

Community-Based Strategies to Improve Primary Health Care (PHC) Services in Developing Countries. Case Study of Nigeria

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Oluwasogo A. OLALUBI^{1*} and Ibrahim Sebutu BELLO²

¹Department of Public Health, School of Basic Medical Sciences, Kwara State University, Nigeria

²Department of Family Medicine, Obafemi Awolowo University Teaching Hospital Complex, Ile-Ife, Nigeria

Abstract

Primary Health Care (PHC) still remains the minimum package of healthcare that should be provided to every individual and community across Nigeria Health System. The aim is to improve relatively the health status of the nation ensuring provision of healthcare services to people in the rural area which is indicated by reduced mortality and morbidity and improved survival rates in such communities. However, the situation of health status in Nigeria has not yet attained the desired level. Data shows that as at 2015, the country recorded 814 maternal deaths / 100,000 live births which put her in the same category with the poorest countries in the world such as Chad, Niger and Somalia among others. Furthermore, Nigeria's health profile reveals that 2,300 under-five children and 145 women of childbearing age die every single day. Moreover, malaria, pneumonia, diarrhoea and other preventable infectious diseases still remain the major causes of under-five deaths in Nigeria. In view of these problems faced by PHC in the country, there is an urgent need for "one health" approach integrating the principal stakeholders, current Minister of Health, state commissioners for health, all 774 Local Government chairmen as well as the National Postgraduate Medical College of Nigeria (NPMCN) to revisit manpower need of PHCs and secondary healthcare facilities. There is also the need for policies restructure, leadership and running of these PHC institutions. Promoting health and prolonging life requires prompt detection and effective management of common communicable and non-communicable diseases cases which can only be achieved through a robust primary healthcare facility. A national health insurance system that provides cover for the vulnerable special groups, aged, the young adolescents, school children, as well as pregnant mothers is a necessity towards reducing inequality in access to basic primary healthcare. This will reduce dependence on out of pocket spending and improve access to healthcare services.

Keywords: Primary Health Care, One-Health, National Postgraduate Medical College of Nigeria, National Health Insurance System

Background

Nigeria is the most populated country in Africa having about 191 million people. This population has been on the increase over the years and future projections hold more increase in the country's population [1, 2]. This clearly shows that more resources will be required to meet exigency needs of the populace, especially demand for quality healthcare services. Also, the pressure on the existing healthcare resources will significantly increase. A national crisis lurks around in the future if there are no commensurate improvements in supply to meet the expected increased demand for quality health care services. Healthcare is a fundamental human right. As such every country is expected to provide the minimum package of health care to all its citizens and communities, according to WHO and UN global standards [3-6].

History Of Health Care Services In Nigeria

Nigeria currently practices the American Presidential system of 4 years for each ruling term. The foundation of a formal health system in Nigeria started from the British colonial era when missionary hospitals and health posts were established in an attempt to provide health care for the people [7]. The early health care service was either out of the Christian missionary outreach package or to keep people working for the colonial masters healthy towards achieving maximum productivity. Later, medical schools and more health facilities were established by the British government and Christian health institutions began to increasingly spring up [7, 8]. Primary Health Care

*Corresponding Author: Oluwasogo A. Olalubi, Department of Public Health, School of Basic Medical Sciences, Kwara State University, Nigeria.

(PHC) which is the minimum package of healthcare that should be provided to every individual and community was introduced to the Nigeria Health System in 1978 which relatively improved the health status of the nation especially ensuring provision of the healthcare services to people in the rural area [9,10]. The PHC is to ensure that the health status of communities is improved which is indicated by reduced mortality and morbidity and also improve survival rates in such communities.

The situation of health status in Nigeria has not yet attained the desired level. Data shows that as at 2015, the country recorded 814 maternal deaths / 100,000 live births which put her in the same category with the poorest countries in the world such as Sierra Leone, Niger, Chad, Somalia, Angola among others [11]. Furthermore, Nigeria's health profile further reveals that 2,300 under-five children and 145 women of childbearing age die every single day [12]. Moreover, malaria, pneumonia, diarrhoea and other preventable infectious diseases still remain the major causes of under-five deaths in Nigeria. Life expectancy in Nigeria stands between 45-50 years and communicable diseases are one of the major causes of death accounting for about 82% of all deaths [11,12].

Primary Health Care In Nigeria

Primary health care as an intervention was declared in the 1978 Alma Ata conference that took place in the USSR drawing together 134 countries, 67 international organisation and many other non-governmental organisations [9,13]. The powerful resolution they came out was based on the fact that health, which is the state of complete physical, mental and social well-being, is a fundamental human right of every citizen of the world requiring action from the social and economic sectors [10,13]. The existing inequality in the health status between the developed and the developing nations was seen to be politically, economically and socially unacceptable and needs to be urgently addressed [9, 10, 13]. Primary health care was defined at the conference as a form of healthcare that is "based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people's full participation and at a cost that the community and country can afford" [10]. Researchers have continuously evaluated this definition with the innovations and changing paradigm of disease across the developing and developed world.

PHC forms an integral part of the country's health system and a central point for social and economic development of every community. It is the first level of health service contact for individuals, families and communities and the national health system at large [13]. PHC brings healthcare service as close as possible to people regardless of where they live and work though it is the first level of a continuing healthcare process. The development and implementation of PHC throughout the world has continuously been pushed through various means especially the International Conference on Primary Health Care. This conference had the primary aim of calling for urgent and effective national and international actions towards effective and proper implementation of PHC [14]. It was realised that there is a big disparity in actual reality in the developed world and that of the developing counterpart which has slowed down the global implementation and development of PHC. This called for international cooperation or collaboration especially between

the developed and developing world institutions to bridge the gap, uplift the weakness of the later and empower them to actualise maximum attainment of their possible level of PHC service implementation.

Developmental Trend Of Primary Health Care In Nigeria

The inception of primary healthcare in Nigeria began with the advent of Basic Health Services which was introduced as an integral part of the country's third development plan in 1975. This comprised of the establishment of 20 health clinics and 4 primary health care centres which were spread across the local government regions. Also, mobile clinics were added to provide support for another 150,000 people [7, 8]. This could be regarded as the early development phase of PHC in Nigeria but it suffered a major set-back due to non-participation by local communities. There was another effort to revitalise primary healthcare in Nigeria between 1986 and 1992. It was more expanded and geographically distributed than the first attempt of 1975. It was primarily characterised by the creation of model primary health care centres across 52 local government areas in the country with full mandate and funding to implement all components of PHC as stated in the Alma Ata declaration [7, 8, 10]. Also, efforts were made to overcome the set-back of the first attempt by setting up the village health system which was followed by training of volunteer health workers. This brought the community to be a part of the health care provision system. In this second effort, essential drug scheme and drug revolving funds were also set up in line with Bamako initiative which further strengthened community participation. Furthermore, baseline surveys, situation analysis and progress formulation reports were produced which were part of the components that strengthened monitoring and evaluation [7, 8, 10].

Full implementation of Primary Healthcare scheme in Nigeria started taking shape in 1992 and this era in the history of primary health care extended to 2001. The renowned Prof. Olukoye Ransome-Kuti played a significant role in ensuring the success of the scheme. It was in this PHC developmental era in Nigeria that 80% immunization coverage was recorded for the first time among under-five children [9]. Also, community participation and focus on issues that bordered on health system strengthening were keys to the success experienced in this era. In fostering better community involvement in healthcare service, the ward health system with a representative councillor emerged as the basic operational unit for primary healthcare. This period also marked the creation of the National Primary Healthcare Development Agency (NPHCDA) which was established to coordinate and oversee primary healthcare services in the country [9, 14].

During this period, there was the devolution of power of primary health care to local governments without the necessary technical and manpower capability. This made local governments responsible for the primary healthcare centres and services within their areas. It was discovered that almost all the local governments lacked the capability to adequately run and cater for the primary health care services in their area. This led to the crumbling of the primary healthcare scheme in Nigeria which was further accentuated by the withdrawal of major donor agencies from sponsorship of the scheme. WHO, DFID and UNICEF withdrew their funding and support to NPHCDA in protest to the

military government of the period. This dealt a major blow to the PHC scheme as the country could not successfully fund and give the required support to the scheme on her own [9,13,14]. Furthermore, Nigeria experienced instability in governance as there were series of change of powers between military and civilian rule during this period. Also, the coups used as a means to take over power contributed significantly to instability. This situation affected every sector of the nation including the health sector. Also, some leaders that cease power, lacked vision for the nation especially the health sector which the PHC scheme had to suffer grossly for over time. As this situation persisted, low morale to work among the staff resulted, which lowered their productivity and was detrimental to the PHC scheme. PHC services being transferred to the local governments who were not prepared to shoulder all the responsibilities worsen the downturn of PHC in the country [13, 15].

The National Primary Health Care Development Agency

The agency has been overseeing primary health care in the country and has the responsibility of developing PHC. The democratic government allowed for a robust policy formulation and establishment of various schemes by the agency. These policies and schemes include reactivation of routine immunization, polio eradication initiative, midwives service scheme, primary healthcare reviews, integrated primary healthcare governance and strengthening of the National Health Management Information System (NHMIS). It is important to note that various strategies were adopted by the NPHCDA to overcome socio-cultural and other barriers faced by PHC. This has led to the success in the control of wild polio virus in the country achieved in 2014 [14, 15]. As shown in (Table 1), PHC system has some minimum standards with respect to distribution, administration and service delivery. The lowest level at the village and ward levels are to offer Ward Minimum Health Care Package. This package includes; non-communicable diseases prevention, control of communicable diseases, child survival activities, maternal and new-born healthcare, nutrition services, community mobilization and health education [14]. The PHC system was further strengthened with the passing of the national health bill.

The National Health Bill

The biggest ever boost recorded in PHC funding is the 'Basic Health Care Provision Fund'. This fund was created from the National Health Bill after it became an Act in 2014. The Act directs the Federal Government to set aside 1% of the Consolidated

Revenue Fund for the purpose of purchase of essential drugs, vaccines and consumables which should account for 40% of the Basic Health Provision Fund [7, 8, 13]. Other areas the fund is to cover are provision and maintenance of facilities, laboratory, equipment and transportation (30%), human resources development (20%), and emergency medical treatment (10%). Most of these areas are all essential components of PHC and the financial commitment stipulated for them will have a positive developmental effect on PHC [7, 8, 13]. The Act is also set to achieve Universal Health Coverage and provide for the elimination of quacks from professionalism. Provision of healthcare insurance and some free services to deprived and vulnerable group in the population was also captured under the Act. For example, more pregnant women would have access to free delivery services while their children are assured of standard paediatric services in the nation's health facilities.

Evidences Of Primary Healthcare Collapse In Nigeria

There were a number of indications and evidences of collapse of PHC in Nigeria which included poor ranking of the Nigerian Health System by WHO in 2000; the country ranked 187th position out of the 191-Member States of WHO [11,12]. Other health indicators further showed the downturn situation of PHC in Nigeria; only 14% of children received full immunization, 41% of children had zero immunization. Neonatal mortality rate was 52/1000 live births, postnatal mortality rate was 47/1000 live births, infant mortality rate 187/1000 live births and under-five mortality rate was 1000/100,000 live births [11, 16]. Nigeria has been unable to meet the health-related Millennium Development Goals (MDGs) during their era and also the universal health coverage was not achieved. Currently, the country's progress towards a more comprehensive Sustainable Development Goals (SDGs) has been assessed to be slow. This alarming situation calls for urgent interventions to strengthen the PHC system in the country.

Factors Responsible For Failure Of Primary Health Care In Nigeria

Several factors were identified to have detrimental effects on PHC in Nigeria, some of these factors date back to the colonial era. A typical example was that the colonial model of healthcare was not tailored to the need of the people. It is known that the colonial masters and authorities were primarily concerned with establishing and sustaining their powers and exploited resources. Therefore, their healthcare model was focused on keeping the workforce and military active which did not cater for the actual needs of the people [8, 10].

Table 1: Health facilities hierarchy

Old system of health facility classification	New system of health facility classification	Levels of administrative management	Expected numbers / density of health facilities
Teaching/Tertiary hospitals	Teaching/Tertiary hospitals	Federal and state governments	Minimum of 1 per state.
General hospitals	General hospitals	State government	1 per LGA thus minimum expected in the country is 774
Comprehensive health centre, model PHC centre	Primary health centres	Local government	1 per ward. With an average of 10 wards per LGA; 7,740 expected
Maternity centre, basic health centre	Primary health clinics	Local government and ward development committee (WDC)	1 per group of villages/neighbourhoods with about 2,000 to 5,000 people
Dispensary	Health posts	Village development committee (VDC)/ Community development committee (CDC)	1 per village or neighbourhood with about 500 people. Density is as many as the number of villages

Source: Adapted from NPHCDA [14]

Furthermore, after independence, there was scarcity of physicians and nurses which led to the use of community health extension workers (CHEW) to run most of the Primary healthcare clinics. The limitation of the services the CHEWs can provide has drawn back the full implementation of components of PHC. Another problem that comes with this is the fact that the CHEWs attempt to do beyond their level of training which pose a great risk of life to the people in the community [10].

Also, over the years, there have been several new and infectious diseases that are emerged such as HIV/AIDS, Ebola and Lassa fever. Tuberculosis and other locally endemic diseases have plagued the country which has put even more pressure and slow down the rate of development of primary health care in Nigeria [15]. Every year, vast resources are allocated to combatting these diseases which makes less resource available for running other aspects of the PHC system.

Poor leadership and administration evident in poor organisational structures, insufficient funding and corruption has also contributed to the failure of the primary health care in Nigeria. All the sectors of the nation are under the plague of corruption. This is typically obvious in various cases of funds diversion and misappropriation of funds found at every level of government. A number of the donors to health services in the country have been withdrawing, reducing their support and/or giving much more scrutiny to the implementation of the programmes and interventions for which they are giving support [15, 17]. Also, the health sector has received less than the expected/required budgetary allocation of the years which made funds inadequate even for the running and development of the health sector [13]. The structures operated in many of the health system create so many bottlenecks in administration within the health system.

Furthermore, mismanagement from poor policy formulation, analysis and implementation of programs has had detrimental effect on primary health care in the country. Policies are formulated to foster political interests and financial gains rather than address the problems facing primary health care. Corrupt practices such as falsification of reports, diversion of resources for personal use among others have also plagued the implementation of various policies and interventions that are meant for the development of primary health care. Funds released for the provision of PHC services in various communities have been embezzled by the various personnel in charge [16, 18]. Moreover, corruption across various levels in Nigeria have not only impeded the funding of health care but also led to consequential widening health inequalities between communities. The limited resources available to make quality care available, accessible and affordable to the populace are spent in misguided and unfair ways such that the underprivileged continue to suffer more.

The success and continuity of laudable programmes that have been significantly effective hang on proper human resources for health planning [14]. Many of these programmes lack this key factor which has brought serious failure and abrupt stop to them over time. It is also important to note that the realities in the urban centre differs greatly from that of the rural areas which most planning and implementation do not put into consideration [15,19].

There is a clear line of division between the rural areas

and urban centres. The urban centres are the beneficiary of most intervention and allocations while the rural areas are still deprived of the basic health services [19]. Therefore, the gap between the rural and urban populations as regards health service gradient is very wide and has continued to widen as these conditions persist. The wide gap reflects on the poor national health indicators because such indicator covers both the rural and urban areas.

The wide gap is also experienced along socio-economic lines. Moreover, corruption has contributed to the gap in the socio-economic line as the rich are getting richer and the poor are getting poorer. It is known that those of high socio-economic status are able to afford better healthcare and if need be, seek such outside the country [19]. A number of such individuals are those in power expected to make policies towards the development of the health care system within the country. However, primary health care within the country have received less attention in all aspects from those in power and in the capacity to foster development [16, 20]. Poor funding of PHC has increased out of pocket expenditure on health of the populace which means the people have to spend more from their limited earnings to cater for their health. This has led to low patronage of many PHC centres and more people seek alternative means of preventive and curative care. A common situation in most PHC centres is the lack of materials and basic equipment such that patients have to purchase drugs and other medical goods at relatively high prices in drugs or/and patent medicine stores [16, 19, 20]. This has been evidently proved to reduce patronage of PHC centres. The reality of by-passing the primary level of care to the secondary and tertiary level has also contributed to the reduction in the patronage of PHC. This by-pass has been observed to not only occur in the urban centres where the secondary and tertiary health facility are usually located but also in the rural areas. There exists significant evidence that rural dwellers travel to the urban centres to access care in the secondary and tertiary facilities even for services that are available in the PHC centres available in their local community.

Furthermore, health insurance which is meant to reduce cost and especially out of pocket spending in health is being utilized by only 5% of the population. The initial coverage of the National Health Insurance Scheme was only for civil servants and military personnel, with a limited package for some of the masses [16]. This shows that a large percentage of the populace are still left of this beneficial scheme which has been proven to reduce cost burden and improve accessibility to health care.

Basic social amenities are necessary for effective PHC impact and the health status of communities as they stand as supporting pillars. For example, safe drinking water, sewage or disposal system, good housing, adequate power supply and good roads are basic amenities that every community is expected to have at the minimum. Most African communities still lack a number these amenities which has contributed the poor health status of such communities [13]. For example, many diseases have been associated with lack of portable water, road network makes PHC centres more accessible and bring more intervention to the communities, and proper sewage system prevents a number of diseases. The lack of these basic amenities has impeded the development of PHC as they make support functioning of PHC.

The national economic meltdown has also contributed immensely to worsening the conditions in the country and the health system has not been spared. This downturn experienced by the country has further made fewer resources available for PHC strengthening.

Insurgencies especially in the North-East region have also plagued the country in recent times. This also has its detrimental effect on the development of PHC in the country. Since May 2013, violent attack by the Boko Haram sect operating in the North-East region has led to widespread displacement and an escalating humanitarian crisis. The most devastating effects of this insecurity has been the rise of internally displaced persons (IDPs), food insecurity, spread of infectious diseases and sexual based violence. Many of the PHC centres have been destroyed and others left desolate as the whole community have had to leave for a more peaceful place. Also, healthcare service providers such as doctors, nurses, pharmacists and other care givers have fled for their lives which have led to the shutdown of services including vaccination programmes in the region. When vaccination is managed to be done, the workers are sent with heavy security officers, they quickly administer the vaccines and flee immediately [21].

As high as 1.4 million people have been displaced from their communities in North-East Nigeria alone and many others have sought refuge in neighbouring countries. PHC centres in areas where the IDPs have settled have been overwhelmed which has been making them less effective and stand a risk of collapse. The cases of acute malnutrition, suspected measles and prevalence of other diseases such as cholera, malaria and respiratory tract infections have relatively increased in these communities especially among the IDPs. Also, communities receiving scores of IDPs usually stand a risk of experiencing new diseases which can easily spread in the case of communicable disease [9, 21, 22]. This situation further put more pressure on the already overwhelmed PHC centres. In areas where insecurity looms and there are no health facilities around, the sick have to travel/trek long distances to receive medical treatment. Pregnant women and the critically ill have had to use donkeys and auto-rickshaws to negotiate difficult terrain to further reveal the hardship people in such areas go through in order to access healthcare services.

However, it is important to state that international relief such as Doctors without Borders (MSF) has been doing their best to help by opening primary health care clinics in this region where insurgency has been ravaging. Also, regular donations from a number of organisations are also made to local hospitals in order from them to deal with the mass casualties resulting from boom attacks [17].

Interventions To Combat Challenges Of Primary Health Care In Nigeria

- (1) In view of these problems faced by PHC in the country, there is an urgent need for a clamouring call to the principal stakeholders that includes; the current Minister of Health, all state commissioners for health and all the 774 Local Government chairmen as well as the NPMCN to revisit manpower need of PHCs and secondary healthcare facilities.
- (2) There is also the need for policies for the structure, leadership and running of these PHC institutions.

- (3) The new academic Departments of Family Medicine nationwide should tailor their curriculum for undergraduate teaching and research. These should be aimed at overcoming the challenges the nation is currently facing in the practical implementation and realisation of the benefits of PHC.
- (4) Promoting health and prolonging life requires prompt detection and treatment of common communicable and non-communicable diseases cases which can only be achieved through a robust primary healthcare.
- (5) A national health insurance system that provides cover for the aged, the young adolescent, school children, vulnerable special groups, as well as the pregnant mothers is a necessity towards reducing inequality in access to basic primary healthcare. This will reduce dependence on out of pocket spending and improve access to healthcare services [18].

Conclusion

Despite several decades of financial and human capital investments, Nigeria failed to achieve the MDG targets by 2015. The coverage of key health indicators is still low even by Sub-Saharan African standards, quality of care is inadequate. The PHC system in Nigeria has been plagued with poor conditions as result of several factors. The country need to set up strategies and reforms in the system. Furthermore, policies should be formulated to combat these identified factors in the quest to strengthen the PHC system and the health status of the populace. This will also help to effectively meet the health-related targets of the SDGs in a bid to achieve Universal Health Coverage (UHC) by 2030.

Ethical approval

All aspects of the study were approved by Kwara State University Research Committee and Obafemi Awolowo University Teaching Hospital Complex, Ile-Ife Ethical Review Board.

Competing interests

No competing interests were disclosed.

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Authors' contributions and consent for Publication

OAO provides structural analysis, interpretation of data revising it critically for important intellectual content, researched the literature and provided further technical inputs. SIB conceived the idea and initiated the primary draft of the manuscript. All authors read and approved the final manuscript for publication in accordance with the policy of Kwara State University Research Committee and Obafemi Awolowo University Teaching Hospital Complex, Ile-Ife, Nigeria.

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