Evaluation of Primary Health Care Centres in Ahoada West Local Government Area Rivers State

Prof. Innime Righteous
Department of Public Health
Highstone Global University Tx, US.
Original Author: vc@highstoneglobaluniversityus.site, innime_righteous@uniport.edu.ng

Dr. I. N. Ojule
Deaprtment of Community Medicine
University of Port Harcourt
Corresponding author: inumanye.ojule@uniport.edu.ng
DOI: 10.56201/ijmepr.v9.no2.2025.pg25.34

Abstract
Evaluation of Primary Health Care Centre's in Ahoada West Local Government Area. Quality systems can help to manage change while maintaining a high quality of care. A new model of quality systems inspired by the works of Donabedian has three factors: This study adopted a focus group discussion and population of the study comprises of primary health care centers staffs in Ahoada West Government Area. However, the Local Government Council has only 14 HCs and all these were included in this study. The objectives of this paper were to determine the capacity s of primary health care in Ahoada west local government area to render quality health care services. The instrument for the study was a structural quality protested questionnaire on facilities and equipment's as predictors of effective health care delivery service and checklist of items on infrastructural quality and equipment. All 14 (100%) primary health care facilities in Ahoada West Local Government Area implement Essential Drug List Regulation. The 14 (100%) primary health care facilities have anti-malarial and haemathinics. Health care workers should ensure that they have adequate knowledge on how to handle their equipment.

Keywords: *Human's Resources, Structural Quality, Primary, Health Care, Capacity, Evaluation.*

Introduction

Primary Health Care infrastructural quality is understood in both qualitative and quantitative terms to mean the structural quality of care and accessibility to health care delivery within a country. It is judged by the quality of physical, technological and human resources available at a given period (Erinosho, 2006). Physical structural quality entails the buildings and other fixed structural quality such as pipe borne water, food access roads, electricity, wit1in the healthcare environments (Erinosho, 2006). Human resource comprises the health professionals including doctors, pharmacists, nurses, midwives, laboratory technologists, administrators, accountants and other sundry workers. All these put together form the structural quality upon which the healthcare delivery is anchored in any society and the determinants of its infrastructural quality. Health infrastructural quality is a part of a larger concept of the health system which contains the health policy, budgetary allocation, implementation and monitoring of utilization of the health

infrastructural quality (Adebayo and Oladeji, 2006). In sub-Saharan Africa and Nigeria in particular there are recognized existence of different types and practices of health seeking behaviors: traditional, biomedical/orthodox and synthetic with different structural quality qualities Ademiluyi et al, 2009). Structural quality of health care refers to the availability of the physical and human resources required for the provision of care. Measures of structural quality include physical equipment, measures related to staff expertise, staff coordination and organization (Donabedian, A, 2005). Even though this type of quality may not by itself ensure improved outcomes, it is important because it focuses on the availability of all inputs necessary for the provision of care, without which better health outcomes may not exist.

The definition of structural quality used in this study focused on the adequate supply and functional state of resources used for the provision of health care. Good structural quality, then, ensures availability and access to health care, which is necessary for the achievement of universal health coverage. Universal health coverage is achieved for a given population when all residents, regardless of income, are able to have access to adequate health care without suffering financial hardship (Donabedian, A, 2005). In a developed country like Norway, structural quality of primary health care facilities are of standard such that health care services are been shifted from secondary care to primary care thereby reducing garden of health care services on both secondary and tertiary levels of care. Results include better response to the challenges of an aging population, falling lengths of hospital stay, a rising rate of discharge, and a reduction on pressures on primary care settings, Norway has begun to establish supplement primary health care units (also called Sykestue in Norwegian), which will have a key responsibility in taking care of patients upon Discharge from hospital, or where there is a risk of admission to hospitals when the condition could be appropriately managed at a lower intensity care setting (OECD, 2014). In developing country like Ghana, the government owns more than 50% all the health facilities in the country and is responsible for the availability of all physical and human resources in public facilities. The structural quality of health-care provision in the public sector is therefore subject to public norms and institutions (Donabedian, A, 2005). A cross-sectional study conducted in 14 PHCs that were randomly selected with, 2 each from 7 hocks of Rajkot district, India. Was aimed assessing the quality of facilities available at primary health care centers in line with India Public Health Service (IPHS) guidelines. The study used a retested close ended questionnaire and findings showed that standard infrastructural quality was essential for delivery of quality health care by PHCs (Ninama et al, 2014).

The first organized medical services in Nigeria were provided by Christian missionaries Ademiluyi et al, 2009); which were mobile and rural based. in the 1900s our colonial master British) provided hospital based services, established to take care of epidemics such as sleeping sickness, small pox malaria (Aluko-Arowojo, 2006). There were copious infrastructural quality deficiencies in health care facilities in the rural areas; this is also event today more than fifty-five years of independence. In an attempt to address these challenges globally, the International Conference on Primary Health Care,
in Alma Ata, Kazakhstan in September, 1978 convened. The conference endorsed the health for all programme through the Alma Ata Declaration; to be driven by the Primary Health Care (PHC) system. PHc programme stands on five principles, these are: accessibility (equal distribution); health promoti01 appropriate technology; inter-sectorial collaboration and community

participation. These were designed to work together and be implemented 'simultaneously to bring out better outcomes for the entire population (Omuta GED, 2015). Healthcare services delivery of immense benefit to the populace requires availability of adequate infrastructural quality such as diagnostic medical equipment, drugs and well-trained medical personnel (Norheim, 2015 Sengupta, 2013). In Nigeria, Rivers State and Ahoada West Local Government area in particular, poor funding and mismanagement often characterize healthcare service delivery thereby effecting coverage and quality of healthcare services. These had led to criticisms of the health sector in the Local Government (Oyekale, 2017). Realization of Sustainable Development Goals DGs) health targets, depend on improvement of these lapses (Vega, 2013; Evans, 2013. Health care system requires standard infrastructural quality to ensure that services delivered is efficient, effective and timely. Such infrastructural quality defines the quality of services provided based on their activities qualitative and quantitative characteristics (Erinosho, 2006; Aderniluyi et al, 2009). Health human resources – also known as human resources for health or health workforce – is defined as "all people engaged in actions whose primary intent is to enhance health", according to the World Health Organization's World Health Report 2006.

Statement of the Problem

Distribution and accessibility of PHCs to target population enhance utilization of health services provided. It is imperative therefore those PHCs be established near its catchment area to optimize utilization. Distance of two hundred meters or less is approved (Eboreime et al, 201 5). Health care infrastructural quality has been characterized into 'hard infrastructural quality' (things at Support the economy) and 'soft infrastructural quality (things that support the system's social response and capability). Infrastructural quality is, collectively, the underlying foundation that supports a larger structural quality. It is the intrinsic framework of a system or Organization and the 'structural quality' that underpins the 'super structural quality. Infrastructural quality of the capacity and capability of the system to carry out its main functions and deliver on their core mandates and the corresponding quality of the care and accessibility to health care delivery in a society (Erinosho, 2006; Stephenson, 2012; NACCHO, 2015; Ademiluyi et al, 2009). In Ghana, for example, the government owns more than 50% all the health facilities in the country. The government is responsible for the availability of all physical and human resources in public facilities. The structural quality of health-care provision in the public sector is therefore subject to public norms and institutions (Donabedian, A, 2005). PHCs established with proper infrastructural quality are aimed to provide comprehensive quality healthcare to the defined (target) population. Studies carried out showed that existence of infrastructural quality, manpower, essential drugs, equipment, good telecommunication system and good organizational structural quality are essential for good health care delivery service; these are seen in developed country like Norway (Omuta GED, 2015).

In the large number of fast-growing health economies — which is where 3 billion people live — that very growth provides opportunities to base health systems on sound primary care and universal coverage principles at a stage where it is in full expansion, avoiding the errors by omission, such as failing to invest in healthy public policies, and by commission, such as investing disproportionately in tertiary care, that have characterized health systems in high-income countries in the recent past. The challenge is, admittedly, more daunting for the 2 billion people living in the low-growth health economies of Africa and South-East Asia, as well as for the more than 500 million who live in fragile states (WHO -World Health Report, 2008). In India, the quantity and

quality of healthcare providers are essential in rendering comprehensive and quality health care delivery services. Therefore, an adequate number and well qualified health professionals are needed to implement health care services (Ninama et al, 2014). Primary Health Care services certification and accreditation of health plans and providers are based on detailed evaluation of health system structural quality.

The concept of Primary Health Care

Primary Health Care as a model of healthcare was adopted in the declaration of the International Conference on Primary Health Care held in Alma Ata. Kazakhstan in 1978 (known as the "Alma Ata Declaration"), became a core concept of the World Health Organization's goal of Health for all (WHO, 2011) The Alma-Ata Conference mobilized a "Primary Health Care movement" of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the 'politically, socially and economically unacceptable" health inequalities in all countries. There were many factors that inspired PHC; a prominent example is the Barefoot doctors of China (Marcos, Cueto 2004, WHO. October 2008, WHO, December, 2008). Primary healthcare (PHC) refers to 'essential health care" that is based on "scientifically sound and socially acceptable methods and technology, which make universal health care accessible to all individuals and families in a community. It is through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO, September, 1978). In other words, PHC is an approach to health beyond the traditional health care system that focuses on health equity-producing social policy (Starfield, Barbara., 2011, Public Health Agency of Canada, 2011). PHC includes all areas that play a role in health, such as access to health services, environment 'and lifestyle (Marcos, Cueto 2004). Thus, primary healthcare and public health measures, taken together, may be considered as the cornerstones of universal health systems (White, 2015). Political will and commitment to PHC on the part of governments first requires acceptance of these values. Commitment, however, is itself a process and shades or levels of commitment are usually the reality, rather than political commitment existing or not. Furthermore, governments are by no means homogenous in their shades of commitment and several different shades may exist in countries at the same time. Some countries already have policies and are pursuing patterns of development in conformity with these principles. Some political systems are more favorable to PHC precisely because they emphasize these values and are concerned with a broad attack of poverty and inequality and the socio-economic structural quality maintain them. Even for the health sector, the pattern of existing health systems and opportunities for change reflect wider sociopolitical values. It will be easier to undertake the kinds of changes discussed above, in countries where the overall development policy gives priority to equity and social justice, than in countries where economic growth is being pursued regardless of human consequences. It has to be clearly understood at the outset that commitment to PHC is a commitment to a political goal which will have to be fought for against opposition forces and progress is likely to be slow. Therefore, PHC is a political issue (Commun Dis 1982 Sep; 14(3): 169-76).

The Concept of Health

The most famous modern definition of health was created during a Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946 and signed on 22 July 1946 by the representatives of6l States (Official Records

of the World Health Organization, no. 2, p. 1 00) entered into force on 7 April 1948. The World Health Organization (WHO) defined health in its broader sense in its 1948 constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Some definition of good health emphasized self-actualization the fulfillment of the individual with normal body function and concept of well-being Datong (1988) and (Mahler, 1996) emphasized that health does **not only** mean the fitness of the body but also the soundness of mind and emotion which makes life worth living. Some authors have criticized this definition by WHO like Huber et al., (201 I) in their analysis of the WHO concept of health argued that there are limitations to this definition most criticism of the WHO definition concerns the absoluteness of the word "complete" in relation to wellbeing. The requirement for complete health "would leave most of us unhealthy most of the time" Smith R (2008). They also state that since 1948 the demography of populations and the natures of diseases have changed considerably. In 1948 acute diseases presented the main burden of illness and chronic diseases led to early death. In that context of WHO health definition it articulated a helpful ambition. But due to epidemiological and demographic transition, disease patterns have changed, with public health measures such as improved nutrition, hygiene, and sanitation and more powerful healthcare interventions. The number of people living with chronic diseases for decades is increasing worldwide; even inthe slums of India the mortality pattern is increasingly burdened by chronic diseases (Kanungo, et al., 2010). Ageing with chronic illnesses has become the norm, and chronic diseases account for most of the expenditures of the healthcare system, putting pressure on its sustainability.

The Concept of Structural quality

Notable concept of structural quality in health System was developed by Donabedian in 1988, 2005 his work on evaluation of health care delivery. He conceptualized evaluation of care into three dimensions: structural quality, processes and outcomes (Donabedian, 2005). Structural quality refers to prerequisites, such as hospital buildings, staff and equipment (Donabedian A. 1988). Structural quality also refers to the generative rules and resources upon which action and interaction can be built (Giddens 1976). Donabedian further stressed that Structural quality refers to the setting in which care is delivered including adequate facilities and equipment, qualification of care providers, administration structural quality and operations of programs. Using this approach, good care settings and supporting structural qualities contribute to good care. Structural quality variables are often concrete and accessible, making them relatively easy to assess (Donabedian, 2005). Stefan et al, 2007 in their study on structural quality of quality systems is important to the process and outcome, an empirical study of 386 hospital departments in Sweden; observed that there were relationships between structural quality, process, and outcome and that this relationship was of reasonable representation of quality systems at hospital departments ($p = 0.095$, indicating no significant differences between the model and the data set). Structural quality correlated strongly with process (0.72) and outcome (0.60). Given structural quality, process also correlated with outcome (0.20). Good structural quality in health system performance ensures quality health care delivery service. Oyekale, 2017 in his study on Evaluation of primary health care facilities' service readiness in Nigeria, a cross sectional study of twelve states cutting across six (6) geopolitical zones between 2013 and 2014, data collected from 2480 healthcare facilities randomly selected, Opined that for effective delivery of healthcare services by Primary Health Care (PHC) centers require availability of adequate infrastructural quality, diagnostic medical equipment, drugs and well- require a medical personnel. In -Nigeria, Rivers State in particular, -

poor funding and mismanagement often characterize healthcare service delivery thereby affecting coverage and quality of healthcare services. Therefore, the stat of service delivery in the health sector has come under some persistent criticisms. The Minister of Health has revealed that only 20 percent (20%) of health facilities in the country are functional. The minister, during an emergency National Council on Health meeting on the control of Lassa Fever in Abuja, Nigeria January 19, 2016; made the revelation at the dissemination of the 2016 National Health Facility Survey (NHFS). The report is the first nationally representative health facility survey designed to assess primary, Secondary and private health care facilities in the country. The survey provides information on clinical competence; availability of drugs and basic equipment; readiness to provide key save-one- million-lives programme for result interventions; supervision and financial management based on the ward minimum health care package for quality service (National Health Facility Survey (NHFS, 2016).

Conclusions

This study shows that adequate pro vision of infrastructure, equipment, human resources, essential drugs, water, proper waste disposal, electricity, assess road to health facilities is a strong predicting factor for effective health care delivery services. Structure of health care refers to the availability of the physical and human resources required, for the provision of care. Measures of structure include health facilities' physical equipment, and measures related to staff expertise and staff coordination- and organization (Amporfii et al, *2015).* Even though this type of quality may not by itself ensure improved outcomes, itis important because it focuses on the availability of all inputs necessary for the provision of care, without which better health outcomes may not exist. The definition of structure used in this study focused on the adequate supply and functional state of resources used for the provision of health care. Capacity Evaluation, then, ensures access to health care, which is necessary for the achievement of universal health coverage. Universal health coverage is achieved for a given population when all residents, regardless of income, are able to have access to adequate health care without suffering financial hardship (Donabedian, A. (2005).In Nigeria, human capital development through provision of sound and efficient health delivery system is conceived as the bedrocks for economic growth and development. This ideology obviously guided economic planning and development agendas since the post-colonial era. The primary proviso for reenergizing a national workforce that is able to drive development requisites in a manner that optimizes efficiency is perfectly encoded in systematically designed health service delivery system, among others (George et al, 2013; National Bureau of Statistics-S, 2009). Twenty-four years after the leadership of Professor Olikoye Ransome-Kuti, the need to strengthen the PHC in Nigeria is relevant as ever before. The current state of PHC system in Nigeria is appalling with only about 20% of the 30,000 PHC facilities across Nigeria working (Adewole, 2016). Presently, most of the PHC facilities in Nigeria lack the capacity to provide essential health-care services, in addition to having issues such as poor staffing, inadequate equipment, poor distribution of health' workers, poor quality of health-care services, poor condition of infrastructure, and lack of essential drug supply (Chinawa, *2015).* Hence, the need why this study was carries out. In summary: PHCs in AWELGA were organized structurally thus:

a) Administrative - State Ministry of Health (Led by Honorable Commissioner for health) — State Primary Health Care Management Board (Led by Executive/Permanent Secretary) — Local Government Primary Health Care

Management Committee (Led by Medical Officer of Health).

b) Service delivery — L.G.A. health committees (Led by M.O.H.) — Programme Managers — Head of facilities — Facility programme focal persons.

Recommendations

Viewing at the outcome of the study and information derived from the checklist of items on availability, adequacy and provision of facilities and equipment for effective health care, to ensure standard health care delivery in the primary health care facilities; recommendation is of outdated equipment's.

Health Careworkers/Individual Level

- Health care workers should be careful while handling medical equipment.
- Health care workers should stop stealing health facility materials- drugs, consumables, furniture, and money ete.
- Health care workers should take daily inventory of equipment, drugs and other materials of health facility.
- Health care workers should ensure that they have adequate knowledge on how to handle their equipment.

Government /National Level

- The government should ensure proper remuneration to serve as an additional incentive to health care workers.
- The government should make adequate budgetary provision for procurement, maintenance of health facility infrastructure, drugs, equipment, consumable materials, etc. to avoid shortage.
- The government should employ qualified health care workers to reduce the work load of health care providers by increasing health care workers via employment.
- The government should create opportunity for health providers undergo in-service training to help them update their knowledge and skills.
- The government should provide new work equipment and train health care workers on their operation.
- The government should set up committee to inspect health care facilities to ensure that they are safe for service delivery.

Health Facility Management) Organizational Level

- The health facility management should ensure periodic evaluation of inventory materials.
- The management should ensure employee have adequate knowledge of standard operation procedure for health facility equipment maintenance.
- The management should ensure that workloads are in accordance with health workers ability and resources.
- The management should assign a staff to take stock of equipment's, drugs, and consumable materials. These staff should be held liable in an event of theft.

References

Ademiluyi IAA, Aluko-Arnolo SO. Infrastructural Distribution of Health Care Services in Nigeria: An Ovenview. Journal of Geography and Regional Planning. 2009; 2(5):105- 106

Akin-Aina T. Health Habitat and Underdevelopment in Nigeria. International Institute for Environmental Development. London. 1990.

Aluko-Arowolo SO. The Medico-Spiritual and Historical Origin of Malaria Disease. In Faloa T. and Heaton. M.M. (eds.) the Traditional and Modern 6 Health System in Nigeria. African World Press, Trenton and Asmara, 2006. pp. 247-256.

Alhassan RK, Nketiah-Amponsah E, Akazili J, Spieker N, Arhinful DK, Rinke de Wit TF. Efficiency of private and public primary health facilities accredited by the National Health Insurance Authority in Ghana. Cost Effectiveness Resource Allocation. 2015; 13:23.Article Google.

Chinawa J. Factors militating against effective implementation of primary health care (PHC) system in Nigeria. Ann Trop Med Public Health 2015; 8(1): 5-9. [Crossref].

Donabedian, A. (2005). "The quality of care: How can it be assessed?" JAMA. 260 (12): 1743—8. doi:10.1001/jama.1988.03410120089033. PMID *3045356.*

Eboreime E, Abimbola S, Bozzani F. Access to routine immunization: a comparative analysis of supply-side disparities between northern and southern Nigeria. Plus One. 2015; 1 0(12):e0144876.

Erinosho OA. Health Sociology for Universities, Colleges and Health-Related Institutions. Bulwark Consult, Abuja.2006,

Einstein. Jan-Mar 2014 what changes in Research Ethics in Brazil: Resolution no. 466/12 of the National Health Council l2 (1) vii.

Evans DB, Hsu J, Boerma T. Universal health coverage and universal access. In: Bulletin of the World Health Organization. 19th ed. Geneva: World Health Organization; 2013. p. 546.

George TO, Olayiwola WK, Adewole MA, Osabuohien ES. Effective Service Delivery of Nigeria's Public Primary Education: The Role of Non-State Actors. J Afr Dev. 20 13; 15(1):22 1—245. 107

Home RK. Town Planning. Segreaion and Indirect Rule in Colonial Nigeria. Third World Planning Review. 1983:5:165-176. http:/w.wikiw and com/en/Local government area.https://en.wikipedia.org/wiki! Asssant medical officer.(http://www.southafrica.info/about/health/clinical-associates.htm.

Indian Public Health Standards (IPI-IS) Guidelines for Primary Health Centers, 2012).

Li J, Seale H. An E-Hea1th Readiness Evaluation Framework for Public Health Services: Pandemic Perspective. Proceeding 45th Hawaii International Conference on system Sciences. IEEE: Hawaii; 2012. pp. 2800—2S09.

Marcos, Cueto (2004). "The ORIGINS of Primary Health Care and Selective Primary Health Care.". Am J Public Health. 22. 94: 1864—1 874. Doi: 10.2105! Ajph, 94.1 1.1864.

M. E. Kruk, D. Porignon, P. C. Rockers. And W. van Lerberghe, "The contribution of primary care to health and health systems in low- and middle-income countries: a critical review of major primary care initiatives," Social Science and Medicine, vol. 70, no. 6, pp. 904—911, 2010. View at Publisher View at Google Scholar View at Scopus.

National Association of County and City Health Officials (NACCHO). Public Health Infrastructure and Systems. Available at http://www.naccho.org/topics/infrastructure/Accessed d 23/09/2015.

National Standards and Minimum Service Package for Adolescent and Youth-Friendly Health Services in Nigeria.

National Bureau of Statistics-NBS. Annual abstract of statistics. Abuja: Federal Government of Nigeria (FGN); 2009.

National Primary Health Care Development Agency (NPHCDA): minimum standards for primary health care in Nigeria. Production of Department of Planning, Research and Statistics. For all enquiries please contact, The Director, Planning Research and Statistics, NPHCDA Plot 681/682 Port-Harcourt Crescent, Off Gimbiya Street, Garki 11, Abuja

National Health Facility Survey (NI-IFS), 2016.

National Primary Health Care Development Agency. Minimum standards for primary health care in Nigeria. Federal Government of Nigeria.

National Human Resources for Health Strategic Plan 2008 to 2012, WHO, 2006). 108

Ninama R. Thakor N. Vala NI. Dund J. Kadri AM. Quality Evaluation of facilities available at Primary health care centers in Rajkot District India: A Cross Sectional Study. Int J Med Sci Public Health 2014; 3: 1449-1452.

Norheim OF. Ethical perspective: Five unacceptable trades-offs on the path to universal health coverage. IntJ Health Policy Manage. 2015; 4(l l):71 1.

Ogundeie BO, Olafimihan HO. Facilities and Equipment as Predictors of Effective Health Care Delivery Services ‘in Selected State Government Hospitals in Oyo State, Nigeria. Anthropologist. 2009; 11(3):181—7.

Official Records of the World Health Organization, no. 2, p.’l00.

Omuta GED. Infrastructure and Health Care Services in the Niger Delta Region of Nigeria: A Case Study of Physical Amenities in the Primary Health Care System in Delta State. Online J Health Allied Scs. 2014; 14(4):2. Available at URL:http://www.oj has.org/i ssue5 6/2014-4-2 .html

Organizational structure of the Nigerian primary health care system. doi: 10.137 1/joumal.pmed. 1001501 .g002

Oyekale BMC Health Services Research (2017) 17:172 DOT 10.1186/s129l3-017-21 12- 8Public Health Agency of Canada, 2011.

Sengupta A. Universal health coverage: beyond rhetoric, municipal services project.

Occasional Paper No 20. Kingston; 2013. http://www. Municipal services project.org/sites/municipal services project.org/files/publications/OccasionalPaper20 Sengupta Universal Health Coverage Beyond Rhetoric Nov2013 O.pdf. Accessed 5 Oct 2016.

Starfield, Barbara. ‘Politics, primary healthcare and health.” J Epidemiology Community Health 2011; 65:653—655 doi: 10.11 36/jech.2009. 102780.

Stephenson P. Health Promotion Infrastructure: A Thinkpiece, an Occasional Paper, Commissioned by the Health Promotion Forum (HPF) of New Zealand, 2012.

The Journal of Communicable Diseases. 1982 Sep; 14(3):169-76).

The World Bank. Improving primary health care delivery in Nigeria. 2010. Available at http://elibrary.worldbank.org/doi/abs/ 10.1596/978-0-8213-8311-7 (accessed 6 June 201 6) 109 [Crosref].

Vega J. Universal health coverage: the post-2015 development agenda. Lancet. 2013; 381:17980.

World Health Organization. Declaration of Alma-Ata. Adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, and 6—12 September 1978.

WHO -World Health Report, 2008.

White F. Primary health care and public health: foundations of universal health systems Med Prince Pract 2015 doi: 10.1159/000370197.

World Health Organization (WHO). Key components of a well-functioning health system .World Health Organization. 2010.http:/!www.who.intlhealthsystems/ENHS Skey components .pdf. Accessed 15 Sept 2016.

World Health Organization's goal of Health for all (WHO, 2011). World Health Organization. Tracking universal health coverage: first global monitoring report. Geneva: World Health Organization; 2015. 110