# PRIMARY HEALTHCARE AND EFFECTIVE RESPONSE TO CORONAVIRUS PANDEMIC IN RURAL AREAS AND NIGERIA'S SUSTAINABILITY

By

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***Abstract***
*Primary healthcare and effective response to coronavirus pandemic in rural areas and Nigeria's sustainability was examined. Primary healthcare has as one of its objectives to provide effective healthcare services to the rural people. Efforts of government in achieving these objectives are very clear and visible but success has been negligible as could be seen in the poor state of primary healthcare centres across the country. The emergence of covid-19, the paper argued exposed the weakness of Nigeria's healthcare system in the areas of manpower, equipment, infrastructures etc. Yearly revenue allocation to the health sector has been very minimal compared to what is obtained in other countries of the world. The paper highlighted that due to the incessant travels by top government officials in Nigeria and their families abroad for routine medical checkups and treatment, the Primary Healthcare sector has suffered neglect and deprivation. The paper concluded that the Nigeria healthcare system should build capacity to respond effectively to any outbreak of diseases at any time as no one, whether rich or poor can avert the outbreak of a pandemic such as COVID-19. It made some recommendations among which are; the provision of electricity and other amenities to health centres, making available medical laboratory services at the primary health centres, attracting regular visits of consultants to the centres on routine basis, among others.*

***Keywords: Primary healthcare, coronavirus pandemic, rural areas, sustainability***

## Introduction

The concept of Primary Healthcare was established at the Alma Ata Conference of 134 Countries in Russia on September 12, 1978. The conference was organized by the World Health Organization (WHO) and the United Nations Children Emergency Fund (UNICEF). In Nigeria, however, the Primary Healthcare system was established in 1988 by the administration of General Ibrahim Babangida. It was expected to be a collaborative effort of the three tiers of government (Federal, State and Local Governments). It was structured to fit into the cultural and socio economic context of Nigeria and anchored on the interest of the people with the aim of developing local capacity, enhance self-reliance and promote initiatives (Adeyemo 2005).

Primary Healthcare forms a key aspect of the Nigeria social and economic agenda. It is the first contact point of the community members in the country's health system as it is the closest to the people at the grass root level (Akinsola 1993). The Primary Healthcare Principle rests on the understanding that health is wealth and a basic human right that should be enjoyed by the people in various communities across the country in normal situations and in times of emergency.

Primary healthcare development in Nigeria involves devolution of power from the Federal Ministry of Health to all the 774 local governments in the country in direct response to the Nigeria Health Policy which recommends specific functions of the Local Government Health Committees which include; formulation of project proposals, delivery of comprehensive healthcare services within the area with community involvement and inter-sectoral cooperation. collection of basic data as well as mobilization of resources for health programmes in the spirit of self-reliance (Egwu 2015).

These powers, granted to local governments by the federal government are very laudable and well garnished in theory but without practical effort on the part of government to ensure that the local people reap the benefits of primary healthcare services. This is indeed the concern of this paper, especially as the current novel Coronavirus pandemic has revealed the nakedness of the country in providing effective healthcare delivery services to the citizens in emergency situation as was the case in Ebola and the current Covid-19 Pandemic.

**Primary Healthcare and Coronavirus Pandemic**

As conceptualized in the Alma Ata Declaration of 1978, Primary healthcare is "essential care based on practical, scientifically sound and 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 and self-determination (World Health Organization; 1978). Based on this Declaration, Nigeria initiated major moves aimed at raising the standard of her primary healthcare system. These major attempts by Nigeria can be classified into three, each exhibiting its own chequered performance. The first attempt took place between 1975 and 1980 and introduced the Basic Health Services Scheme (BHSS) by the Federal Ministry of Health through the Basic Health Service Implementation Agency. The BHSS provided for the establishment of healthcare facilities at three levels namely; Comprehensive Health Centres (CHC) to Serve Communities with a Population of between five thousand (5000) to twenty thousand (20,000) people; Primary Health Centres (PHC) to Serve communities with a Population of between five thousand (5000) to twenty thousand persons; and Health Clinics (HC) to Serve communities with a Population of between two thousand (2000) to five thousand (5000) Persons.

The first attempt recorded abysmal failure due to many factors such as inadequate orientation and distribution of the health workforce. This failure eventually led to the establishment of the District Health System (DHS) between 1986 and 1992 which commenced with the development of "Project Formulation Documents" (Action Plans) which were funded by the Federal Government in 52 selected pilot local government areas. This scheme made it possible for each local government area to acquire a minimum of seven

(7) Primary Health Centres and thirty (30) Health Clinics with at least one (1) Comprehensive Health Centre at the apex of the Healthcare Services; while larger local governments areas were given at least twelve (12) PHC and fifty (50) HCS that fed into one or more Comprehensive Health Centres (HC'S) (Emuakpor 2010).

In spite of this and similar to the first effort, the District Health System (DHS) achieved partial success with similar hackneyed factors that undermined the Basic Health Services Scheme (BHSS). These factors are poor involvement, poor funding, lack of appropriate infrastructure and equipment as well as substandard drugs and materials. Furthermore, there has been reported by various researchers and authors persistence of paucity of basic health statistics and inequitable distribution of manpower and poor logistics (Adebayo 2020; Abosede & Sholey 2014; Aigbiremolen 2014; and Alenoghena, Abejegah & Eboreime 2014), The partial failure of the District Health System brought about the third effort which was initiated in 1992 with the aim of perfecting and systematizing basic healthcare system. The commencement of the third effort did not show any sign of improvement and seriousness until the emergence of democratic government in 1999 where efforts were made towards implementation of policy document of the third efforts at improving the Primary healthcare subsector in Nigeria. There was the institution of Ward Health System (WHS) in 2001 which used the electoral ward with a representative councilor as the basic operational unit for primary healthcare delivery (Abosede and Sholey 2014). Despite these efforts, the state of Primary Healthcare subsector in Nigeria is yet to achieve perfect success stories. This cannot be isolated from neglect, lack of political will and commitment to improving the primary healthcare system in the country.

As rightly stated by Ayah (2021):

> pandemics and pestilences have always been regular features in human history in the last 120 years, that is, from the 19th century into the year 2020, the world had experienced about 12 occasions of pandemics, meaning an occurrence of one pandemic in every 12 years. Since the beginning of the 21st century, which is from the year 2000, it is on record that the world has had six experiences of pandemic. This means that in the last 20 years, the world has had a pandemic in every three years as follows: in 2003, it was Severe Acute Respiratory Syndrome, otherwise known as SARS; 2009 witnessed the global HINI flu pandemic; in 2010 it was cholera epidemic. Measles pandemic occurred in 2012, while in 2014 the world was trapped by the Ebola hemorrhagic fever pandemic. Zika virus pandemic occurred in 2016; while in 2020, the world experienced the novel coronavirus pandemic. Of the pandemics which occurred in the 20th and 21st centuries as captured in the literature; only three can be compared in depth and scope. The Spanish flu killed about 50 million people; the HIV/AIDS pandemic claimed the lives of about 35 million people while Covid-19 has killed about 2.2 million people globally as of February 2021.

The Coronavirus pandemic, code-named Covid-19 started in the city of Wuhan, China in December 2019 and spread to other countries of the world. Nigeria had its first case on February 27. 2020 but as of February 25, 2021, barely one year after, the country has recorded one hundred and fifty four thousand, four hundred and seventy six (154, 476) confirmed cases with one hundred and thirty one thousand, six hundred and ninety nine (131, 699) discharged and one thousand eight hundred and ninty one (1891) deaths (NTA 26 Feb, 2021).

This has proved that the world has evolved from being a global village to becoming a global family where distance is no longer a barrier and members cannot be shielded or immuned from any condition that affects any part of the world. The Ebola case and the current case of Coronavirus pandemic have proved this to be true. There is therefore the need to protect the earth and citizens of the earth as one family irrespective of location if the global family must continue to exist and remain stable.

The coronavirus pandemic is a wakeup call for the Nigerian government to address pointedly the dilapidated and decayed health system in the country. The Nigerian government should no longer wait for catastrophy to strike or an epidemic to occur before searching for "instant" solutions. The world of "instants" is the bane of our society today: instant education, instant wealth irrespective of where it comes from, instant food, noodles, tea/coffee, instant certificate which has led to certificate forgery as well as instant political power which has thrown up mediocres and people with inordinate ambition who have no positive antecedents in service delivery to the people. These instant politicians come with salivative 'instant' advertisements that are very difficult to reject but which are later discovered were only baits for their selfish interest.

The inability of the Nigerian government to always plan ahead and project into the future at all times is the cause of this embarrassing experience it had during the COVID-19 outbreak. It could be recalled that the Nigeria Centre for Disease Control (NCDC) was established in 2011 in an effort to tackle rising health challenges in the country, but without adequate funding. The trend has remained unchanged or even worse in some cases, but following Bill Gates criticism of poor funding of the primaryhealth care system in Nigeria the Government in November 2018 signed into law an Act establishing the Nigeria Centre for Disease Control (NCDC) and released only six hundred and fifty four million naira (N654m) out of a toal proposed budget of one billion nine hundred million naira (N1.9m) proposed by NCDC (Chidebe 2020). In 2019, NCDC had the worst budgetary allocation with a release of only two hundred and twenty four million naira (N224m) out of a budgeted sum of one billion, four hundred million naira (N1.4b). In the heat of Covid 19 pandemic in 2020, testing laboratories and centres were not effectively distributed. With a population of over 200 million people, the government provided only 169 ventilators to serve an estimated 1,266,440 persons per ventilator as of April 17, 2020 (Maclean and Mark, 2020).

These are indications that the Nigerian government easily forgets the past, else it would have learned from the Ebola epidemic which the government was caught unprepared when the index case of an Italian who tested positive at Lagos on February 2020 was discovered. As rightly observed by Akpan (2014) those who cannot remember the past are condemned to repeat it. While the case of Covid-19 pandemic had circulated to all nooks and crannies of the world, Nigerian legislators, rather than budget for the fortification of Nigerian

Primary healthcare system were busy making financial arrangements for the latest version of about 400 Toyota Camry cars (Baiyewu, 2020). This shows very clearly that our legislators are not representing us but their selfish interests and those of their immediate families. This has been the woes of the Nigerian state over the years.

**Resource Allocation and Primary HealthCare**

Financial allocation to the Primary Healthcare subsector in Nigeria has over the years been very poor. As Egwu (2015) correctly pointed out, Government spends relatively too much on sophisticated hospital services of low cost effectiveness and too little on essential Public health and basic curative services. This disproportionate allocation of health resources has created healthcare crises in most developing countries including some developed ones. The much-talked-about community transmission of coronavirus in Nigeria and the fears associated with it at the inception of the pandemic was as a result of lack of capacity by primary healthcare providers to handle the emergence of the deadly virus at the local level.

Effective healthcare delivery cannot take place in fine and modern designed buildings without drugs, medical equipment, laboratories, and trained health personnel which is the situation in most primary healthcare centres in Nigeria. Poor resource allocation to the primary healthcare subsector and indeed local governments is a major contributor to ineffectiveness of primary healthcare services in Nigeria (Akpan 2019). The fear of community transmission of coronavirus stems from the poor state of primary healthcare centres in almost all local government areas in Nigeria.

Funding has been a major problem confronting Public health system in Nigeria, especially the primary healthcare subsystem. Available records on Health Development efforts show that between 2003 and 2005, the Federal, State and Local Governments accounted for 12 percent, 8 percent and 4 percent respectively (Uzochukwu, Ugbasoro, Etiaba, Okwuosa, Envuladu, and Onwujekwe 2015).

In 2003, the total government health expenditure, as a proportion of the total health expenditure was estimated at 18.69%, 26.40% in 2004 and 26.2% in 2005 respectively (Soyibo, Olaniyan and Lawanson 2009). The implication of these percentages allocated to the health sector is that capital expenditure of government on the health sector has been abysmally low over the years with negative effects on the health of the citizens. At the Abuja Declaration in 2001, Nigeria and other forty three (43) African countries endorsed a Commitment to spend 15 percent of annual budgets on public health, this has not been achieved twenty years after the Commitment (Obansa and Orimisan, 2013; Obi-Ani Ezeaku, Ikem, Isiani and Chisolum 2021).

Under this unfortunate situation, millions of dollars and pound Sterling have continued to be squandered by Nigerian leaders and politicians on foreign medical treatment. The Nigerian Health Sector Market Report (2015) shows that Nigerians spend an estimated two hundred and sixty million U.S Dollars ($260,000,000) in 2012 on medical bills in India alone, forty percent (40%) of all visas to India within the period were for medical attention (Obi-Ani et al 2021).

The Nigerian Medical Association (NMA) estimates that Nigeria spends five hundred million (500m) to one billion (1b) US Dollars on medical tourism every year. In the

same Vein. the British Broadcasting Corporation (BBC) (2016) reported how President Muhammdu Buhari of Nigeria travelled abroad just to treat an ordinary ear infection. Also, in 2017, President Buhari spent more than 100 days in a London hospital (Obi – Ani et al 2021). This is an embarrassment to the Nigerian Government and the entire Nigerian Medical Profession. This embarrassing situation calls for revitalization of the Nigeria Healthcare System from the Primary, Secondary to tertiary levels and a law limiting public officials from seeking medical attention abroad. This however requires that government put our hospitals in proper shape to cater for the overall health needs of Nigerians.

**Implications of primary healthcare response to coronavirus pandemic**

Primary healthcare system is the bedrock of Nigeria's health system and in the face of continued Covid-19 community transmission; the primary healthcare system becomes the more readily available to cater for the health needs of people in rural areas. This however, has not succeeded because the Nigerian government has over the years continued to pay lip service to this important subsector in healthcare delivery. The effect of this action of government with regard to deliberate neglect of the nation's primary healthcare system has been self-evident, especially during the covid-19 experience. Lack of political will on the part of the elites to address the primary healthcare challenges underscores the need to revitalize the healthcare subsector without further delay. The lockdown and cessation of routine activities in the heat of the pandemic with its concomitant cataclysmic consequences such as income reduction, escalation of hunger, boredom, rise in suicide cases, upsurge in insecurity, divorces and paranoia throw a challenge to government to see the need for local production of drugs, medical equipment such as ventilators, surgical masks and vaccines for treatment of epidemic and pandemic diseases as well as building and equipping primary healthcare centres across the country (Obi-Ani et al 2020).

Global lockdown caused by Coronavirus pandemic brought about global economic problems. The decline in economic activities led to a drastic fall in revenues accruing from oil, which is the mainstay of the Nigerian economy and subsequently threw the country into economic recession (Emefiele, 2020). While government at the federal, state and local levels did everything possible to ensure that salaries of public servants were paid, private businesses were incapable of doing so, rather, some of the workers were retrenched while some private businesses were outrightly closed down. In an effort to ease the suffering of vulnerable Nigerians during the period of the Coronavirus pandemic, palliatives were made available by government and well-placed Nigerians but those charged with the responsibility of distributing these palliatives saw it as an opportunity to enrich themselves at the detriment of indigent Nigerians.

The saying that 'health is wealth' and 'a healthy' nation is 'a wealthy nation' makes little or no meaning to highly placed government officials in Nigeria as they and their family members are routinely sponsored for medical checkup in foreign countries. This is one fundamental reason they refuse to pay serious attention to public healthcare system in the country. The good thing about coronavirus pandemic and other diseases is that they are no respecter of persons. It touches the rich as well as the poor, the educated as well as the uneducated, the highly and lowly as well as the young and the aged. A list of deaths from

Coronavirus in Nigeria shows that the rich and well-placed are mostly affected. This is not to say that the lowly-placed and the poor are not victims, but their names and burials are not advertised or taken seriously. Comets are not seen when beggers die but are everywhere at the death of the wealthy, prince and princess. While there is nothing wrong with Nigeria Healthcare Policies as contained in the policy documents, there is something wrong when it comes to implementation of those policies to satisfactory conclusion.

**Primary healthcare and a sustainable Nigeria**

When wealth is lost, nothing is lost, but when health is lost something is lost. The importance of good health in the sustenance of a nation cannot be overemphasized. Population is key element of the state, but for the population to contribute to the growth and development of the state, it must be healthy. No nation can thumb its chest of having attained any meaningful development or sustainability if the health sector is in shambles. Effective primary healthcare is critical to this attainment. A sustainable Nigeria is such that could meet the needs of the present without compromising the capacity to meet future needs of Nigerians. It involves total commitment to improving the quality of life of the citizens. The Nigerian government must be prepared to commit enough resources to the health sector in Its annual budgets as well as ensure that the citizens are able to eat well. Inability on the part of government to provide food to the teaming population of Nigerians is an integral part of the immune deficiency which escalates coronavirus infection. Nigeria cannot achieve sustainability when the citizens are hungry, sick and jobless. With a population of over 200 million people, the Nigerian government ordered for only 4 million doses of coronavirus vaccines into the country which is expected to arrive in March 2, 2021, a year after the emergence of the deathly virus which has claimed many lives. Who are the immediate beneficiary of these 4 million doses? Maybe the government will decide, but certainly, top politicians, government officials and the elites might make the first list.

**Nigeria's Rural Conditions and Coronavirus Pandemic**

The most evident display of Nigeria's underdevelopment conditions is the rural areas. The condition of the Nigeria rural sector is deplorable. This can be discerned primarily from the quality of its population. The rural sector lacks basic infrastructural facilities required to meet the needs of modern living. The rural population constitutes in the main, the Nigerian peasantry, the poor and the country's largest illiterate groups. It is their typology that Frantz Fanon refers to as the 'wretched of the earth' whose endless striving for survival has not been assisted by low incomes and inadequate innovations in farm practices (Akpan & Afia, 2019). Medical facilities are not available in Nigeria rural areas, where primary healthcare centres exist, drugs are not available and medical personnel are hard to come by.

The rural people occupy a very significant position in the advancement of government and the larger society. They support the government by contributing to self-help efforts, yet, these are the same people that are mostly marginalized in the society. As rightly captured elsewhere by Akpan and Afia (2019):

> *The wealth which build modern Nigeria, whether in the era of the dominance of agricultural commodities or of petroleum was derived from the rural areas.*

> *Notwithstanding this, we have witnessed even in the not-two-distant past, the virtual neglect of these areas and their population. The recent phenomenon of mass importation of food and growth of slums in our major cities along with its attendant social, political and economic consequences have been the result of the collapse of the rural economy and infrastructure.*

The Nigerian government should redirect its attention to developing rural areas if the country must attain sustainability. More primary healthcare centres should be established and equipped to modern standard to cater for the health needs of the people and protect them against any outbreak of epidemic such as ebola and covid-19. The poor conditions of the rural people could be alleviated if government is willing to cater for their welfare by providing them with necessary amenities and infrastructures.

**Conclusion**

The study of primary healthcare subsector in Nigeria and its capacity to respond effectively to outbreak of diseases such as the current Coronavirus pandemic has revealed that the country is lacking behind in the provision of effective primary healthcare services to the people. Since the establishment of the primary healthcare system in Nigeria in 1988, it has been seen as a local government affair and allowed to go the way of local government administration in country, instead of collaborative efforts of the three tiers of government – federal, state and local government as expected. As a community-based healthcare facility, primary healthcare centres were meant to cater for the health needs of Nigerians in various local government areas across the country. This has not succeeded due to lack of political will, insincerity and utter neglect of this aspect of health system in Nigeria.

The Coronavirus pandemic which swept across all continents of the world has revealed the poor state of primary healthcare centres in Nigeria and un-preparedness of the country to respond positively to health emergencies when the need arises. Resource allocation to this subsector has been very poor for decades. In some primary healthcare centres, qualified medical personnel are not available or inadequate. There is absent of medical equipment, and where available, there is no electricity to power them. The general environment where these primary health centres are located in most cases are not conducive for medical practice or medical personnel to stay.

With very little budgetary allocation to the health sector every year, the primary health subsector has been seriously affected and unable to operate to full capacity. To stem the tide, government is expected to take a second look at the primary healthcare subsector which caters for a high percentage of Nigerians in the rural areas of the country.

**Recommendations**

i. Government should allocate enough resources to the primary healthcare subsector to assist in providing required drugs and equipment etc.
ii. All primary healthcare centres in the country should be provided with electricity. This will help in drug preservation and samples obtained from patients. It will

equally make the health centres conducive for medical personnel to stay and operate.

iii. Medical laboratories should be established and equipped in all primary healthcare centres. In the face of covid-19, these centres could have been used instead of directing patients to secondary and tertiary medical hospitals for testing.

iv. Government should partner with medical consultants in various areas of medicine in teaching hospitals to visit primary healthcare centres at least twice a week to attend to the healthcare needs of the rural people.

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