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Evaluation of National Policy on Primary Healthcare in Nigeria

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Abstract
This present research work saddled to evaluate the national policy on primary healthcare (PHC) in Nigeria through reviewing secondary sourced data. The paper was formulated in four components. The first component highlights the evolutionary trends of primary healthcare in Nigeria, the past and present act regulating the PHC and financing were discussed in the second components. Meanwhile, present state of primary health care in Nigeria constituted the third aspect while challenges facing the PHC in Nigeria were also discussed. It could be concluded that poor domestic operations of the primary healthcare exist to the extent of depending on international donors for the service delivery for the people in the country compared with past due to poor financing, inadequate provision of facilities and mismanagement. Thus, PHC is crucial for the realization of health-related Sustainable Development Goals (SDGs) which are in turn inextricably linked with the other SDGs such as ending poverty, inclusive education, work and economic growth, reducing inequality and climate action. It is therefore suggested that adequate financing, provision of facilities and effective management should be adopted for sustainable development.

Keywords: Foreign Donation, Facilities, Policy, PHC, Evaluation and Services

INTRODUCTION

Primary Health Care (PHC) provides the most viable route towards achieving the first contact of individuals, families and communities with the national health system. Primary Health Care is defined as a whole-of-society approach to health and well-being based on the needs, peculiarities and preferences of individuals, families and communities (WHO, 2019). PHC in Nigeria, as indeed stressed by the World Health Organization (WHO, 2018), is a deliberate and systematic effort to develop a health care system that caters to the needs of majority populations and poor citizens, at an affordable and sustainable cost and with a guarantee of quality health care service through government primary health care centers and faith-based clinics in rural and suburban areas. PHC has also been found to be highly effective and efficient in treating the main

causes and risk factors of health deficiencies. It is also capable of tackling emerging threats to public health and wellbeing into the future. Primary health care is crucial for the realization of health-related Sustainable Development Goals (SDGs) which are in turn inextricably linked with the other SDGs such as ending poverty, inclusive education, work and economic growth, reducing inequality and climate action. Given the importance of Primary health care, nations across the world devote considerable efforts and resources towards establishing and maintaining viable PHC systems. Nigeria as a signatory to the United Nations' Charter and member of the World Health Organization (WHO), has the mandate to do same and indeed has made efforts to provide primary healthcare to its citizens. It is worthy of note that the success of efforts to provide effective primary healthcare depend on a good choice and combination of adequate and efficient method (s) of financing and on a sound framework for the organization and delivery of health services (Drouin, 2007). Healthcare financing in Nigeria currently involves a combination of tax revenue, out-of-pocket payments, foreign donations, and health insurance (Olakunde, 2012).

Consequently, Primary health care service delivery in Nigeria is extremely poor. Nigeria's health system remains among the worst-performing globally (Ananaba, 2018). Coverage of promotive, preventive, and primary health care interventions is low. The universal health service coverage index – defined as the average coverage of tracer interventions for essential universal health coverage is a dismal 39% (Hafez, 2018). Thus the creation the National Health Act 2014 as the basic national health policy on PHC and is central to providing health for all (Federal Ministry of Health, FMOH, 2014), as well the basic health care provision fund (not less than 1% of federal government consolidated revenue fund). Fifty (50%) of this fund will be disbursed by a National Health Insurance Scheme (NHIS) to provide a basic minimum package of health services to citizens. It requires then the remaining 50% will be used to provide essential drugs, vaccines and consumables, and infrastructure; develop human resources; and ensure emergency medical treatment at the PHC level (FMOH, 2014).

However, the absence of a fully domestic functional primary health care system continues to constitute a development challenge in Nigeria. The situation threatens the achievement of health-related Sustainable Development Goals (SDGs) as well as other health objectives. Efforts by successive governments towards the realization of a functional primary health care system have often been beset by diminutive efforts at accountability, data gathering, openness and sustainability. Other limiting factors include limited institutional capacity, corruption, unstable economic and political context and poor financing (Adinma and Adinma, 2010). The body of research on the effects of the above-mentioned factors on the development of the primary health care system in Nigeria is copious (World Bank, 2010; Aid, 2015; WHO, 2017; Gyuse et al., 2018). Admittedly, Nigeria has not been capable of enabling the attainment of desired health outcomes. Amongst the major challenges facing the health sector in the country is the weakness of the country's primary health care system. Sadly, Nigeria healthcare system depends largely on interventions from foreign donations to address these deficiencies of PHC in the country. Foreign donations include financial assistance given to developing countries to support socioeconomic and health development. Yet, the effects of foreign donations are not easily discernible. For this reason, this paper aimed at evaluating the national health policy on primary healthcare delivery in Nigeria.

AIM AND OBJECTIVE

This paper aimed at evaluating the national health policy on primary healthcare delivery in Nigeria, in an attempt to proper dependable solution.

Specific Objectives includes:

i. To assess the evolutionary trend of primary healthcare in Nigeria.
ii. To determine present act regulating and financing of the PHC
iii. To assess the constraints to proper functioning of primary healthcare system in Nigeria

METHODOLOGY

Study Area

Nigeria is situated between latitudes 4°16' and 13°N53', and longitudes 2° and 15°E. It is Africa's most populous nation with about 200 million citizens. Its population is expected to reach 214,028,302 by the beginning of the third quarter of the year 2020. By 2050, Nigeria's population is projected to have risen to about 390 million, making it the fourth largest population in the world (CIA, 2020). Majority of its population are between 0-14 years (NBS, 2018). National adult literacy rate in any language is 71.6%, 79.3% among males and 63.7% among females. 65.1% of the male gender and 50.6% of the female gender representing 57.9% of the Adult population are literate in the English Language (NBS, 2018). Nigeria has a land area of about 930,000 square kilometers and shares boundary with Republic of Benin in the West, Chad and Cameroun in the East and Niger Republic in the North, and a population of about 150 million (Abdullahi, 2010). With more than 50% living in urban centers (UN Habitat, 2008) with major ethnic tribes of Hausa, Igbo and Yoruba. The World Bank (2010) classified Nigeria as a low-middle income country.

Fig 1. Map of nigeria showing geographical divisions

SOURCES OF DATA

The research paper is basically secondary sourced dada obtained from relevant research articles published as journals, conference papers, books, short communications, technical report sourced from the internet and libraries with the aim of achieving the stated objectives

CONCEPTUAL FRAMEWORK OF PRIMARY HEALTH CARE IN NIGERIA

The Concept of Primary Health Care It is expedient to note that health/health sector is one of the viable pillars for sustainable growth and development. This is in credence to a popular maxim that, "a health nation is a wealth nation"`. This assertion becomes more imperative within the context of locality and community development. To this extent, Primary Health Care is therefore medical service delivery at the community area. The term, Primary Health Care (PHC) was officially launched in 1978 at a World Health Organization (WHO)/UNICEF Conference in Alma-Ata in the former Soviet Union at which some 150 governments were represented (Robson and Brown, 2016:1). In other words, the etymology of "Primary Health Care" can be traced to the global Conference at Alma-Ata where critical issues of national, regional and world health challenges were examined. Subsequently, the Alma-Ata declaration (World Health Organization, 1978) defined Primary Health Care 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 and the country 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 central function and main focus and of the overall social and economic development of the community.

Also, Primary Health Care is the first level of contact of the individuals, the family and the community with national health system bring health care close to where people live and work and constitute the first element of a continuing health care processes (Amason 2010:5) it implied that primary health care is medical services provided for individual and community survival and development. It is easily accessed and made available to the community and families by relevant institutions and government.

The Alma-Ata Declaration identified determinants of health care

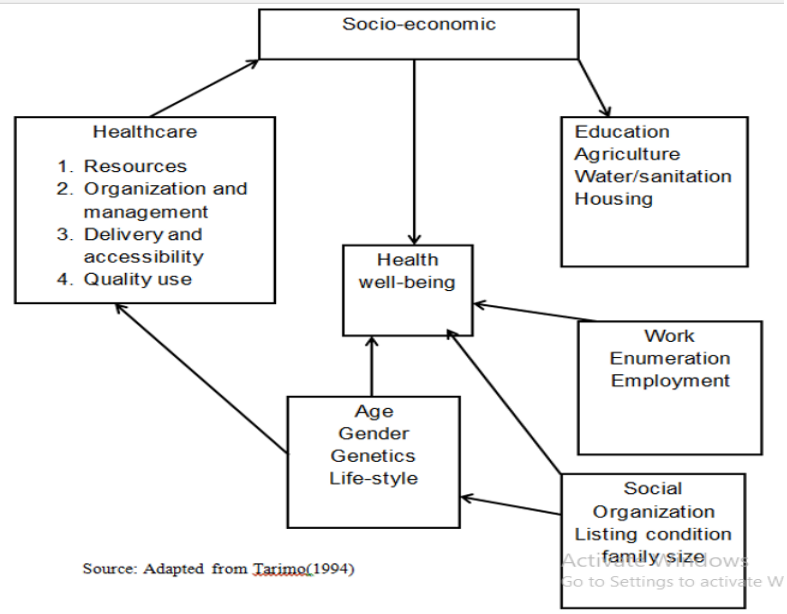

Fig 2. The Alma-Ata Declaration identified determinants of health care
Source: (Adopted from Tarimo, 1994)

The Basic Elements of Primary Health Care The basic elements of primary health care delivery as declared by Alma-Ata) conference in 1978 are:

1. Health Education
2. Identifying and controlling prevailing health problems
3. Food supply and proper nutrition
4. Provision of safe water and basic sanitation
5. Maternal and child health care including family planning
6. Immunization
7. Prevention and control of endemic disease
8. Appropriate treatment of common disease and injured
9. Promotion of mental health
10. Provision of essential drugs

Accordingly, Merriam and Joyce (2007:8) established the roles of primary health care as identified by the World Health Organization, WHO

1. To provide continuous and comprehensive care.
2. To refer to specialist and/or hospital service.
3. To coordinate health service for patient.
4. To guide the patient within the network of social welfare and public health services.
5. To provide best possible health and social services in the light of economic consideration.

EVOLUTIONARY TRENDS OF PRIMARY HEALTH CARE IN NIGERIA

Primary health care as conceptualized by the Ama Ata declaration of 1978 is a grass-root approach towards universal and equitable health care for all (World Health Organization-United Nations Children Fund, WHO-UNICEF, 1978). The strategy is meant to address the main health problems in the community providing promotive, preventive, curative and rehabilitative services (Olise, 2007). It is the first level of contact of individuals, families and communities with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of the continuing health care process. A primary health centre was described by Maurice King as a unit which provides a family with all the health services, other than those which can only be provided in a hospital (Federal Ministry of Health Nigeria, FMOHN, 2004; Raids, 2008). It fundamentally takes its services outside its own precinct to the homes of people within its jurisdiction. Nigeria operates a federal system of government with a national government and sub-national state and local governments. Congruously, Nigeria operates a three-tier system of health care delivery in which the federal government is responsible for the provision of health services through the tertiary and teaching hospitals, the state governments provide same through secondary hospitals, while the local governments deliver health services through the primary health care centers (PHCs).

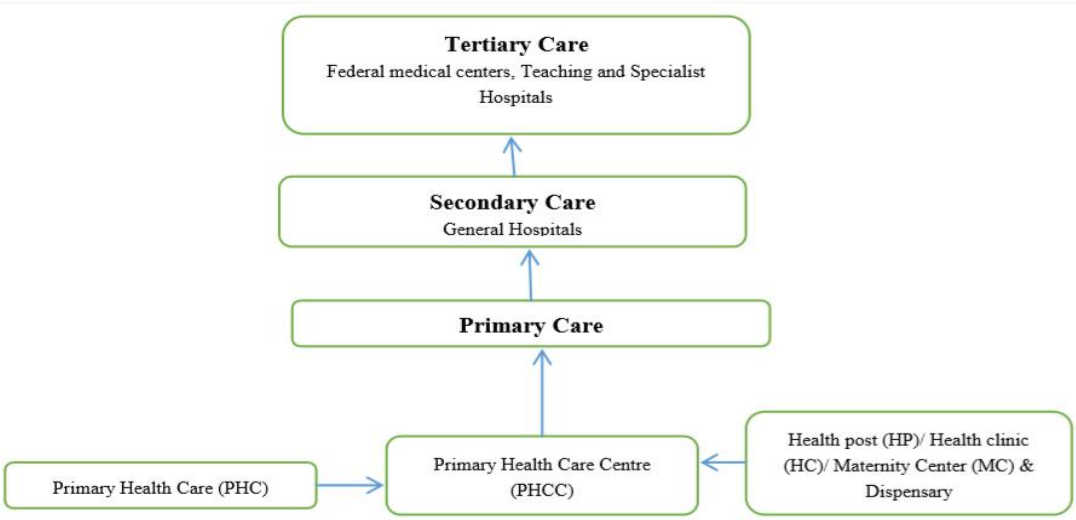

Fig.3. Nigeria healthcare system, relationship and referral pattern
Source: : (https://www.researchgate.net/publication/359692816)

The estimated number of all health facilities in the country in 2018 was 30, 000 primary health care centres across the country, only a measly 20% are functional (Uzochukwu et al., 2015). of which primary healthcare facilities were 85.8%, secondary healthcare were 14% and tertiary healthcare were 0.2 % (Amaghionyeodiwe, 2008). There are 22 Federal medical centers, 20 Federal Teaching Hospitals and 13 Federal Specialty hospitals in the country (Federal Ministry of

Health, 2014). The private sector also makes significant contributions to the Nigeria health system and its impact increases yearly. It provides 60% of health care in the country also owns 38% of the facilities (Amaghionyeodiwe, 2008). The number of private health facilities doubled between 1987 (1,905) and 2000 (3,987) (Amaghionyeodiwe, 2008). Charity health facilities are few. In most cases, international and local charities provide support to existing public healthcare facilities. Traditional medicine in the country stays uncoordinated and there is little evidence about them. The influence of traditional health care practice tends to be stronger in the suburban and rural areas where geographical access to modern healthcare is limited.

PHC is the latest expression of a belief that can be traced to the 19th century pathologist - Rudolf Virchow, that the solution to major human disease problems resided not only in the best science available, but also in brave political proposals for social justice and improvements in the life of the poor (McNeely, 2002). Nigeria is one of the signatories to the Alma-Ata declaration of PHC in 1978. But it is interesting to note that prior to the 1978 Alma-Ata declaration, the country had set the ball rolling with the implementation of the Basic Health Services Scheme (1975-1980), which was Nigeria's first serious attempt at the implementation of PHC. This scheme concentrated on the provision of health facilities, training of health workers and paying little attention to community participation, intersectoral cooperation or use of local technology (Obionu, 2007). In 1988, the National health policy of Nigeria was launched and is seen as a collective will of the government and people of Nigeria to provide comprehensive health care system that is based on PHC. The national health policy therefore, describes the goals, structure, strategies and policy direction of the health care delivery system in Nigeria.

In 1992, PHC implementation started with the commencement of PHC programs in the Local Government Areas (LGAs). Nigeria therefore, became one of the few countries in the developing world to have systematically decentralized the delivery of basic health services through local government administration (Obionu, 2007; Cueto, 2005). In order to ensure the sustainability of PHC in Nigeria, the Federal Government by decree number 29 of 1992, set up the National Primary Health Care Development Agency. This body was charged with the responsibility to mobilize support nationally and internationally for PHC program implementation (FMOHN, 2004; Raids, 2008; Magawa, 2012).

As a result, Nigeria significantly underperforms on key health outcomes- maternal mortality rate is 243 per 100,000, Proportion of births attended by skilled health personnel is 58.6%, Under Five Mortality Rate (U5MR) is 89 per 1000 births, and Neonatal mortality rate is 37 per 1000 (NDHS, 2018). These indices are unsatisfactory and have far reaching implications on health and wellbeing in Nigeria. Nigeria has a significant stock of human resources for health (HRH), but like the 57 other HRH crisis countries, the healthcare personnel-to-population ratio of 1.95 per 1,000 is too low to effectively deliver essential health services (WHO, 2020a). Also, Nigeria has repeatedly and significantly fallen short of the Abuja Declaration where it committed to devoting at least 15% of annual budgets towards improving its health sector (WHO, 2011). In 2016, government health spending was 0.6 percent as a share of GDP or just $US11 per capita. Funding for primary health

care is especially affected as the bulk of spending occurs at the central level and is focused on tertiary and secondary hospitals.

Olakunde (2012) reported that between 1999 and 2007, foreign donations to Nigeria increased from US$ 2.335 and US$4.674 per capita (UNDP, 2011). By comparison, the average foreign donation in Sub-Saharan Africa (SSA) was US$28 per capita. The share of foreign donations in primary healthcare care financing in Nigeria has been on the increase. Foreign donations were estimated as N27.87 billion (4% of Total Health Expenditure) in 2003. This increased by 29% to N36.04 billion (4.6% of Total Health Expenditure) in 2004 and by just 1% to N36.30 billion (4% of Total Health Expenditure) in 2005 (Soyibo et al., 2009). Yet, the outcomes are not commensurate with the inputs (Gyuse et al., 2018).

NATIONAL HEALTH ACT AND PRIMARY HEALTH CARE FINANCING

The National Health Act was signed into law in the year 2014. A key component of the National Health Act is the establishment of the Basic Health Care Provision Fund (BHCPF), which aims to extend Primary Health Care (PHC) to all Nigerians by substantially increasing the level of financial resources to PHC services (Uzochukwu et al., 2015). The National Health Act aims at providing primary health care facilities much needed operational budgets to improve their overall capacity to provide basic services as primary health centers have historically received little to no operating budget and frequently lack basic amenities, equipment, and drugs to be able to deliver quality services (World Bank, 2018). Under the National Health Act, the BHCPF Funding of the BHCPF would be derived from contributions including: an annual grant from the Federal Government of Nigeria of not less than one per cent (1%) of its Consolidated Revenue Fund (CRF), grants by international donor partners and funds from any other source (FGN, 2016). Other sources of funding include funds from grants received from local or international donors and innovative taxes, while requiring a 25% counterpart funding of PHC projects by States and Local governments as a prerequisite for accessing funds from BHCPF (Uzochukwu et al., 2015). It also provides for how funds committed to the BHCPF would be disbursed: Half of the Fund will be used to provide a basic package of services in PHC facilities through the National Health Insurance Scheme (NHIS); 45% will be disbursed by the National Primary Health Care Development Agency (NPHCDA) for essential drugs, maintaining PHC facilities, equipment and transportation, and strengthening human resource capacity and the final 5% will be used by the Federal Ministry of Health (FMOH) to respond to health emergencies and epidemics. (Uzochukwu et al., 2015; Downie, 2017).

In addition, as a statutory transfer, the BHCPF ensures that funding for PHCs would be safeguarded guaranteeing that any unused funds that arise because of low demand, poor uptake, delays in the release of funds or in the receipt of claims from providers will be rolled-over to next year's fund (World Bank, 2018). A breakdown of the percentages allocated to NHIS, NPHCDA and the FMoH show that the intent of the BHCPH is to accelerate the improvement of the health of Nigerians. In this regard, part of the funds managed by NHIS (50% of BHCPF) was for the provision of the Basic Minimum Package of Health Services (BMPHS) for Nigeria which shall consist of six (6) interventions; four (4) for Maternal Health, one (1) for Cardiovascular Disease

and urinalysis test. Access to BMPHS would be free for all Nigerians. The 45% managed by NPHCDA is broken down into 20% for essential drugs, vaccines & consumables in PHCs, 15% to Provision and Maintenance of Facilities, including equipment and transportation in PHCs and 10% to the development of human resources at the PHCs (FGN 2016).

Implementation of allocation of the BHCPF was to begin in rural areas in order to reach the poorest of the poor with essential medical services thus providing greater financial protection to the poorest and sickest households (Hafez, 2018). One major challenge encountered in the implementation of the National Health Act (NHA) has been a lack of funding. The BHCPF has not been funded (Hafez 2018). Funding for BHCPF, a major component of NHA, was not part of the 2015, 2016 budget of the Federal Government of Nigeria (Downie, 2017). There is also the lack of detailed data on health spending and resource flows, including the cost and use of health services, needed in planning and advocating for investment into the health sector (World Bank, 2018). Hence, the challenge of the primary health care system in Nigeria is not the absence of a legal framework for the development of a functional and sustainable primary health care system as there are many laudable provisions towards such development in the National Health Act (2014). It is worthy of note that while foreign donations are not designated for use in the recruitment of healthcare personnel, they could have been used for health systems strengthening such as provision of health infrastructure and other health related interventions in remote and rural areas across Nigeria. Doing so would have freed up funds from annual budgetary allocations for the recruitment, training and re-training of health care personnel in the primary health care system.

Primary Health Care in Nigeria Local Government System Accordingly, Fajiobi (2010:120) remarked (as earlier indicated) that local governments are responsible for primary health care delivery. They are to budget, implement, manage, monitor and evaluate primary health care within the local government areas. In Nigeria local government system, the primary health care delivery is premised on eight components which are: i) Health Education (ii) Maternal and child health including family planning iii) Immunization iv) Prevention and control of disease v) Adequate water supply and sanitation vi) Food supply and nutrition vii) Provision of essential drugs viii) Treatment of minor ailments These components and structures stem from the country's health care system. A Health care system comprises all medical care services involved in prevention, diagnosis, treatment and rehabilitation service as provided by the government, public and private institutions (Tandon, et al 2013:5). Again, health care system comprises of four-model: The individual, patient, the care, complex system of interacting approaches of human health that has an ecological base that is economically and socially viable indefinitely. In Nigeria, health care is funded by a combination of tax revenue, donor funding, user fees and health insurance, social and community (Anyika, 2014:16). The Nigerian government is committed to quality and accessible public health services through provision of heath care at the community areas as well as provision of preventive and curative service (Nigeria Constitution, 1999). Primary Health Care (PHC) is provided by local government authority through health centers 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:

(a) Prevention and treatment of communicable disease

(b) Immunization, maternal and child health service

(c) Family planning, public health education, environmental health and collection of statistical data on health and health related events.

The health care delivery at LGA is headed politically by a supervisory councilor and technically and administratively by a PHC coordinator and assisted by a deputy coordinator. The PHC coordinator reports to the LGA Chairman (Adeyemo, 2005, Federal Ministry of Health, 2004). The different components of the LGA PHC are led by personnel of different diverse specialty. The LGA is running her primary health care service delivery in compliance with the framework principles of the National Health Policy (Nigerian National Health Bill, 1987). Similarly, primary health system in Nigeria inspite of its strides and remarkable achievement over the years is still constrained with challenges that stem from the governance and leadership, service delivery and funding. In this vein, Eyitayo(2015) remarked that inadequate political commitment to primary health care development, the limited resources and failure of effectively managing the PHC, lack of logistic facilities to facilitate taking service to remote areas, quality of service are generally poor, low priority accorded to health at all levels especially at local government, under staffing of many of the PHC facilities, poor management of health workers etc.

THE PRESENT STATE OF PRIMARY HEALTH CARE IN NIGERIA

In Nigeria and globally, achieving universal health coverage as conceived under the Sustainable Development Goals (SDGs) involves taking health service delivery to all parts of the globe where people can be found. This also is the vision of World Health Organization for achieving all health-related SDGs (WHO, 2018). Nigeria has a large proportion of its population living in rural areas where access to basic health care system is crucial. The geographic configuration of many of the rural settlements and villages make access to these villages and settlements a challenge. Poverty, distance, bad road networks, and high cost of travel may limit the desire to seek medical services in urban or more developed areas by settlers in hard-to-reach villages. Hence, reaching people in hard-to-reach areas requires the establishment of a health care system that caters to the needs of a relatively small population and which delivers essential preventive and curative medical services to the communities served at an affordable and sustainable cost. To this end, primary health care is widely recognized as the most cost-effective way to reach the goal of universal health coverage and address comprehensive health needs close to people's homes and communities (WHO, 2019). Primary healthcare in Nigeria is grossly inefficient and inadequate to provide quality health services for Nigeria's teeming population. Of the 30, 000 primary health care centres across the country, only a measly 20% are functional (Uzochukwu et al., 2015).

Demographic indicators highlight the need for a developed, functional and far reaching primary health care System. Extreme poverty and illiteracy rates are high. In 2018, Nigeria attained

the unenviable designation of "poverty capital of the year", with 86.9 million Nigerians living in extreme poverty (Quartz, 2018). That represents close to 50% of its entire population. If the current trajectory is unchanged, an estimated 110 million will be living in extreme poverty in Nigeria by the year 2030 (Kharas et al., 2019). The widespread poverty and high level of illiteracy in Nigeria affects their access to quality and healthy nutrition, thereby leaving them susceptible to diseases. Access to basic amenities such as portable water and electricity is low in poor and rural communities while sanitation is poor and open defecation is prevalent. The high and growing rate of extreme poverty coupled with a high level of illiteracy in Nigeria makes the case for an efficient and sustainable primary Health Care System even more urgent. It is projected that developing a functional and sustainable primary health care system in low- and middle-income countries, such as Nigeria, would save at least 60 million lives and increase average life expectancy by 3.7 years by 2030 (WHO, 2019).

Nigeria currently has some of the worst health outcomes in the world, due in part to the poor state of primary health care services, which are characterized by a lack of coverage (especially in rural areas), inadequate health facilities and high user fees (Uzochukwu et al., 2015). Also, across PHCs, health workers are untrained and trained workers lack a thorough grasp of the modern concept of PHC (Abdulraheem et al., 2012). The absence of a fully functional primary health care system has resulted in a large number of people seeking medical services, that should be offered by the primary health care system. Nigeria needs a functional primary health care system in order to forestall the collapse of the already overburdened secondary and tertiary health facilities in the country. The additional burden placed on secondary and tertiary health institutions in Nigeria amplifiers fundamental challenges towards service delivery and stretches beyond limits the merger resources of these underfunded institutions. Hence, failure to develop a functional and sustainable primary health care system in Nigeria portends the collapse of already weak public health system in Nigeria.

CONSTRAINTS TO PROPER FUNCTIONING OF PRIMARY HEALTHCARE SYSTEM IN NIGERIA

The governmental factors include lack of political will; inadequate funding/misappropriation of funds; inadequate inter-sectoral collaboration; and conflicts between Local and State Governments. The people/client factors include community perceptions of poor quality and inadequacy of available services in the PHC centers; under/low utilization of PHC services; and poor community participation. Other factors include lack of motivation in the workplace including poor remuneration; unhealthy rivalry between various categories of health workers; noninvolvement of private health sector in the planning and implementation of PHC; and poor management of information system, heavy dependence on initiatives funded by foreign donors like UNICEF and USAID.

Lack of political will

Government commitment has proven to be crucial in the decentralization of health services to improve access to PHC - especially in rural areas (Magawa, 2012). Apart from civil strife, politics can negatively affect the implementation of health programmes (Olise, 2007). Most leaders

do not show enough concern for the wellbeing of their citizens. Many of them who will not approve the release of funds for routine health activities will readily endorse/approve any opportunity that will portray them publicly as the champion of the people's cause. There is great emphasis on the construction of gigantic physical structures compared to the provision of good health services which in most instances cannot be measured. Most of the national programmes in Nigeria which are geared towards solving some critical health conditions (like poliomyelitis elimination) only succeed because of support from external agencies. Unstable leadership is an ill wind. In the last fifteen years, there has been no less than eight Ministers of Health in Nigeria. At the Local Government Area (LGA) level, the headship has also been very erratic. Some of the councils have had three chairmen within a period of twelve months. This high leadership turnover has negative influences in the implementation of PHC services (Adeyemo, 2005).

Inadequate funding/misappropriation of funds

The WHO recommends that at least 5% of GNP should be set aside for health. While the developed nations spend as much as 10% of their GNP on health, developing countries generally spend 1.5 to 4% (Olise, 2007). Inadequate finance and overdependence of the LGA on federal, state and international agencies for support, because the meager internally generated revenue of the LGA cannot sustain the healthcare services. The financing of (but not the responsibility for) public health is tied to the flow of funds from the federation account. Funds are shared between levels of government according to an allocation formula that keeps about half at the federal level, allocates a quarter to the 36 states, and gives the other quarter to the LGs (Abimbola, 2012; Budget Office of the Federation, 2014).

In a study to examine the management of the Primary Health Care Services in Nigeria using both primary and secondary data, it was found out that the primary health care programme was grossly underfunded and this manifested in the low performance of the PHC facilities (Omoleke, 2005). In poorer nations, funding of health activities is largely from budgetary allocation by the respective levels of government. High personnel cost (70-80%) of the health budget at the grassroots (LGA) level are for settling personal emoluments. Quite often, the workforce is over bloated and many workers can be seen idling away for 70% of the time in their places of work (Olise, 2007). Most health expenditures in the grassroots are from out of pocket expenditures.

Poor inter-sectoral collaboration and conflicts between the Local and State Governments

One of the laid down principles of PHC is intersectoral collaboration but we find out that this is grossly missing in the Nigerian State. Primary health care should be intersectoral, addressing intersectoral determinants in health and involving all other sectors related to the various components. There should be intersectoral collaboration between the health sector and other sectors such as agriculture, water, industry, education, housing, and works, among others (Obionu, 2007).

Collaborations with other non-governmental organizations (NGO) have resulted in duplication of efforts without proper coordination. There have been instances where two different agencies with varied mission refuse to share information even when the need arises. They therefore

increase the workload of the PHC staff that has to source this information for them. Weak support system for PHC is been experienced all over the nation. PHC does not operate in a vacuum. It is part of the National Health System. It therefore, requires the support of other higher levels of care in such areas as training, technical assistance, information and supervision. The secondary health care provides the immediate backup services including referral support. Where the two-way referral system is weak or the other levels of care are in a state of decay as in many poor countries, primary health care also suffers.

Health services in Nigeria mirror political organization. The federal government is responsible for tertiary care, state governments for secondary care, and the local governments run primary care. The financing of public health is tied to the flow of funds from the federation account. Funds are shared between levels of government according to an allocation formula that keeps about half at the federal level, allocates a quarter to the 36 states, and gives the other quarter to the LGs. These resources are not sectorally earmarked and the States and Local Governments are not constitutionally required to provide budget and expenditure reports to the federal government. Nigeria thus leaves the most important and consequential level of health care – primary health care – to the weakest level of government. This results in poor coordination and integration between levels of care, giving rise to a weak and disorganized health system, in which widely varying patterns of outcomes depend on local situations (Abimbola, 2012).

Community perceptions of poor quality of services at PHC facilities

Perception influences acceptance which in turn determines utilization. Most Nigerians have a wrong perception about PHC. Little wonder individuals would prefer to queue up in a teaching hospital for treatment of common ailment such as malaria, wasting resources and time instead of visiting a PHC facility closer to them where they can get some level of care. Such perceptions include the belief that PHC is meant for the rural poor which inputs the mentality that the services are meant for lower class citizens. In addition, health workers in PHC facilities, apart from being insufficient are perceived to be less qualified when compared to their counterparts in tertiary health facilities. Others include the view that PHC is an avenue for diversion and misappropriation of funds by the Local Government officials and that free health care services available in the facilities are of poor quality. Inadequate community participation Utilization of services depends strongly on community ownership which comes through community participation. Alma-Ata declaration identified 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 community development (WHO-UNICEF, 1978). Community participation is the hall mark of primary health care, without which it will not succeed. It is a process by which individuals and family assume responsibility for their own health and those of the community and develop the capacity to contribute to their/and the community development. Participation can be in the area of identification of needs or during implementation. The community needs to participate at village, ward, district or local government level. Community participation has been apparently institutionalized through the formation and creation of Village Development Committees (VDC) and Ward Development Committees (WDC). Some of these committees which were formed to improve the workings of PHC at the

grass-roots have been turned around and are now either non-functional or are being used for other purposes such as being politics. The expected mutual support from the community and government has broken down in recent times. Inadequate community mobilization and advocacy are some of the reasons for poor community participation.

Problem with human resources for health

No health system can function effectively without an effective workforce. As a matter of fact human resources form the pillar of every health system. Unfortunately, the implementation of PHC in Nigeria has met with a number of problems relating to health manpower. These problems range from inadequacy of personnel, inequitable distribution of available personnel, inter-cadre conflicts, poor job satisfaction, and paucity of accurate data on the available staff (Health Reform Foundation of Nigeria, HERFON, 2009; Abdulraheem, 2012). The problem of human resources in Nigeria is further worsened by lack of planning. In some other instances where recruitment of skilled manpower is achieved there have been reported failures in the interpretation of their job descriptions. Several cases have been reported by the Nigerian Medical Association (NMA) concerning some states in which Medical Officers are denied the headship of the PHC departments even after they have been employed into the services of the Local Government.

CONCLUDING REMARKS

Primary health care in Nigeria is currently inefficient and is incapable of achieving health related sustainable development goals. Given the low level of government funding of health sector, particularly the PHC system over the years, foreign donations have been increasing and have become essential for the development of a functional and sustainable primary health care in Nigeria. This challenge becomes more urgent against the background of projected declines in foreign donations towards improving healthcare because of a number of socioeconomic factors. Foreign donations have created two major spillover issues: weakening of commitment to domestic funding and neglect of health system strengthening. Foreign donations cannot be a replacement for increased domestic spending on public health. Increased domestic funding must be made a prerequisite for foreign funds. Increase in domestic funding for health along with the strengthening of the health system in Nigeria will ensure that when donor funds are no longer available, Nigeria's primary health care system would be ready, and able to deliver quality health care to Nigerians.

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