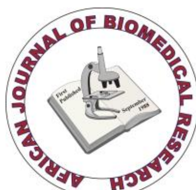

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Research Article

Qualitative Analysis of One Primary Health Care per Ward in Ekiti State, Nigeria

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ABSTRACT

The "One Primary Health Care (PHC) per Ward" policy is an important health care component for achieving health for all. This study assesses the functionality, successes and challenges in the implementation of 'one PHC per ward' policy in Ekiti State, Nigeria. In-depth and key informant interview guides serve as qualitative research instruments for data collection. Relevant information was sourced from different stakeholders, including the Executives of the State Primary Health Care Development Agency (SPHCDA), the Local Government Chairmen, the Heads of Departments in PHCs, Staff of PHCs and patients who visited PHC facilities, amounting to twenty-five in-depth and seven key informant interviews. Although all the wards assessed had at least one PHC facility, none of the PHC facilities visited met the minimum standards recommended by the National Primary Health Care Development Agency (NPHCDA). PHC facilities located in the rural areas had fewer infrastructural and human resources than those in the urban areas. Routine immunization exercises were improved across the PHC facilities as the Universal Drug Revolving Scheme adopted by the PHCs was successful, largely because of the re-investment of both principal and profit into the purchase of drugs. Results suggest that while routine immunization as an aspect of PHC services had received remarkable successes, the PHC facilities suffered from inadequate equipment and personnel. There is need for a political will and concerted actions that are designed to improve PHC facilities if PHCs are to realize the objectives for setting them up.

Keywords: *Immunisation, patient safety, health funding, health systems, primary health care*

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INTRODUCTION

Primary health care (PHC) is key to accessing universal health coverage. It is an important health care component for achieving health for all, especially in the less developed countries where access to quality healthcare is minimal (Barrett, 2020). The concept of "one PHC per ward" was widely accepted at the Alma-Ata Declaration of 1978 as a vehicle for ensuring that more people all over the world have access to quality healthcare (World Health Organization, 1978). Forty-two years after its support of the Alma-Ata Declaration of 1978, Nigeria which has a population of over 200 million people and is the seventh most populated country in the world, is yet to meet the goals stipulated in the declaration (United Nation, 2013, Worldometer, 2020). As a matter of fact, a large number of Nigerians do not have access to medical health services; those in the rural areas are the worst-hit (Nnabuihe and Lizzy, 2005).

The poor state of the PHC system in the country has made a good number of Nigerians, especially those in the middle and upper classes to seek health care services from better managed health care providers (at the secondary and tertiary health care levels) (National Primary Health Care Development Agency (NPHCDA), 2005; Oyekale 2017). Those who can afford to seek health care services outside Nigeria without contacting PHC providers in the country are also doing so (Atim and Bhatnagar, 2013). As such many Nigerians ignore the referral health policy and services of PHC facilities which are much closer to the people than the other levels of health care (Oyedeji and Abimbola, 2014). Consequently, there is an increase in the population of people who access secondary and tertiary health care facilities, thus increasing the workload of the staff of these healthcare facilities who sometimes have to attend to patients that could easily have been treated at PHC facilities (Alenoghena, Aigbiremolen, Abejegah and Eboreime, 2014; Fusheini and Eyles. 2016).

Most of the less educated Nigerians who are often in the lower classes prefer staying at home, engaging in self-medications or consulting traditional medicine providers for prevention, diagnosis and cure of diseases to contacting PHC providers for care (Ezekwesili-Ofili and Okaka, 2019). Some of the reasons for this preference include the poor state of the PHC facilities, the fear of not being attended to by medical

experts, the lack of financial means and an ignorance of the procedures for accessing PHC services (Atim and Bhatnagar, 2013; Mills and Ranson, 2012).

Over the years, the Nigerian government has made concerted efforts at addressing these challenges in the PHC system by setting up policies and programmes, and partnering with non-governmental organizations (Federal Ministry of Health Nigeria, 2004). Some of these programmes are the National Health Policy, the National Health Act, the National Strategic Health Development Plan, the National Health Insurance Scheme, the National Routine Immunisation Strategic Plan, and the Minimum Standards for Primary Health Care in Nigeria, the Ward Minimum Health Care Package, the PHCOUR Implementation and the One Functional PHC Per Ward Strategy (Federal Ministry of Health, 2012; NPHCDA, 2015).

In spite of the launch of these well lauded and well-meaning programmes, Nigeria's PHC system is still in a bad state as all these programmes have experienced lots of setbacks (Alenoghena et al, 2014). This paper thus presents an analysis of the "one PHC per ward" policy in Ekiti State Nigeria. It assesses the functionality of the PHC, and the successes and challenges of the PHC system.

MATERIALS AND METHODS

Study area and design: The study was conducted in Ekiti State Nigeria. It adopted a cross-sectional qualitative research design. With this, it accommodates subjective judgments while providing profound themes and perspectives.

Sampling technique and instrument: A purposive sampling technique was employed while in-depth and key informant interviews were used. The questions featured in the interview guides include the functionality of the PHCs, the services offered and utilised in the PHCs, and the successes and challenges in PHCs. The instrument was designed to capture key elements of PHC assessment as stipulated in the Minimum Standards for Primary Health Care in Nigeria and the Ward Minimum Health Care Package. The instrument was subjected to primary health care experts' verification. A pilot study was also conducted among 12 stakeholders in PHC facilities outside Ekiti State to get first-hand information that helped in the amendment of the interview guides.

Sample size/data collection: Twenty-five in-depth and seven key informant interviews were utilized. The in-depth interviews were conducted among staff of PHC centres and patients who visited the PHC facilities. The key informant interviews were conducted among the Executive Secretary of SPHCDA, Director of SPHCDA, Local Government Chairmen, and Head of Departments of PHCs in Local Government Areas. This provided the opportunity to check for variations in the responses generated.

Data analysis: Data gathered through tape-records were transcribed, coded into ATLAS.ti Qualitative and Scientific Software, and content-analysed for results.

Ethical considerations: The Ekiti State Primary Health Care Development Agency granted the approval for the study and all the study participants consented to the study after being briefed on the purpose of the research. The research processes complied with the Helsinki 1964 declaration and its later amendments, hence, ethical principles of voluntariness, beneficence, confidentiality, and non-malfeasance to participants were strictly adhered to.

RESULTS

Functionality in the PHC System: The participants in the study stated that Ekiti state has at least one PHC in each ward, but that the functionality of the PHC Under One Roof (PHCOUR) policy was yet to be achieved. One of the participants revealed that the staff of the PHC were under the control of the local government. As such, although the Ekiti State Primary Health Care Development Agency (SPHCDA) had been set up, effort to bring all the operational functions and staffs of the PHC centres under the control of the SPHCDA was ongoing, but not yet fully implemented. According to the participant:

> *"At the moment the PHC is under the control of the local government. Although efforts are being made to bring all the PHCs under the control of the SPHCDA, for now the implementation is pending. ... Currently, all wards in the State have at least one PHC" (KII/SPHCDA/E1).*

The statement indicates that all the wards in the State had at least one primary health care facility just as the Alma-Ata Declaration of 1978 stipulates. However, the state of the health facility also counts as it is expected that each PHC facility must be functional and at par with the minimum international standards.

The discussion with the participants revealed that operational functioning of PHC centres in Ekiti State was coordinated in such a way that everyone has access to health care irrespective of their socioeconomic status. The interviews revealed that the aspects of healthcare covered by the PHC in the State included maternal and child health care in addition to common diseases like HIV/AIDS, Malaria and Tuberculosis. The participants highlighted that most of the programs under the State PHC were supported by donors and partners like UNICEF, WHO and the MDGs. These partners also improved the delivery of PHC services by sponsoring health programs which enabled indigent individuals to access some health care services for free. The interviews revealed that the Malaria Control Programme which was also supported by the donors made the supply of diagnostic materials and drugs free for malaria control. The same situation applied to the diagnosis and treatment of tuberculosis in the State. In the interviewee's words:

> *The PHC in the State is coordinated in a way that everyone including those in the grass root can access health care irrespective of their socioeconomic status. The areas covered by the PHC in the state are mainly the maternal and child health care and the diseases that are common among the people like HIV/AIDS, Malaria and Tuberculosis… Most of the programs under the State PHC are supported by donors or partners such as the*

UNICEF, WHO, MDGs, etc. These partners make the delivery of PHC services more accessible for the people in the local government areas by sponsoring these programs so that that if individuals do not have money, they can still access some components of health care for free… For instance, the Malaria Control Programme which is supported by donors has made the supply of diagnostic materials and drugs free for malaria control. The same is applicable to diagnosis and treatment of tuberculosis which are also free. (KII/SPHCDA/D2).

Successes in the PHC System; Discussion with participants revealed that the Ekiti State PHC categorizes child survival intervention services under the reproductive health class and concentrates on the provision of care for pregnant mothers and their children. The State undertook this intervention by providing trainings to health workers in nearly all the 320 PHCs in the State. The health workers were trained on how to manage maternal health, especially during antenatal and delivery situations. With regard to the increase in the number of mothers who visited PHC facilities, the interviews with the study participants revealed that the State Primary Health Care Development Agency (SPHCDA) had set up a body called the Social Mobilization Group to handle aspects of the PHC intervention project that bordered on health education. As at the time of the study, the Ekiti SPHCDA had Community Resource Persons who were trained since 2016 with the support of partners. One of such partnerships included that with the UNICEF in collaboration with the National Orientation Agency (NOA). The main responsibility of the Community Resource Persons was to mobilize people, especially mothers of under-five children, to visit the PHC in their wards. Their trainings were conducted in the three senatorial districts while the participants drawn from different religious, cultural and social groups within the communities. One of the criteria for selection was that each participant had to be a representative of a unit group of his/her community. At each training session, opinion leaders from different groups in the communities were invited to participate. The interviewee put it this way:

Ekiti State PHC groups child survival intervention services under the reproductive health… The State undertook this intervention by providing training to health workers in nearly all the 320 PHC facilities in the State… The health workers were trained on how to manage the maternal health of women during antenatal care and delivery… The SPHCDA has set up a body called the Social Mobilization Group to handle health education aspect of the PHC project. At present, the Ekiti SPHCDA has another group of people called the Community Resource Persons who were trained since the year 2016 through the support of partners like UNICEF in collaboration with National Orientation Agency (NOA) to assist on maternal health mobilization issues. (KII/SPHCDA/D3).

The interviews also revealed that on May/June 2016, the training of community resource persons took place at various town halls in each of the senatorial districts in the State. The interview further revealed that health educators, programme officers, and directors of the Ekiti SPHCDA trained the resource persons on how to inform members of their communities about the services of the PHCs. The interviewees also indicated that by October 2017, Saving One Million Lives (SOML) had trained a group of people called the Community Vanguards to facilitate health care mobilization. Going by the answers gotten from the interviews, the training took place in all parts of Ekiti State. The purpose for the training was mainly to mobilize parents, mothers and other community members to seek healthcare from local PHC facilities. Traditional birth attendants (TBAs) were also trained on how to refer pregnant women to PHC facilities. The interviews indicated that the SOML incentivized referrals by TBAs. One of the interviewees put it this way:

On May/June 2016, training was undertaken at various town halls in each senatorial district of Ekiti State. This time, the health educators, the programme officers, and the directors of the Ekiti SPHCDA were the trainers, while the trainees were trained on how to sensitize community members on the services of PHC so that people can utilize these services... By October 2017, the Saving One Million Lives (SOML) trained group of people called the Community Vanguards… The training took place in all parts of Ekiti State. The purpose for the training was to mobilize parents, mothers and other community members to seek healthcare from PHC facilities… Traditional birth attendants were equally trained on how to refer pregnant women to PHC facilities, and were remunerated for referral. (KII/SPHCDA/D4).

Another project undertaken by the SPHCDA was the use of jingles to facilitate health care information. Radio stations were used as a means of informing the public, particularly the mothers on the importance of immunization and other healthcare services offered by the PHC. The interviews revealed that the project was supported by the UNICEF which was particularly responsible for the supervision and mobilization aspects of the project. According to one of the interviewees:

"…during health campaign, we are usually on radio phoning programmes and discussions on the activities in the PHC level.…UNICEF has been of great support on aspect of financing for supervision and social mobilization to provide jingle radio announcement about routine immunization to enable mothers to know when to bring their children for immunization" (KII/SPHCDA/D1).

The statement above revealed the need for the adoption of several strategies including radio programmes and phone calls to inform mothers of the need to visit PHC facilities for immunization, health check-up and delivery.

An interview with another respondent revealed that some of the primary health care facilities in the State had substantial patronage by patients who needed immunization and child delivery services. The interviewee revealed that child delivery was initially free at PHC facilities in the State. However, the health care facilities were ill-equipped during that period. According to the respondent, the introduction of delivery charges, led to an improvement in the standard of primary health care available to patients. According to the respondents the PHC facilities charged pregnant women the

sum of seven thousand and five hundred naira (₦7,500) [equivalent to 20 dollars] for delivery services. The discussion with the respondents revealed that the money charged was used to equip the health facilities to meet basic health needs:

"For this month alone, we have delivered up to 88 births. Our delivery system is good. The staffs are knowledgeable. We do have up to 100 deliveries in some months... No problem about delivery because the staffs are good. We collect little stipend from patients, that is what we use to buy little things needed for delivery. That is why delivery is easier here… The stipend for delivery is ₦7,500. On the case of HIV/AIDs patients, we refer after testing and confirming to be positive... We have Disease Control Department in this health facility. If there is any symptom of disease, we will notify them and they will come… We operate on shifting (work shifts), so if a patient comes even in the mid night, we will be here to attend to the patient… The health centre is improving because we are taking stipends from patients. Before, when it was free, the health centre was not improving at all. Since we started taking stipends from patients, the health centre has improved... We do antenatal care on Tuesdays and Thursdays. Mondays are for booking. We usually give patients health education on antenatal care days" (KII/CNO/PHC/C1).

The interviewee in the above statement claimed that the PHC facility had qualified staff who rendered healthcare services to patients at all times. It was also indicated by the interview that these staff operated on shifts which regulated their work hours across 24-hour days, all 7 days of the week. According to the interviewee, work shifts allowed health workers to offer uninterrupted health services to patients, regardless of their underlining health conditions.

The interviews conducted with patients were in the same vein as the statement above. They revealed that the relationship between health workers and clients in the PHC facilities was cordial. The patients also attested that the health workers were experienced and reliable. A patient mentioned that the PHC facility she visited had a labour ward and a pharmacy that were both functional. She emphasised that the PHC pharmacy only sells drugs to patients who have obtained prescription from doctors; the aim being to discourage self-medication. In the words of the interviewee:

"This is where I gave birth to my two children. The staff here are well behaved, especially those in charge of labour ward. The reason I prefer this facility is because I notice that the doctor and the nurses are experienced staff. You cannot compare them to private clinics/hospitals that are after money. Here, the staff are not working mainly because of money… For an example to prove that the staff in this primary health care are professionals, my baby is sick, they did not just give me drugs but have asked me to do some medical testing, just to be sure of the problem before prescribing drugs. You cannot just go to the PHC pharmacy to buy drug and the pharmacy sells to you. The prescription must come from the doctor in the clinic before they will sell to you... There is a laboratory in this PHC… I went to the lab to do the test. I am coming from a far place to this health centre. ...there are primary health care centres along where I came from… For an instance, there is health centre at Odo-Ado which is very close to me, I use those health centre only for immunization. I do not go there for test because there is no functional laboratory there" (Patient/PHC Facility/P1).

The above statement reveals that not all primary health care facilities in the State were well managed as the one the patient visited. The patient disclosed that she chose the PHC she was at over other primacy health care facilities that were much closer to her because it was well equipped. According to the patient's statement she visited the PHC closest to her mainly for immunization purposes alone because it was not equipped for medical check-up or laboratory testing. The implication is that many patients would be ready to access PHC facilities if the health centre met minimum international standards.

Interactions with respondents further revealed that some drugs were provided free of charge to patients in the PHC facilities, while others were paid for by the patients. For instance, while HIV/AIDS and tuberculosis drugs were provided free of charge, drugs for cough, cold, malaria and pain relief were for sale. The interviews revealed that the State operates a programme called the Unified Drug Revolving Scheme. This programme allowed specific drugs to be sold to patients with the profits obtained from the sales being invested into buying more drugs. The aim of the programme was to ensure that the PHC replaced sold drugs so that drugs are always available for sale. An interview conducted with a local government chairman affirmed this:

"We practice drug revolving scheme. I am an advocate of this scheme. I do not support a complete free health care service. Let the people pay a token so that it can be used to stock in drugs in the PHC facilities." (Chairman/LGA/Ekiti State/E1)

Challenges in the PHC System: Nearly all the PHC facilities in Ekiti State lack staff and do not meet the prescribed minimum standards. Both the State and the Local Government are aware of this situation and have attributed it to a lack of funds. There was a shortage of funds to pay the current staff so employing new health workers was a challenge. An interview conducted with one of the Local Government Chairmen revealed that, as at the time of this study, the local governments had not employed any new PHC staff for years. In the interviewee's words:

"The government has not recruited new staff for some years now due to lack of finance. Our intention is to pay the present staff on board" (KII/Chairman/LGA, C1).

The above statement suggests that the PHC system in the State is in a poor state of affairs based on the observation that some members of staff at these PHC facilities may have retired, died or changed job during the period in question. The dearth of new staff has actually contributed to the moribund state of the PHC system despite the fact that there is at least one PHC facility in all the wards in the State. A key stakeholder in the SPHCDA shared his view on this thus:

"The State has at least one PHC per ward but we are lacking enough staff. We also do not have enough funds to employ them… The infrastructure, also, is not enough in the PHC facilities" (KII/SPHCDA, E1).

The statement above shows that the State Primary Health Care Development Agency is aware of the inadequacy of staff in the primary health care system but are financially constrained to change the situation. More so, as at the time of this study, the power to employ staff into the primary health care system lay with the Local Government Chairmen since the salaries of the primary health care staff were certified by the local government council. By implication should the State Primary Health Care Development Agency decide to employ PHC staff without approval from the Local Government Chairmen, paying the newly employed staff would be difficult.

Another challenge in the PHC system in the State was the poor infrastructure which discouraged patients from accessing the facilities and made the staff of the facility feel inadequate. The dilapidated state of primary health facilities in the state had also attracted the attention of the National Primary Health Care Development Agency (NPHCDA). An interview with one of the Heads of Department in the PHCs further affirmed that the PHCs are in dire need of staff. Indeed, one of the staff had to attend to several patients at a time while several other patients waited. The interview revealed that nurses or doctors weren't the only personnel in short supply. There was also a dearth of community health extension workers (CHEWS) who are supposed to provide adequate extension and mobilization of health care to communities and households. According to the interviewee':

> *"PHC in the local government has really short of standard… In terms of infrastructure, most of our infrastructures are not good enough. I guess that is why the government of Nigeria in the present administration has made policy to support PHC's infrastructural development. I have seen the staff of NPHCDA from Abuja coming around to make a survey. …The issue of personnel, in fact is a very big challenge. None of our health facility has enough staff to render the necessary services in the centre... For me as you can see, I am expected to see some other patients now. I am the only doctor in this LGA. That is even better because primary health care is not expected to be doctor driven. More so, nurses are not enough. In fact, the standard that we should have at least one skill attendant to attend to a patient has not been met… We have some PHCs where it is not only nurses that are not enough, the CHEWs are also not enough or available to assist in delivery... We have a situation whereby it is only the Health Assistant that would be available in the PHC facility, and you know its implication on health services" (KII/HOD PHC/LGA/H1).*

An interview conducted with one of the Chief Medical Officers of a PHC reinforced the point that the retirement of staff without replacement contributed to the insufficient number of employees in the PHC facilities. She also revealed that some of the current staff were advanced in age and as such could not perform certain tasks that were physically demanding. In her words:

> *"Some staffs have retired without replacement. Some others are advanced in age and incapable of performing the task that require smarter and younger individuals to perform notwithstanding their worth of knowledge and experience in the service" (KII/Chief Medical Officer/LGA, M2).*

Another challenge in the PHC is inadequate equipment in all the PHC facilities visited. Some of the health facilities have faded wall paints. The buildings are old and require renovations. The beds in the facilities are bad. Some of the PHC facilities lack security guards and fences. Most of the health facilities lack power supply and do not have functional generators for alternative power supply. The laboratories are also not updated so some of the laboratory technicians find it very difficult to carry out essential tests because of lack of power and functional equipment. Water supply was also a major challenge in all the facilities visited. Some of the facilities relied on wells which often dried up during the dry season. All the understudied facilities also lacked functional boreholes.

Patients had to pay to access some of these inadequate services. Some of the services patients had to pay are delivery and laboratory tests. An interview conducted with a Chief Nursing Officer (CNO) in one of the PHC facilities goes thus:

> *"There is no enough equipment here because the Local Government that is supposed to supply us everything didn't give us. The little resources we have in this facility are from the patient out-of-pocket payment for services… Parts of the money paid by patients are still sent to the Local Government… The payment from patients comes from delivery charges and laboratory sections" (KII/CNO/PHC/C1).*

The above depicts that despite the insufficient funding of the PHCs, part of the money generated by the PHCs through out-of-pocket payment were forwarded to the Local Government for remittance. An interview conducted with an Officer in-Charge of Health Facility at a PHCs revealed that most of the patients found it difficult to access health care due to the unavoidable out-of-pocket payments. One of the interviewees revealed that the agency in-charge of Millennium Development Goals (MDGs) helped to provide free healthcare services and also encouraged patients to visit the PHCs for check-up and delivery without out-of-pocket payment. This was in a bid to avert the challenge of financial constraint impeding access to healthcare. The interviewee bemoaned the fact that the free health care services and gifts to pregnant women and mothers had stopped following the end of the MDGs and the onset of the SDGs. In the interviewee's words:

> *"Most patients do run away with delivery money without paying us… The MDGs when they were here do give money for services of patients who come to this health centre. They were also giving them mama kits, pampers and many other things. There is nothing like that now… We are moving towards dry season. The only water well we have cannot cater for everybody… The MDGs gave us borehole but it is no more functioning. Early this year we called on repairers to work on the borehole, it only functioned for two months and spoilt again. We now rely on the well water which may dry up during dry season… We need borehole water here… The State Ministry of Health supplied beds to us but those beds are not good. We called the welder to repair it and it spoilt again… They gave us about 17 beds but most of them are not*

good. We have packed some of them outside. If you go outside you will see them… The beds were given to us about three months ago. When patients lie on it, it will spoil… There is no incubator here to take care of new born babies. No functioning machine… If we have preterm babies, we do refer them to the Teaching Hospital but the Teaching Hospital is currently on strike". (KII/Officer in-Charge of Health Facility/PHC/LGA, O1).

The above statement reemphasised the fact that PHCs in the State are in a dilapidated condition. Well water as reportedly used by the health facilities is not the ideal source for water but the health workers have no alternative than to utilize it in the absence of functional boreholes. The lack of functional beds and delivery equipment are good enough reasons to dissuade patients from accessing healthcare services from PHCs. More so, because of the lack of security, electricity and the shortage of staffs, some primary health care facilities in the study operated only during the day. In the words of the interviewee:

"We have problem of electricity supply. There is no way we can attend to patients in the night without electricity supply… We don't allow patients to sleep here because of lack of security, electricity and sufficient staff… For our own safety and the safety of patients, we don't work in the night because the health facility is not fenced" (KII/CNO/PHC/LGA, C3).

The above statement further reveals that primary health care workers were willing to work at night but could not do so because of the lack of fence and the attendant insecurity concerns. A health centre that lacks a fence exposes staff and patients to avoidable security risks.

DISCUSSION

Every ward in Ekiti State had at least one PHC facility while some densely populated wards had two or more PHC facilities. This is partly in line with the Alma-Ata Declaration of 1978 which stipulates the "one PHC per ward" policy (World Health Organization, 1978). However, none of the PHC facilities visited met the expected minimum standard for PHCs as recommended by the NPHCDA (National Primary Health Care Development Agency, 2005). Most of the PHC facilities located in the rural area had more dilapidated buildings and suffered from inadequate equipment and personnel than those in the urban areas. This deviates from the Alma-Ata Declaration of 1978 which stipulates a functional "one PHC per ward" policy (World Health Organization, 1978). In an earlier study, Nnabuihe and Lizzy (2005) asserted that rural areas suffer the most in health care services because they lack the expected standard.

The study found that the government of the State supportively established the SPHCDA with a functional board to provide the needed support for the implementation of the National Health Policy in all matters patterning to PHC in States (NPHCDA, 2005). Majority of the health workers lamented that they do not have enough staff and this inadequacy of staff in the health facilities was evident. An assessment of the list of staff of PHC Departments by the researchers revealed same. An earlier study conducted by Reich *et al,* (2016) revealed that human resource is an important component that should be incorporated in health care services. The findings revealed that there was no employment of new staff in the PHCs for years despite the retirement and resignation of workers. The lack of good fences and night guards forced some PHC facilities in the study area to limit their service to the day time. The implication is that the life of community members who wish to visit health facilities at night for emergency cases or delivery were at risk owing to the closure of the health care facilities at night. This supports the position that countries need to have a sound economic policy and political will to achieve universal health coverage (Michael and Odeyemi, 2017).

The study's findings revealed that the partners of PHCs like WHO and UNICEF among others had extensively supported PHC projects in the State. The partners assisted the SPHCDA with fund and materials for the implementation of projects. The support from the international agencies demonstrated the desire of international bodies to provide effective and efficient health care to people at the grass root level. A report from the WHO (2010) specifically noted that despite the goodwill and the concerted efforts of countries around the world to implement functional PHC systems, an estimated 400 million people around the globe still lack access to quality PHC services. The study also revealed that PHCOUR is yet be fully implemented in the State. As a matter of fact, the study further revealed that an arrangement to bring all the components of PHC under the SPHCDA was ongoing but was not yet implemented. Kidd *et al,* (2015) opined that the successful implementation of PHC may not be an easy task although it is the best route to achieving UHC and SDGs.

The study showed that routine immunization is an aspect of PHC services that has received remarkable successes in all the PHC facilities visited. The PHCs practiced home/community visit for immunization purpose. The community health extension service provides an avenue to encourage community members to access PHC facilities for immunization and other services. Similarly, the MICS/NICS 2016-17 report showed that the percentage of children aged 12-23 months who have received full vaccination against vaccine preventable childhood diseases in Ekiti State is 48.0%, while it is 22.9% across Nigeria. Ekiti State is ranked as the State with the second highest percentage in the South West after Lagos (68.1%) (NBS and UNICEF, 2017). In the same vein, most of the patients revealed that they often patronised PHC mainly for immunization purpose while they patronised better healthcare providers for solutions to other health issues because of the poor state of the PHCs. This finding supports an earlier study conducted by Oyedeji and Abimbola (2014) which revealed that most people opted for secondary and tertiary health care providers instead of PHCs.

The study also found that the Universal Drug Revolving Scheme adopted by the PHCs was a huge success. The re-investment of both principal and profit on the purchase of drugs made the Drug Revolving Scheme sustainable. The scheme allowed each health facility in the State to have drugs in stock and prevented community members from travelling far in search of drugs that should have been gotten from nearby PHCs. This has helped in providing an essential health care service system that is based on practice and socially

accepted methods at community levels (WHO, 1978; Fusheini and Eyles, 2016).

However, the study noted that most of the visited PHC had poor infrastructure. They had old buildings, faded wall paints, broken fences, leaking roofs, insufficient/no security guards, non-functional refrigerator for the cooling of vaccine, irregular power supply and non-functional generators for laboratory tests, the preservation of vaccine and the powering of the health facility. This corroborates earlier studies that in addition to physical building in pursuit of SDGs, the standardisation of health care service and quality is imperative (Oyekale; 2017; Goldstone, Bantjes and Dannatt, 2018; Naidoo, Suleman and Bangalee, 2020).

In conclusion, projects should not be implemented at PHC facilities without adequate consultations with the designated staff of the concerned PHC facilities. This is because the PHC is in the best position to define its peculiar challenges. The government should not defend their inadequacy in supporting primary health care development by lack of finance, political will and determination to develop PHC are essential, otherwise reduced attention will grossly and continuously affect the PHC's development.

With regard to specific projects that are in line with the goals of the government, there should be an arrangement where the government pays part of the funds needed to execute said projects. The funds from donors should be supplementary and not the principal for the project. It should also be clearly stated that the donors reserve the right to withdraw funding if the government fails to contribute its quota within a stipulated period.

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