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FACTORS AFFECTING SERVICE DELIVERY OF PRIMARY HEALTH CARE CENTERS IN NIGERIA: A CASE STUDY OF ISIALA-NGWA NORTH LOCAL GOVERNMENT

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ABSTRACT

Primary Health Care (PHC) plays a very vital and significant role in the decentralization of health care services in the society. The services of primary health care are designed to ensure that the coverage of health care delivery at the community level remains at an efficient level. This involves the efforts of the government and the community to ensure improvement in the living standard of the citizens. Primary health care centers should provide preventive, curative and rehabilitative services to the communities which they serve. The sole objective of this study is to find out the factors which impede the growth and retard the services of PHC with special attention to the situation in Isiala –Ngwa North LGA. The study used cross-sectional descriptive design with a structured questionnaire which was used to collect data from the Primary health care workers, Doctors, nurses, Community health extension workers, the community heads as well as patients. A total of fifty respondents were used for this study. Data collected was analyzed via SPSS version 16 and results presented in frequency distribution tables and $x^2$was used for statistical test of significance at 5% confidence level. The study revealed that there is shortage of health care workers, also poor funding which could be responsible for the inadequate medical facilities observed in the study. Primary health-care workers are faced with many challenges such as delay in payment of salaries and work stress due to lack of equipment to work with. All these are responsible for lack of job motivation.

Keywords: **Primary Healthcare, Challenge, Service Delivery, Factors, Services.**

Introduction

The implementation of primary health care is still passing through diverse challenges (Alenoghena, et al 2014). Most of the Primary Health Care facilities in the country lack the capacity to provide essential and adequate health-care services to the members of their host communities. Such poor and insufficient services are the consequences of phenomena such as poor staffing, inadequate equipment, poor health workers distribution, inadequacy in the numerical strength of available qualified health services personnel, together with dilapidated condition of infrastructure, and lack of the availability of essential drugs (Aregbesola and Khan 2017). More cursory observations in Udenta&Udenta (2018) portray the practice of

primary health care services in the country as being in a state of abysmal performance and inadequacies. Most primary health care (PHC) facilities located in various states in the country are in severe condition of disrepair with equipment and infrastructure being either absent or obsolete as the referral system is almost extinct (Udenta&Udenta, 2018).

The Concept of Primary Health Care (PHC)

The popular Alma Ata declaration on Primary Health Care (PHC) being pronounced in 1978 was rooted in the need to address the basic health problems in communities with the aim of providing, promoting preventing, and rendering curative services to the people coupled with rehabilitative services for health and healthy living (Alenoghena, et al 2014). Nigeria was among the 134 signatories to this invaluable idea. Subsequently, several re-organizations of the Nigeria health structure to align with the new vision were made. The implementation of PHC, primarily through services provided at the primary health centers vary based on the type of PHC facility in Nigeria. Several other PHC services within the health precinct include community mobilization, service integration and selected PHC programmes under the auspices of international collaborators. Primary Health Care (PHC) is driven by a political philosophy that emphasizes a radical change in both the design and content of conventional health care services. It also advocates an approach to health care principles that allow people to receive health care that enables them to live socially and economically productive lives (Obioha&Masemote, 2011).

History of Primary Health Care in Nigeria

Primary Health Care (PHC) is a grass-root management approach with the general aims and focuses towards providing health care services to communities. The concept of the operation of Primary Health Care was first published in 1978. Hence, various countries have attained different levels of progress in implementing the strategy (Aigiemolen et al, 2014). Starting from its independence in 1960, there was little or absence of strong focus on health systems development in Nigeria (Aregbesola and Khan 2017). However, policy makers and political office holders of the time made efforts to establish and expand health-care infrastructures with much emphasis being placed on curative medicine rather than preventive medicine (Fatusi 2015). From 1975 to 1980, health system development was initiated with PHC as the cornerstone.

In another view Oluwasogo and Sebutu (2020) posit that the inception of primary healthcare in Nigeria began with the advent of Basic Health Services, a concept which was introduced to be an integral part of the nation's third development plan in 1975. This innovation led to the establishment of 20 health clinics and 4 Primary Health Care (PHC) Centers which were spread across the local government regions. Furthermore, the launching of Nigeria's first comprehensive national health policy based on PHC took place in 1988. From 1986 to 1990, the then minister of health, Professor Olikoye Ransome-Kuti expanded PHC to all local governments, achieved universal child immunization of over 80%, and devolved responsibility for PHC to local government areas (Aregbesola and Khan 2017). He worked committedly between 1985 and 1992 to ensure the implementation of PHC policy.

Contemporary Challenges in Primary Health Care Delivery in Nigeria

In the ideal function and objective of operation, primary health care (PHC) centers are designed to be the filtering units for those who require specialized services at the higher levels

of care. However, Abdulraheem, et al (2012), observe that vital specialized medical services such as radiotherapy, orthopedic procedures and surgeries are obvious and completely absent in the centers. On the global setting, Uzochukwu (2017), opines that Health systems around the globe still fall short of providing accessible, good-quality, comprehensive and integrated care. "As the global health community is setting ambitious goals of universal health coverage and health equity in line with the 2030 Agenda for Sustainable Development, there is increasing interest in access to and utilization of primary health care in low- and middle-income countries" (Uzochukwu, 2017: 2).

While it was both logical and visionary that Primary Healthcare, being a community oriented medical care arena, be established and operated around the lower tier of government and being perceived to be closest to the people, the surrendering of primary health care services to the capacity of local government areas accrues negative implications on sustainability and quality of healthcare services rendered (Aigiemolen et al, 2014). Knowing very well that governance at the local government level in most cases has the weakest technical capacity to support the required healthcare facilities and services due for the members of a community (Aigiemolen et al, 2014). Poor leadership and administration evident in poor organizational structures, insufficient funding and corruption has also contributed to the failure of the primary health care in Nigeria (Oluwasogo and Sebutu 2020). This problem is a great prove that all the sectors of the nation are under the plague of corruption. Typically, this phenomenon is obvious in diverse cases of funds diversion and misappropriation of fund at every sphere of government. Consequently, a high number of the donors to healthcare services in Nigeria are withdrawing and reducing their support as questions and calls for much more scrutiny to the implementation of the programmes are being made (Alenoghena, et al 2014).

The State of Supervision of PHC

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 heath related events. The health care delivery at the LGA is headed politically by a supervisory councilor, technically and administratively by a PHC coordinator who is assisted by a deputy coordinator. The PHC co-coordinator reports to the supervisory councilor who in turn reports to the LGA chairman (Abdulraheem, et al 2012).

Assessment and Improvement

The performance of Primary Health Care is assessed yearly to find out whether there is progress in terms of dealing with or alleviating the health problems of the people. Performance is assessed from the records of the eight aspects of PHC which act as the benchmark and rules to adhere to (Obioha&Masemote, 2011).Results of findings in Nosayaba (2011) show a lot of decay in the primary health care sector and a lack of proper management as well as deviation from the defined and affirmative action of the primary health care in the country. This is a challenge that beckons to be solved, since previous research reveals that a number of indications and evidences of collapse of PHC in Nigeria could be traced to the poor ranking of the Nigerian Health System by the World Health Organization (WHO) in 2000; as the country woefully ranked 187th position out of the 191-Member States of WHO (Oluwasogo and Sebutu 2020).

Research Setting and Methodology

This study was a cross-sectional descriptive method. It was conducted in selected Primary health care centers in Isiala Ngwa North LGA of Abia state, Nigeria. There are twenty (20) primary health care centers (PHC) in the local government area. A convenience sampling method based on proximity, resource limitation and time constraint was used to select two primary health care centers involving Ihie and Ahiaba-Ubi communities within the local government area. The sample for this study includes the health care workers in the two Primary health care centers comprising of the Doctors, Nurses, community health extension workers, community heads as well as patients who were randomly selected to make a total of fifty individuals who willingly accepted to participate in the study. Data was obtained using a self-administered structured questionnaire which was sorted out, coded serially and analyzed via SPSS (Statistical Package for Social Sciences) version 16 software and results presented in frequency distribution tables. Two sets of hypotheses were tested using the Chi-square statistical test at 5% confidence level. The first hypothesis is that there is no significant association between the quality of treatment at the primary health care centers and the inadequacy of drugs. The second hypothesis is that there is no significant association in the perception of the quality of treatment at the healthcare centers and the inadequacy of qualified medical personnel.

Data Analyis/ Discussion of Findings

Section A: Demographic Information

Sex Status of the Respondents				
	Frequency	Percent	Valid Percent	Cumulative Percent
Male	22	44.0	44.0	44.0
Female	28	56.0	56.0	100.0
Total	50	100.0	100.0	
Age Status of the Respondents				
	Frequency	Percent	Valid Percent	Cumulative Percent
16-25	8	16.0	16.0	16.0
26-35	8	16.0	16.0	32.0
36-45	25	50.0	50.0	82.0
46 and above	9	18.0	18.0	100.0
Total	50	100.0	100.0	
Marital Status of the Respondents				
	Frequency	Percent	Valid Percent	Cumulative Percent
Single	15	30.0	30.0	30.0
Married	26	52.0	52.0	82.0
Widowed	9	18.0	18.0	100.0
Total	50	100.0	100.0	
Educational Qualification of the Respondents				
	Frequency	Percent	Valid Percent	Cumulative Percent
SSCE	4	8.0	8.0	8.0

OND/equivalent	20	40.0	40.0	48.0
Degree	16	32.0	32.0	80.0
Postgraduate	10	20	20	100
Total	50	100.0	100.0	
Occupation Status of the Respondents				
	Frequency	Percent	Valid Percent	Cumulative Percent
Doctors	2	4.0	4.0	4.0
Nurses	8	16.0	16.0	20.0
Other health Workers	15	30.0	30.0	50.0
Others	25	50.0	50.0	100.0
Total	50	100.0	100.0	
Religious Affiliation of the Respondents				
	Frequency	Percent	Valid Percent	Cumulative Percent
Christian	45	90.0	90.0	90.0
Muslim	5	10.0	10.0	100.0
Total	50	100.0	100.0	

Section A: The table above reveals that majority of the participants were female 28(56.0%), while the minorities of the respondents were male 22(44.0%). Thus, the majorities were female, and minorities were male. The age of the respondents shows in the above table 25(50.0%) of the participants were from age 36-45, 8(16.0%) of the participants were from 26-35, another 8(16.0%) from age 16-25 and 9(18.0%) is from 46 and above. Therefore, majority of the respondents were age 36-45. The table above states the marital status of the respondents, thus, 26(52.0%) of the participants which is the majority were married, 15(30.0%) of the respondents were single, while 8(18.0%) were widowed which were the minority. The table above revealed the educational qualification of the respondents, that 20(40.0%) of the respondents were OND/equivalent, 16(32.0%) were degree holders, 10(20%) were postgraduate certificate holder, and 4(8.0%) of the participants were SSCE holders. Therefore, majority of the respondents were OND and its equivalent holders. Table above shows the occupation of the respondents, hence, 15(30.0%) of the participants were other health worker, 8(16.0%) were Nurses, 2(4.0%) were Doctors, while 25(50.0%) were individuals of differs occupations. Lastly on Section A, states the religious affiliation of the respondents, therefore, 45(90.0%) of the respondents were Christians which are the majority and the largest in the community, 5(10.0%) of the participants were Muslim which were the second and the lowest in the community.

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Section B: Awareness of the existence of Primary Health-Care Centers in the LGA.

I know that there are primary health-care centers in this local government				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	34	68.0	68.0	68.0
Agree	11	22.0	22.0	90.0
Disagree	5	10.0	10.0	100.0
Total	50	100.0	100.0	
I know some people who work in the primary health-care centers in this local government				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	27	54.0	54.0	54.0
Agree	15	30.0	30.0	84.0
Disagree	8	16.0	16.0	100.0
Total	50	100.0	100.0	
I know that people visit the primary health-care centers in this local government for treatment				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	19	38.0	38.0	38.0
Agree	29	58.0	58.0	96.0
Disagree	1	2.0	2.0	98.0
Strongly Disagree	1	2.0	2.0	100.0
Total	50	100.0	100.0	
I am a staff of primary health-care center				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	40	80.0	80.0	80.0
Disagree	6	12.0	12.0	92.0

Strongly Disagree	4	8.0	8.0	100.0
Total	50	100.0	100.0	

The first part of Section B reveals that 34(68.0%) of the majority participants strongly agreed that they know that there are primary health-care centers in this local government, and 11(22.0%) agreed. The minority 5(10.0%) disagreed that they know that there are primary health-care centers in this local government. The table shows 27(34.0%) of the respondents strongly agreed that they know some people who work in the primary health-care centers in this local government, 15(30.0%) agreed. The minority 8(16.0%) disagreed. The above table states that the participants know that people visit the primary health-care centers in this local government for treatment. 29(58.0%) strongly agreed, 19(38.0%) agreed. The minority 1(2.0%) strongly disagreed, and another 1(2.0%) disagreed. Finally, majority of the respondents 40(80.0%) strongly agreed that they are staff of primary health-care center,6(12.0%) disagreed, and 4(8.0%) strongly disagreed which are the minority.

Section C: Quality of health care service delivery in primary health

Quality treatment is received when patients visit primary health-care centers				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	28	56.0	56.0	56.0
Agree	10	20.0	20.0	76.0
Disagree	7	14.0	14.0	90.0
Strongly Disagree	5	10.0	10.0	100.0
Total	50	100.0	100.0	
There is willful avoidance of primary health centers				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	22	44.0	44.0	44.0
Agree	10	20.0	20.0	64.0
Disagree	10	20.0	20.0	84.0
Strongly Disagree	8	16.0	16.0	100.0
Total	50	100.0	100.0	
Patronizing patent medicine dealers is preferred to primary health centers				
	Frequency	Percent	Valid Percent	Cumulative Percent

Strongly Agree	14	28.0	28.0	28.0
Agree	24	48.0	48.0	76.0
Disagree	7	14.0	14.0	90.0
Strongly Disagree	5	10.0	10.0	100.0
Total	50	100.0	100.0	

People prefer traditional medicine to visiting primary health centers				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	8	16.0	16.0	16.0
Agree	21	42.0	42.0	58.0
Disagree	12	24.0	24.0	82.0
Strongly Disagree	9	18.0	18.0	100.0
Total	50	100.0	100.0	

Section C first part shows that Patients receive quality treatment when they visit primary health-care centers. Therefore, 38(76.0%) agreed, from it, 28(56.0%) strongly agreed, and 10(20.0%) agreed. The minority, 7(14.0%) disagreed and 5(10.0%) strongly disagreed. The table reveals that People willfully avoid primary health centers. From the responses, 22(44.0%) strongly agreed, 10(20.0%) agreed, another 10(20.0%) disagreed, and 8(16.0%) were strongly disagreed. Thus, majority of the respondents agreed. The table also states that People prefer visiting patent medicine dealers to primary health centers. From the responses gathered, 24(48.0%) agreed, 14(24.0%) strongly agreed, which are the majority. The minority, 7(14.0%) disagreed and 5(10.0%) strongly disagreed. Lastly, the above shows that People prefer traditional medicine to visiting primary health centers. 29(58.0%) agreed, of which 21(42.0%) agreed, and 8(16.0%) strongly agreed. The minority, 12(24.0%) disagreed, and 9(18.0%) strongly disagreed. Thus, majority agreed that People prefer traditional medicine to visiting primary health centers.

Section D: Key challenges affecting primary health-care delivery

Primary health centers lack adequate staff				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	33	66.0	66.0	66.0
Agree	9	18.0	18.0	84.0
Disagree	8	16.0	16.0	100.0
Total	50	100.0	100.0	

Primary health care centers lack drugs and other necessary health facilities				
	Frequency	Percent	Valid Percent	Cumulative Percent
Agree	31	62.0	62.0	62.0
Disagree	16	32.0	32.0	94.0
Strongly Disagree	3	6.0	6.0	100.0
Total	50	100.0	100.0	
Salary of primary health care workers are delayed				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	19	38.0	38.0	38.0
Agree	18	36.0	36.0	74.0
Disagree	7	14.0	14.0	88.0
Strongly Disagree	6	12.0	12.0	100.0
Total	50	100.0	100.0	
Primary health care centers have "ghost workers" (i.e.) people who do not work, but receive salary				
	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	22	44.0	44.0	44.0
Agree	22	44.0	44.0	88.0
Disagree	6	12.0	12.0	100.0
Total	50	100.0	100.0	

First part of Section D reveals that Primary health centers lack adequate staff. From the responses gathered, majority 33(66.0%) strongly agreed, and 9(18.0%) agreed. The minority, 8(16.0%) disagreed that Primary health centers lack adequate staff. The section above shows that Primary health care centers lack drugs and other necessary health facilities. The majority 31(62.0%) of the respondents agreed. The minority 16(32.0%) disagreed, and 3(6.0%) of the participants strongly disagreed that Primary health care centers lack drugs and other necessary health facilities. Again, the section reveals that Salary of primary health care workers are delayed. From the responses gathered, it shows that 19(38.0%) of the respondents strongly agreed, and 18(36.0%) agreed. Minority, 7(14.0%) disagreed, and 6(12.0%) strongly disagreed that Salary of primary health care workers are delayed.

Finally, from section D above states that Primary health care centers have "ghost workers" (i.e.) people, who do not work, but receive salary. Majority of the respondents 44(88/0%) agreed. Out of which 22(44.0%) strongly agreed and another 22(44.0%) agreed that Primary health care centers have "ghost workers" (i.e.) people who do not work but receive salary. The

minority of the participants 6(12.0%) disagreed that Primary health care centers have "ghost workers" (i.e.) people who do not work but receive salary. Hence, majority agreed.

Test of Hypothesis

Hypothesis One

H_0: There is no significant association between the quality of treatment at the primary health care centers and the inadequacy of drugs.

H_1: There is a significant association between the quality of treatment at the primary health care centers and the inadequacy of drugs.

We reject H_0 if P-value is less than α =0.05. Otherwise we do not reject.

From the test of association conducted using Chi-square (χ^2), it revealed that χ^2 = 62.085, df =6 and P= 0.000. Thus P <0.05. We reject H_0.

Hypothesis Two

H_0: There is no significant association in the perception of the quality of treatment at the healthcare centers and the inadequacy of qualified medical personnel.

H_1: There is a significant association in the perception of the quality of treatment at the healthcare centers and the inadequacy of qualified medical personnel.

We reject H_0 if P-value is less than α =0.05. Otherwise we do not reject

From the test of association conducted using Chi-square (χ^2), it revealed that χ^2 = 66.30, df =6 and P= 0.000. Thus P <0.05. We reject H_0.

Conclusion

Primary health care centers are located across Isiala Ngwa North LGA especially in the rural areas as is the common practice globally. The Primary health care centers are close to the local population as revealed in the study. The existence of these centers is however not known to some people while some other groups of people that are aware of the existence of these centers have not had any cause to visit any of them for medical help. There are however differences in the perception of the quality of treatment received at these centers by the people. Those that perceive the quality of medical care at these centers as below standard have resorted to willfully avoiding a visit to these centers when they fall sick. The perceived low-quality medical care at these centers also makes some individuals resort to patronizing patent medicine stores and traditional healing homes.

It was further gathered from the study that the primary health care centers are facing quite a number of challenges which are militating against the delivery of quality healthcare services. A common challenge is inadequate manpower. There is shortage of qualified medical personnel to effectively handle the basic care expected of a primary health care center. Another problem identified is the lack of essential drugs necessary for treatment common of illnesses. Delay in the payment of remuneration of health workers was also identified which

can lead to lack of job motivation on the workers and consequently result in poor service delivery.

From the test of hypothesis conducted, the decision taken on the first hypothesis is that there is a significant association between the quality of treatment at the primary health care centers and the inadequacy of drugs, and on the second hypothesis we concluded that there is a significant association in the perception of the quality of treatment at the healthcare centers and the inadequacy of qualified medical personnel.

Recommendations

1. The implication of Primary Health Care (PHC) sustainable strategies as well as operational planning should not be speculative, rather, an evidence-based phenomenon that will prove to community members that their health and happiness is of paramount interest of the government.

2. Investment in healthcare research and healthcare delivery is an enterprise that should be pursued with collective vigor by all, as it remains an integral and important strategy for implementing primary health care in Nigeria.

3. Government should have a re-think and new workable strategies which will lead to a renewed commitment since PHC has proven to be a crucial means in the decentralization of health services with the aim to improve access to healthcare especially in rural communities.

4. The burden and budget of providing health care services to the grass roots should not be carried by government alone. Good will and philanthropic individuals and non-governmental organizations (NGOs) should be encouraged to be taking active participation in funding and supervising PHC centers.

5. Primary Health Care (PHC) workers rendering medical services to community members should not be treated as second-class or lower class medical practitioners, and in this case they must receive government's attention in terms of remuneration, promotion and prompt salary payment, with job motivation packages with the objective of capacity building and commitment to service.

6. Primary health care services and management should not be a place for quacks, unqualified and less devoted medical personnel. Therefore, there is great need for PHC workers to be trained and frequently retrained by being sent to workshops, seminars, specialized courses, and be encouraged to obtain higher degrees in their various health discipline.

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