the emergence in China, in the 1960’s of the concept of ‘barefoot doctors’, who were “a diverse array of village health workers who lived in the communities they served, stressed rural rather than urban health care, and preventive rather than curative services and combined Western and traditional medicines” (Cueto, 2004: 2). On the African continent and in many developing countries, with the emergence of decolonised nations, alongside the spread of nationalism, anti-imperialist and leftist movements, modernisation was longer seen as replication of the model of development followed by the West, particularly, Europe and America. The stage was, therefore, set for fashioning an alternative approach to hospital-based, vertical approach to health care delivery.

According to Cueto (2004), the term ‘primary health care’ was used probably for the very first time in 1970, in the journal, *Contact*, established by the Christian Medical Commission (CMC). The CMC was formed in the late 1960s by medical missionaries working in developing countries; with an emphasis on the training village workers at the grassroots level, equipped with essential drugs and simple methods. In 1974, the collaboration between the CMC and the World Health Organization (WHO) was formalized. It is noteworthy that Bryant (1969) and Taylor (1976) who have independently been protagonists of a grassroots approach to health care delivery system, are members of the CMC.

It was, however, in 1978 that the formal shift in the paradigm of health care delivery, from hospital-based vertical to the grassroots primary health care approach was enshrined. The landmark event that birthed the primary health care concept was the International Conference on Primary Health Care (PHC), which was held in Alma Ata, Kazakhstan, USSR, from September 6 to 12, 1978, at which 134 countries were represented. Paragraph VI of the conference’s main document titled the *Declaration of Alma Ata*, states as follows:



*“Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (WHO, 1978).*

Furthermore, Article VII of the document declares the following as the eight attributes of the PHC system. It

- ♣ reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
- ♣ addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
- ♣ includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. (These are now recognized as the eight elements of the PHC system);
- ♣ involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing,

public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

- ♣ requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
- ♣ should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need; and
- ♣ relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community (WHO, 1978).

By implication, the Alma Ata declaration recognized that: health is a fundamental human right and the attainment of the highest possible level of health is a global social goal; existing gross inequality in the health status between people in the developed and developing countries was unacceptable in all its ramifications; people have the right and duty to participate individually and collectively in the planning and implementation of their health care; governments have a responsibility for the health of their citizenry, which can be fulfilled only by the provision of adequate health and social measures; all government should formulate national policies, strategies and plans of action to launch and sustain PHC; year 2000 was set as target for achieving “an acceptable level of health for all people”. (WHO, 1978a, 1978b).

Pemberton and Cameron (2010) have summarised the major landmarks in the global evolution of the PHC concept in Table 1.

**Table 1: Major Chronological Milestones in the Global Evolution of the Primary Health Care System.**

S/N	Timeline	Contribution	Impact
1	Late 1960s-1970s	Cold war	Early criticism of the 1950's United States and WHO's vertical malaria eradication programme.
2	Late 1960s	Increase in WHO projects related to development of basic health services from 85 in 1965 to 156 in 1971	These projects became the institutional predecessors for PHC.
3	Late 1960s	Christian Medical Commission (CMC)	Missionaries worked in LMICs and emphasized training of village workers at the grassroots levels. Carol Taylor and John Bryant were members.
4	1967	Kenneth W. Newell	A WHO staff member who was a researcher on medical auxiliaries in developing countries published <i>Health By the People</i> .
5	1969	John Bryant published <i>Health and the Developing World</i>	Questioned the transplantation of hospital-based health care system to developing countries and lack of current focus on prevention.
6	1970	CMC created the journal <i>Contact</i>	Is the first published reference to "primary health care"
7	1972	Carl Taylor	Became the founding chair of the National Council for International Health, now known as the Global Health Council.
8	1972	WHO Division of Strengthening of Health Services created, Kenneth Newell appointed as Director	First WHO Division dedicated to equitable community based health care.
9	1973-1988	Halfden Mahler elected WHO's Director General	Maher led the WHO to become the leader in establishing PHC at an organization level and

			contributed a strong social justice mentality to the WHO.
10	1973	WHO Report entitled, Organizational Study on Methods of promoting the Development of Basic Health Services published	Formed the basis for a redefinition of the collaboration between WHO and UNICEF.
11	1974	Canadian Lalonde Report published	De-emphasized the importance attributed to quantity of medical institutions and proposed four determinants of health: 1) Biology, 2) Health Services, 3) Environment, and 4) Lifestyles.
12	1974	UN General Assembly adopted a resolution on the international Economic Order	Purpose was to aid in “uplifting” less-developed countries.
13	1975	28 <sup>th</sup> World Health Assembly	Concluded that the construction of national programs in PHC were an urgent priority.
14	1976	29 <sup>th</sup> World Health Assembly	Halfden Mahler introduced the slogan, “Health For All by the Year 2000.”
15	1978	International Conference on Primary Health Care	Alma-Ata Declaration unanimously by the international community.

*Source:* Pemberton and Cameron (2010: 6).

The PHC concept has five principles that have been designed to work together and be implemented simultaneously to bring about a better outcome for the entire population. These are:

- ♣ *Accessibility* (equal distribution): this is the first and most important key to PHC. Healthcare services must be equally shared by all the people of the community irrespective of their race, creed or economic status. This concept helps to shift the accessibility of healthcare from the cities to the rural areas where the most needy and vulnerable groups of the population live;

- ♣ *Community participation*: this includes meaningful involvement of the community in planning, implementing and maintaining their health services. Through the involvement of the community, maximum utilisation of local resources, such as manpower, money and materials, can be utilised to fulfil the goals of PHC;
- ♣ *Health promotion*: involves all the important issues of health education, nutrition, sanitation, maternal and child health, and prevention and control of endemic diseases. Through health promotion individuals and families build an understanding of the determinants of health and develop skills to improve and maintain their health and wellbeing;
- ♣ *Appropriate technology*: technology that is scientifically sound, adaptable to local needs, and acceptable to those who apply it and for whom it is used; and
- ♣ *Inter-sectoral collaboration*: to be able to improve the health of local people the PHC programme needs not only the health sector, but also the involvement of other sectors, like agriculture, education and housing.

Two major reports were published to mark thirty years of PHC, in 2008 (WHO, 2008a; 2008b). Although the continued relevance of the PHC system was recognized, even now than ever, some key issues were also acknowledged, including the restriction of its effects to mother and child health, as well as to only malaria and tuberculosis; the emergence of new diseases that threaten past gains; political instability; deepening poverty; and conflicts.

### **The Nigerian Primary Health Care Situation**

Following the *Alma Ata Declaration*, serious attempts had been made at a health systems reforms in the country in the 1980s. Thus the 1988 *National Health Policy* which was based on the principles of primary health care and primary health care implementation was the result of that era. Primary Health Care (PHC) has therefore been at the centre of the Nigerian health system for over forty years. It has been conceived as the key to providing basic health services to people with their full participation. The system provides promotive, preventive, curative and rehabilitative services to a

community. The philosophy and implicit principles of the primary health care system in Nigeria can be said to have commenced in 1975, when General Gowon launched the *Basic Health Service Scheme* (BHSS) as part of the *Third National Development Plan* (1975-1980) (Lambo, 1982). The objectives of the programme included: increasing the proportion of the citizenry receiving health care from 25 per cent to 60 per cent; initiating the provision of adequate and effective health facilities for all Nigerians; correcting the imbalance in the distribution and location of health facilities; correcting the imbalance between preventive and curative care; establishing a health care system best adapted to the local conditions and level of health technology; and providing infrastructure for all preventive health programmes (Adeyemo, 2005; Metiboba, 2009).

The basic elements of the scheme were to build in each local government area, one comprehensive health institution, which would serve as headquarters; four primary health centres; and 20 health clinics. This complement of facilities was called the 'a basic health unit', designed to serve a threshold population of 150,000. The clinic was the lowest order facility, serving a threshold population of 2,000. The primary health centre was to serve as a referral facility for four clinics serving 20,000 people, while the comprehensive health centre (CHC) and the four clinics under it would serve a population of 50,000 (Akande, 2002). There was also provision for the construction of schools of health technology and for the training of community health workers (Oyegbite, 1989). With the emphasis of the *Fourth National Development Plan* (1981-1985) on the establishment of teaching and specialist hospitals, the BHSS was practically abandoned (Sani, 1990).

PHC is provided by local government authority through health centres and health posts and they are staffed by nurses, midwives, community health officers, health technicians, community health extension workers and by physicians (doctors) especially in the southern part of the country. The services provided at these PHCs include: prevention and treatment of communicable diseases, immunization, maternal and child health services, family planning, public health education, environmental health and the collection of statistical data on health and health related events. The health care delivery at the LGA is headed politically by a supervisory councillor

and technically and administratively by a PHC coordinator and assisted by a deputy coordinator. The PHC co-coordinator reports to the supervisory councillor who in turn reports to the LGA chairman (Adeyemo, 2005; Federal Ministry of Health, 2004). The different components of the LGA PHC are manned by personnel of diverse specialty. The LGA runs her primary health care services delivery in compliance with the principles / framework of the National Health Policy (Nigerian National Health Bill, 1987). The LGA is divided into various health districts/wards so as to enhance maximum benefit of the principle of decentralization of the health sector whereby people are involved, participate and mobilized in the PHC processes.

The adoption of the primary care approach in Nigeria in the 1980s has a number of implications as follows:

- a. The various governments of the federation have responsibilities for the health of the people, which shall be fulfilled by the provisions of adequate health and social services. The citizens shall have the right and duty to participate individually and collectively in the planning and implementation of these services.
- b. Health care shall be accorded higher priority in the allocation of the nation's resources than hitherto.
- c. Health resources shall be equitably distributed giving preference to those at greater risk to their health and the under-served communities as a means of social justice and concern.
- d. Information on health shall be disseminated to all individuals and communities to enable them to have greater responsibility for their health.
- e. Self-reliance shall be encouraged among individuals, communities and on a national scale.
- f. Emphasis shall be placed on preventive and promotive measures, which shall; be integrated with treatment and rehabilitation in a multi-disciplinary and multi-sectoral approach.
- g. All social and economic sectors shall cooperate in the effort to promote the health of the population.
- h. That primary health care shall be "scientifically sound" implies that all health practices and technologies, both orthodox and traditional

shall be evaluated to determine their efficacy, safety and appropriateness.

The greatest boost to the primary health care delivery efforts in Nigeria was between 1985 and 1992, during General Babangida's administration. The Federal Government of Nigeria evolved a national health care delivery system implemented at the local government level. The main elements of the system were the drawing up of a National Health Policy (NHP) in 1988, and the creation of the Primary Health Care Directorate in the Ministry of Health, under Ransome-Kuti as Minister. The Ministry was charged with the responsibility of "formulating, developing and implementing the National Primary health Care System, in line with the recommendation of the 1978 (Alma Ata) International Conference on Primary health Care" (Adeyemo, 2005: 153).

During the 1985-1992 period, a national health care delivery system that was mainly implemented in local government areas was promoted. As part of this system, a National Health Policy (NHP) was drawn up in 1988 that recognised Primary Health Care (PHC) services as pivotal to the healthcare system. The policy was based on the principle of the Alma Ata Declaration of 1978, which sought to promote community health and reduce mortality, especially among children. By the end of 1992, the well articulated programme had deteriorated to the point that that it soon ceased to exist. Consequently, the National Primary Health Care Development Agency (NPHCDA) was set up in 1992 to extend healthcare delivery services to the rural areas, a role it took over from the Federal Ministry of Health. The mandate of the agency is comprehensive and can be summarized as follows: Providing support to the National Health Policy as it related to primary healthcare; Providing technical support to the planning, management and implementation of primary health care; Mobilizing resources at the national and international levels for the development and implementation of primary health care programs; Providing support to the monitoring and evaluation of primary health care and by extension the National Health Policy; Promoting human resource for health development as well as Promoting and support the village health system, among others. Basically, NPHCDA is expected to solve over 70 per cent



of Nigeria's health care problem by collaborating with the rest of the health system (Federal Government of Nigeria, 2012).

Although the NPHCDA had some modest achievements in its early years, it was not until 1999 at the advent of democratic governance that it earnestly began to formulate, establish and implement policies that would secure its place in the supervision of PHC in Nigeria. The agency undertook numerous capacity building efforts across board, facilitated the establishment/revitalization of Ward and Village development Committees to ensure active community participation, reviewed and developed 'Standing Orders' for community based work and worked with Partners on various projects. Since 2009, the NPHCDA has focused on the implementation of a few selected innovative programs, which has yielded positive results for the country. These programs include; using traditional rulers to eradicate polio in the northern parts of the country, Intervention of the Governors Forum; National Midwifery Service Scheme (MSS); and middle level management for PHC (Federal Ministry of Health, 2010, 2011).

The inauguration of the Northern Traditional Leaders Committee for PHC and Polio Eradication in June 2009, has led to the reduction of the prevalence of poliomyelitis in Nigeria. There has been a 99 per cent reduction in burden of polio, compared to the first half of the year when traditional leaders were not involved. Over the period, this Committee, under the overall leadership of the Sultan of Sokoto, has met regularly and undertaken a series of activities ranging from advocacy acting role models, mass mobilization, and community education, monitoring of immunization and other health activities, and most importantly addressing polio vaccine non-compliant cases. Over the years NPHCDA has drawn upon as much resources as it could from within and outside the country resulting in increased funding being provided for the Agency to execute its programmes.

Closely associated with the success of the Traditional Leaders Committee is the successful engagement with the Governor's Forum of Nigeria. Again with the stimulus generated by the visit of Mr. Bill Gates to Nigeria, all 36 Governors in Nigeria signed a Declaration to ensure the eradication of

Polio from their respective states. Following the Declaration, a good number of State Governors including the Delta State Governor who is a medical doctor provided much need additional resources to their LGAs and State Ministries of health to tackle the issue of polio and PRC generally (Delta State Ministry of Health, 2007,2009,2010a, 2010b, 2011a, 2011b, 2011c, 2011d, 2012, 2012b, 2012c, 2012d).

The *Midwives Service Scheme (MSS)* is a direct intervention of the Federal Government of Nigeria, aimed at addressing the unacceptably high maternal and child morbidity and mortality. The scheme is designed to mobilize unemployed and retired midwives for deployment to selected primary health care facilities in rural communities in order to facilitate increase in the coverage of Skilled Birth Attendance (SBA); an intervention that has been identified as the key to the reduction of maternal, newborn and child mortality. The Midwives Service Scheme which is being funded through the Office of the Senior Special Assistant of the President on MDGs, utilizes a cluster model of hub and spoke arrangement in which four (4) selected primary health care facilities with capacity to provide Basic Essential Obstetric Care (BEOC) are clustered around a General Hospital with the capacity to provide Comprehensive Emergency Obstetric Care. The scheme currently covers 163 clusters comprising of 652 primary health care facilities and 163 General Hospitals.

A major attraction of the scheme is that it provides opportunity to refocus attention on Maternal Newborn and Child Health outcomes, and indeed the revitalization of the PHC system and accelerate progress towards the attainment of the Millennium Development Goal. The MSS is a collaborative effort amongst the three tiers of government based on Memorandum of Understanding signed between the Federal and State Governments and identified strategic partners such WHO, UNICEF, UNFPA, PRRINN-MCH, Pathfinder International, ACCESS/JEPHIGO and PPFN among others. So far, a total of 2,488 midwives have been deployed to 652 frontline facilities in rural areas linked to 163 referral General Hospitals, all selected based on agreed eligibility criteria (focusing on maternal mortality). The midwives have had an orientation workshop to acquaint them with the scheme, and after a call up exercise in the state capitals where they were officially handed over to the State governments

and FCT, have since resumed duty at the designated facilities in all States and FCT where the Governors have signed Memoranda of Understanding (MOUs) with the Federal Government to return the Midwives when the Scheme winds down. The midwives are expected to provide facility and community based maternal, newborn and child health services including outreaches, compile community pregnancy and child profile and report maternal and child deaths.

### **The Performance and Challenges Facing the PHC System in Nigeria Since the 1980s**

The performance and challenges facing PHC system in Nigeria can be examined from the records of the different aspects of PHC which act as the benchmark and rules to adhere to (Emeka *et al*, 2011). Thus the performance and challenges of PHC services in Nigeria in the last four decades can be assessed using the key aspects of PHC in line with the Alma-Ata declaration, namely, education about prevailing health problems and methods of preventing and controlling them; the promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning and care of high risk groups; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries and finally, the provision of essential drugs (Gupta *et al*, 2004; Gilbert *et al*, 2009). Against the background of these key variables this section focuses on examining aspects of the performance and challenges of PHCs in Nigeria over the years (Omoleke, 2005; Lancet, 2008)).

This assessment of the performance of PHCs in Nigeria is based on findings of the literature review as well as the qualitative findings of the on-going research project titled “*Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region*”. The project is funded by Canada’s *International Development Research Centre (IDRC)*, Ottawa and the *West African Health Organization (WAHO)*. The general objective of the research programme is to contribute to a body of evidence on the strengthening of the health system in Nigeria that can influence the development and modification and

implementation of policies on equitable access to health care with specific focus on the primary health care component. The qualitative surveys of primary health centres and the localities in which they are located across nine target Local Government Areas (LGAs) in Delta State entailed key informant interviews and focus group discussions with key stakeholders and groups. A qualitative, descriptive and exploratory research design was used to examine a variety of issues relating to primary health care delivery and utilization in the sampled target local government areas including the health workforce situation. The population of the qualitative survey comprised health professionals of various categories working in primary health centres, student nurses in nursing schools, community leaders in localities where primary health centres are located, users of primary health services, women, especially those of child bearing age. The respondents and participants were selected randomly from the communities and from the staff of the primary health centres located in them. The participants selected from the primary health centres included nurses, midwives who had worked in the primary health-care setting for more than one year. Key informant interviews entailed collecting data by means of unstructured questionnaires which lasted between 60 and 120 minutes each, using the direct contact approach. The unstructured interviews were carried out more like normal conversation, but with a purpose (Legard, Keegan, and Ward, 2003).

During the interviews probing questions were asked in order to elicit more information from the participants and show participants that the researcher was interested in their experiences. The interviews were recorded by means of a tape recorder to prevent loss of data, and transcripts were made of the recordings. The research team made appointments with the participants and interviewed them while they were off duty at the clinics where they worked, or at their homes. Focus Group Discussions (FGDs) with randomly selected community leaders and other stakeholders including primary health staff were conducted in the nine target local government areas (Kruegar and Casey, 2000). The discussions with respect to health workforce covered health staff experiences, attitudes towards working in rural areas and suggestions about potential interventions to improve health worker distribution in primary health centres. Discussions lasted between

one and two hours, and were digitally recorded, supplemented by note taking. FGD recordings and field notes were reviewed for clarity, transcribed, uploaded into the qualitative analysis software and subjected to content analysis. This involved development of a coding “tree” or thematic framework. A draft coding tree was developed from the FGD topic guide and refined using themes emerging from transcripts. Information under each code was then compiled and tabulated to obtain a clearer picture of the issues arising from the data, and to compare views across different groups of participants.

Approval and permission to conduct the study was granted by the Delta State Government of Nigeria through the State Ministry of Health Research (Delta State Ministry of Health, 2007,2009,2010a, 2010b, 2011a, 2011b, 2011c, 2011d, 2012, 2012b, 2012c, 2012d; Ogundipe, 2013). The research protocol entailing the research methodology and the survey instruments were approved by the Delta State Ministry of Health’s Ethical Review Committee. For each participant interviewed, informed consent was obtained. Similarly focus group discussion participants also gave their consent before being asked to participate in the discussions. The project research team informed the participants regarding the purpose, methods and procedure of the study. The participants made an informed choice to take part in the study, and did so freely and voluntarily. They were asked to sign or thumb print on a form to indicate that they had given their informed consent to be interviewed or participate in any discussion and were informed that they could refuse to answer any question or discontinue their participation at any time. The privacy of the participants was respected throughout the surveys and all information collected has been kept strictly confidential. The participants’ anonymity was ensured by substituting their names with numbers or codes. Participants were treated fairly and any unclear information was clarified for them during the study. The findings reported in various sections of the assessment of the performance of PHCs in this paper is therefore based on the views of the stakeholders and the actions and policy recommendations they suggested to improve health workforce in primary health care centres in different parts of Delta State.

### **Accessibility of Primary Health Care**

Primary Health Care has always been an initiative to be the first contact level to alleviate some of the problem of inaccessibility to health care products and services. With the introduction of PHC services in Nigeria, the level of inaccessibility to basic health services has been reduced to some extent because PHCs are in some respects decentralized to reach people in various communities. In some parts of Nigeria members of various communities have physical access to PHC services because they are strategically located so that they can be accessible to users. However, situations in which PHCs are readily accessible to the people in remote communities in different parts of the country are not common. In an examination of the distribution pattern of PHCs in Nigeria, Odubanjo *et al* (2009) noted the marked inequitable access to PHC services between urban and rural areas, public and private sectors, and the north and south of Nigeria. With specific reference to the situation in Delta State, Agaja (2012) in a study of the spatial distribution of PHC in Ughelli South and Warri South LGAs of Delta State reported that PHC distribution is clustered in specific localities while other areas with difficult terrain and physical environment are neglected. Agaja concluded that health of the populace in the two local government areas of Delta State will improve if the prevailing mal-distribution of PHCs is corrected. In another study in Osun State, Sanni (1990) reported the existence of gaps in access to healthcare facilities among local government areas in the state. He concluded that there was an urgent need for serious intervention on the part of the government in the provision of healthcare facilities in Ogun State. In another study of the distribution and accessibility of PHCs in Kogi State, Awoyemi, *et al* (2012) reported that household size, distance and total cost of seeking health care affect the utilization of PHCs while total cost of seeking health care and the quality of access route affect the use of traditional care. They suggested that that distance to PHCs and the total cost of seeking health care need to be reduced to enhance accessibility to PHCs by various socio-economic groups in the state (Onokerhoraye, 1977, 1999; Omotor, 2011).

The qualitative findings of the on-going project on *“Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC)”* noted earlier shows that users of PHCs in different communities in Delta State emphasize the importance of accessibility of PHCs in the health system. Participants and key informants pointed out that distance from their homes to PHCs is a major constraint to the use of PHCs for maternal and child health services, especially in the remote, rural wards of their local government areas. Some participants complained that in those rural communities which are relatively far from the existing PHCs, people needed to walk on foot for up to one hour or more to reach the nearest centre. This according to them is stressful, for example, for a woman who is pregnant. In case of the health care of a child, the mother may not be able to carry the child and walk long distances to PHCs located far away from their communities. They pointed out that the popular motor cycle which is a common means of transport in many communities may not be convenient for use by women and their children. In some of the communities motor cycles are not even available because of the nature of the terrain. This shows that even women that are aware of the maternal and child health care services provided in PHCs and are willing to use them may not visit such centres due to the distance constraint. One of the focus group participants reported that:

*‘... a community health worker once educated us about vaccination and how to care for our children but we fail to do so because the health post is too far and our husbands mostly did not allow us because that will mean that food may not be ready for them in time...’*

A similar view was expressed by a health extension worker when she stated that *‘... there are villages very far from available health facilities in which case no health extension workers are accessible. In such areas voluntary members of a society gave training and some services to mothers, but when we go for vaccination every month it is difficult to say they are getting the care because many mothers will not go due to the distance...’*

Another key informant observed that “*distance is not the only factor because some women are lazy and feel that they cannot walk from their houses and come to the PHC. This makes them not to attend while others say they have a lot of work to do in the house that they cannot come to the clinic*”

### **The Health Work Force Situation**

Remarkable inequities, as well as insufficient absolute numbers of health personnel, have been identified as some of the key impediments in the improvement of health systems performance in Nigeria (Labiran et al, 2008). The PHC health workforce situation can be examined using indicators such as health workforce performance, which include availability, competence, responsiveness and productivity. The PHC health workforce situation in Nigeria with respect to rural areas is still poor despite efforts to improve the situation over the past thirty years. As a result of a lack of social amenities, attracting and retaining medical doctors and nurses has long been a problem. Primary care in Nigeria is overwhelmingly nurse-based. Most PHCs are staffed by professional, enrolled and auxiliary nurses who are supported by some clerical and general health workers. In the face of a rising demand due to increased burden of disease and a growing population, the training of sufficient numbers of nurses with appropriate skills has been inadequate (Bangdiwala, Okoye, and Tollman, 2010). The demands on the nurses in rural areas are multiple and diverse. Often, in rural primary healthcare settings, one registered nurse is placed on duty with only a nursing assistant and no attending physician at the clinic, either during the day or at night. The primary health-care facility is managed on a daily basis by a single qualified professional nurse. This contributes to excessively high workloads and the poor performance of these nurses, which can tarnish the reputation of nurses in the eyes of the communities. Low staff ratios, high workloads and a growing population led to an increase in the utilisation of personnel with fewer skills and a decline in the quality of care offered. The poor working conditions have led to many nurses leaving the profession. The lack of both material and human resources resulted in poor performance in nursing in rural primary health-care settings (Beaglehole, Sanders and Dal Poz, 2003). When patients find PHC facilities poorly staffed, lacking medicines, and poorly organised, they under utilise primary health care clinics and go ‘up the



chain' to a higher level, often to more costly public hospitals, or to the private sector.

The qualitative findings of the on-going project on *“Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC)”* demonstrate the challenges faced by PHCs, especially in the remote rural communities. Key informant respondents and participants in focus group discussions agree that most PHC services in the target LGAs are staffed mainly by community health workers and nurses/midwives. They pointed out that there are remarkable differences between public and private providers in their LGAs in that private providers are generally better staffed by nurses, midwives, and doctors compared with public PHCs. Thus private primary health centres are better staffed than those owned by the public sector. The outcome of the discussions during focus group meetings and during key informant interviews indicate that on the demand and supply side, participants agree that there is persistent health personnel shortage in primary health centres in the target local government areas, especially in those established by the various levels of government. There was also agreement among the participants that PHCs located in urban centres are better staffed than those in rural areas and that this applies to PHCs owned by both private and public agencies. Participants noted that a typical PHC in the urban area does have as many as thrice that staff in the PHC located in rural areas. In addition PHC in urban centres have a full complement of staff of various professional background including nurses, doctors and pharmacists compared with those in rural communities which do not regularly have the services of doctors. It against this background of inadequate staff in PHCs located in rural areas that participants presented their views on the various challenges facing health workforce in PHCs in the target LGAs.

In the first place participants view rural areas to be those which are generally remote and characterized by poor infrastructure (bad roads, limited transport services, no electricity, poor mobile phone network, and low water supply), poor health services, limited variety of available housing and hardly any recreational facilities. They point out that government policies and programmes over the years in Nigeria have not paid adequate

attention to the challenges facing rural communities. The participants point out that inhabitants of rural communities are generally disadvantaged in the development programmes of the country and this explains the absence of basic social and infrastructure services. This perception and the reality of rural life in the target LGAs have implications for the posting and retention of health workforce in PHCs located in such areas. On the other hand, urban areas are perceived by the key informant respondents and focus group participants to be more accessible with stronger infrastructure, better health services and educational institutions, and a variety of recreational facilities. Some of the health staff who are married, commented that they often get separated from their children when they are posted to rural communities, as their children are schooling in urban areas away from them because rural schools are generally of substandard quality both in terms of quality teachers and teaching facilities. One of the focus group participants stated as follows:

*“...you know our country, Nigeria, how things are despite over fifty years of independence and the implementation of various development plans, infrastructure is still bad, if you take me to a remote area, there is no accessibility, there is no infrastructure, and there are no motorable roads, when it rains one is stranded in this community because of bad roads. This makes it difficult for me to rush to see my family in the urban area in case of any emergency, especially those associated with violence by youth groups. How can I be happy working here? ....”*

Secondly, some health staff and student nurses during the interviews and focus group discussions indicated that they know that the rural settings in the target LGA are characterized by poor infrastructure, poor health services, limited variety of available housing and few quality educational institutions for their children. When asked whether they have the desire to work in PHCs located in rural communities, they expressed fear of living in communities characterized by lack of basic facilities. According to them rural settings are resource constrained in terms of personnel and equipment. This results in dissatisfaction among nurses due to the unbearable working conditions which result in stress and frustration. It was revealed during the discussions that nurses working in primary health-care settings in the target LGAs were experiencing emotional and physical

strain as a result of the shortage of human resources. Furthermore, participating health staff expressed the view that poor communication channels in rural areas limited the flow of information on training opportunities such as workshops and seminars. In addition, they revealed that staff shortages denied them the opportunity to pursue their studies because a replacement was not always available. One of the participants stated as follows:

*“...when you stay in rural communities as a health worker, you might end up missing some of the privileges that our colleagues in urban areas do enjoy. For example there could be seminars and refresher programmes for staff of your category and while your colleagues in the urban areas are able to attend one may not be aware. In addition the pressure of work may prevent us from going to participate even if one is aware of such courses...”*

Thirdly, participants in the focus group discussion and the respondents of key informant interviews pointed out that the health workers in PHCs in rural areas are experiencing major difficulties in the delivery of their services due to remarkable shortages of all categories of health personnel. They pointed out that in some PHCs health care is managed on a daily basis by a single qualified professional nurse. This contributes to excessively high workloads and the poor performance of such staff, which tend to tarnish their reputation in the eyes of the stakeholders in the communities. A key informant participant who is a PHC staff noted that:

*“.....we are terribly understaffed, we work very hard, and most of the time one is totally exhausted. When one nurse is on maternity leave or sick leave, there is no replacement we have to cover her part of the work. This is tough. Effective health care services covering all the components of primary health cannot be provided in this community with the present inadequate staff situation.....”*

The participants who are PHC staff pointed out that they have to cope with infrastructural constraints, including lack of basic necessities such as accommodation, communication systems, water and electricity. They reported that some of them do feel frustrated about the shortage of water which they consider basic and should be made available in the PHCs so

that they can effectively deliver their services to the community members. They emphasized that it was difficult to perform any task without regular electricity supply and that health services do come to a standstill when there is no light. Some of the participating PHC staff reported that maternity cases were sometimes attended to using candlelight and that could hamper the delivery of quality care. To cut and suture episiotomies using candlelight may lead to complications that could be harmful to patients. One of the focus group participants stated as follows:

*“.....As I am talking right now we have not had water for the past three weeks; patients assist by bringing water with small buckets. In some situations patients are expected to bring water along when they bring a woman in labour. The problem has not been attended to despite repeated requests. The toilets are a big health hazard when we are without water. In this situation how are we being expected to teach the community about a safe water supply and usage when the clinic does not even have its own water supply”?*

Another participant stated ... *“we stay three to four days without water in the clinic, yet we are supposed to wash hands between patient examinations.”*

Some of the focus group participants also mentioned the inadequate supplies of drugs as a constraint to caring for clients. According to them, the supply of drugs did not cover the number of clients that needed them in most PHC facilities. The supplies tend to be exhausted before the next order was due. This situation puts further pressure on health staff. This tends to make health staff to be viewed by stakeholders and users as not providing adequate care to them.

In the fourth place, key informant respondents and focus group participants, especially PHC staff, expressed emotions such as anger, sadness, fear and suffering. They also indicated that in certain instances they felt frustrated and hopeless. They said that working 24-hour shifts was strenuous, especially because patients do not understand the situation under which they work. They pointed out that lack of time due to inadequate staffing precludes quality patient care. Most of the focus group participants including community-based stakeholders and users of PHC

services agreed that lack of rural human resources can impose an additional burden on nurses, thus contributing to anger, sadness, suffering and frustration, which lead to high staff turnover. Due to the shortage of staff nurses, they sacrificed and worked long hours, which contributed to fatigue, stress and burnout. A lack of adequate staffing and organisational resources is obviously one of the most common characteristics of nurses working in PHCs located in rural areas. Some participants added that patients expect the best treatment, no matter what the staffing situation is. In some primary health-care facilities the number of professional nurses employed remained the same despite the increase in the use of their services. One participant noted as follows:

*“.....the shortage of staff is their greatest challenge, a challenge that required them to use all their knowledge and various skills. At rural primary health-care facilities, the few staff managed large numbers of patients every day. They had to assess, plan, implement and evaluate treatments, as well as conduct home visits. This tends to make them to be viewed as incompetent and ineffective...”*

Finally, focus group participants and key informant respondents felt that their children needed their mothers' guidance, as well as assistance with school work and other reassurance. Without their mothers' presence, children's progress at school often declined as their father may not have the required time to assist the children in their home work. Participants pointed out that health workers in rural PHCs would be encouraged to remain in rural areas, if managerial structures recognised that they had roles and responsibilities, such as child care and housework, apart from their waged work. They emphasized that flexible scheduling not only meets patients' needs, but also attracts health staff who cannot work traditional nursing shifts. They noted that separation from families for long periods of time could negatively affect nurses' marriages and their relationships with their children. The kinds of feelings expressed by the participants were often suppressed as a result of the culture of the work environment. Professional nurses had to be responsible and display an accurate and positive image of the profession and the life of the patient had to be their first consideration. Yet there are fundamental dissatisfactions with the condition under which

health workers work in rural areas and could seize any opportunity available to abandon rural localities for urban centres.

### **Quality of Services**

The performance of primary health care systems has traditionally been assessed in terms of coverage of services with little attention to the quality of the services provided. The ability to assess the quality of care provided is an essential component of quality assurance and improving quality. Inadequacy in the quality of health service delivery at the primary health care level is a product of failures in a range of quality measures - structural problems, process failings and a lack of a protocol for systematic supervision of health workers (Baltussen and Yazoume, 2005; Abiodun, 2010). There are several indicators of poor quality of health care. These include overall management weaknesses, technical incompetence, lack of drugs owing to mismanagement of drug supply, drug leakage or illegal drug selling, poor attitudes and behaviour of health staff, low staff motivation and morale, and insufficient supervision. The major challenge is thus how to approach and improve such a detrimental state of affairs. A study of PHC in Nigeria undertaken by the World Bank (2003, 2010) which focused on the analysis of the performance of PHC providers and the variables driving this performance using the World Development Report (WDR) 2004 accountability framework shows that despite Government efforts, the delivery of quality primary health care services remains a challenge in Nigeria. The condition of the infrastructure is poor; many facilities do not have the required equipment or the pharmaceutical products to offer quality care. In addition, household satisfaction with services is low and very few outreach services are provided. In addition, health personnel salaries are often delayed and are not linked to the provision of services. The study concluded that defining lines of responsibilities, performance-based financing of local governments and providers, and the collection, analysis and sharing of information are some options that can help to re-align incentives and improve accountability of policymakers and providers. It noted that reinforcing client's power and increasing their demand of services can compensate for weaknesses in the "long route" of accountability for the delivery of primary health care.

The qualitative findings of the on-going project on “*Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC)*” show the importance which users attach to the quality of services provided in PHCs. The results of the discussions in focus group and key informant interviews show that users of PHC services are particular about three indicators of the quality of PHC services in their locality. The first relates to the conduct of staff and the professional care they provide. Generally there were various positions expressed by respondents and participants with respect to the conduct of staff and the professional care they receive from PHCs in their localities. Among the factors known to influence how patients experience of health care services are responsiveness and empathy on the part of health personnel. These might be outwardly displayed in the attitude of health workers. Generally, the respondents in the PHC study perceived the attitude of the various categories of health workers to be good but some feel very strongly that some staff in public PHC facilities are not helpful to patients when they visit the centres. The focus group participants reported that staff in public PHC show varying attitudes. While some PHC staff members are reported to be polite others are perceived as being overly very insensitive to patients. Often they pointed out that most male staff are less harsh whilst most female staff tended to be harsh towards youngsters who visit, especially those with sexually transmitted diseases. Many of the participants and respondents emphasised the insensitivity of PHC staff in public facilities towards patients who needed urgent attention as well as general laxity in dealing with patients waiting for attention. Differences were noted between private and public health services such that private facilities treated patients better than in public facilities. According to some participants rudeness is expressed by being shouted upon in public PHC facilities compared with those in private PHCs which tend to be generally friendly. Some of the participants noted that PHC staff tend to discriminate between patients according to their status or influence. The higher the perceived status of the client, the better the service provided compared with clients from low income background that often receive poor attention. Some participants acknowledged that a few PHC health staff show respect and compassion towards their patients but many especially in the public PHCs do not. Other PHC staff are said to be insensitive to particular problems of patients.

Many of the respondents and participants pointed out that consultation with health staff tend to be brief with no thorough examination except for discussions around the patient telling what is wrong with him/her and then given medication on the basis of those reports. The problem of diagnostic practice is seen to be related to the failure of health staff to examine the patients thoroughly before they can determine treatment. Some respondents said that sometimes prescriptions were written even before examinations were done which was discouraging. They argue that this may be a reflection of the inadequate health staff and limited experience of those posted to rural areas.

One of the participants in a focus group discussion compared visiting a public PHC facility in their locality with visiting a traditional health care facility as follows:

*“If I go to a traditional health care facility I am sure that I will be treated very friendly from the onset. When you knock at the door of the traditional healer you are immediately offered a seat, and thereafter one will be examined after reporting the health problems that one is having. After some examination, the traditional healer will say what is wrong with one’s health. I do not have to explain what is wrong with me as the traditional healer will tell me after his/her examination. Unlike at the public PHC facility, where one is asked what is wrong and why you have that pain. ....how am I supposed to know why I have pains as if I am a doctor?. I think they treat people better in traditional health care facilities than in public primary health one. This explains why many people prefer to visit traditional healers rather than visit public primary health centres ...”*

Another focus group participant reported as follows, *“At the PHC clinic, the greetings come out more as threats rather a welcome’. You are not offered a place to sit before questions are thrown at you such as “are you attending school, what is your age and level of education, are you working and all that in front of other patients. They are not even writing anything down.” “I should point out, however, that “at a private PHC facility they take good care of patients. You are given a chair on arrival, and then you will be given a bed later. The staff often speak to patients politely. The helpers show happiness and respect on their faces and they also greet patients. At the private health centre there is more privacy. The staff tell you your*



*problems while you are in the examining room. The staff show compassion and understanding, when telling him or her what you feel.”*

Another participant in one of the focus groups stated as follows:

*“Some health staff at the clinic when one is ill even abuse the patient saying that “from the morning of the day one went to the clinic, you knew that you were not feeling well, why are you coming here now?” Then you will try to explain that the pain was not very bad by then, it only got worse later. Some rude health staff will say: “there is no such, there’s no such...you cannot tell me such a thing I have been a nurse for years, you know nothing. This attitude of health staff discourages people from these health centres....”*

One other participant stated as follows:

*“The nurses and midwives don’t talk to patients well. May be they always have bad mood from home and put it on their patients. If she had a problem with her family, she becomes crossed with patients for no apparent reason. The nurse will just scold you even if you did nothing wrong. For example, you are on the queue and she says, ‘next’, while you are still deep in thoughts, she won't speak with you well. She will shout, ‘why did you not come here?’”*

Another of the participants emphasized the attitude of health staff with respect to discrimination based on status within their communities as follows:

*“They treat you depending on your background, i.e. it depends on the kind of family you come from; your appearance also contributes towards the whole thing. If you visit the clinic wearing nice clothes and jewellery they will give you first preference. If you come in tattered clothes, then things are different. It is painful to a sick person who needs care because any person who is sick cannot have time to dress as if he/she is going to the market or party..”*

*“They look at the kind of person you are, if they don’t like you, they won’t give you the urgent attention. The nurses look at the surname. If one patient is related to her, the service is faster. “The nurses should not judge us because of where we come from or which families we are coming from. They should treat us in the same way, equally.”*

Another of the respondents emphasised the poor medical examination of sick persons during visits to health care facilities. According to the respondent:

*“The nurses do not examine you; they just ask what is wrong with you and give you medication. You actually have to know what is wrong with you when you go to these places otherwise you will not be helped. People who complain about feeling pain in general and do not point to any specific place on their bodies cannot be helped. The medication you get is based on the patient’s ‘own diagnosis....”*

Another participant reported along the same line as follows:

*“When you are ill the first thing to do is to tell PHC staff what you are suffering from. They won’t tell you what kind of illness it is, what causes it, and the functions of medicines they are giving you. They will only tell you that you must take 1 tablet 3 times a day. They do not tell you that for a particular type of disease, you should not eat this and that.. ” “They do not ask, they just take an injection and fill it up, then say undress the baby. They will then say you will massage the buttock on the way, while you are busy walking. They do not tell us what the function of that injection is. We take children to clinic 6 weeks after birth, and we are not told what it is for. At the clinic they do not tell us the reason for injecting us...” “We are often not satisfied with the outcome at the clinic, we just tell ourselves that God will heal us because the drugs they are giving us are just useless, they are not strong enough to cure patients. The nurses give us medication for other diseases, not for what we are really suffering from.”*

The second indicator of the quality of PHC services which the respondents and participants in the focus group discussions emphasized relates to the availability of facilities and drugs. Generally, the participants in the focus group discussions reported relatively good cleanliness of the PHC facilities. Basic amenities of health services such as clean waiting rooms are aspects often highly valued by patients. However, some participants and respondents complained of having small buildings as PHC centres that force them to queue outside sometimes in the sun or rain. There are no resting places and often chairs or benches for sitting are not adequate, people have to sit under tree shadows waiting for attention. Beds are only available for a few patients not more than two or three people at a time. The participants singled out the lack of drugs as a major challenge in public

PHC facilities and this tend to discourage users from visiting them. Participants agreed that it is the government and not the PHC staff that should be held responsible for the lack of drugs in the PHCs. However, some of the participants pointed out that even when drugs are available health staff do not have patience to explain the use of the drugs to them.

One of the focus group participants recounted her experience in the PHC in their locality as follows:

*“The health staff generally do not explain how we should take the pills. At the health centre they give you medicines but they do not tell you the function of these medicines. All they tell you are take 3 teaspoons 3 times a day and keep out of reach of children. But at the private practitioner clinic they explain the function of the pill and guide you properly on how to use them ...”*

Another focus group participant pointed out as follows:

*“Sometimes the medicines we get from health centres help but most of the times they are useless. Sometimes you can clearly see that they have added water to the medicines. PHC medicines are too weak. You can give those medicines to a child with flu; he or she won’t get better. Two weeks can pass without any change. “We want to believe that the medication that we are supposed to be given is used by the health workers for their own purposes” This problem of poor drug supply to patients do force most of us to take a child to the private PHCs where better drugs are provided”*

A health staff in one of the PHCs also blamed the patients for not following the instructions given to them with respect to the use of the drugs and only for them to turn round to blame the health staff. He pointed out that *“... there was a time when I attended to a patient and gave him the prescriptions on how to take the medication; I had instructed him to take certain painkillers two times a day when he was sweating in an awkward way. It so happened that he took the medication many times within one day and not as I prescribed. He got worse in his condition, in which I was unnecessarily blamed for the failure of the patient to follow instructions.”*

The members of one of the focus group discussions concluded by making the following recommendation with respect to improving the drug supply situation in PHCs.

*“As a solution to this problem of lack of medication the government should introduce fees for drugs. This will mean that we will get proper undiluted drugs.”*

Finally, users participating in the qualitative surveys across the target local government areas of Delta State were particular about the time they spend in PHC facilities before they receive attention. Prompt attention has been shown to be a key dimension in surveys of community satisfaction with health services. Individuals value prompt attention because it might lead to better health outcomes, allaying fears and concerns that come with waiting for diagnosis and treatment. Prompt attention on its own is not a function of health improvement, but it is a dimension of patient satisfaction. The participants at the focus group discussions pointed out that the ideal total waiting time should be about one hour and patients expected to be seen quickly, attributing long waiting times to unnecessary delays. Some patients identified the dispensary and injection rooms as places likely to delay patients, so management will have to find out the causes of such delays and help minimize them. There was a general perception by the focus group participants that at PHCs patients must have to wait for a long time until they are attended to and are even sometimes turned back if they come late in the queue. Long queues are also experienced on antenatal and postnatal days in the PHCs. There was also a problem of lack of waiting space. People wait under tree shades. At private practitioners the waiting time was very little.

One of the participants stated as follows:

*“At the PHC we stand on the queue for a long time and we become tired. You will read every pamphlet on the wall until your eyes are painful.” “At clinic the queue is always long because of free services whereas at the private practitioner there is absolutely no queue due to high payments.”*

*“At the health centres the queues are always long, especially where there are supposed to be free or lower cost of services whereas at the private practitioner there is absolutely no queue due to high payments.”*

### **The Utilization of PHC Services**

It is well known in many parts of Nigeria that despite the progress and achievements made so far in the implementation of the primary health care programme, the services provided are grossly under-utilized. Abdulraheem *et al* (2012) reported on the low utilisation of PHCs in rural communities in different parts of the country and concluded that the responsibility for perpetuating the existing low use of PHC services should be held by PHC policy makers and LGAs. The authors observed that responsible and capable health personnel in PHCs can build a new social order, based on greater equity and human dignity. They suggested that building and empowerment of communities through orientation, mobilization and community organization as regards training, information sharing and continuous dialogue, could further enhance the utilization of PHC services by rural populations. In Delta State where some aspects of health services are free such as free maternal and child health services, a significant proportion of the women, especially in rural communities do not utilize these services. Despite the need and availability of antenatal care, its utilization by pregnant women is low, leading to the high rate of maternal morbidity and mortality (Uzochukwu and Onwujekwe, 2005). In most Nigerian communities, expectant mothers prefer to put to birth at homes and this has implications for the health of mothers and infants. It is not uncommon to hear or find cases of maternal complications and subsequent death due to the ineffective utilization of ANC by expectant mothers. The high rate of deaths of women during pregnancy, childbirth or in the immediate postpartum period is due to different influencing risk factors. These are directly linked to socioeconomic, reproductive and health service factors. The general socioeconomic status of mothers, ability of women to manage resources and make independent decisions about their health has an impact on reduction of maternal mortality. Women and children are among the major stakeholders of health and the most vulnerable group in the society and bear the brunt of the consequences of the deteriorating health system. Most of the health care services target women and their

children and thus they are in a better position to assess and evaluate services provided at the PHC centres in the spirit of community involvement and ownership.

The factors determining the utilisation of PHCs in Delta State were examined by Okumagba (2011) in which he pointed out that the choice of Health-Care utilization, generally, is determined by nearness to health care facility and belief system. The study specifically examines factors that influence the choice of health-care system by the elderly and the results show that factors such as distance from health care facility, belief system, quality of health service received and finance were important determinants of choice of Health Care System utilized by the elderly. Furthermore, Awusi *et al* (2009) in a study of the utilisation pattern of antenatal care services in Emevor, Delta State observed that the majority of the women who attained secondary education (69%), post-secondary education (96%), those whose husbands had secondary education (69%), post-secondary education (82%) and those who had income-yielding occupations (36%) utilized ante-natal care services. They suggested that low-income, uneducated women should be targeted for enlightenment in addition to promoting education of the girl-child and women empowerment (Navaneetham and Dharmalingam, 2002).

The qualitative findings of the on-going project on “*Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC)*” reflected some of the factors influencing the utilisation of PHC facilities in the state. With specific reference to maternal and child health care, key informant respondents and participants at focus group discussions drew attention to a number of factors influencing the utilisation of maternal and child health services provided in PHCs. These include the awareness of skilled maternal and child health services; distance to available Primary Health Centres; quality of services provided in PHCs; household decision making pattern; cost of maternal and child health services; and cultural belief affecting the utilisation of maternal and child health services.

With respect to awareness of skilled maternal and child health services, key informant interviews and participants at the focus group discussions consistently pointed out that lack of awareness on the part of users of maternal and child health services provided in PHCs is a significant factor contributing to the poor utilization of maternal and child care services in their communities. It was pointed out that many women in rural communities, especially those in remote localities with poor access roads, of the target LGAs are not even aware of the need to seek maternal and child health care due the lack of adequate enlightenment and health education. It was pointed out during discussions and key informant interviews that women do get knowledge on the importance of skilled maternal care provided in PHCs and hospitals in different ways such as (i) previous exposure to skilled maternal services; (ii) health education campaigns of some PHC health staff; (iii) community based health education, through community media often carried out by some civil society organisations; and (iv) the educational status of mothers and their husbands. In most cases women with at least one antenatal or post natal care in previous pregnancies tend to be motivated to use skilled maternal and child health care. It was pointed out during discussions that skilled maternal care during pregnancy, delivery, and postnatal period increased steadily with the educational level of women because those with secondary and above education are associated with antenatal and delivery care by a skilled provider.

A key informant who is a health worker in one of the PHCs stated that: *“Some pregnant women don’t know about skilled maternal and child health care services and that is why they do not attend, especially the women in the rural areas are not aware”*.

Another PHC staff expressed similar views as follows:

*“Many of the users particularly in these rural communities are not aware. On the other hand, in the urban areas most of the users are aware and they visit health centres, but in the rural areas I think many of them are not aware. This prevailing ignorance situation is compounded by poverty, to even access health services because for many of the patients to transport themselves to the health centres is difficult....”*

Another health staff pointed out that:

*'... We usually inform the mothers on maternal health services, and they do have awareness about the service but most of them need to be motivated every time to use the service...'*

Finally, one of the community leaders, who is a key informant re-emphasised the issues of awareness by users of maternal and child health facilities when he stated that:

*"I think maternal and child health service utilization in our PHCs depends on the educational status of women especially in this community. Initially the more educated women tend to search for maternal and child health care while the less educated ones remain at home, they never even attend a single antenatal care before delivery and they will deliver at home, they will manage their children, and funny enough some of them don't turn out to have problems."*

On the issue of the quality of services provided in PHCs, participants in focus group discussions pointed out that many users are discouraged from using the maternal and child health services provided in PHCs because of their assessment of the quality of services provided in some of them, especially those located in the remote rural communities. But because of work load and inadequate staff health workers' visits are quite limited in the target communities. At the health facility level the availability, readiness, and quality of services as well as the type, competence and caring behaviour of providers are very important for maternal services. Participants complained about the limited availability of maternal and child health services particularly equipment and drugs: mainly in remote areas where vaccines are less available in PHCs. Health worker's visits have a significant influence on the utilization of full antenatal care and postnatal care services among rural adolescent women. Yet these are not common in most of the communities.

A key informant respondent who is a health staff in one of the PHCs noted that:

*"Functioning obstetric facility means performing the essential services for normal situations and complications and these services should be available 24 hours a day"*



*and 7 days a week. The presence of all signal functions reflects better performance (quality) of a health facility.”*

Closely related to the issues of lack of equipment and drugs is that of the perceived attitude of health staff which they regard as discouraging women from visiting the PHCs. Some women participants in the focus group discussions admitted that the attitude of health workers is not encouraging at all and hence does not motivate the women to attend PHCs for maternal and child health services. A female participant in a focus group discussion pointed out that:

*‘... When my child gets sick there is no drug at the health post and full service even if they informed us about the care...’ Only they vaccinate our children in our ward, there is no satisfactory service here and there is no drug ...’*

One major constraint mentioned by mothers was absence or frequent travel of health staff out of their station. She observed *‘... I gave birth before three months but when I went there after a first month for vaccination the health worker was not available. I did not go back again as I was not sure I will meet anybody if I go...’*

Another key informant respondent noted as follows:

*To be candid some women like to come for maternal and child health care but they are afraid of the attitude of the health workers who shout and treat them in a hostile manner. That is why some say let them stay at home and use traditional means and then refuse to attend the clinics for the ANC.*

Furthermore, another respondent confirmed the statement: *“Health workers should stop shouting or abusing the pregnant women. You see this is not good it even makes a woman not to attend.”*

A further indicator of the quality of services which the focus group participants highlighted relates to the waiting time in PHCs before attention. This issue, the participants observed, prevents women from visiting PHCs when they need the services provided by them. A participant narrated as follows: *“If the pregnant women attend once they don’t normally*

*come back, the women normally say that if they attend once when they come back again it is not likely for them to receive the maternal services on time.”*

A health worker respondent pointed out that: *“most of the pregnant women think of maternal health care as a stress because of coming to the clinic and waiting for longer hours before they are finally seen, may be in the late afternoon hours. Therefore, some of the pregnant women cannot wait or stay for longer time at the clinics and this distracts them from attending clinics.”*

Another factor highlighted by respondents and key focus group discussants relates to the household decision making pattern in their communities. Research has shown that the ability to make a decision has a major role to play in the utilization of maternal and child health care. It is reported that mothers who can make a decision were more likely to use maternal and child health services than those who cannot make a decision. The possible reason for mothers not to make a decision might be the community belief about the hierarchy of authority in the household and economic dependency of mothers on husbands (Mohammed, 2005). Some participants in the focus group discussions observed that some women fail to visit PHCs for maternal and child health services because their husbands and in-laws do not allow them to attend despite the fact that they appreciate the importance of using the maternal and child health services provided in the PHC centres.

There is no way they can disobey their husbands’ directives. A participant in one of the focus group discussions noted that: *“What I want to say is that most of the problems are from husbands. For instance I had the experience of consoling a crying woman who was pregnant but her husband and her mother in-law refuse to let her attend PHC for maternity services. Most of the problems are from men and when childbirth comes it is the woman who suffers not the men.”*

A key informant respondent who is a staff of a primary health centre reaffirmed the situation by stating that: *“...sometimes it is the husbands who have the problem. They don’t have the money to give their wives to come to the health centre.”* She pointed out further that *“Some husbands do not have sufficient money to pay for the hospital bills so they cover up, and pretend that they do not want the women to attend maternal health care services.”*

From the cultural perspective another participant pointed out as follows: *“Any pregnant woman in our community who does not deliver at home is believed to have been unfaithful to her husband when she delivers in the health facility. She is believed to be hiding something from the husband and the family. This is a belief that still holds to date,”*

Another focus group participant stated that *“Pregnant women in this community usually deliver at home under the care of a traditional birth attendant—even though delivering at home can be extremely dangerous, and the health centre itself is new and presents an ideal environment for delivery.”*

Furthermore, the cost of maternal and child health services was also identified as a key factor in the assessment of the quality of services provided in PHCs. Women’s health seeking behaviour in the target communities is also influenced by the cost of maternity services and their capacity to cover the expected expenses. For instance, a substantial proportion of antenatal care users among the focus group participants and key informant interviews did not deliver or use postnatal care by a skilled provider because they claim that maternity services, especially delivery care, are expensive. Participants in the focus group discussions agreed that despite the claim of free maternal health services by the government, payment requirement at the time of delivery was an important barrier to using PHC services. They observed that there are many other costs which they must bear if they visit PHCs for maternity care. For most households, maternal health care could take more than half of their annual income.

One PHC health staff observed with respect to the resources available in PHCs as follows: *“Actually, I need to speak the truth. Most of the work we do is achieved using personal materials and funds. We require facilities such as a nutrition demonstration room which is not available. In fact, I am not satisfied. Personal funds are used to pay for photocopying of documents in a bid to keep records and statistics.”*

Finally, cultural belief in pre-destination was also identified as a factor influencing the utilisation of maternal and child health care services in the various communities. The cultural belief in some communities that going

to health institutions for delivery is not necessary is strongly prevalent in some rural communities covered in this study. Some participants at the focus group discussions pointed out that there were those in their communities who strongly believed in pre-destination, meaning that whatever happened to them was the will of the Creator. Some participants did not feel the need for PHC services unless their children were sick after delivery.

A PHC staff during the key informant interview stated that: *“... Yes this is a known fact among many households in the communities because they believe that their ancestors and God will deliver them of their children safely.”*

Another focus group participant stated that: *“Since I did not get sick I did not go to the health post and never used family planning...”*

### **Community Participation in the PHC Program**

Without the communities there would be no Primary Health Care and without Primary Health Care, communities will experience health problems. The PHC is mainly tailor-made for the people at community level. It requires the participation of community members, nurses, health workers so that they interrelate and interconnect to eradicate health problems (Florin and Dixon, 2004; Mike, 2010).

In the qualitative survey carried out in different parts of Delta State, some female community members pointed out that they participate by attending public gatherings whenever they are held so that they get the health education offered by nurses and other health workers. They also participate by showing up at the health centres for further information and consultations about their health. They cooperate with the village health workers by doing whatever they want them to do. Relatives who are invariably members of the community are also at the fore front as actors or the leading care-givers because they are always with the patients, which is also a strong indication of the community participation in their health problems.

### **Funding of the PHC System**

Nigeria's health care system is generally underfunded with available funds largely committed to secondary and tertiary health services based largely in urban centres. Over the years, over 70 per cent of health expenditure by federal, state and even local governments in Nigeria went into primary and secondary and tertiary health centres. This suggests that the vast proportion of health expenditures in Nigeria benefit about 30 per cent of the population. Furthermore, the Nigerian health system which developed from colonial health services has over the years placed an emphasis on overpriced, high-tech, urban concentrated and curative health care. Finally at the time when the PHC system was introduced in the late 1970s and early 1980s, the implementation process has been met with serious challenges which include falling gross domestic product (GDP) and shrinking health budgets, inadequate political will, and increased burden on health care services as a result of emerging new diseases such as HIV & AIDS. The health sector was not spared from the economic depression of the 1980s as it experienced a shortage of health staff and deteriorating health services and infrastructure. In addition, there was little or no action by the Government to redistribute the available resources more equitably to localities with the greatest health need - especially in rural areas. Even basic health promotion and prevention activities that had proved to be effective, such as health education, could not be sustained. As a result of these challenges, there was an increase in both vaccine preventable and communicable diseases. Thus obstacles of falling GDP and budget cuts have seen to the decline of PHC services and health outcomes.

There is no doubt that comprehensive PHC which Nigeria has adopted is expensive to implement as it requires a multi-sectoral, multi-disciplinary and holistic approach. It calls for an increased number of health staff in all disciplines, proper supply chain system for drugs and laboratory services, improved transport services and infrastructure, as well as sufficient water and sanitation. It is in this context that with falling GDP and shrinking health budgets, comprehensive PHC has remained elusive in Nigeria.

### **Inadequate Political Will**

Inadequate political will at all the three levels of government in Nigeria has also contributed to the failure of PHC in the country. Although the PHC concept is well articulated in Nigeria, the slow response by Government to provide equitable and quality health services to all individuals has hampered progress in achieving the desired health outcomes. This was aggravated by the frequent changes in governments in Nigeria during the military era and the associated weak leadership in the health sector, particularly related to the decentralisation of health services, poor infrastructure and services - especially in the public sector - inequities in resource allocation and distribution. Thus Nigeria has been experiencing an increased burden on health care services largely as a result of rising communicable diseases including HIV/AIDS. Due to the increase in disease burden, efforts to improve PHC have proved to be challenging, as there are shortages of health workers and health infrastructure, all of which have contributed to the current poor health indices (Adeyemo, 2005).

### **The way Forward for Policy Makers and Providers of PHC Services**

The conception of PHC over thirty years ago was based on the principle of social justice and equity as key to health improvements in the rural communities of the then developing world (Green, 2004). It also highlighted the role of prevention, multi-sectoral collaboration, appropriate technology and sustainability. The need to improve the lot of those living in abject poverty was a major emphasis. There is no doubt that Nigeria embraced these principles in the articulation of its PHC system. However, as the review of the available evidence in this paper has shown, Nigeria has not consistently made any remarkable progress in developing the PHC system as a major component of the overall health care delivery in the country. Contrary to the planned and expected outcomes, not only was the goal of the PHC system of providing accessible health for all by the year 2000, not achieved, the outlook appears unrealistic even in the next decade. For Nigeria to realise the goal of the Alma Ata Declaration, a number of issues must be addressed. The way forward for PHC policy makers and providers presented in this section incorporates the recommendations of key informant respondents and focus group participants as they relate to the issues that they believe are critical for the

revitalization of the PHC system in their locality (Ransome-Kuti, 1987; Asuzu, 2004).

### **Filling the Data Gap and Scaling Up**

Not enough is known about the critical issues and challenges facing the PHC sub-section of the health sector. Existing studies are piecemeal and have gaping gaps, which make them unable to inform policy. Going forward, therefore, requires that a robust platform be designed for the collection of comprehensive data on PHCs. As the irreducible minimum, such strategy must include data on health status, funding, socio-demographic parameters, social services and amenities, existing health facilities, as well as the attitudes and cultural/traditional beliefs of the populations. The Delta State PHC research project is designed to achieve this objective. This will be achieved by generating information and knowledge of high integrity that can influence policy. However, because of the need for its scaling up, so that the information can also properly inform national policy, the study should be replicated in more states in Nigeria.

### **Accessibility Policy Issues**

Public health goals at all levels of government in a country such as Nigeria are influenced by demographic and background variables. In view of this, information about community felt needs become significant and indeed paramount. These needs should be properly evaluated and coordinated with different sectors and incorporated into existing PHC services. In addition, new programmes should be developed to meet their unfulfilled needs. Some PHC centres in Nigeria including Delta State are badly located in terms of physical accessibility to the disadvantage of remote communities in rural areas. Accessibility can be improved by either relocation of some of the existing PHC centres, or adding more centres at the local government level to bring the services within walking distance of the population of the catchment area.

Mobile health services intended to meet the needs of the remotest population in some parts of the country have proved ineffective and rather too costly. In summary, such mobile services are not cost-effective. The establishment of health centres to serve remote populations would be a

better strategy. It is in this context that PHC services should be based on fixed structures with a reasonably wide coverage, sufficient flexibility and adequate mobile capacity to fulfil their obligations to all sectors in the population, especially the highly remote rural communities. Legislation should be enacted for special services like immunization and reproductive health. Family health file/card should be prepared with all information related to health, so that they can be taken by families on the move from one place to another for quick acceptance, greater access and prompt management. Secondary-level health care facilities should be empowered to monitor and supervise PHC services. The secondary health facilities should also have some disciplinary authority on erring PHC centres.

### **Improving PHC Workforce**

It is essential that PHC personnel are trained and re-trained to orientate people towards the concept and principles of PHC (Rowe, *et al*, 2005; Chen, 2010). In the context of the participatory action research carried out in Delta State, the participants in the focus group discussions and key informant interviews were asked to suggest ways in which the prevailing health workforce situation of PHCs can be improved. A synthesis of the recommendations proposed by the participants and respondents is as follows:

- Efforts must be undertaken in Delta State in particular and other parts of Nigeria in general to limit the impact of the health worker shortage on its health system by giving considerable attention to the recruitment of staff for PHCs, especially those located in rural areas.
- Presently low health staff production, particularly of nurses, has to be substantially accelerated to catch up with growing demands and attrition.
- Improve the retention and distribution of the health workforce in rural PHCs by improving working conditions and financial (and non-financial) incentives, such as free days, study or maternity leave and better social dialogue.
- Improve the performance and productivity of existing staff by increasing opportunities for life-long training and improving career development prospects.



- Develop and strengthen rural health service coverage by equipping the semi-skilled health workforce to maintain rural health centres.
- The government needs to invest not only in its health workers but in its facilities, by ensuring regular medical supplies, upgrading facilities and improving working conditions in rural and poorer areas.
- Provision of housing for health workers in under-served areas;
- In-service training and career development opportunities for health workers;
- Formulation of hardship pay policy for health workers in rural/underserved areas;
- Articulation of a programme on the utilization of unemployed and retired health workers through expanded hiring and contracting;
- Increased use of new cadre of health workers.
- Development of an overtime policy for their health-care workers. This would supplement the professional nurses' salaries and assist with filling the gap in available human resources.
- A rural housing programme should be put in place so that rural houses should be built in target communities in order to accommodate professional nurses with families.
- A solar system should be installed at all facilities to supplement the electricity supply during power cuts.

### **Improving the Delivery of Quality PHC Services**

Improving the quality of PHC services is a key factor to their utilisation by the people in rural communities. The participants in the qualitative surveys of PHCs in Delta State emphasised the need to improve the quality of PHC services in the rural communities of the state by making a number of recommendations as follows:

- (i) The range of drugs given was limited to mainly painkillers, vitamins and anti-malarial. Consequently more drugs should be provided in the PHCs;
- (ii) The staff were inadequate so the few available were overworked and tired affecting their performance. Efforts should be made to employ more staff in the PHCs;

- (iii) The referrals were too many and costly, encouraging self-medication. They suggested having qualified medical doctors visit PHCs on specified days to reduce referrals.
- (iv) There is the need to provide ambulances or vehicles in the PHCs especially to help transport referred cases.
- (v) Some health workers were perceived as rude, unfriendly, unapproachable or impatient, or did not respect patients. They should be trained on how to handle patients because the attitude of health staff towards patients complicate their health challenges;
- (vi) Favouritism was sometimes practiced to the chagrin of other patients. They advocated respect for all in respective of their social status;
- (vii) There were no services in most PHCs on weekends. In certain facilities even medical assistants were not available over the weekends. The situation should change with the employment of more staff or the payment of weekend allowance;
- (viii) Waiting times were longer, especially at the dispensary or when going for an injection. The suggested ideal total waiting time for seeking medical help should not be more than one hour; and
- (ix) Health workers should be effectively supervised to reduce illegal charges.

### **Promoting the Utilization of PHC Services**

There is urgent need to put in place strategies to promote the utilisation of PHC services because unless services are utilised resources would have been wasted while the health care situation of the people in such localities would continue to remain poor. Improving community awareness and perception on skilled providers and their care by targeting women who prefer non-skilled providers and those who do not have any awareness is very important. The participants in the qualitative surveys made recommendations that could enhance the use of skilled health facilities provided in PHCs as outlined below:

- (i) There is need for increased attention to safe motherhood education using the available communication networks in the rural communities;

- (ii) There urgent need for informational campaigns in the remote rural communities so as to improve the awareness and perceptions of women with regard to the importance of skilled maternal and child health services provided in PHCs;
- (iii) Ensuring the improved performance of basic essential obstetric care facilities in PHCs is also very critical, especially for improving the rate of skilled attendance at birth;
- (iv) Increasing availability and accessibility of maternal health centres to rural women in underserved communities, especially in the wetland areas of the state;
- (v) There should be vigorous campaigns against social norms that are harmful to women's health;
- (vi) Efforts should be made to increase women's socio-economic status in society, especially in rural communities;
- (vii) Campaigns with respect to the utilisation of maternal and child health services should specifically target men so that they can support their wives in maternal and child health care provided in PHCs;
- (viii) Improve the access of rural communities to PHCs through improved roads and other means of transportation;
- (ix) Conscious efforts must be made to ensure the provision of PHCs in localities that are at present too far from the existing ones;
- (x) Health workers should be trained on the need to be nice to their patients so that they are not scared away;
- (xi) One policy action suggested by participants is to institute regular customer- relations training courses run professionally to help staff improve or maintain good inter-personal skills;
- (xii) Complaint desks should be established at all PHC facilities with assurance that concerns would be addressed effectively, while allaying fears of victimization;
- (xiii) Drugs should be made available and affordable in the PHCs, so that they could receive all their prescriptions at one place;
- (xiv) Health workers, especially nurses and doctors whenever they are available should thoroughly examine patients so that the patients can have confidence in the health staff in terms of being capable of handling their health challenges;

- (xv) Lastly, the national drugs policies and essential drugs list need to be reviewed, making them more responsive to patients' needs and improving availability.

### **Community Mobilization and Participation**

Community participation must be enhanced if the PHC system must be effective in the delivery of services. For this purpose, the 1978 Declaration of Alma Ata, in Article 44 defines community participation as: “The process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community’s development (WHO, 1978: 50).” Article 46 elaborated further by stating that: “There are many ways in which the community can participate in every stage of primary health care. It must first be involved in the assessment of the situation, the definition of problems and the setting of priorities. Then, it helps to plan primary health care activities and subsequently it cooperates fully when these activities are carried out (WHO, 1978: 51).”

Issues around participation and empowerment also have been promoted in the context of governance of health service provision. A growing literature argues that concerns about accountability of public expenditures should be placed in the hands of those intended beneficiaries of those services. These issues centre on both the accountability of services to perform to the satisfaction of the users and the accountability of finances to be used in the way in which they have been allocated. Concerns are developed in discussion about "voice" whereby service users have the ability and capacity to demand the providers perform to user satisfaction. Evidence from the implementation of the Bamako Initiative shows how accountability can catalyze improvement in efficiency and effectiveness of local service delivery.

Commitments to meet this challenge continually demand professionals to hold serious dialogues with those for whom they provide service and care. To date this dialogue has often been delayed in many parts of Nigeria by several factors. Firstly, there is the existence of attitudes of professionals who tend to disregard opinions and views of those outside the profession. Secondly, there is the historic view that health interventions can only be

verified by outcome measures. This view ignores the vital role of process in sustaining the improvements that bio-medicine and technology contribute. The World Health Report 2008 discusses in detail the role of service providers yet does not address the second issue of process. Commitment to addressing both issues is critical to PHC in Nigeria (Akande, 2002).

Community mobilization and participation facilitate the common ownership of the project by the researcher, decision-makers and end-users. Adah, Ogbonna, Anga, Chingle, Ashikeni, Envuladu, Agaba, Audu, Bupwatda and Zoakah's study of the comprehensive health care centre in Gindirin,

(<http://www.ajol.info/index.php/jjm/article/download/55093/43567>)

confirm that they involve encouraging the community, through their credible representatives, to take part in their health care and development, thereby enhancing the integrity of the work by: injecting grassroots information; integrating the indigenous knowledge system (IKS) that is in harmony with local beliefs, cultures and traditions; as well as monitoring the quality of service provided. Indeed, it is for the purpose of community participation that the National Health Policy in Nigeria (FMoH, 1987) emphasizes community engagement in the provision of PHCs, pursuant to the spirit of the Bamako Initiative of 1987. Community participation was institutionalized in Nigeria in 2003 through the creation of District Development Committee (DDC) and the Village Development Committee (VDC) Abdulraheem, Oladipo and Amodu, 2012: 8). In spite of their strategic importance to the actualization of the goal of equitable access to, and utilization of, PHC services, community mobilization and participation have not been strong components of the PHC system. There is, therefore, the urgent need for such committees to be created, where they do not exist. Furthermore, where they exist, they must be strengthened to deliver on their mandates.

The Delta State PHC research project has provided for the integration of community participation. This is done by involving all stakeholders, particularly rural health care seekers and end-users of PHC services, in the implementation of the project through: gender-balanced membership of the project management committee, on the one hand, and attendance and

participation at all briefing and information-sharing meetings at which felt needs are articulated and prioritized, on the other. This will enable them to assume responsibility for their health and welfare, as well as building their capacities to contribute to policy on health through involvement in planning, implementing, monitoring, evaluating and above all, ensuring the sustainability of health interventions.

### **Advocacy and Political Support**

The PHC system in Nigeria is characterized by inequity and social injustice. Abdulraheem, Oladipo and Amodu (2012: 10) have identified what is called the *social gradient in health*, which means that “health outcomes are associated with people’s position in the social hierarchy”. The implication of the gradient is that, those at the lower end of the social ladder tend to receive less care than those higher up. There is, therefore, the need to strengthen and reposition the disadvantaged groups to receive quality health care. To do this, we must ensure that while targeting particular segments of disadvantaged and vulnerable groups, like women and children, and particularly rural dwellers, policies and programmes should also strive to meet the health needs of all groups. Since social inequality is positively and very strongly linked to unequal access to non-health sectors of the society, improving health outcomes also call for support for such sectors as agriculture, energy, education, employment and welfare.

There is also the need to develop the political capital essential for the implementation of the PHC system. For this purpose, there must be a clear political commitment, not only to health for all, but specifically to PHC. The unequivocal and manifest support of government is essential to addressing the social and physical inequality in the provision of health facilities at the grassroots (PHC) level. Government must be committed to the building and equipping attractive PHC centres, including the supply of drugs. More importantly, the facilities must be supported with a full complement of adequate and qualified health workers. Given the huge financial resources required, the operations of PHCs should be the responsibility of the tier to government that can fund them. The present situation of inverse relationship, where the federal or state governments build PHC centres and hand them over to local government to operate

cannot ensure quality health care. Consequently, patronage is low (even when the services are rendered free-of-charge) because the facilities are dilapidated, wrongly sited, they lack basic facilities and drugs; as well as qualified workers. It is recommended that the building and operation of PHCs should be the responsibility of the National Primary Health Care Development Agency (NPHCDA).

### **Conclusion**

An effective and sustainable PHC system in a developing country such as Nigeria is expensive in terms of material and human resources. Nevertheless the PHC system provides a more holistic approach to addressing the health needs of individuals especially those located in remote communities, promotes the development of the overall health infrastructure and is critical for sustained improvements in the health of deprived communities. It is in this context that PHC services are indispensable components to the success of the national health system in Nigeria. In this study we have identified, with the participation of key stakeholders, the challenges and necessary commitments that need to be addressed if PHC is to remain relevant in a large country such as Nigeria. Revitalizing PHC principles without developing a framework to address concrete measures for health improvements is not sufficient. The challenges and policy recommendations made by stakeholders and users of PHCs discussed in this paper need to be examined in a systematic and integrated way to produce flexible policy options and solutions that can be implemented. To do this, particularly in a time of financial and security challenges which Nigeria is facing at the moment, requires a willingness to dialogue and appreciate a range of different and often contradictory views working toward consensus. With political commitment, an enabling economic environment and equitable distribution of resources, comprehensive PHC has proved to be a better strategy in achieving the goal of health for all.

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