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An Appraisal of Primary Health Care Policy Implementation in Nigerian Rural and Semi-Urban Sector after Four Decades

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PHC remains the foundation and functional background for public health services accessibility. However, implementing the policy in Nigeria has raised unanswered questions over four decades, which the study seeks to answer. The study's objectives are to investigate the implementation of the policy and analyze the conditions of Primary Health Care Centers (PHCCs) in Nigeria. The research adopted a literature review methodology to portray and discuss the dilapidated status of PHCCs in selected rural and semi-urban communities across geopolitical zones. Relevant literature and data were used to analyze how the policy implementation was manipulated to the advantage of the elite class. The pictorials in the appendixes revealed the state of PHC infrastructures in Nigeria. The results revealed that there is no provision of efficient health care services, poverty and poor maintenance of infrastructure and facilities, poor political will in policy implementation, monitoring, and evaluation, low human resources, poor funding and management, and community apathy. Based on the results, it is concluded that decisive implementation of PHC policy remains the only avenue for the inhabitants of the rural sector to obtain standard and affordable health care services. The framework engendered social equity and availability. The study demonstrated the 'Urban Bias Theory', which no known study on PHC has adopted to appraise and analyze the sad situation of PHC policy and PHCC structures in Nigeria. Therefore, the study recommends the revival and resuscitation of the decayed infrastructures and facilities; regular maintenance of all the available PHCCs across Nigeria; deliberate initiation of workable Public-Private-Partnership plan for the enhancement of Community Development Associations/Based Organisations [CDAs, CBOs, and NGOs] in the provision and management of funds for strategy and sustainability of PHCCs to put an end to apathy and non-ownership posture.

Keywords: *Primary Health Care, International Policy, Health Infrastructure, Community Health, Rural and Semi-urban Sector, Urban Bias*

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Introduction

The 1978 Declaration of Alma-Ata founded the movement for Primary Health Care, which emphasized "health for all," healthcare accessibility as a fundamental human right, and economic and individual development (WHO, 2019).

For instance, SDG 3 aspires to ensure health and well-being for all, including a bold commitment to end the epidemics of AIDS, tuberculosis, malaria, and other communicable diseases, universal health coverage, and accessibility to safe and effective medicines and vaccines for all by 2030. Furthermore, international development and donor agencies globally have been bedeviled with the major challenges of security and safety issues for vulnerable citizens, health care services, financial security, and social justice. Thus, Nnebue *et al*. (2014) asserted that Nigeria moved into adopting and domesticating PHC global healthcare policy in 1988 under Gen. Babangida's administration as Head of State and Prof. Olukoye Ransonse-Kuti as Health Minister. The development was aimed at ensuring "health for all by the year 2000 and beyond" through PHC as the foundation for development. It is crystal clear that developing nations have been overwhelmed by the hydra-headed menace of healthcare poverty and worsening conditions of living conditions, which some scholars attributed to colonialism and unequal partnership in international relationships. This is consequent upon the suspension and replacement of the 'bottom-top' methodology, 'home-grown' model, and 'all-round' growth approach in the administration of development projects as the fundamental solutions to various underdevelopment concerns.

Nevertheless, it can be ascertained that Nigerian healthcare delivery architecture has witnessed several revolutions over the years, which aimed at dealing with the crisis in public health management (Aregbeshola, 2019). Scott-Emuakpor (2010), Asakitikpi (2019), and Marques & Ferreira (2020) list them include the "National Immunisation Coverage Scheme (NICS), Midwives Service Scheme (MSS), National Health Insurance Scheme (NHIS), and Nigerian Pay for Performance Scheme." In the healthcare sector, PHC, or "health by the people" is considered the pivotal driver of healthcare services.

Consequently, the nation's Health Department, referred to as the Federal Ministry of Health, has the mandate of meeting the World Health Organisation (WHO) targets with regard to eliminating and eradicating diseases, reducing mortality and morbidity rates arising from communicable and terminal diseases, upturning the increment and prevalence of non-communicable diseases, and significantly increase life expectancy and quality of the citizenry. From the foregoing, the domestication, development, and implementation of the health policy of PHC in the years after the Alma Ata Declaration and the undertaking of additional fundamental actions were aimed at strengthening and improving the nation's health care for affordability, efficiency, and effectiveness in services that invigorate the provision of health care. This is because healthcare remains the thrust of accelerated social, economic, and sustainable development (Nagar, 2021). Notwithstanding, it is posited that;

> We had health for some, but not for all. Progress had been uneven and unfair between and within countries, with a 31-year disparity between those countries with the shortest and longest life expectancy. At least half of the world's population lacked access to essential services, while the cost of paying for care out of pocket pushed people into extreme poverty. Too great a focus has been placed on fighting individual diseases at the expense of strengthening health systems and promoting health (WHO, 2019).

PHC has provided an enabling health care development opportunity to nations like Argentina, Kazakhstan, the Islamic Republic of Iran, Ukraine, Nepal, Indonesia, etc., to accomplish a significant level in the health care delivery system, thereby leading to a great reduction in the extent of infant and maternal mortality rate. This is connected to the fact that the PHC structure and design are rural and semi-urban inclined and considered to be rapid in nature and affordably oriented.

In Nigeria, for example, the tale of the policy implementation is diverse. PHCCs, which are majorly in the domains of the countryside, are identified by inadequate personnel in all facets, ramshackle buildings and infrastructural facilities, and above all, a dearth of drugs and other medical aid supplies (Obansa & Orimisan, 2013; Croke & Ogbuoji, 2024). The centers face

environmental cleanliness challenges due to indiscriminate defecation and invasion by insects and rodents. Moreover, since the policy implementation suffers on the altar of politics and elite compensation, many of the PHCCs are wrongly sited outside the community centers and are mostly uncompleted with a lack of necessary facilities (Reerink & Sauerborn, 1996). These deficits always forced patients and workers alike to adopt the nearby bush as a 'restroom.' As Adetiba (2021) noted, it has been observed that since the targeted population and consumers of the policy were not involved in conceptualizing the program, unrealistic attainment of its objectives and complaints remain the bane, particularly in developing countries. It is perceived that PHC, a rural and semi-urban-based health care modality to achieve "health for all by the year 2000," was idealistic and not feasible, attesting to the continuous marginalization of the rural semi-urban poor in their affairs. As a corollary, this paper is meant to demonstrate the challenges bedeviling PHC policy implementation in the rural and semi-urban areas after "the Alma Ata Conference in 1978" in Nigeria.

Statement of the Problem

> There have been many improvements in the decades since Alma-Ata, most notably in child and maternal mortality and longevity, but a number of challenges remain. In reality, many people in resource-poor settings still do not have equitable access to even essential services. This gap is widening in many places [like Nigeria] (Hall & Taylor, 2003; WHO, 2019).

According to Okonofua (2013), the primary objective of "Health for All by the Year 2000" is directed at salvaging the difficulties in accessing adequate and qualitative health care by the rural semi-urban dwellers and the vulnerable whose sole medical opportunity is dependent on foreign medical aids and technology. Therefore, the establishment of Colleges of Health and Sciences and Technology (CHST) across the Regional States in the country in the early 1980s was meant to aid the localization of PHC through the training of Community Health Extension Workers (CHEWs) and Technicians between two to three years period. This is a sound foundation for the distribution and development approach that will enable healthcare service delivery to close the wide gap between rural and semi-urban dwellers in Nigeria.

Notwithstanding, the monitoring and evaluation strategy of the health givers is inadequate. Consequently, "there is a serious knowledge gap among the rural and community health extension workers and technicians in responding satisfactorily to identified problems and challenges in health care" (Abdulraheem, Olapipo & Amodu, 2012:7). Therefore, the modus operandi of CHEWs' services in the rural semi-urban settings are discouraging as they always attempt to handle symptoms of patients contrary to their training of preventive and first-aid health care activities. They classified and acclaimed themselves as medical doctors, consultants, and authorities in medical sciences. The resultant effect of this situation is the continuous high rate of maternal and infant mortality rate in semi-urban and rural centers. They are hasty and superficial in their activities. For example, one of the author's wife died following this development in 2014. This glaring failure is not unconnected to poor training and supervision by the officers saddled with the said responsibility. It is observed that all the community health extension workers and technicians are preoccupied with managing their own clinics and maternity homes instead of the PHCCs in which they were employed to work.

The problem is compounded more by the Local Government Council (LGC) system, which is constitutionally empowered to oversee the activities of PHC. For instance, the LGC Supervisory for Health, Head of Department (HOD), and ward coordinators of health rarely visit PHCCs in rural semi-urban areas. This supervision and leadership problem has demoralized health personnel posted to these areas to render health services. In addition, there is no prompt payment of salaries and allowances for CHEWs and technicians due to the existence of "Joint Local Government Accounts" at the state government level. This ugly development has made the system a 'burden-bearer' of diverted and mismanaged funds. This can be supported by the study of Odutolu *et al*. (2016), who said, "The issue of fragmentation with respect to the provision of health services and management of staff, funds, and other resources remained a major problem for the management of PHC, prompting the need for yet another reform."

In a nutshell, poor management, decay of infrastructural facilities, unprofessional practices, and poor financial aid have all been identified as the bane in the implementation and delivery of PHC. In addition, "despite the fact that several PHCCs were established across the country, the

approach still did not impact effectively to improve the health status of the predominantly rural community in the nation" (Okonofua, 2013, p. 2352013, p. 235).

Perhaps it can be stated that the explanation of PHC policy implementation attainment remains an illusion, though politicians emptily publicize its development in Nigeria. The argument for and against it "was heard in the debates on selective versus comprehensive, and vertical versus horizontal PHC." In the recent period, over 40 years, the PHCCs have been on retrogression instead of progression and are a definite threat. Although the WHO and development partners are worried about the spate of implementation of the PHC by the developing nations, it also calls for individual concern in Nigeria. Worthy of is the fact that the policy failed as a result of the implementation strategy that is elitist in nature (leading to marginalization of the immediate policy beneficiaries) rather than collectivity, preventive health care services was relegated to curative care, poverty of management resulting in wastage of resources, wrong location of the facility, data and health information paucity, lack of research and development in all facet, critical infrastructural deficit and logistics; scarcity of finances, and poor critical infrastructural facilities. From the foregoing, a question arises: What are the challenges impeding PHC policy implementation in the rural and semi-urban areas after “the Alma Ata Conference in 1978” in Nigeria?

The Methodology

The research adopted literature review method data to portray and discuss the dilapidated status of PHCCs in selected rural and semi-urban centers across Nigerian geopolitical zones. Relevant literature and secondary data were equally used to analyze how the implementation of the policy was manipulated to the advantage of the elite class. Primary pictures in the appendixes revealed the sorry state of PHC infrastructures in Nigeria. The pictographic presentation provided “the opportunity for the understanding of the variables and issues associated with the subject matter” (Nassaji, 2020; Maxwell, 2021; Pandey & Pandey, 2021; Gambo *et al*., 2021). The description is used as the design of the study.

The gathered data was qualitatively assessed to robustly describe the sad remains of PHCCs, particularly in Nigeria and developing countries at large. All research materials cited were referenced.

Theoretical Framework and Application

The theoretical fulcrum of this research is "Urban Bias Theory," which is popular in development studies. To this end, Varshney (1993), Bezemer & Headey (2008), Jones & Corbridge (2010), Varshney (2014), Shearmur (2017) subscribed to the fact that Lipton (1977), Lipton (1984) and Robert Bates (1981) works were the early associated research to the theory. The theory reposited the 'naked' situations that appertain to the formulation and implementation of rural-urban development programs in developing countries, a disposition of the elite, and resource allocation. The essentials of the theory are that; "the growth and development circle in the developing countries is systemically biased against the rural semi-urban setting; and that this bias is extremely entrenched in the politico-cultural alchemy of these nations, subjugated as they are by the membership of the urban sectors."

Major national health programs and projects, which are primarily tertiary health care, are always carefully planned with the inputs of the consumers (the elite) and overemphasize the above PHC, which is rural, semi-urban, and community-based. For example, National Hospital Abuja, Teaching Hospitals, Specialist Hospitals, Federal Medical Centres, Cottage Hospitals, and General Hospitals are preferentially allocated huge budgets because they are urban-centred and elite-inclined. However, these modalities are not applicable to PHC programs and projects. They are not consultatively planned. Community-based Organisations (CBOs), rural health-related Non-governmental Organisations (NGOs), and Community Development Associations (CDAs) input are not always requested.

Again, an unfathomable degree of inequalities exists in the amount of resources and funds allocated to National Hospital Abuja, Teaching Hospitals, Specialist Hospitals, Federal Medical Centres (FMCs), Cottage and Comprehensive Hospitals, and General Hospitals. This is contrary to that of the CHEW's training institution, known as the State Colleges of Health Science and Technology (CHSTs). Urban bias manifests in "unmerited public spending on goods and services

in urban areas compared to rural regions. It also deals with the view that the concentration of some goods and services in urban areas is necessarily an indication of bias or predation" (Jones & Corbridge, 2010). Thus, "there has been too much concentration of medical personnel at the urban (centers) to the neglect of the rural areas" (Abdulraheem, Olapipo & Amodu, 2012, p. 7).

Following these perspectives, the stunted growth and underdevelopment of PHCCs in rural and semi-urban communities of developing countries at large and Nigeria, in particular, cannot be divorced from the marginalization tendency and resource diversionary attitude of elite groups in the urban sector. Scholars like De Maeseneer *et al*. (2007, p.4) maintained that "in developing countries, there is a shift of manpower from the local primary health care system towards vertical disease-oriented programs. Moreover, there is a shift from rural semi-urban areas and townships towards more affluent areas in cities. On a global scale, there is an increasing emigration of health care providers from developing countries to higher-income countries." As Pimmer *et al*. (2017), Witter *et al*. (2017), and Janse van Rensburg (2019) posited, although the training of many CHEWs and Technicians specializing in different fields of PHC administration carried out by CHST across the country and deployed to PHCCs in rural and semi-urban communities notwithstanding, they lack depth and 'jump ship' to handling symptoms which they should ordinarily refer to secondary and tertiary health centers. These, together with weak supervision, have rendered their performance ineffective, unimpressive, and disappointing. Therefore, Olalubi, Sebutu, and Bello (2020) alluded to the fact that the failure and swift developmental relegation of PHCCs as public health institutions are largely due to the aforementioned factors. Essentially, there is a great disparity between the rural semi-urban health care centers and the urban ones that policy initiators and implementers will permanently relegate to the background. Kipton (1977, p.1) believed that the big difference dwells in a situation where;

> The rural sector contains most of the poverty and most of the low-cost sources of potential advancement, but the urban sector contains most of the articulateness, organization, and power. So, the urban classes have been able to "win" most of the rounds of the struggle with the countryside, but in doing so, they have made the development process slow and unfair.'

This illustrates the degree of development witnessed by the city health care centers and PHCCs, which are on the outskirts of the urban areas. To this end, Gebre and Gebremedhin (2019) asserted that rural semi-urban areas had suffered severe marginalization, neglect, and relegation. There were excuses that because PHCCs are remotely located, supervision and observation are difficult, and as such, they are capacity-wise deficient in service rendering, inadequate equipment and provision of drugs, and uneven distribution of CHEWs (Chinawa, 2015; Aregbeshola & Khan, 2017). From the foregoing, the marginalization of rural semi-urban areas is primarily characterized by a lack of standard schools, motorable roads, simple and standardized health care centers, power supply, portable water, financial institutions, security posts, agricultural extension workers, and development institutions. Generally, the absence of these facilities has made life difficult for rural semi-urban dwellers and has resulted in high rural-urban migration, thereby putting unnecessary pressure on the facilities in urban areas.

The Nigerian Health Care Structural Review and Development Perspective

Since the modality of Nigerian health care structure was not specific, it was dependent on traditional birth attendants, native doctors, and herbalists, who provided health services in the pre-independence period. According to Isola (2013), spiritual health-giving, African traditional medicine, and orthodox or Western medicine are categories of healthcare services from the independence period to the contemporary period. On the other hand, there were medical officers who treated colonial masters and their family members.

The colonial masters handed over the responsibility and administration of national health care delivery policies immediately after the independence in 1960, and this brought another dimension into the formulation and implementation through the National Development Plans (NDPs) and the Rolling Plans (RP). The first NDP was initiated between 1962 and 1968 by the Nigeria Basic Health Service Scheme (NBHSS) in the post-independence with the assistance of WHO from 1975 to 1980. According to Uzochukwu, Onwujekwe, Mbachu (2015), and Odutolu *et al*. (2016), the chief aim of the scheme was to;

i. increase the percentage number of beneficiaries of health care services from 25 – 60% and restore the inequity in the creation and localization of health institutions,

ii. Provision of infrastructural facilities to assist the facilitation of all health care preventive programs, which are family and reproductive health, environmental health, control of communicable disease, and nutrition.

iii. Establishment of health care structure that can be easily localized.

After the NBHSS, PHC was inaugurated in 1987 as an offshoot of the National Health Policy (NHP) instituted on the ideology of "social justice and equity to achieve health for all Nigerians by the year 2000 and beyond." The PHC resonated with the need for collaboration among all stakeholders in healthcare promotion. The development resulted in partnerships between religious and non-governmental organizations, CBOs and CDAs, and other development partners to step down and democratize health care delivery among the rural, semi-urban populace. Though this was the main target for the domestication of PHC in 1987, Nwama (2021) argued that the policy implementers hijacked the program on the excuse of inadequate human resources and poor road and transportation networks.

In another development, Odutolu *et al*. (2016) stated that the structural healthcare system was multifaceted in the dimension of Nigerian federalism in Federal, State, and Local Governments. In this way, the federal government oversees tertiary health care; the state government manages secondary health care, such as general and cottage hospitals, whereas the local government handles the PHCCs and health care outposts, respectively. Precisely, Basch (2011), Odutolu *et al*. (2016), Okebukola & Brieger (2016), WHO (2017), and Eboreime (2019) summed the responsibility of the federal government in the following:

i. Policy development, technical assistance, directive, and implementation.

ii. Harmonization of State-level implementation of health care policy directives,

iii. Creation of Health Management Information Systems (HMIS),

iv. Disease reconnaissance, drug regulation, and vaccine management, and

v. Medical personnel's education and training, including the administration of health care institutions like the teaching, orthopedics, psychiatric hospitals, and the FMCs.

In another development, the state government is responsible for managing secondary hospitals and providing technical support for PHCCs, CHEWs, hygiene, and community environmental

sanitation (Odutolu *et al*., 2016). The following table depicts the structural framework of the operations of PHC in Nigeria.

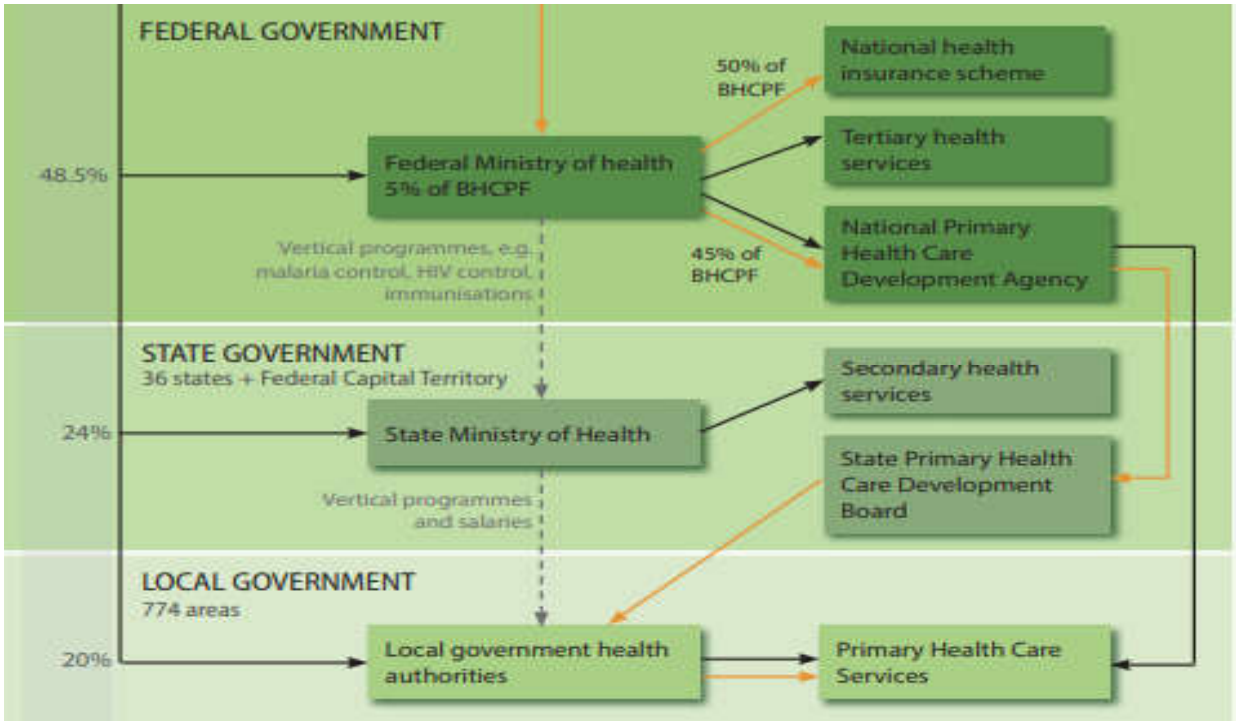
Table 1: The Management of PHC in Nigeria

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: NPHCDA (2014).

From the table 1 above, the administration of PHC is divided into three segments. It is observed that the running PHC is the responsibility of the Local Government Council (LGC) through "the Ward Development Committee, Committee, Village Development Committee, and Community Development Committee." In the table, an average of 7,740 health centers are expected initially to be built in each ward across the 774 LGCs in Nigeria and a village with the least population of 2,000 to 5,000 maximum. According to Okonofua (2014), NPHCDA responded in 2007 under President Umar Musa Yar'Adua 2007 by immediately building 774 PHCCs across the country, with each located in the headquarters of the LGCs in Nigeria. However, the projects were abandoned due to litigation from the State governments over the constitutional control of the LGCs.

Figure 1: Flows of Health Services



Source: Health Policy Research Group Brief (2015).

As noted in Figure 1, the federal government is 45% in charge of tertiary health delivery, NHIS, and NPHCDA. The figure also shows that the state governments control 24% of secondary health care services and state PHC development, while the LGAs are 20% responsible for the conditions of PHC in the rural and semi-rural sectors.

The Primary Health Care: A Treatise

Accordingly, PHC is a fundamental health care system that is universally, scientifically, practically, technologically, and socially sound and accessible to 'all' at an affordable rate and with the complete participation and development of the community members in the sense of health care determination and self-reliance. Ultimately, Whiteford & Branch (2008), Okonofua (2013), and Macdonald (2013) defined the approach to be the essential health care "value reorientation of affordability that focuses on people closest to the places where they reside so as to engender social equity and to increase access to health care to the poorest and most vulnerable people in any given community." Roemer (1986) typically asserted that the PHC emerged as a structure that will assist in achieving significant healthcare delivery in developing nations

through the condensed capacity building of CHEWs and technicians (see Table 1 and Figure 1). The abridged trained personnel, who are midwives, nurses, community health officers, environmental health officers, medical laboratory technicians, community health information officers, and visiting medical doctors, are those who ensure the operations of the PHCCs in Nigeria.

The services rendered by these personnel at PHCCs are not far-fetched. They include public health education, maternal and child health services, environmental health, family planning, prevention and treatment of communicable diseases, immunization, and data collection on health-related matters.

Although the conceptualization of PHC is not recent, it assumed prominence in 1978 with the WHO's discovery that developing countries are devastated by healthcare delivery challenges (Chukwuani *et al*., 2006; Adebimpe & Bamidele, 2009; Kruk Freedman, 2008; de Leeuw, 2017; Adafin *et al*., 2018; Adafin, 2018; Gambo *et al*., 2021). The WHO conceptualized the model with an attempt to localize the uneven and urban-based distribution of health care structure. Hence, Okonofua *et al*. (2018) argued that the adoption of PHC, for instance, transformed healthcare matters in Nigeria. Historically, Okonufua (2013) said;

> PHC received a considerable boost in Nigeria in the mid-80s when one of the participants in the Alma Ata Declaration of the concept in 1978 (Professor Olikoye Ransome-Kuti) became the nation's Minister of Health. Ransome-Kuti provided the ideal template for the institutionalization of PHC in Nigeria, acting as an advocate, key policy proponent, and implementer on all aspects of PHC.

Therefore, "the Declaration of Alma-Ata was the first document to set out a holistic view of health and put an emphasis on the contribution of health to economic and individual development" (WHO, 2019). It, therefore, implies that the health care approach of PHC is an amendment to the success recorded by medicine to the economic situation of the affected countries.

The Management of PHC resides with the LGC Chief executive through the Supervising Councillor for Health, who is from the political side of the administration, and the Head of Department (HOD) Health, who is a civil servant who gives professional reports, advice, and guidance to the Supervisor. They are both answerable to the Finance and General-Purpose Committee (F&GPC) (Adeyemo, 2005; Federal Ministry of Health, 2004; Abdulraheem, Olapipo & Amodu, 2012).

In order to bring health care delivery closer to the people, PHC was conceived and domesticated to ensure a continuous process and health care liberalization to prevent the spread of communicable diseases and the infant and maternal mortality rate.

Findings and Discussion

The necessity of PHCCs surfaced in the event of various pandemics that rocked humanity without exception in the 21st century. The viral ones like HIV/AIDS, Lasser Fever, Ebola Virus, and contemporary COVID-19, among others, reaffirmed the need to prioritize the proper implementation of the PHC program the world over. Thus, a careful survey of the present state of the PHCCs reveals apathy, dilapidation, non-functionality, and abandonment by "the powers that be." This is happening amidst the WHO (2021) statement of facts that "about 930 million people worldwide are at risk of falling into poverty due to out-of-pocket health spending by 10 percent or more of their household budget, and scaling PHC interventions across low and middle-income countries could save 60 million lives and increase average life expectancy by 3.7 years by 2030."

It has been discovered that Nigeria has found it difficult to properly implement the PHC program as articulated by the WHO in the 1978 Declaration of Alma-Ata. Scholars like Aliyu, Alabi, Adeowu (2018), Ogunlana (2019), Eregha, Olusegun, and Osuji (2019) identified corrupt practices in government, elite-centered policy implementation technique, and policy summersault as factors predicting the failure and unproductivity of both home-grown and foreign policy success in Nigeria. The healthcare sector in Nigeria has suffered a lot from this situation, partly because of the prevalent medical tourism phenomenon among the elite class, which is the policy implementers. Subsequently, the remote meaning, conceptualization, and intention of PHC with PHCCs as a grass-root health care model in accordance with "the first level contact of

individual and the first step to accessing basic health care facilities in a rural semi-urban community with the national health care system" became eroded and moribund respectively (Agarwal *et al*., 2017; Li *et al*., 2017; Dassah *et al*., 2018; NeJhaddadgar *et al*., 2020).

From the foregoing, the apparent dilapidated status of PHCCs drew the attention of the then Military government of General Ibrahim Babangida (retired) to enact Decree No. 29 of 1992, which created the NPHCDA to develop and provide "leadership that supports the promotion and implementation of high quality and sustainable PHC for all through resource mobilization, partnerships, collaboration, development of community-based systems and functional infrastructure" (NPHCDA, 2014). As Onyeji (2017) reiterated, the NPHCDA structure posited that:

> …a PHC will have one or more doctors, a pharmacist, a staff nurse, and other paramedical support staff to provide outreach services such as immunizations, preventive and basic curative care, monitoring and evaluation services, as well as maternal and child health services.

Conversely, Nigeria's rural and semi-urban communities are now living with tattered and dilapidated, ill-equipped PHCCs without any appropriate substitute (Dioka, 2017; Ojoye, 2018; Makinde *et al*., 2021). For instance, Ogbonna, Okpella, and Ekosodin are communities that have PHCCs that represent extreme abandonment in the Etsako and Esan-speaking areas of Edo Northern and Central zones of Edo State. The PHCC, located in Odot, Nsit Atai Local Government Area of Akwa Ibom State (South-south Region), is an eyesore as well (see Appendix I).

From the middle belt, we considered the sorry states of PHCCs in Okenya-Ajaka and Ayeke-Ibaji in the Igala-speaking area of Kogi State (see Appendix II and III). The Kogi State situation is tragic because PHCCs have been closed since 2015 because of hazardous manpower audits and non-payment of local government personnel, which led to the sacking and resignation of 60% of CHEWs, CHOs, EHOs, and HIOs. As Edoka (2021) noted, the LGCs in the state have no statutory allocation that will enable them to meet their financial obligation for themselves since Yahaya Bello assumed duty as the governor. In another

development, the PHCCs in the rural semi-urban setting of Abuja were not spared. For example, PHCC in Dutse-Makaranta in the Bwari Area Council works on a rise-and-sunset basis due to the absence of a power supply to the Clinic (see Appendix V). The center was established to work on 24 24-hour basis, but the reverse has been the case since its inauguration in 2017.

In the Southwestern Region, an assessment revealed the same poor situation of PHCCs. Ajuwon and Ogungbade in the Ifo Area of Ogun and Okinnin-Egbedore in Osun States, respectively, are semi-urban centers with poorly maintained PHCCs (see Appendix VI and VII). The clinics are wrongly situated. The Ajuwon PHCC is at the main Bus Stop and is a hub for commercial, social, and religious activities of different types. The Clinic is in the middle of shopping malls, central mosques, and Christian worship centers. The Okinnin PHCC is acutely short of capacity to the extent that it has a day-in-a-week visit of a medical doctor from far away Oshogbo, the State capital. It is the only known medical facility for the poor and vulnerable in the area who cannot afford international and local medical tourism like the privileged few.

PHCCs in Efon-Ekiti presented a different position of a sorry story of the facilities. One of the major centers has turned into a semi-military base that guards the major highway. In another development, the second PHCC in the community is located in the middle of the bush, and worst of all, it was named after the former governor of the state, Dr. Kayode Fayemi (see Appendix VIII).

In the same way, PHCC in Umuokanne, Ohaji-Egbema, an area in Imo in South Eastern Nigeria, is characterized by falling and leaking roofs and ceilings (see Appendix IX). The structure was built over twenty years through community development efforts and donated to the LGC to ease access to health care services for the citizens of the community whose economic mainstay is agriculture. Apart from the worsened nature of the structure, the environment is bushy, and there is no medical equipment in the laboratory, maternity, accident and emergency, or children's wards. Umuokkanne community is a semi-urban center

that is densely populated, and the PHCC in the area is grossly short of medical personnel in comparison to her population and the prevailing health challenges that it handles on a daily basis.

In North Eastern Nigeria is Shokwari PHCC within the Maiduguri Metropolitan Council (MMC) in Borno, where health care services are administered under the canopy and tree (Appendix X). To this end, Okech (2019), cited by ICRC (2019) description of northeastern Nigeria's healthcare delivery condition thus:

> "Treatable illnesses such as malaria become deadly as people simply cannot get medical care due to the hostilities. Childbirth has also become a dangerous undertaking. North-East Nigeria has the worst maternal mortality rate in the country, with more than 1,500 deaths for every 100,000 live births. The health centers are much overstretched, and it is difficult for them to recruit medical staff."

As WHO found in 2019, "40% of health facilities are either fully destroyed in Adamawa, Borno, and Yobe states where nearly two million women are of reproductive age and 1.6 million men are sexually active." Consequently, the citizens of the northern, eastern region who need more medical attention and health care services are women and children who undergo preventable and curable diseases and are not well served. The WHO (2021) study further revealed that "the North Eastern region of Nigeria showcases the worst indicators of maternal and child health in that endemic malaria is still responsible for more than 50% of infant mortality and morbidity rates with severe respiratory tract infection, serious malnutrition, and watery diarrhea as remote causes of illness."

We can succinctly posit that the PHC policy will continue to remain properly unimplemented since it is domiciled with the LGC, which is considered the lowest tier in all ramifications of the federal structure in Nigeria. Therefore, it can be submitted that the interference in the affairs of the LGC, particularly finance, is excessively alarming. Perhaps Idagbon in Otu (2001), cited by Odo (2014:108), observed that there is too much control of the local governments in Nigeria "by the state governments to such an extent that there [are] no more local governments but local administrations or more precisely, local arms of the state administrations." The LGCs are the

'cash cow' of the State governments in Nigeria. They empty the purse of the council on a monthly basis through what is called "the joint allocation committee," thereby famishing the system of essential services rendering, including PHC, which is an impactful and democratized health care model (Odo, 2014, p. 108). Besides the LGC's inability to financially muscle the PHC program, Okonofua (2013) recognized a lack of technical support and institutional capacity programs to carefully embark on monitoring and evaluation of the activities of PHCCs. Thus far, a vacuum exists in the continuous "serious commitment to the right to health care or any other substantive socio-economic right" (Nnamuchi, 2008, p. 2).

The foregoing analysis of data represents the ill-domestication of PHC policy in Nigeria, which is contrary to the health care accessibility hope, yearning, and aspiration of the targeted population and the outlined initiative of the WHO at "The Declaration of Alma-Ata" in 1978. Hence, the following are major identifiable hurdles facing the PHCCs in Nigeria:

i. Lack of decisive political will for program implementation, monitoring, and assessment.
ii. Lack of infrastructural facility maintenance.
iii. Poor and inefficient operation.
iv. Absence of required quality and quantity of skilled human resources.
v. The paucity and misappropriation of funds and community apathy.

Conclusion and Recommendations

Nonetheless, PHC is the sure qualitative alternative and democratized framework for accessibility and affordability of health care services by the rural and semi-urban dwellers in developing countries at large and Nigeria in particular. Through the program, healthcare delivery approachability and social equity are stimulated. From the foregoing, we can conclude by deducing that the challenges facing the proper implementation of PHC in Nigeria will linger if the LGCs remain the continuous driver of PHC, there is the persistence of elite dominance, dictate and directive of the policy, absence of service delivery, monitoring, and evaluation mechanism are absent, community apathy and lack of ownership is not addressed, and there is lack of institutional capacity and technical support programs. Therefore, the following recommendations are being forwarded.

i. The 10th National Assembly and Houses of Assembly across the States of the Federation should prioritize constitutional amendment to grant the LGC financial autonomy and enable her to administer social responsibilities in health care delivery and other ancillary services.

ii. The efficiency of operation should be emphasized to avoid the rendering of epileptic services by PHCCs.

iii. The relevant government agencies and development partners should revitalize and regularly maintain PHCC infrastructures.

iv. CSHT should be equipped with the necessary training infrastructures to continuously assist the PHCCs in producing the qualitative and quantitative skilled manpower they need.

v. A decisive and determined political will is required for the continuous implementation of PHC programs and projects.

vi. CDAs, CBOs, and NGOs should be involved in providing and managing funds for the strategy and sustainability of PHCCs. This will end the community's apathy and non-ownership posture.

Contribution to Knowledge

i. The study demonstrated the 'Urban Bias Theory, ' which no known study on PHC has adopted to appraise and analyze the sad situation of PHC policy and PHCC structures in Nigeria.

Policy Implication

i. The study urges all stakeholders to urgently address the development and management of PHCCs, the only major public healthcare institutions in the rural and semi-urban sectors. This implies that though there is a huge and superior emphasis on tertiary health care, it should not detriment PHCCs' development programs and projects.

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APPENDIXES I – X

Appendix I: Ekosodin PHCC in Edo Central Area of Edo State.

Source: The Researchers (2021).

Appendix II: Okenya Health Centre In old NRC Building, Kogi State.

Source: The Researcher (2021**).**

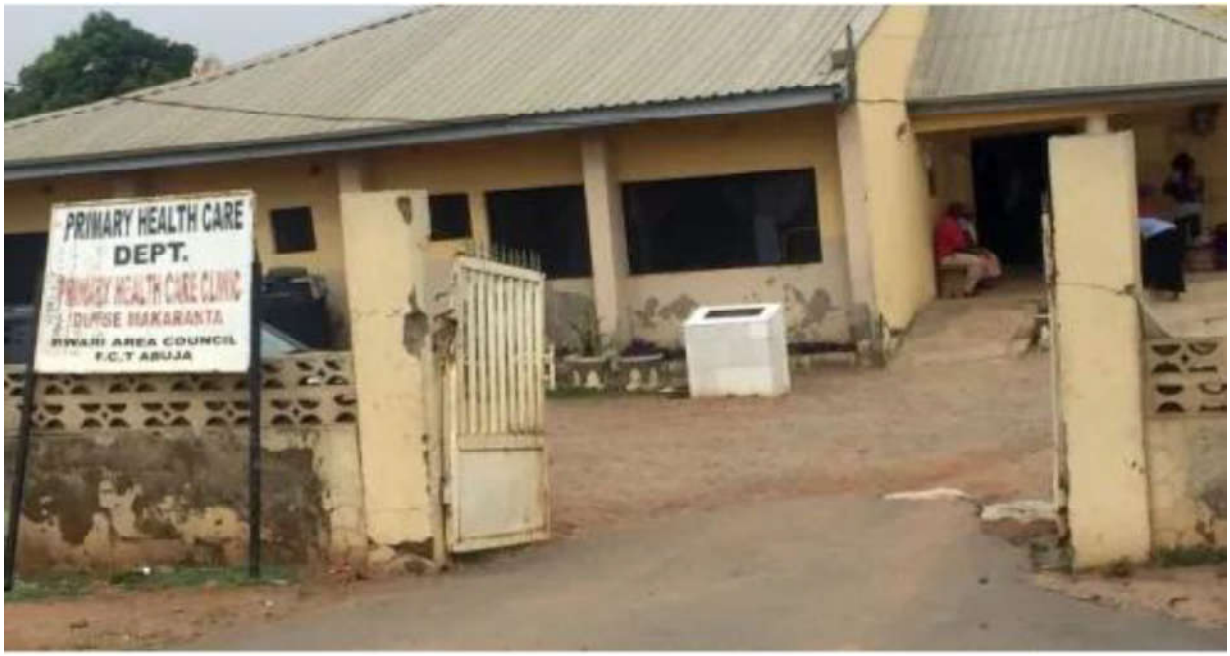
Appendix III: PHCC Ayeke, Ibaji

Source: The Researchers (2021).

Appendix IV: PHCC Kabba Junction Obajana, Nigeria

Source: The Researchers (2021).

Appendix V: PHCC Dutse Makaranta, Abuja



Source: The Researchers (2021).

Appendix VI: PHCC, Ajuwon, Ifo, Ogun State

Source: The Researchers (2021).

Appendix VII: Interior and Exterior of PHCC Okinnin, Osun State

Source: The Researchers (2021).

Appendix VIII: PHC, Efon in Ekiti State

Source: The Researchers (2021).

Appendix IX: PHCC in Umuokanne in the Ohaji/Egbema, Imo State

Source: The Researchers (2021).

Appendix X: The Shokwari PHCC in Maiduguri, Borno State

Source: ICRC (2019).