An Overview of the Worsening Situation of Primary Health Care in Nigerian Rural Sector

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ABSTRACT

Primary Health Care (PHC) is notably one of the major domesticated critical health care policies that are more resilient to situations of health crisis, proactive detection of epidemics, and supplementary situated for rapid response to emergencies in health care services demand. Thus, PHC remains the "front door" and "grass root" health care structure which functions in the provision of the foundational strength for essential public health services. However, the programmer is a pitiable one in Nigeria. This study therefore investigated the situation of PHC and Primary Health Care Centres (PHCCs) in Nigeria with the adoption of mixed methods and descriptive research design. It employed and applied "Urban Bias Theory" and discovered that there is the prevalence of epileptic health care services lack of infrastructural facility maintenance absence of skilled middle - level manpower required lack of decisive political will for policy implementation and evaluation the paucity of funds and its management, and community apathy. Consequently, the study recommends among others the resuscitation of infrastructural facility and maintenance of all the PHCCs across the nation strategic sustainable development of Public - Private - Partnership for the enhancement of Community Development Associations / Based Organizations [CDAs / CBOs] participation in PHCCs management in order to avoid apathy for funding intervention.

KEYWORDS
Community health, Health infrastructure, International policy, Primary health care, Rural sector, Urban bias

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INTRODUCTION

The 1978 Declaration of Alma - Ata founded the movement for Primary Health Care. It called for health for all and was the first declaration of health as a fundamental human right. The Declaration of Alma - Ata was the first document that set out a holistic view of health and put an emphasis on the contribution of health to economic and individual development. The major policy and development concern among both local and international donor agencies in the world over deal with social justice, financial security and safety for the poor and vulnerable populations. According to in 1988, Nigeria adopted a National Health Policy aimed at achieving health for all Nigerians by the year 2000 and beyond using primary health care as the basis for development. This is based on the evidence that developing countries are experiencing difficult health care challenges and devastating conditions of living. Though the genesis of this crisis according to Gish (1979) is traceable to colonialism, contemporary national and international relationships are perpetuating essential characteristics of the inherited health care and other systems. Partly in response to this growing crisis, the narrow emphasis on 'all - round growth' as the primary solution to underdevelopment has been largely replaced, at least in international discussion, by an approach that requires the meeting of everyone's basic human needs. This made to maintain that the Nigerian health care structure has evolved over many decades through various transformations targeted at addressing the public health crisis challenging the nation. Identifiable ones are not far - fetched. Lists them to include "National Health Insurance Scheme (NHIS), National Immunization Coverage Scheme (NICS), Midwives Service Scheme (MSS), and Nigerian Pay for Performance scheme." In the health sector, PHC or "health by the people" is considered as the principal conveyor of health care services. Subsequently, the Nigerian Federal Ministry of Health was keen to reduce morbidity and mortality due to communicable diseases, reverse the increasing prevalence of non - communicable diseases, meet World Health Organisation (WHO) targets with regards to eliminating and eradicating diseases, and significantly increase life expectancy and quality of her citizens. Therefore, Nigeria's mission to domesticate, develop, and implement the PHC policy after the Alma Ata Declaration as well as undertake other fundamental actions was aimed at reinforcing the improvement of national health care for efficient, effective and affordable services that energies the health care delivery. It serves as a propeller for accelerated socio - economic growth and sustainable development Nevertheless, 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 basic services, while the cost of paying for care out of pocket pushed people into extreme poverty. Too great a focus had been placed on fighting individual diseases at the expense of strengthening health systems and promoting health. Aside from the criticism against the programme from the very beginning of its initiation, the domestication of PHC has enabled many countries like - Kazakhstan, Namibia, Argentina, the Islamic Republic of Iran, Indonesia, Ukraine, Nepal, etc., to greatly achieve high - level health care delivery system thereby reducing the degree of maternal and infant mortality rate. This is because it was believed to be the only way to reach out to the rural dwellers on rapid and affordable health care services. However, the Nigerian situation is a different story. PRIMARY HEALTH CARE CENTRES (PHCCs) across States in Nigeria are majorly characterized by dilapidated buildings and infrastructure, inadequate manpower, and lack of supply of medical aids including drugs. The surrounding environment of PHCCs is unkept and subjected to defecation and invasion by rodents and insects. Also, because of its uncompleted project nature and location outside the community centres, workers and patients usually excrete in a nearby bush due to the absence of necessary toilet facilities. As Van der Geest, Speckmann and Streefland noted, unrealistic conceptualization remains the major complaints and challenging factor to the existentiality of PHC across the world. The wide - ranging and rural - centred health care model was believed to have concentrated on idealism thereby relegating feasibility to the background. As a corollary, this study is undertaken to carry out an overview of the contrast between the unanimous vision and missions of PHC at the Alma Ata Conference in 1978, the surrounding confusion of its operational purview among the three tiers of government, the sad empirical features of the PHCCs in Nigeria, and suggestions of possible way - out of the quagmire.[1-9]

MATERIALS AND METHODS

Research Methodology

This study explores the mixed method of data collection to ascertain the present state of selected PHCCs in the geo - political zones of the country. The primary and secondary data were adopted to discuss both relevant literature and findings concerning the state of PHCCs in Nigeria. Subsequently, primary data showcase the dilapidated PHC structures and facilities in Nigeria (as seen in the appendixes). The researcher visited and snapped the PHCCs whose pictures were displayed in the report. These provided the opportunity for the understanding of the variables and issues associated with the subject matter. Hence, the design of the study is descriptive. The study did a qualitative assessment of the data gathered in order to present a vivid description of the overall conditions of PHCCs and for further development of limited understanding on the present sad status of PHCCs in Nigeria and by extension developing countries. All the sources consulted have been well referenced.[10-14]

Theoretical Framework and Application

This study is hinged on "Urban Bias Theory" which has a long - standing history in development research. Agree that the theory is primarily associated with the works. The theory acknowledges the real situation concerning the development policy formulation, resources' allocation, a disposition among the powerful, and programmers implementation in rural - urban sectors in developing countries. The fundamentals of the theory state that the growth and development circle in the developing countries is systemically biased against the rural 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. Therefore, national health policies of nations emphasize the need for PHC as a response to high capital involvement in the tertiary health care facilities with relegation of the rural sector to the back seat. For instance, PHC services originally ought to be jointly planned and controlled by the government and critical stakeholders like Community Development Associations (CDAs) and Community Based Organisations (CBOs) in all inter - related sectors of Nigeria's socio - economic growth. In contrast, there is a reflection in the unfathomable inequalities

that exists between the amount of funds allocated to teaching and specialist hospitals, cottage, and comprehensive hospitals against the meager allocation often given to the Colleges of Health Science and Technology that trains personnel of PHCCs themselves in rural areas. Urban bias manifested 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". Thus, "there has been too much concentration of medical personnel at the urban (centers) to the neglect of the rural areas" From the urban bias perspective, it can be posited that retarded growth of PHCCs in the rural areas of the developing country is caused by the interest groups in urban sector who always divert the resource allocation to the city centres. For instance, "in developing countries, there is a shift of manpower from the local primary health care system towards vertical disease - oriented programmers. Moreover, there is a shift from rural 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" noted, though capacity development of many CHEWs and technicians has taken place in various State Health Colleges and posted to rural communities where PHCCs are located nonetheless, they lack depth with weak supervision, thereby making their performance to be unimpressive and disappointing. Thus assert that many PHC programmers lack this fundamental factor which has led to serious failure and sudden developmental neglect in Nigeria over time. Most importantly, the realities in the urban health care centres differ greatly from that of the rural areas which most programme planners and implementers do not put into critical consideration. Lipton 1977 emphatically averred that the rural sector contains most of the poverty, and most of the low -cost sources of potential advance 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.' It is an illustration of the level of health care infrastructural facilities in the cities and the dilapidated Primary Health Care Centres in the rural setting. The above - painted condition occurs as a result of the fact that the rural areas in Nigeria have largely been marginalized and relegated. Consequently, the absence of critical infrastructural facilities like simple and standardized health care centres, motorable roads, electricity, security posts, portable water, microfinance institutions and outlets, agricultural development institutions and centres, etc. that ought to make life easier and economically balanced with high earning strength for the residents of the rural sector are absent. Following their setting that is out of observers both local and international sight, most of the PHCCs in Nigeria are capacity - wise deficient in the provision of important health care services, in addition to inadequate equipment and drugs supply, poor staffing, the pitiable situation of the available infrastructural facilities, and uneven distribution of health workers.[15-24]

RESULTS

Statement of the Problem

There have been many improvements in the decades since Alma - Ata, most notably in child and maternal mortality and in longevity, but a number of challenges remain. The reality is that many people in resource - poor settings still do not have equitable access to even basic services. In many places this gap is widening the primary target of " health for all by the year 2000 " surfaced in order to salvage the challenges of huge health care facing the inhabitants of the countryside together with the vulnerable people who are dependents of expensive imported medical aids and technology. Hence, the domestication of PHC in Nigeria led to the creation of Colleges of Health Technology (CHT) in all States to shortly train Community Health Extension Workers (CHEWs) and technicians say for two / three years period depending on the course of study. This was identified as a sound health care services distribution and development strategy that brought the rural and semi - urban dwellers into the closest operational structural system of health care delivery. Nevertheless, there is inadequacy in the monitoring and evaluation of this group of health givers. 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. Therefore, the dimensions of operation of community health extension workers services among the rural residents are not encouraging as their most energy is dissipated on handling of symptoms of patients against their primary training of preventive programmers activities and first - aid. They claim generalists and authority thereby usurping the role of a medical consultant (s) and doctor (s). The high rates of maternal and infant mortality prevalent in the rural and semi - urban sectors in Nigeria are the products of the superficial and hasty work of the community health extension workers and technicians. For example, the researcher's wife has died following this development in 2014. These shortcomings are not unconnected to absence of services and management of PHC by those officers who are saddled with the responsibility. It is observed that all the community health extension workers and technicians are preoccupied with the management of their own clinics and maternity homes instead of the PHCCs in which they were employed to work. Moreover, the Local Supervisory Councillor (LSC) for health, Head of Department (HOD) health, and ward coordinators of health care services hardly pay unscheduled visitation to PHCCs and community health outposts. This lack of leadership has created demotivation and relegation of community health extension workers and technicians to the background. Since their salaries and wages are being paid by the local government council whose financial allocation from the federation account is diverted by State governments in Nigeria, many of them rarely get paid well. This can be supported by the view that says, "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." Evidently, poor financial aids, high decadence of infrastructural facilities, bad management, and unprofessional practices have been identified as the bane in the delivery of PHC in Nigeria. The high morbidity and maternal mortality rates in most Nigerian communities and other developing countries in the world are attributable to poor health care delivery, dilapidated PHC buildings and facilities, and the absence of equipment and drugs at the PHCCs. 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". In Nigeria, the PHC success story is a mirage and criticized anytime the government attempts to publicize and politicize its development. The argument for and against it "was heard in the debates on selective versus comprehensive, and vertical versus horizontal PHC". Presently, more than 40 years of PHC conception in Alma Ata, the domesticated policy is on a

backward journey and actual threat. The WHO and donor agencies are worried on the state of PHC particularly in developing countries which Nigeria is amongst. The plan failed because of lack of community involvement leading to exclusion of the direct policy beneficiaries and self - help population coverage predisposition that the health facilities were mostly politically located in centres where they are not supposed to be curative care was overemphasized to the detriment of preventive services poverty of manageability in the health care system resulting in wastage of scarce resources and system failure absence of data, health information, research and development poor financial and resources allocation and critical infrastructural deficit and logistic support.[25-35] In this paper, we shall attempt the investigation of:

i. Nigerian health care anatomical description and development perspective.

ii. A discussion of the Nigerian PHCCs situation after 43 years of Alma Ata declaration, and

iii. Possible recommendations that will restage the PHC structure in Nigeria.

DISCUSSION

In the trend of the various viral pandemic like the HIV / AIDS, Ebola Virus, Lasser Fever, and the contemporary Covid - 19 pandemic among others that have hit both rural and urban sectors alike, the significance of PHCCs manifold multiplied. But, a number of these centres are dilapidated and non - functional. This is amidst the challenging key facts enumerated by the WHO (2021) which states that:

- About 930 million people worldwide are at risk of falling into poverty due to out - of - pocket health spending by 10 per cent or more of their household budget.
- Scaling up Primary Health Care (PHC) interventions across low and middle - income countries could save 60 million lives and increases average life expectancy by 3.7 years by 2030.
- Achieving the targets for PHC requires an additional investment of around US$ 200 to US$ 370 billion a year for a more comprehensive package of health services.
- At the UN high - level UHC meeting in 2019, countries committed to strengthening primary health care. WHO recommends that every country allocate or reallocate an additional one per cent of GDP to PHC from government and external funding sources.

As usual, Nigeria as the most populous nation of the blacks in the world is bedeviled with the hurdles of the administration of a domesticated international health care policy popularly referred to as "Primary Health Care." This is predicated on the frequent change of government with policy summersault and prevalent corrupt practices that have rendered the Nigerian public sector unproductive. There is nowhere this is salient than the health sector environment. Categorically, PHCCs hardly function in Nigeria. Consequently, this challenges the remote conceptualization and the meaning of PHC implies the first level contact of the individual and the first step to accessing basic health care facilities in a rural community with the national health care system. Therefore, the poor nature of PHCCs across the regions of Nigeria prompted the federal government to establish the NPHCDA in 1992 by Decree No: 29 with oversight function of development and provision of "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". As contends, the blueprint of the NPHCDA states that: 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. However maintain that there are many ill - equipped and dilapidated PHCCs diagonally in the Nigerian States where poverty - ridden residents' access health care due to a lack of suitable alternatives. For example, Ogbonna village is one of the communities where PHCC is located in the Etsako - East local government in Edo North, Ekosodin community in Edo Central Area of Edo, and Odot, Nsit Atai Local Government Area of Akwa Ibom States all in South - South Region, Nigeria (Figures 1,2).[36-42]

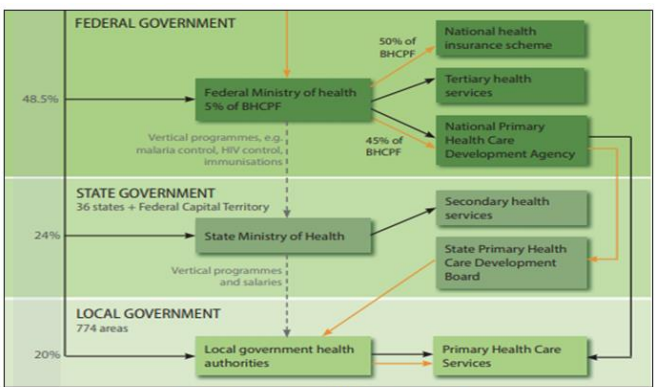

Figure 1. Flows of Health Services.

Figure 2. Ekosodin PHCC in Edo Central Area of Edo State.

The PHCCs in these communities depict extreme abandonment. In the North - Central Nigeria, the PHCCs in Ayeke - Ibaji, and Okenya - Ajaka in Ibaji and Igalamela / Odolu Local Government Areas of Kogi State Eastern part (Figures 3,4).

Figure 3. Okenya Health Centre in old NRC Building, Kogi State.

Figure 4. PHCC Ayeke, IBAJI.

Ile - Loke Government Reserve Area (GRA) Ilorin Kwara State Government House and Etutuekpe, Ogbadibo Local Government Area of Benue State Zone C, are not safe of underdevelopment and decadence (Figure 5).

Figure 5. PHCC Kabba Junction Obajana, Nigeria.

It is pathetic to note that a survey by the researcher reveals that many PHCCs in Kogi State are presently under lock and key since 2015, owing to the sacking and non - payment of Community Health Extension Workers (CHEWs), Community Health Officers (CHOs), and Environmental Health Officers (EHOs). According to the Local Government Areas of Kogi State had no allocation to themselves since the assumption of Governor Yahaya Bello. Similarly, the PHCCs in many parts of Abuja, the nation's capital was not left out of this sad situation. For instance, PHC in Dutse - Makaranta in the Bwari Area Council of Abuja operates without a power supply and on a 12 hours basis instead of 24 hours (see Figure 6).

Figure 6. PHCC Dutse Makaranta, Abuja.

It was discovered that there has never been any form of power supply since 2017 that the centre was inaugurated. Accordingly, the conditions of PHCCs in Ajuwon and Ogungbade Ifo Local Government Area of Ogun State, and Okinnin - Egbedore, State of Osun, South Western region of Nigeria have been branded with darkness and dilapidation (Figure 7).

Figure 7. PHCC, Ajuwon, IFO, Ogun State.

These PHCCs in are situated close to major noisy Bus Stops and worship centres respectively. Particularly, the PHCC in Okinnin has only a weekly visiting medical doctor and the only available and profound healthcare facility that the residents of the town knew, particularly the vulnerable poor who cannot afford the services of private hospitals or embark on international medical tourism and attention like some few privileged Nigerians (Figure 8).

Figure 8. Interior and Exterior of PHCC Okinnin, Osun State.

In the same development, the two major PHCCs in Efon - Ekiti were not spared. While one of the major centres has been occupied by military personnel who were deployed to safeguard the highway along the area, the second PHC in the area presented in the has been left in the bush (even though it was immortalized after the Executive Governor of Ekiti State) (Figure 9).

Figure 9. PHC, Efon in Ekiti State.

In close development, the appalling shape of PHCC in Umuokanne, Ohaji / Egbema Local Government Area of Imo State is worth mentioning as the roof and ceiling are supported by standing sticks (Figure 10).

Figure 10. PHCC in Umuokanne in the Ohaji / Egbema, Imo State.

A careful observation of the plague that marked the commissioning of the center indicated that the facility was built over 20 years ago with a community development effort and handed over to the local government health department. The structure remains the only PHCC in the area whose citizens' occupation is chiefly agriculture. It is noticed that apart from the sad situation of the edifice, its roof leaks water during rainfall and that has made parts of the ceilings to have fallen off. More so, the compound has been taken over by grasses, and some wards like maternity, children, accident, and emergency and medical laboratory lack essential services. In short, beds and needed medical equipment are lacking. The worst aspect of the state of Umuokanne PHCC is that the medical personnel are inadequate when compared to the population that accesses the facility for medical assistance. In the same situation, Shokwari PHC shown in is located in the Maiduguri Metropolitan Council (MMC) in Borno State, Northern Nigeria, and in a pathetic situation (Figure 11).

Figure 11. The Shokwari PHCC in Maiduguri, Borno State.

By extension, cited by ICRC describes the health care delivery and the structural situation in North - Eastern Nigeria thus: "Treatable illnesses such as malaria become deadly as people simply can't 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 centres are much overstretched and it's difficult for them to recruit medical staff." In the findings of the WHO, forty per cent 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. Thus, the inhabitants of the North - Eastern zone of Nigeria ranging from women to children in dire need of health care services are either underserved or suffer from preventable and curable health challenges. The WHO further maintained that the North Eastern region of Nigeria showcases the worst indicators of maternal and child health. Basically, endemic malaria is still responsible for more than fifty per cent of infant mortality and morbidity rates with severe respiratory tract infection, serious malnutrition, and watery diarrhea as remote causes of illness. It can be deduced that the major challenge facing PHC policy in Nigeria hangs on the fact that the programmer is domiciled and to be implemented by the local government the weakest and least organ of government structure of the federation that is suffering from continuous downplaying of its enabling functionality and financial power. To this end says, there is an

excessive command of local governments in Nigeria "by the state governments to such an extent that there no more local governments but local administrations or more precisely, local arms of the state administrations." All the state governments in Nigeria have famished the local governments of constitutional grants in order to deny the system of funds to embark on rendering of essential services like the PHC, which could be impactful to the lives of those at the grassroots level Besides the absence of economic muscle by the local government to finance the PHC project, identifies lack of institutional capacity and technical support programmers to keep the PHCCs afloat, and to properly monitor and evaluate their activities. Thus far, there is a continuation of a vacuum of "serious commitment to the right to health care or any other substantive socio - economic right". From the above description, the state of PHC affairs in Nigeria is categorically condemnable and unacceptable considering the yearning, hope, and aspiration of the people which remain largely unmet. The major identifiable challenges with PHCCs in Nigeria are poor and inefficiency of operation epileptic health care services lack of infrastructural facility maintenance absence of skilled middle - level manpower required lack of decisive political will for policy implementation and evaluation the paucity of funds and its management, and community apathy.[43-49]

The Nigerian Health Care Structural Review and Development Perspective

In the pre - independence period, the Nigerian health care system has no specific modality but the health services were mainly provided by native doctors, herbalists and traditional birth attendants Perhaps, colonial masters in Nigerian communities have their own medical personnel who cater for their health needs, families and staff. Notwithstanding, Isolate (2013) categorizes health care services in Nigeria from the colonial period till date into African traditional medicine, orthodox or western medicine, and spiritual healing. After the political independence in 1960, the formulation and implementation of health care delivery policies took several dimensions following the National Development and the Rolling plans to meet the health care need which was no longer the responsibility of the colonial officers. In the post - independence, the Third National Development Plan gave birth to the Nigeria Basic Health Service Scheme (NBHSS), which received the assistance of WHO (1975 - 80). The structure was targeted at increasing the percentage of the health care beneficiaries from 25 to 60 per cent and the correction of imbalances in the siting and spreading of health institutions. It is also aimed at providing the infrastructural facilities for all health care preventive programmers like the control of communicable disease, family and reproductive health, environmental health, nutrition and others as well as establish a health care system best adapted to the local condition and to the level of health technology Furthermore, Nigeria launched PHC in August 1987 following the 1988 National Health Policy (NHP) founded on the philosophy of "social justice and equity to achieve health for all Nigerians by the year 2000 and beyond." Basically, the dimensionality brought the development partners, religious and non - governmental organizations that have at various times attempted at providing health care needs of the citizenry thereby taking health care to the rural areas in Nigeria though contends that most of the services particularly government and some private institutions were located in the urban center due to poor road network, poor transportation system and inadequate manpower supply in the rural areas. In furtherance, posit that Nigeria operates a multifaceted health care system in accordance with the organized federal structural context - Federal, State, and Local Governments where the federal government is in charge of tertiary health care, the state takes care of secondary like general and cottage hospitals whilst the local government handles the primary health care centres and outposts. More specifically, further maintain that the federal government is solely responsible for the provision of policy planning and formulation, directive, and technical assistance coordination of state - level implementation of the National Health Policy and the establishment of Health Management Information Systems (HMIS). In addition, it is responsible for disease surveillance, vaccine management, drug regulation, and training of health professionals, as well as the management of teaching, psychiatric, and orthopedics, including Federal Medical Centres (FMCs). Conversely, the state government is responsible for the management of secondary hospitals. The local government regulates and provides basic technical support for PHC services, facilities, community health, sanitation, and hygiene. Figure 1 indicates that the federal government is forty - five per cent responsible for NHIS, tertiary health services, and National Primary Health Care Development Agency (NPHCDA).[50-55] The figure further shows that the State government directs the affairs of secondary health services and PHC development board at twenty - four per cent and the local government is primarily in charge of all the affairs of PHC services in the rural sector at twenty per cent. While PHC is not a new concept, it received uttermost attention in 1978 following the realization by the World Health Organisation (WHO) that the developing countries, in particular, are ravaged with acute health challenges. The conceptualization of the approach was an attempt by the WHO to situate the lopsided hospital - based and city - centred nature of the world health care system. In Nigeria, the domestication of PHC emerged as the cornerstone of health care delivery system. 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". The PHC plan was an attempt to adjust the achievements of medicine to the economic reality of the countries concerned. PHC simply means essential health care based on practical, scientifically sound, socially acceptable methods, and technologically - made universal health care services accessible to individuals and families in the community through their full participation and at a cost which the community and country can afford to maintain at every stage of their development in the spirit of self - reliance and self - determination and Macdonald (2013) describe the model as the most basic 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) classically notes that PHC was developed as an alternate methodology to meeting basic health care needs in developing countries, with the framework of abridges trained CHEWs and technicians. This is portrayed by Table 1 and Figure 1. Table 1 pointed to the fact that the management of PHC is provided by local government authority through the Ward Development Committee, Village Development Committee, and Community Development Committee. Table 1 shows that an average of 7,740 PHCCs were expected to be delivered to all wards, one per group of villages with a minimum population of 2,000 and a maximum of 5,000 in the 774 local governments in Nigeria.[56-58]

Old system of health facility classification	New system of health facility classification on	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 GA trust minimum expected in the country is 774
Coal) recessive health centre, model PHC centre	Primary health centres	Local government	1 per ward. With an average of I_0 wards per GA; 7,740 expand
Maternity centre basic health centre	l Primary health drips	Local government and Ward Development Committee (WDC)	t pet group of villages neighbourhoods with about 2,000 to 5,000 people
Dispensary	Health posts	Village Development Committeey (VDC) Community Development Committee (CDC)	t pet village or neighbourhood with about 500 people as many as the Dumber of villages

Table 1. The Management of PHC in Nigeria.

In response, NPHCDA between 2003 - 2007 started the construction of numerous PHCCs with a policy directive to locate at least one in each of the 774 local government councils across the country. Mainly, PHCC outposts are manned by CHEWs and technicians who include community health officers, medical laboratory technicians, environmental health officers, and community health information officers. Others are nurses, midwives, and visiting medical doctors in some parts of Nigeria. The services provided at these PHCs include prevention and treatment of communicable diseases, immunization, maternal and child health services, family planning, public health education, environmental health, and the collection of statistical data on health and health - related events. The PHC in the local government council is under the leadership of an appointee of the Local Government Chairman known as supervisory councilor (serving as a Minister at the local level) and Head of Department (HOD) health on Grade Level (GL_{16}) who acts as coordinator from the civil service milieu. The HOD reports to the supervisory councilor who is the chief accounting officer that is answerable to the LGA chairman and the Finance and General Purpose Committee. The different components of the PHC are manned by personnel of diverse specialties ranging from public health, medical laboratory, health information services, and pharmacy technicians to community health officers. From the foregoing, PHC is an attempt at bringing health care as close as possible to where people live and work and contributes the first element of a continuing health care process. PHC received a considerable boost in Nigeria in the mid – 1980's, at the time when one of the participants at the Alma Ata Declaration of the concept in 1978 became the nation's Minister of Health. Ransome - Kuti provided the ideal template for the institutionalization of PHC in Nigeria, acting severally as an advocate, key policy proponent, and implementer on all aspects of PHC.

CONCLUSION

Notwithstanding the foregoing, PHC remain the sure way to grassroots qualitative and affordable health care delivery framework. With it, health care social equity and accessibility are engendered. However, identifiable issues from the obtained data which cut across the above discourse that gave birth to major recommendations and policy actions include the unfortunate and incompetency of operation, epileptic health care services, lack of infrastructural facility maintenance, absence of skilled middle - level manpower required, lack of decisive political will for policy implementation and evaluation, the paucity of funds and its management, and community apathy. Consequently, we recommend that there should be:

- Stressing efficiency of operation in order avoid the rendering of epileptic health care services.
- Resuscitation of infrastructural facility and maintenance in all the PHCCs across the nation.
- Equipping of Colleges of Health Science and Technology (CHST) in Nigeria with both capacity and instruments that will lead to the production of high quality and quantity skilled middle - level manpower required by PHCCs.
- A determined and decisive political will for PHC continuous projects and programmes implementation and appraisal.
- Financial implication analysis so as to provide a favourable environment for the average management and creation of PHC services.
- Strategic sustainable development of Public - Privat - Partnership for the enhancement of Community Development Associations / Community Based Organization's [CDAs / CBOs] participation in PHCCs management in order to avoid apathy thereby encouraging integration and funding intervention.

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