Health Care Delivery and Health Systems Development in Rural Nigeria: An Overview

S. Akinmayọwa Lawal, PhD
Abolaji Adewale Obileye,
Adeola Jesutofunmi Bakare
Department of Sociology,
Olabisi Onabanjo University,
Ago-Iwoye, Ogun State, Nigeria.
Emails: sakinlawal@gmail.com, obileyabolaji@gmail.com, adebakray@gmail.com

Abstract

Effective healthcare delivery in each country remains one of the parameters for ascertaining the country’s level of development. Today countries in developed countries have better functioning health care delivery systems compared to those in developing countries such as Nigeria. Hence, the standard of health care delivery in Nigeria pre and post-independence has not effectively performed to meet the health needs of its growing population especially those in rural areas. In fact, extant reviews of literature further justify the wide lacuna in health care channelled to rural areas as against the urban centres in the country. Therefore, this conceptual paper discusses healthcare delivery in rural Nigeria. Issues such as inadequate health workforce, complex health care systems, poor health financing mechanisms, poor quality of care, unavailability of drugs and vaccines are discussed in this paper pre and post-independence. The paper depicts that the Nigerian government shows greater attention and preference to urban centres as against her largest occupant “rural dwellers” – who needs improved care and medical attention. This is implying that healthcare delivery of urban centres grows at a geometric rate while the rural areas receive little or no care. It was also discovered that health delivery in Nigeria is not standardised as multiple providers exist. The paper suggests that adequate funding must be channelled towards rural areas as at utmost priority. More so, health policies/programmes should be designed and implemented in a participatory way for rural settlers.

Keywords: Development, Health Systems, Healthcare Delivery, Rural Nigeria.
INTRODUCTION

Globally, the priority placed on healthcare delivery for citizens and non-citizens in their respective locations as either rural or urban remains paramount in the present time due to the interventions, programmes and agendas designed/implemented from the global north to the global south (WHO, 2016; Abrampah, Syed, Hirschhorn, Nambiar, Iqbal, Garcia-Elorrio, Chattu, Devnani & Kelley, 2018). By percentage, the African continent health status is claimed to be worrisome as against the everyday realities of developed nations – where sound healthcare system exists (Adefolaju, 2014a; Oyekale, 2017; United Nations, 2018). An earlier report of KPMG (2012) further justified that Africa is not healthy as a continent. On all health indicators, African countries are way behind the rest of the World, and even behind poor countries of South Asia and South East as against a few decades ago. This is arguably linked to the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic which hit Africa harder than any other continent on Earth.

As reported above “Africa is not a healthy continent”, Nigeria, therefore, has a larger share of the claim for her population and economic stand in the region. Noticeably, the period of colonialism set the pace/priority for the pursuit of orthodox healthcare delivery as against the traditional pathways but there is no proportional delivery of healthcare for rural and urban areas since then (NBS, 2015; WHO, 2016; Adeyi, 2016; Oyekale, 2017). Exactly fifty-eight years after Nigeria’s independence, the indicator of her health outcomes and coverage of basic health services were below expectation, both in absolute and relative terms to other nations with similar levels of economic development (NPC & ICF International, 2014; NBS, 2015; WHO, 2016; Oyekale, 2017). Yet, though the decline in infant and child mortality could be swifter, the trend of these indicators overall is in the right direction.

Furthermore, the country’s recent successes against Ebola Virus Disease (WHO, 2014) and Guinea worm disease, poliomyelitis (WHO, 2015) show areas of high performance despite systemic weaknesses. According to Ademiluyi & Aluko-Arowolo (2009), the unequal distribution of health facilities between rural and urban centres in Nigeria is an offshoot of the colonial era. The urban centres occupied by rich, powerful and highly educated people received a larger share of the health facilities/ infrastructure (Oyekale, 2017). Because a larger percentage of Nigerians reside in rural areas, there is an urgent need to redistribute health infrastructure for the benefit of all its citizens.

Although Nigeria’s past health systems experience has led to its underperformance and its present delivery remains challenging, there are grounds for measured optimism about the future of health in Nigeria (Adeyi, 2016). What is the basis for achieving health coverage universally? The National Health Act of 2014 provides a legal groundwork for transforming a dysfunctional system
into a functioning one for the population, particularly the poor (Federal Republic of Nigeria, 2014). Doing so, therefore, requires sustained work on multiple fronts. Despite strong global call on the need to improve health sectors, there is little or no structural backing and technical know-how for achieving that in developing countries, as a result of the government lackadaisical attitude on implementing interventions (WHO, 2009). In most cases, the core problem is the inability of the broader health system to provide interventions in the area that needs them.

The challenges and constraints that therefore exist across the health system are: inadequate supply of human and material resources, low belief system in new healthcare system, poor attitude of health practitioners, zero level of people’s involvement, inefficient service provision (Okwaraji, Cousens, Berhane, Mulholland & Edmond, 2012; Krumkamp, Sarpong, Kreuels, Ehles, Loag & Schwartz, 2013; Adam & Awunor, 2014; Oyekale, 2017; Uzochukwu, Onwujekwe, Mbachu, Okeke, Molyneux & Gilson, 2018). These issues affect the reality of the Nigerian healthcare system especially in rural areas.

Nonetheless, this justifies the wide lacuna between the standard of healthcare delivery systems in developed nations and developing nations. The Nigerian experience pertaining to healthcare delivery favours the insignificant percentage “urban centres” as against the core of her population “rural areas” thereby affecting reports of her health status (Asakitikpi, 2016). The core of the country’s population is still struggling with minor health conditions (alongside major health issues) that had been solved by other developed nations of today (KPMG, 2012). However, a significant number of the rural populace has been plagued with several illnesses and diseases alien to their knowledge. One of such long-term intractable diseases is malaria. According to Akinpelu, Amamgbo, Olojede & Oyekale (2011), it is estimated that thirteen per cent (13%) of the rural dwellers’ expenditure goes to malaria treatment per month. This is simply a risk for ninety-seven per cent (97%) of Nigeria’s population which determines increasing case of morbidity and mortality in the nation.

In the view of Scott-Emuakpor (2010), as early as the 1960s, accessibility to healthcare services in Nigeria only covered ten to fifteen per cent (10-15%) of the entire populace. Such services were more channelled towards the urban centres at the detriment of rural centres i.e. more than fifty per cent (50%) of the people in urban centres had access to healthcare, while less than five per cent (5%) of the rural occupant had such care. In fact, Adefolaju (2014a) revealed that about seventy per cent (70%) of the population still patronise traditional health practitioners. Considering these, it is quintessential to discuss the healthcare delivery and health system development in rural Nigeria. For more clarity, the concept of a healthcare system is described in the next section.
Basic Healthcare System

Basically, healthcare system comprises all medical services provider saddled with the responsibility to prevent, diagnose, treat and rehabilitate patients with a ailment, illness or disease. The system, therefore, entails the health structure, workforce – medical practitioners that render services, the government, private organisations and non-governmental agencies that finance the service delivery (Ferlie & Shortell, 2010). In simplicity, it can be deduced that a typical model of the healthcare system entails the patient, the medical team, and the economic and political environment of the operation.

To buttress further, Figure 1 shows the synergy between and among each actor who plays a different interrelated role for sustaining and improving the healthcare system. The Organisation as used in this paper are the non-government organisations, personal donors, and also union members that protect/support the medical team to enhance effective healthcare delivery. The Government is the overseer of the political activities inherent in the healthcare system. He is concerned about the overall wellbeing of its’ inhabitants – migrant and even citizens in both rural and urban setting by staffing efficient medical practitioners in the health sectors and also providing important health infrastructures for the successful improvement of the health standards while the Medical Team - Doctors, Nurses, Midwives, Labouratory Technicians, Traditional Birth Attendants are the agent saddled with the responsibility of improving the patients’ overall well-being.

However, for the healthcare system to be effective in Rural Nigeria, there is always a need for a stakeholder (representative of the rural people) to stand in between the government and the rural dwellers due to their special needs. As such, it is not out of place to involve rural leadership in drafting and executing rural development policies in Nigeria due to the number of resources wasted in the time past (Ogidefa, 2010).
World Health Organisation (WHO) Health Systems Framework in the Nigerian Context

Figure 2: The WHO Health Systems Framework

Source: WHO (2018)

The framework of the World Health Organisation (WHO) above justifies how health system functions with important apparatus capable of yielding projected results – wide coverage and quality delivery. Hence, it is crystal clear that the important facilitator of the system’s growth and development is the leadership/governance in charge. In the Nigerian context, the government at various level – local, state and federal – play significant roles in ensuring health projects are financed to cater for the needs of the people. These needs are not met with the available/accessible human and material resources as highlighted in Figure 1 and 2 due to corruption, misappropriation of funds, budgeting issues and other sharp practices of health leaders (Anyika, 2014; Kanwanye & Ovenseri-Ogbomo, 2018).

Furthermore, the goals highlighted in Figure 2 are at risk or unachievable where the leadership is not efficient enough to make adequate provisions for the medical/non-medical team, medical products, technologies and information needed for sound health care delivery in specified areas. In essence, where the government lacks the responsiveness to the peculiar needs of areas like rural areas, the chances of achieving maximum coverage and quality delivery remain questionable. This, therefore, confirms the current reality in Nigeria where the workforce (medical/non-medical), medical products, medical structures, technologies, and information available are rather insufficient to achieve maximum health coverage and quality delivery respectively (Welcome, 2011; Obansa & Orimisan, 2013; Eboreime, Abimbola & Bozzani, 2015; Oyekale, 2017; Uzochukwu et al., 2018).
Rural Nigeria in the 21st Century

Nigeria is basically a rural society because a considerable amount of her population resides in the area (Aboyade, 1976; Nwuke, 2004; Ugwuanyi & Emma, 2013). It was claimed by the highlighted authors that about seventy percent (70%) of Nigerians dwell in the rural areas. For developmental tendencies, this setting should attract most of the attention as against the urban centres but the reverse is the case in Nigeria. From the colonial era, the rural area is simply the socio-economically backward areas of Nigeria. Ever since the lacuna between the rural and urban centres has persistently increased. Invariably, the set of people who occupy rural areas to produce the much-needed agricultural goods for the nation’s survival are neglected by the government on health grounds (Ogidefa, 2010; Obetta & Okide, 2012). This situation supported the increasing rate of rural-urban migration, declining agricultural production, unemployment, urban congestion, poverty and its abettor.

In simplicity, rural areas refer to the topographical areas that lie outside the densely built-up environment of cities/towns occupied by people engaged primarily in agriculture and other rudimentary forms of activities (Adebayo, 1998; Nyagba, 2009; Abah, 2010; Ugwuanyi & Emma, 2013). According to the International Fund for Agricultural Development (2011), rural Nigeria remain in shambles regardless of its contribution to the national economy compared to the urban centres. Investments in all kinds of health infrastructures have therefore been largely focused on the urban centres while the rural areas have limited access to core services such as safe drinking water, standardized health services, schools, and other social amenities that can reduce poverty and improve their overall wellbeing (IFAD, 2011). Furthermore, Laah, Abba, Ishaya & Gana (2013) noted that the rural poor are often the segregated set of people, less vocal and live barely above subsistence level.

HEALTHCARE DELIVERY IN NIGERIA: A PRE-COLONIAL, COLONIAL AND POST-COLONIAL ANALYSIS

According to Ademuluyi & Aluko-Arowolo (2009); and Iyalomhe & Iyalomhe (2012), the evolution of healthcare centres brought into effect various specialties to advance medical technology, the discovery of new illness/disease and shaky belief system in the new development. Hence, the prevalence of diseases was noticeable in the urban areas all because of the conglomeration of people with a different background working in the factory. Invariably, healthcare delivery has been practiced in a lot of ways from the pre-colonial, through the post-colonial time. For clarity reason, it is imperative to discuss the practices of healthcare delivery in a chronological order.
Pre-Colonial Healthcare Delivery in Nigeria

Prior independence, Nigerians had their designated way of healthcare delivery and services – child birth, disease control which is culturally inclined salvaging them before the arrival of the colonial masters’ alternative. The traditional way of life – marriage, education (informal), family, religion, and health, was the order of the day prior independence. According to Scott-Emuakpor (2010), the traditional form of healing and medicine was the main system of healthcare delivery in pre-colonial times in Nigeria. The service providers in pre-western time included divine healers, herbalists, midwives, soothsayers, spiritualists, mental health therapists, bone-setters, and even surgeons.

Supporting this view, Asuzu (2014) revealed the indigenous names called the pre-colonial healthcare practitioners in Nigeria – the dibias; adahunse, elesije, babalawos and onisegun; the wombais, the gozans and the malams. They focused on all kinds of illness and ailments. He further noted that the activities of these traditional healthcare providers are unrecorded and as such there are no statistical representation of the number of healthcare services rendered. In spite of the long-time existence of Western style medicine, traditional medical practices remain an essential part of the complex healthcare system in Nigeria (Scott-Emuakpor, 2010). This therefore leads to the need to understand healthcare delivery from colonial times in Nigeria.

Colonial Healthcare Delivery in Nigeria

From the onset “colonial age”, the pattern of the healthcare delivery favours the urban centre at the expense of the rural dwellers (Pearce, 2001). Although the first notable healthcare centre in Nigeria was established in the rural area by the Christian missionaries (Onokerhoraye, 1982), this however, was with the support of colonial masters to expand Christianity. These healthcare centres, discussed above were mobile clinics to treat primary health problems such as animal attacks (snake bites in particular) and other minor injuries. A full-fledged hospital was later established during the British rule to treat epidemics, such as malaria, small pox, sleeping sickness, and so on (Onibonoje, 1985; Aluko-Arowolo, 2006).

Noticeably, medical centres built were majorly concentrated in the urban centres populated by the government officials and Europeans (Home, 1983; Akin-Aina, 1990). Later, the colonial government extended her health services to civil servants and people living around the stations. Official residential quarters such as Government Reserved Areas (GRAs) also called European Quarters in Lagos, Ibadan, Jos, Kaduna, Enugu etc. were reserved for government senior workers. This arrangement above therefore has two spin-off effects in terms of healthcare. Firstly, there was a total neglect of rural areas in terms of healthcare. Secondly, there exist inequality in urban areas between colonialist leaders and the
masses. Despite Nigeria’s independence, these patterns of residence remain noticeable in our cities and towns today (Home, 1983; Mabogunje, 2007).

During the colonial era, several development plans were designed to accommodate the health needs of Nigerians. The first colonial development plan began from 1945-1955 with the focus of ensuring national health services for all with more preference to rural areas considering the urban centres were well developed. In the plan, medical materials and adequate personnel were deployed to such centres to ensure the success (Scott-Emuakpor, 2010). The second colonial development plan which starts 1956 and ended in 1962 further agitated for maximum health delivery coverage.

Aside these, there were little or no emphasis on the traditional healthcare structure(s) and a wide margin was created that further substantiated inequality between the rich and poor of both the rural and urban settings. The dichotomy brought about the challenges in the healthcare system and other associated services crucial for efficient hospital system viz; food, pipe-borne water, electricity for storing drugs and maintaining surgical operations e.t.c. (Aluko-Arowolo, 2005). Mabogunje (2007) therefore noted that this basically influenced the national development plans in Nigeria.

**Post-Colonial Healthcare Delivery in Nigeria**

After independence in Nigeria, the emerging indigenous political class determined to improve citizen’s life with the need to continue with colonial policies by adopting orthodox medicine and specifically expanding colonial health structures in both rural and urban centres for effective healthcare delivery (Schram, 1971; Alubo, 1985). At that point, the missionaries already established about seventy-five (75%) medical centres in different parts of the country with low patronage level for cultural reasons (Scott-Emuakpor, 2010).

In order to improve the situation, the government’s health programme based on the colonial administrators’ ideology carried out massive training of medical practitioners both within and outside the country to develop the indigenous capacity for modern healthcare provisioning (Asakitikpi, 2016). Aside from the training and development of medical practitioners, the government also established efficient structures for the delivery and management of healthcare facilities for rural and urban dwellers. The agenda was basically total medical coverage (Scott-Emuakpor, 2010). These commitments formed the basis for post-independence health policies with a primary aim of providing modern medicine to the significant amount of the entire populace through health centres with unrestricted medical consultation and easy accessibility to drugs supplied at reduced rates (Lambo, 1991).
At higher levels of government, both secondary and tertiary healthcare centres were established and furnished as the main goal for investing public funds. At the same time, attention was given to the training and development of medical practitioners – nurses, midwives, and doctors – for the basic purpose of occupying the newly developed health centres (Erinosho, 1993). This welfare scheme was at first sluggish and not popular among citizens due to their unwillingness to forsake traditional healthcare but the government, therefore, resort to various campaign programme to enlighten rural dwellers on the need for modern healthcare delivery through the new healthcare centres.

However, the reluctance of the rural public to adopt orthodox medicare was based on the diversity in the approach to restore human health status by the traditional and western world. While trained western medical practitioners adopted germs theory in explaining the factors responsible for diseases and illnesses, traditional practitioners believed in supernatural and preternatural forces in approaching health related issues (Abdullahi, 2011; Benedict, 2014; Asakitipki, 2016; Ibeneme, Eni, Ezuma & Fortwengel, 2017; Jaeger, Bechir, Harouna, Moto & Utzinger, 2018). Besides, the call to embrace an alien and completely opposed healthcare delivery system became very challenging. Therefore, the government had to face the burdensome task of orientating rural dwellers on the advantages of contemporary medical care, which provides a superior quality of life (Iyalomhe & Iyalomhe, 2012; Adefolaju, 2014a; Asakitikpi, 2016). Hence, the ideology of nationalists that the state is an important instrument for ensuring the identification of social milieus and its solution encouraged the substantial investment in healthcare systems.

Consequently, after independence - the first two decades witnessed the relative functioning of public healthcare centres due to the availability and accessibility to essential drugs and ease of access to qualified medical practitioners while the public responded positively to the new healthcare system (Asakitikpi, 2016). On the contrary, Oyekale (2017) confirmed that the state of healthcare delivery through its system remains worrisome recently.

Health Systems Development in Nigeria

Most importantly, it is highly paramount at this juncture to reveal health systems development in Nigeria from the pre-colonial, colonial, to the post-colonial era. Comprehensively, Nigeria as a nation, therefore, operates a double dosed healthcare delivery system i.e. traditional and orthodox means depending on the area of concentration (rural/urban). According to Oyibocha, Ironoye, Sagua, Ogungide-Essien, Edeki & Okome (2014), orthodox healthcare is provided by public and private sectors while traditional healthcare system is delivered based on the customs and practice of the land. The traditional healthcare system is designed by the indigenous people often called “native doctors” in a jurisdiction for the new and existing inhabitants.
Prior colonial times, the prevalent health care system in Nigeria was purely traditional without any rivalry from any other means as reflective under the healthcare delivery overleaf while the colonial and the post-colonial times had more concentration on the orthodox means of health care with little or no role played by traditional health systems especially in urban centres. Although, flashes of traditional health care centres still remain obvious in the urban centres but it is majorly utilised by the rural dwellers even in contemporary times. However, the nature of healthcare services in Nigeria remains complex with numerous service providers in both the private and public sectors (Olakunde, 2010; Lawal, 2016; Lawal, Barry & Omololu, 2018). The private sector is a healthcare system owned and managed by a private individuals/body for profit (private health centres/clinics) or, not-for profit and so on. In a public manner, Nigeria runs a regionalized healthcare system in its three tiers of government: Federal Ministry of Health (FMOH), State Ministry of Health (SMOH), and Local Government Health Department (LGHD) (Lawal, 2014).

The FMOH is the supreme of all the other systems because it operates at the federal level. It is responsible for the development, implementation and coordination of national health policy and anchors health related activities in the whole thirty-six (36) States of the Federation (Abuja inclusive), and the seven hundred and seventy-four (774) local government areas (LGAs). Importantly, FMOH provides tertiary care for patients through the federal medical centres and teaching hospitals respectively.

Secondly, the SMOHs is the next to FMOH because of their operation/activities at the state level. SMOH provides secondary healthcare through the hospitals and comprehensive health centres, while the LGA’s primary health centres provide primary healthcare (PHC) services. However, all the agencies participate in the management of the PHC; resulting sometimes in the overlap of responsibilities, conflict, and waste (World Bank, 2010). According to Adie, Igbang, Otu, Braide, Okon & Ikpi (2014), several communities (small) have evolved primary healthcare services, with an active level of community involvement. The capacities of health facilities installed years back were overstretched and health infrastructures are currently in a dilapidated state. Due to this, rural settlers revert to the traditional care providers, because of accessibility and affordability challenges (Scott-Emuakpor, 2010; Abdulraheem, Olapipo & Amodu, 2012).

Moreover, the Nigeria’s demography shows that a significant percentage - about fifty-five percent (55%) of her population reside in rural areas while the rest occupy the urban centres (Omoruan, Bamidele, Phillips, 2009). Nevertheless, the goal of National Health Policy (1987) as revised in 2004 (FMOH, 2004) was to ensure a wide-ranging healthcare delivery system based on PHC that is preventive, protective, rehabilitative and restorative to all Nigerians. Also, to ensure health promotion within the available resources, so that communities at
large are guaranteed a productive quality of life (Abdulraheem, Oladipo & Amodu, 2012).

Nonetheless, the structural make-up of the health systems in Nigeria was developed consciously according to plans as laid down by the colonialists. The development plan began immediately after independence – 1962 and it span through both military and democratic era in Nigeria. Chronologically, the national development plan started and ended from: 1962-1968, 1970-1975, 1975-1980, 1981-1985, 2004-2008 (Scott-Emuakpor, 2010). All the plans on health matters were for a nationwide coverage but in reality the objectives have not been achieved due to dilapitated hospitals in both rural and urban centres, high out of pocket expenditure in health by citizens, inadequate personnel, non-availability of drugs and other medical materials needed by all and sundry (WHO, 2010; Saksena, Xu, Elovainio & Perrot, 2012; Egbe, 2014; Oyekale, 2017; Uzochukwu et al., 2018).

The National Health Insurance Scheme (NHIS) established in 2005 by Decree 35 of 1999 (Adefolaju, 2014b; Adeniji, 2017) was targeted at improving healthcare financing, by reducing the healthcare treatment cost for individuals. The scheme benefits mainly people in the formal sector while people in the informal sector were never beneficiaries (Palmer, Mueller, Gillson, Mills & Haines, 2004). Donor agencies such as the UNICEF, WHO, and USAID continually plays an active role in financing health programmes in Nigeria.

**Healthcare Delivery and Health Systems Development in Rural Nigeria**

Basically, to justify the concern of this paper “healthcare delivery and health systems in Rural Nigeria” it is quintessential to discuss the similarities and dissimilarities between rural-urban health care deliveries. According to Adefolaju (2014); and Asakitikpi (2016), the public health system in Nigeria was completely disjointed into varying forms and dysfunctional with the return of democratic rule in 1999. These ranged from public healthcare centres managed by the government; chemist shop owners – licensed/unlicensed – who procure and dispense drugs to the public; unregulated private health services; religious healing homes and traditional health practices among others. Hence, the public health sector comprising of the FMOH, SMOH, and LGHD were also disjointed, operating with insufficient human/material resources and poor coordination.

According to Welcome (2011); Obansa & Orimisan (2013); Anyika (2014); Asakitikpi (2016); Oyekale (2017); and Uzochukwu et al., (2018) the Nigerian health system experiences poor condition of service, infrastructural decay, and zero morale among the staff who stayed around amidst brain drain syndrome. The situation was very critical in the rural areas due to the total desertion of community health posts in consonance with the PHC initiative that targeted rural areas basic health needs in the 1970’s. By the turn of the century,
only a few health stations were noticeable in rural areas while both public and private health structures and facilities were heavily concentrated in urban centres.

By 2002, seventy percent (70%) of all healthcare expenditure was on urban health even though severe health attention were needed in rural areas. The allocation of health personnel and distribution of health facilities never improved since then and there was no visible attempt by subsequent governments to correct the anomaly (McKenzie, Sokpo & Ager, 2014). According to Ibama & Dennis (2016), Primary Health Centres were established in rural and urban Nigeria to ensure equity on all front but the reality remains that rural Nigeria are seriously under-served compared to their counterpart. In other words, the distribution of PHC facilities is tilted towards the urban people as against the rural communities about seventy percent (70%) of the general population, making total health coverage a challenge and the attainment of sustainable national development unrealistic (Ibama & Dennis, 2016).

Overall, twenty three percent (23%) of rural women deliver with a skilled traditional birth attendant as against sixty seven percent (67%) in urban areas. Fapohunda & Orobaton (2013) therefore revealed that one in five (1-5) births in Northern Nigeria takes place at home with no one present – which is very risky. These patterns are replicated in other reproductive health key indices (NPC & ICF International, 2014). The healthcare worker to Nigeria’s population density (20 doctors, nurses and midwives per 10,000 population) is quite below the WHO recommendations of 23 per 10,000 (WHO, 2010). However, the health practitioners in Nigeria are poorly distributed to urban areas, southern zones, secondary and tertiary healthcare centres (NPC & ICF International, 2014; Oyekale, 2017).

In Nigeria, the healthcare system is financed by a mixture of: user fees, health insurance (social and community), tax revenue and donor funding (WHO, 2009). Most economies in the world today adopt a mixture of these methods. The success of these methods is measured by the general impact on equal access in different areas (rural/urban) and healthcare outcomes, revenue generated and efficiency, and the effects on the users and care providers (Palmer et al., 2004). Since launching NHIS in 1999 till mid-2012, the scheme only covered about three percent (3%) of the Nigeria’s population with mixed success, while the launch of rural-based healthcare insurance program to cover more Nigerians were at a low ebb (Dutta & Hongoro, 2013). Above all, Saksena Xu, Elovainio & Perrot (2012); and Anyika, (2014) noted that healthcare systems vary widely in performance, and countries with similar levels of education, health expenditure, and income have different ability to attain key health goals.
Factors Affecting Healthcare Delivery and Health System Development in Rural Nigeria

There are several factors affecting the performance of the Nigerian healthcare system (Adinma & Adinma, 2010; Obansa & Orimisan, 2013; Anyika, 2014; Eboreime, Abimbola & Bozzani, 2015; Oyekale, 2017; Jaeger, Bechir, Harouna, Moto & Utzinger, 2018). These includes:

- **Inadequate healthcare structure and facilities:** The number of structures – buildings for different departments, and other facilities for delivering healthcare services in Rural Nigeria are not in a commensurate level with the exact need of such areas (Oyekale, 2017). In fact, with structural imbalances in the urban centres which received a significant level of concentration. What hope does rural area has? There is an infrastructural challenge affecting healthcare delivery and health systems development in the country.

- **Uneasy access to essential drugs and supplies:** Difficulty in accessing essential medical materials disbursed to rural areas in Nigeria pose a great challenge. At a broader level, Eboreime, Abimbola & Bozzani (2015) noted that there exists a wide gap in the access to healthcare facilities across Nigeria’s geopolitical zones. It was also discovered that the location of most medical centres in rural communities seems to be a far off which is often a discouraging factor to the few rural dwellers that believed in orthodox health care delivery (Titus, Adebisola & Adeniji, 2015; Oyekale, 2017).

- **Inadequate supervision of the healthcare system:** Supervision of healthcare system by medical officers in Rural Nigeria are rather inadequate because most of the officials in charge occasionally visit the centres (Jaeger, Bechir, Harouna, Moto & Utzinger, 2018; Uzochukwu et al., 2018). This is an encouraging factor to other medical practitioners whose service are often needed as at when due but are usually nowhere to be found because they do not reside permanently in such locations.

- **Demotivated set of medical practitioners:** Another worthy challenge affecting health care delivery and health systems development in Nigeria are the set of medical actors in the area. It is usually discovered that medical officers in public hospitals/clinics are demotivated based on their remuneration package and the stress inherent in shuffling between their duty post (rural centres) and their base (Welcome, 2011; Obansa & Orimisan, 2013). This state of mind affects the quality of health care received by the patient and at the extreme, the health systems development in Rural Nigeria would not be achievable.
Lack of fair and sustainable healthcare financing: This emphasises on the wide lacunae between the allocation directed to the rural and urban centres in Nigeria. It is therefore paramount to reveal that the share of the rural areas in terms of healthcare financing in Nigeria is not fair enough to meet their needs as against what is channeled to the urban centres (Titus, Adebisola & Adeniji, 2015; Uzochukwu et al., 2018).

Unstable political and economic sector: The nature and the standard of political and economic weather in Nigeria is arguably one of the determinants of the underperformance rates of most sectors (Adinma & Adinma, 2010). This wave has therefore made the healthcare delivery difficult and health systems development in Rural Nigeria unrealistic due to budgeting issues, corruption and neo-liberal economic policies, misappropriation of funds (Kanwanye & Ovenseri-Ogbomo, 2018). Also, the absence of a community-based integrated system for disease prevention, diagnosis and treatment was another factor affecting health care delivery and health systems development in Rural Nigeria. Other factors in the same league are; shortage of medical staff to cater for the need of rural dwellers, poor state of social amenities in the rural area, lackadaisical attitude of government at different level, negative attitude of rural leadership, non-acceptance of the orthodox health care system by rural dwellers to mention but a few. Due to these factors, it is necessary to enlist plans or strategies that would checkmate the highlighted factors that fight against effective healthcare delivery and health system development in rural Nigeria.

Leadership in health delivery services: Leadership importance in the Nigerian health sector is nowhere different from the needs of other sector in the society plagued with corruption and other sharp practices of leaders affecting sectoral growth and development (Anyika, 2014). In order to tackle the challenges facing health care delivery and health systems development, an attitudinal shift from the heads of operations in the sector is important to achieve the desired goal.

Increase fund to manage the health sector: Funding is a crucial element that keeps any sector running in Nigeria. As such, to make provisions for structural and infrastructural needs in Rural Nigeria, funding from all stakeholders – federal, state, local government and even the non-governmental organisation is quintessential (Obansa & Orimisan, 2013; Oyekale, 2017).

Need for Policy Modification and Development: Current health policies must put into consideration an appropriate scheme to encourage health practitioners to provide services in underserved areas (Asakitikpi, 2016). In fact, new policies are necessary to ensure the health system
develops in Rural Nigeria for their benefit. Health policies/programmes should be designed and implemented in a participatory way for rural settlers’ successful transition to orthodox means of healthcare. Besides, there is an urgent need to provide complimentary social amenities in rural communities to link up the areas to the outer world. This would encourage private healthcare services. In the same vein, an effective structure needs to be established to regulate the activities of the private sector preventing them from selling sub-standard drugs. Also, proper monitoring and supervision of the health delivery teams’ activities by an external body will aid the development of the system.

CONCLUSION

The delivery of healthcare services by the health sector in Nigeria can be seen as a propeller of the dichotomy that exists between the rural and urban centres over time. This is implying that the attention given by Nigerian government to urban centres’ health priorities surpasses that of the rural centres “the largest of her population” – regardless of her needs. On another note, the health systems development from the colonial times had been in favour of the urban centres compared to rural areas. This is justifying the wide disparity between rural areas and urban centres health status.

Based on the framework of analysis, it is important for much concentration on the systems building blocks as highlighted by World Health Organisation (WHO) in order to achieve the desired goal of healthcare delivery and health system development in rural Nigeria. These building blocks – workforce, technologies, health financing, governance, medical products, information and service delivery – interdependently and inter-relatedly works to ensure quality healthcare and maximum health coverage in totality. Unless the Nigerian government works it out in its building blocks, achieving the goal of efficient healthcare delivery and health systems development would be very difficult.

However, it is imperative for the government to understand the dynamics at play in Rural Nigeria to facilitate effective healthcare delivery and overall health systems performance on a national level since most of the country’s population are rural dwellers. Considering these, it is essential for the Nigerian government to recognize the inextricable role played by rural areas on the country’s human capital development. Hence, there is a need to ensure a paradigm shift to the centre needing more health concentration.

Nevertheless, it is recommended that Nigerian government should ensure a significant amount of the annual health budget is channelled to the rural areas for the medical teams and other resources needed to facilitate healthcare delivery and health systems development. In the same vein, the improvement of the basic
infrastructures and other social amenities in rural areas would be a great force supporting medical practitioners to deliver healthcare services. Above all, the participation of rural dwellers and their leadership at a different phase of the health project is quintessential for the success of the delivery and health systems development in Nigeria.
REFERENCES


