



An Overview of the Primary Healthcare System in Nigeria

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ABSTRACT

This paper describes the structure and operation of the primary healthcare system in Nigeria, the sequence of its evolution from inception to what is obtainable now and the effectiveness of the system. Prior to that, a detailed description of the WHO targets through its Alma-Ata declaration in 1978 was explained and evaluated in comparison with the Nigerian healthcare system. Emphasis was laid on the concept, principle and element of the primary healthcare system as well as the challenges and the current state of the system. In conclusion, Primary healthcare in Nigeria, particularly in rural areas, has come a long way, but more work is undoubtedly still needed to realize the objective of universal health now and in the future. Priority should be given to improving people's living conditions beyond the current poverty level in order to promote healthier living. Local governments, as well as all other levels of government, must increase their allocations to the health sector among other things.

INTRODUCTION

Globalization is putting many countries' social cohesion under strain (Daboul, 2022). People are growing increasingly frustrated with healthcare providers' inability to provide levels of national coverage that meet stated demands and changing needs. Health systems, as key components of modern society's architecture, are clearly not performing as well as they should. Health systems must respond better and faster to the challenges of a changing world as a result of their failure to provide services in ways that correspond to expectations. The solution is Primary Health Care (PHC). The values pursued were explicit in the Alma-Ata Declaration: social justice and the right to better health for all, participation, and solidarity (Wael Daboul, 2022a).

From the World Health Organization down, primary healthcare has risen to the forefront of attention (Sanders et al., 2018). The anticipation that placing more of an emphasis on primary care will result in less expensive and better care won't come true until a more comprehensive investigation of its issues is conducted and some of its flaws and weaknesses are corrected. Its duties must be more clearly defined, the work must be divided among team members, training and education must be better tailored to the organization's needs, and much more in-depth analysis of the available data is needed to determine what is relevant and what is not (Sanders et al., 2018).

Every healthcare system inevitably has different degrees of care. There is self-care first. Self-care or self-help is becoming more popular for the same reasons that professional primary health care is (Sanders et al., 2018). Although a greater amount of care and the prevention of illness and symptoms occur there, the medical community has virtually completely disregarded this region, which calls for it to be a vital component of primary healthcare. Consumers should embrace personal responsibility for maintaining their own and their families' health and preventing sickness since they are becoming so much more interested and concerned with health. Putting the blame on the medical community is pointless. The public may be given a code of conduct for healthy behaviour that they ought to respect (Sanders et al., 2018).

Primary professional care is the second distinguishable level of care. Once a family decides they require professional, experienced medical assistance, they enrol in the true health system (Tulchinsky&Varavikova, 2019a). They seek advice from a primary healthcare provider. He or she must carry out specific jobs and duties; must be readily available, reachable, well-trained, equipped, and capable of assuming responsibility for the continuity of good care or being able to send the patient to specialized units when necessary and communicate with them during the care. In all systems, specialists are considered third level of care (Tulchinsky&Varavikova, 2019b). However, given that primary healthcare is a distinct field, this may be confusing; It differs from other specializations in that it covers the entire field of medical and social service welfare, whereas other specialties are typically limiting and associated with a small and vertical field of diseases, organs, or age groups (Sanders et al., 2018).

Primary healthcare encompasses a wide range of professions in addition to medicine – primary care physicians, family doctors, general practitioners, paediatric specialists, and internists do not have exclusive authority over it (Daboul, 2022). Nurses, social workers, and many other professional organizations are also welcome there. It is plausible to say that there is a solid argument for a faculty of primary health care that should include and involve everyone working in this specialized field of care because they must all collaborate as a team (Wael Daboul, 2022b).

LITERATURE REVIEW

Origin of Primary Healthcare

PHC and the Alma Ata Declaration, which was signed in 1978 during an international meeting in Alma Ata, Kazakhstan, are frequently linked (Jones et al., 2020). PHC became a central idea of the World Health Organization's (WHO) objective of health for all following Alma-Ata, which lifted health equity to the top of the political agenda for the first time in the worldwide community. Along with seven recommendations for states looking to enhance their healthcare systems, this PHC concept was included in a study that was submitted to the WHO Executive Board in January 1975. These recommendations emphasized the significance of planning primary healthcare (PHC) around community lifestyles and involvement, making the most use of community resources while respecting financial limitations, an integrated approach that encompasses preventive, curative, and promotional services for both the individual and the community, and interventions to be carried out by the most qualified healthcare professionals at the most remote feasible level (Jones et al., 2020).

The WHO's Division for Strengthening of Health Services Director Kenneth Newell provided guidance for the creation of the PHC concept paper. I'll be tracing some of the publications and people who had an impact on the writing team responsible for it (Jones et al., 2020). The contact with members of the Christian Medical Commission (CMC) staff and its Board, including James McGilvray, Nita Barrow, Haken Hellberg, Jack Bryant, and Carl Taylor, was one of the team's most significant influences, aside from the case studies that were published in the magazines *Health by the People* and *Alternatives Approaches* (Jones et al., 2020). They provided us with knowledge beyond our own, inspiration, and encouragement. But there were other historical influences that extended much farther back in time: PHC-like ideas were present as early as the first half of the 20th century. Conferences held in the 1930s by the Rockefeller Foundation, the League of Nations Health Organization, and other organizations assisted China in developing rural health programs that facilitated collaboration and offered a path forward.

Concept of Primary Healthcare

The primary healthcare (PHC) idea was developed in the 1970s and was influenced by the basic needs approach to social development. In order to achieve Health for All by the year 2000, WHO and UNICEF created a primary healthcare strategy. This plan drew inspiration from the failures of the basic health services approach, as well as from China's impressive health improvement and the numerous small-scale, community-based healthcare projects that have been successful in developing nations, mostly thanks to non-governmental organizations (PHAO 2022). PHC affects society and politics in a big way. In addition to providing basic healthcare needs in a more equitable, appropriate, and effective manner, it specifically outlined a plan of action that would address the underlying social, economic, and political reasons of poor health (PHAO 2022). Principles such as universal accessibility and coverage based on need, comprehensive care with an emphasis on disease prevention and health promotion, individual and community involvement and self-reliance, intersectoral action for health, appropriate technology, and cost-effectiveness in relation to available resources were to form the foundation of the PHC approach (PHCA). Social justice had a major effect on the concept of PHC (PHAO 2022).

It was acknowledged that, should the plan be implemented correctly, the PHCA would have far-reaching consequences even in the development of the Alma Ata Declaration (WHO and UNICEF, 1978). In addition to the health sector, other social and economic sectors as well as community structures and procedures would also need to modify in order to implement the principles (PHAO 2022). A few of the changes that would be required include the redistribution of the health system's current resources (financial, material, and human), a reorientation and expansion of health personnel's skill sets to better prepare them for the challenges of implementing PHC and to work in teams as well as with other professionals in the field and communities, and improved health system design, planning, and management (Horton & Pang, 2018).

Goals and Objective of Primary Healthcare

Primary healthcare is defined by the Alma Ata Conference as essential healthcare that is provided to all individuals and families in the community at all times, at a cost that the community and the nation can afford, and with their full participation and means that are acceptable to them. This definition applies to all stages of development, in the spirit of self-reliance and self-determination. Primary healthcare is dependent on methods and technologies that are helpful, reasonable from a scientific standpoint, and socially acceptable. Primary healthcare is dependent on methods and technologies that are helpful, reasonable from a scientific standpoint, and socially acceptable. It serves as the primary goal and function of the nation's health system and is essential to the community's overall social and economic development. In light of this, the PHC's goals are:

- The Alma Ata Declaration's global objective is to achieve self-reliance and Health for All by the year 2000.

- Health is created or destroyed where people live and work, therefore it starts at home, in the classroom, and at work.
- It also implies that people will utilize better methods than they do now to prevent illnesses, treat unavoidable illnesses, and lessen disabilities, as well as to have better ways of developing, aging, and passing away gracefully.
- It also means that the population will be distributed equally among all available health resources.
- It implies that everyone will have appropriate access to basic healthcare services that are reasonably priced.

Principles and Elements of Primary Healthcare

The principles of PHC are stated thus:

1. Equity
2. Community Participation
3. Intersectoral Coordination
4. Appropriate Technology
5. Support Mechanism Made Available

Equity/Equitable Distribution

The first crucial component of the primary health care plan is equity, or the equitable distribution of health services. Everyone has to have access to health care, regardless of their financial status; wealthy or not, living in an urban or rural area, should not be a barrier. Since most people in developing nations live in towns, the majority of them do not currently have access to health care.

Community Participation

The State is the one with main responsibility. The promotion of each person's own health and welfare must involve families, communities, and individuals as part of primary health care. PHC coverage cannot be achieved in the absence of community involvement in the planning, provision, and upkeep of healthcare services.

Intersectoral Coordination

PHC, according to the Alma-Ata Declaration, encompasses not just the health sector but also adjacent disciplines and facets of local and national development, including housing, industry, public works, education, housing, agriculture, animal husbandry, and food production.

Appropriate Technology

Excellent science-based technology is adaptable to local conditions, well-liked by users and intended beneficiaries, and easily maintained by the general public using resources that their community and nation can afford.

Using the right healthcare technologies is one of the most crucial ways to improve the accessibility and availability of healthcare services. It is

"technology that is scientifically sound, adaptable to local needs, and acceptable to those who apply it and to whom it is applied," according to one description. Additionally, people can maintain technology on their own using resources that the nation and society can afford, in keeping with the idea of self-reliance." Science states that widely utilized, less costly, and scientifically proven instruments and procedures comprise appropriate technology.

Additionally, it is vital to guarantee that the technology is:

- Valid and dependable from a scientific standpoint;
- Adapted to meet local needs;
- Accepted by the community; and
- Affordably accessible for local resources.

Support Mechanism Made Available

Support networks are essential for both a healthy lifestyle and a good standard of living. The support mechanism is a well-known technique in basic healthcare for raising quality of life. Customers of primary health care receive instrumental, personal, physical, emotional, and spiritual support in order to meet its goals. Primary health care requires an adequate quantity and distribution of licensed medical physicians, nurses, community health workers, allied health professionals, and other professionals who work together as a health team and get local and referral-level assistance.

Millennium Development Goals

The Millennium Development Goals (MDGs) put health at the center of development and are pledges made by governments across the globe to combat illness, decrease poverty, and end hunger.

1. Put an end to severe hunger and poverty
2. Make basic education universal
3. Advance gender parity
4. Enhance maternal health
5. Lower child mortality
6. Fight HIV/AIDS, malaria, and other infectious diseases
7. Ensure sustainability of the environment
8. Create international collaboration for growth

Primary Healthcare in Nigeria

A community-based management approach for providing healthcare services is called primary health care (PHC). Different countries have achieved differing amounts of progress in implementing the plan since it was initially announced in 1978 (A.O. et al., 2019). Current measures to revive basic healthcare in Nigeria include the Maternal Newborn and Child Health (MNCH) Week, PHC Reviews, the Midwives Service Scheme (MSS), and the National Health Management Information System (NHMIS). The roles of the people, the government, and health professionals need to be clearly defined and pursued in order to maximize the benefits of primary health care (A.O. et al., 2019).

In order to accomplish the lofty goal of "Health for All," primary healthcare, or PHC, has become a popular tactic since its establishment in 1978. Achieving Health for All—which encompasses the rich and the poor, the

educated and the ignorant, the old and the young, men and women, children and the elderly – is the only path to a healthy world. By providing preventative, therapeutic, and rehabilitation treatments, the primary healthcare system is a grassroots approach intended to address the key health challenges in the community (Goffin & Olise, 2018). The term "primary healthcare" refers to care which is "based on practical, scientifically sound, socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance" (WHO, 2021).

Primary healthcare's core principles highlight the strategy's great value. Fundamental healthcare, community involvement, equity, intersectoral collaboration, and the use of appropriate technology are the guiding principles that support primary healthcare's efficacy in achieving universal health coverage (A.O. et al., 2019). Primary health care is intended to provide services to the majority of the population based on needs without regard to financial, social, or geographic constraints through their involvement in the planning, administration, and assessment of health programs. It means leveraging resources from both inside and outside the health sector and using technology depending on applicability (A.O. et al., 2019).

One of the most essential human rights included in the World Health Organization's constitution is the right to the best possible health (World Health Organization, 2018). Therefore, it is the responsibility of each and every UN member to provide its citizens with accessible, universal healthcare. The most practical way to carry out the aforementioned commitment is through primary healthcare (PHC). Primary health care is a comprehensive approach to health and welfare that takes into account the unique requirements, preferences, and characteristics of each individual, family, and community (WHO, 2019). According to K A (2020), PHC acts as the first point of contact between individuals, families, and the federal health system. According to the World Health Organization (WHO, 2018), Nigeria's primary healthcare system is the most relevant, distinctive, and significant component of the country's three-tiered healthcare system. Through government primary healthcare centers and faith-based clinics in rural and suburban regions, secondary and tertiary health facilities provide care to urban people. Primary healthcare, on the other hand, is a deliberate and methodical effort to establish a health care system that guarantees high-quality medical care while meeting the requirements of the majority population and individuals who are underprivileged. The cost of this system is also intended to be cheap and sustainable. Regardless of social or economic standing, everyone should be able to access and use the primary healthcare system as their first point of contact (K A, 2020).

PHC offers comprehensive care, promotes healthy lifestyles through health education, treats and prevents infectious and non-infectious diseases, manages public health, and offers rehabilitation and palliative care to all patients, all with the goal of providing healthcare for people from birth to death. Primary healthcare is essential to the survival of all humankind as well

as the growth and advancement of individual countries. By treating people and communities as stakeholders and duty bearers in their well-being and overall health outcomes, PHC systems are able to respond locally and quickly to rapid changes in the economy, demographics, and technology. This has the demonstrated potential to yield enormous benefits globally (WHO, 2018).

It has also been found that PHC treatment is highly effective and efficient in addressing the primary causes and risk factors of health deficiencies. It can also be used to address emerging threats to the health and welfare of the general public. The Sustainable Development Goals (SDGs) pertaining to health must be accomplished, and these goals are closely related to other SDGs such as ending poverty, guaranteeing equal access to education, fostering economic growth, reducing inequality, and tackling climate change (K A, 2020).

Because primary health care is so important, countries all over the world invest a lot of time, money, and energy into creating and sustaining PHC systems. Nigeria has been mandated to offer primary healthcare to its inhabitants as a signatory to the United Nations Charter and a member of the World Health Organization (WHO). The country has made efforts in this regard. It is important to remember that the effectiveness of initiatives to supply basic healthcare depends on the selection and combination of appropriate and efficient financing methods as well as a strong framework for the administration and provision of healthcare services (Olakunde, 2012). Nigerians presently pay for their healthcare through a combination of tax money, private savings, international donations, and health insurance (Olakunde, 2012). The success of PHC in Nigeria is impacted differently by the employment of these funding mechanisms, either alone or in combination.

History and Conceptualization

The National Health Policy of 1988 (FMOH, 2020) established primary healthcare as the cornerstone of the Nigerian health system in an effort to promote equity in the use of essential medical services. Since then, Nigerian primary healthcare has seen multiple phases of development. More than 85% of all healthcare institutions in Nigeria were said to be primary healthcare facilities in 2005 (FMOH, 2020). Nigeria has made three notable attempts in the past to create and sustain a health system that is focused on the needs of the society and its citizens. A first attempt was made in the period spanning from 1975 to 1980. The crucial point of the period was the adoption of the Basic Health Services Scheme (BHSS). The creation of the Basic Health Services Scheme in 1975 was a crucial component of Nigeria's Third National Development Plan (1975-79) (Adeyemo, 2020). It was split up into "basic health units," which consisted of four main healthcare centers and twenty health clinics dispersed throughout each LGA, in addition to mobile clinics that could treat roughly 150,000 patients each. This project failed because the local communities that benefited from the programs were not involved. As a result, the Scheme could not be continued after the end of the third national development plan era. A second attempt was made between 1986 and 1992 under the direction of the late Professor Olukoya Ransome-Kuti (Kuti et al, 1991). In fifty-two (52) pilot local

government districts that were all implementing all eight primary healthcare components, model primary healthcare was established to represent this phase. Achieving 80% immunization coverage for children under five who had received all recommended immunizations was one of the main objectives of this dispensation. The concept of active community engagement was carefully put into practice, and issues pertaining to HSS were given consideration, which contributed to the success that was attained. The third attempt to provide primary healthcare to the general people was the establishment of the National Primary Healthcare Development Agency (NPHCDA) in 1992. This period, which ended in 2001, saw the implementation of the Ward Health System (WHS), which uses the electoral ward – which has a representative councillor – as the basic operational unit for the provision of primary healthcare. This was done as a result of the primary healthcare system being transferred to local governments by the military government at the time. Additionally, a cost-effective set of health interventions having a major impact on morbidity and mortality was established under the Ward Minimum Health Care Package (WMHCP). The package took into account priority diseases of national concern, current trends in disease prevalence, and the burden of sickness on the nation. Nigeria's Millennium Development Goal (MDG) targets are met by the Ward Minimum Health Care Package, which was developed inside the Ward Health System. To complement this new strategy, the federal government built more than 500 hundred model health facilities around the nation (NPHCDA, 2022). A key factor in the creation of the Ward Health System and community mobilization was the formation of Ward creation Committees, which are composed of selected community leaders and are centered around model primary healthcare institutions. Since local government units are considered to have the least technical expertise, the abrupt transfer of primary healthcare to them may have had a negative impact on the sustainability of quality. However, it made sense to center community-focused primary healthcare around the level of government thought to be closest to the people. The Federal Government's involvement in local government regions through the construction of model health facilities was contrary to the recently formed concept of devolution of healthcare, notwithstanding its good intentions. Even while this action might have been justified during the military dictatorship, when democracy eventually triumphed in 1999, it was placed in peril.

METHODOLOGY

This paper describes the structure and operation of the primary healthcare system in Nigeria, the sequence of its evolution from inception to what is obtainable now and the effectiveness of the system. Prior to that, a detailed description of the WHO targets through its Alma-Ata declaration in 1978 was explained and evaluated in comparison with the Nigerian healthcare system. Emphasis was laid on the concept, principle and element of the primary healthcare system as well as the challenges and the current state of the system. In conclusion, Primary healthcare in Nigeria, particularly in rural areas, has come a long way, but more work is undoubtedly still needed to realize the

objective of universal health now and in the future. Priority should be given to improving people's living conditions beyond the current poverty level in order to promote healthier living. Local governments, as well as all other levels of government, must increase their allocations to the health sector among other things.

RESEARCH RESULT AND DISCUSSION

Primary Healthcare System in Nigeria

Africa's Sub-Saharan region is home to Nigeria. It is the most populated country in Africa with more than 200 million people living in it. Its population by the beginning of the third quarter of 2025 is projected to reach 214,028,302. With an estimated 390 million inhabitants, Nigeria is predicted to have the fourth-largest population in the world by 2050 (CIA, 2020). The majority of its citizens are in the 0–14 age range (NBS, 2018). The rate of adult literacy in any language in the country is 71.6%, with a higher rate of 79.3% among men and 63.7% among women. The percentage of adults who are literate in English is 57.9%, including 65.1% of men and 50.6% of women (NBS, 2018). Nigeria is governed by a federal system that includes state and local governments at the subnational level in addition to the federal authority. Nigeria, predictably, has three levels in its healthcare delivery system: the federal government, which operates tertiary and teaching hospitals, state governments, which operates secondary hospitals, and local governments, which operates primary health care centers (PHCs).

The Federal Ministry of Health (FMOH, 2014) states that the National Health Act of 2014 is the cornerstone of national PHC policy and is crucial to guaranteeing that everyone has access to healthcare. It is necessary to create a basic health care provision fund that will contribute at least 1% of the federal government's total consolidated revenue. Fifty percent of this amount will be distributed to the National Health Insurance Scheme (NHIS) so that citizens can receive a minimally appropriate range of healthcare services. It states that the remaining 50% must be used for PHC-level emergency medical care, infrastructure development, training of human resources, and the purchase of essential medications, vaccinations, and other supplies (FMOH, 2019). Primary healthcare services are horribly underprovided in Nigeria. According to Ananaba (2018), Nigeria's healthcare system is still among the worst in the world. Less money is allocated to primary, preventative, and promotional healthcare initiatives. According to Hafez (2018), the universal health care coverage index, which measures the average coverage of tracer interventions for required universal health coverage, is a dismal 39%. As a result, Nigeria significantly underperforms on key health outcomes, with rates of maternal death of 243 per 100,000, 58.6% of births attended by trained medical personnel, under-five mortality of 89 per 1,000 births, and neonatal mortality of 37 per 1,000 births (NDHS, 2018). Nigeria's health and well-being are significantly impacted by these poor statistics. Nigeria has a substantial amount of human resources for health (HRH), but like the 57 other nations experiencing an HRH crisis, it does not have enough staff members (1.95 per 1,000 inhabitants) to effectively deliver basic healthcare services (WHO, 2020a). Furthermore,

Nigeria has repeatedly and severely fallen short of the Abuja Declaration, which committed the country to allocating at least 15% of its yearly budget to improving the country's health system (WHO, 2021). In 2016, the government spent \$11 per person, or 0.6 percent of GDP, on health care. Because most federal expenditure is focused on tertiary and secondary hospitals and occurs at the federal level, primary healthcare funding is especially affected.

Accessibility and closeness to the impoverished are not as crucial to the operation, prevention, and treatment of a primary healthcare system as services are. Health promotion, community-oriented interventions to tap into intersectoral inputs that effect health (such as improved sanitation and clean drinking water), and disease-oriented interventions in support of local (and national) public health goals should be given priority in a functional primary healthcare system. It is recommended that frontline health workers offer preventive and curative ambulatory care in close proximity to impoverished communities (Shaw et al., 2015). In addition to treating common illnesses and injuries, basic medications, basic services and supplies for women, mothers, and children, and preventing, diagnosing, and treating HIV/AIDS, TB, and malaria, a primary healthcare system must also perform basic and essential surgery, particularly "first-line" surgery related to burns, wounds, and fracture management, as well as handle complex cases (Shaw et al., 2020). Given the existing situation, Nigeria is still a long way from providing effective primary healthcare and universal health coverage. Nigeria's ongoing development problem is the absence of a comprehensive and operational primary healthcare system. The scenario puts in jeopardy not just the Sustainable Development targets (SDGs) relating to health but also the achievement of other health-related targets. A functional primary healthcare system has often been impeded by a lack of suitable measures for sustainability, accountability, data collecting, and openness. A lack of institutional capacity, corruption, an unstable political and economic climate, and insufficient finance are among other barriers (Adinma & Adinma, 2018). The effect of the previously described factors on the development of Nigeria's primary healthcare system has been the subject of numerous research (World Bank, 2010; Aid, 2015; WHO, 2017; Gyuse et al., 2018).

The Present State of Primary Health Care in Nigeria

Health care delivery must be expanded to every area of the world where people are present in order to achieve universal health coverage, as envisioned by the Sustainable Development Goals (SDGs), both globally and in Nigeria. This is the objective that the World Health Organization has set for achieving all of the health-related SDGs (WHO, 2018). The majority of people in Nigeria reside in rural areas, where having access to a basic healthcare system is crucial. Because of the topography of many of the rural villages and communities, access might be difficult. Due to factors like poverty, isolation, inadequate road infrastructure, and high travel expenses, residents of isolated villages may be less likely to seek medical attention in cities or other developed areas (K A, 2020). Therefore, in order to reach people in remote areas, it is imperative to

offer significant preventative and curative medical services at a reasonable and sustainable cost to the populations served. It is necessary to set up such a healthcare system and make it able to serve a comparatively tiny population. In order to accomplish this goal and address comprehensive health requirements near to people's homes and communities, primary healthcare is largely recognized as the most economically feasible approach (WHO, 2019).

The basic healthcare system in Nigeria is dreadfully inadequate and underdeveloped, failing to provide for the demands of the vast population. According to Uzochukwu et al. (2020), just 20% of the 30,000 basic healthcare facilities in the nation are open for business. The need for a well-designed, workable, and all-encompassing primary healthcare system is highlighted by demographic data. Extreme poverty and illiteracy are prevalent at high rates. The unfortunate moniker of "poor capital of the year" was bestowed upon 86.9 million Nigerians who are living in extreme poverty (Quartz, 2018). That represents almost 50% of its total population. If the current trend is maintained, 110 million people in Nigeria are expected to be living in extreme poverty by 2030 (Kharas et al., 2019). Nigerians are more susceptible to sicknesses because they have less access to nutrient-rich food due to the nation's widespread poverty and high prevalence of illiteracy. In impoverished and rural areas, open defecation and poor sanitation are commonplace, and access to basic utilities like portable water and electricity is restricted. Nigeria's high and growing rates of extreme poverty and illiteracy make an efficient and long-lasting basic health care system even more important. According to projections, the implementation of a robust and efficient primary healthcare system in low- and middle-income countries such as Nigeria by 2030 is expected to avert a minimum of 60 million deaths and increase average life expectancy by 3.7 years (WHO, 2019).

Because of the inadequate primary healthcare services that are offered there, Nigeria currently has among of the lowest health outcomes in the world. According to Uzochukwu et al. (2020), these services are characterized by inadequate coverage, especially in rural areas, poor quality health facilities, and excessive user costs. Furthermore, in PHCs, health workers with and without training do not fully comprehend the new PHC idea (Abdulraheem et al., 2022). More people are increasingly seeking medical services that the primary healthcare system should be able to deliver in secondary and tertiary care clinics because there isn't a fully working primary healthcare system. Nigeria needs a functional primary healthcare system to avoid the collapse of the already congested secondary and tertiary healthcare systems in the country. The additional burden on Nigeria's secondary and tertiary health institutions exacerbates their already-existing challenges in delivering care and depletes their pooled resources. Therefore, if a workable and sustainable primary healthcare system cannot be established in Nigeria, the country's already precarious public health system is expected to collapse.

CONCLUSIONS AND RECOMMENDATIONS

Rural residents in Nigeria tend to underuse the basic health services, despite the fact that PHC clinics are fairly evenly located throughout the country. Although there isn't a single answer for this issue in Nigeria, certain measures have been suggested that might increase how often rural areas use health facilities. Rural populations may use PHC services more frequently if communities are empowered and their capacities are increased through community organization, information exchange, and training, as well as through orientation and mobilization. Those in managerial roles must ensure the quality of care and service delivery. In times of scarcity, it is especially crucial to preserve standards of practice when enormous demands are placed on workers, often resulting in less-than-ideal behaviour. Staff members need to know that their managers are on their side precisely in these circumstances, and managers need to know that the limited health budget is being used wisely. Primary healthcare in Nigeria, particularly in rural areas, has come a long way, but more work is undoubtedly still needed to realize the objective of universal health now and in the future.

1. In order to encourage healthier living, people's living situations should be improved above the current poverty line. Thus, in order to eradicate illnesses like typhoid, malaria, and other infectious diseases, strong and efficient public health education is needed.
2. The health sector needs to get more funding from all levels of government, including local ones. On the other hand, local governments ought to focus more on generating income internally and act more aggressively. The purpose of this is to lessen the reliance on the federation account to finance health care initiatives.
3. Political unrest and weak leadership are to blame for the majority of government health care delivery policies and initiatives failing. Thus, in order to foster an atmosphere that is conducive to the execution of PHC initiatives, strong leadership and political stability are preferred. This will inevitably lessen the issue of unfinished medical projects.
4. Program assessment, supervision, and monitoring has to be aggressively pursued and adequately staffed. More training for rural health workers should be a top priority for Nigerian health policymakers. This is to stop health personnel from rural areas from moving to cities.
5. Maintaining minimal health standards, better housing circumstances, a sufficient quantity of drinkable water, environmental sanitation, and a sufficient supply of food are all necessary for maintaining good health.
6. State governments should not assign LGAs needless responsibility. Local governments are frequently given authority over some federal and state government duties. Examples of these duties include the procurement of refrigerators, solar fridges, ice liners, and broken generators, as well as the implementation of sponsored programs. These all put a strain on the

meager resources available to local governments, which has implications for the provision of healthcare.

7. More financial and other incentives should be provided to prevent high staff turnover among health workers.

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