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**HISTORY | RESEARCH ARTICLE**

**Covid-19 pandemic and The Nigerian primary healthcare system: The leadership question**

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**Abstract:** Since the outbreak of the Covid-19 pandemic, the pathetic nature of the Nigeria healthcare system has become more glaring. In First World countries, the ravaging nature of the pandemic, marked by a high death toll, elicits trepidation among Nigerian citizens. What is more, these fears are not necessarily as a result of the lethal nature of COVID-19 but rather, they are consequent of certain conditions amongst which include: an inept and unconcerned leadership, accompanied by dilapidated health institutions characterized by poor working conditions and incentives. It is in lieu of these unhealthy conditions that the dreaded disease found its footing in the Nigerian environment. Against this background, this paper argues that the outbreak of Covid-19 pandemic in Nigeria, its local dispersion occasioned by paucity of medical personnel and supplies due to decades of neglect of health care system is worrisome. This study recommends an overhaul of the healthcare system with the aim of achieving a robust health care system for Nigerian citizens. Thus far, various scholars have focused on corrupt leadership practices of Nigerian leaders without a detailed and in-depth study on the nexus between the health sector and this failure. It is this obvious gap in scholarship that this present study sets out to fill. The paper adopts a qualitative approach which will be anchored on primary and

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**PUBLIC INTEREST STATEMENT**

In developed countries, the ravaging nature of the Covid-19 pandemic, marked by a high death toll, elicits trepidation among Nigerian citizens. What is more, these fears are not necessarily as a result of the lethal nature of Covid-19 but rather, they are consequent upon certain conditions amongst which include: an inept and unconcerned leadership, dilapidated health institutions characterized by poor working conditions and incentives. The paper postulates that the Covid-19 pandemic should have marked the critical juncture in Nigeria healthcare scheme which has been neglected by successive governments since independence. They tend to wake up only when there is an emergency, but like every other issue afflicting Nigeria, once the emergency abates, the health challenges confronting the country will be swept under the carpet. The paper concludes that the coronavirus pandemic is an opportunity to revitalize our healthcare system. We may not be so lucky next time.
secondary sources of historical methodology. Thus, its significance lies in its ability to bring to the fore the nexus between leadership failure in Nigeria and the neglect of primary healthcare system. It will also expose the vulnerability of the Nigerian rich and poor in the face of the global pandemic.

Subjects: History; Cultural Studies; Public Health Policy and Practice

Keywords: Covid-19; Nigeria; leadership failure; healthcare system; pandemic

1. Introduction
The history of Nigeria has been shrouded in a garb of leadership failure that overtime has been lampooned by cynical Nigerian citizens. Consequent to this, Achebe (1983) summarized in his seminal work, The Trouble with Nigeria that the problem with the country is simply a failure of leadership. Three decades later, his observations have continued to resonate; however, no time in the chequered history of Nigeria has leadership failure been more brazen than in the face of the Covid-19 pandemic. In lieu of this, Nigerian leadership in its wobbling approach to tackling emergency, despite the timely knowledge of the ravaging disaster of the pandemic in other countries, has created a vivid picture of an uninspiring culture of leadership. More so, this inability to adopt a systematic approach to addressing the pandemic has generated immense concerns amongst Nigerian citizens whose angst arises from the deliberate neglect of the country’s healthcare system. Historically, from 1970 till date, the country has made three major attempts at sustainable healthcare system via various outlets amongst which include: The Basic Health Services Scheme (BHSS) from 1975 to 1983; the District Health System (DHS) from 1986 to 1992 and the National Primary Healthcare Developing Agency (NPHCDA) from 1992 till date (Abosede and Sholey, 2014; Aigbiremolen et al., 2014). Nevertheless, despite these structures, no policy efforts have achieved a remarkable success at implementation; and this owes largely to a lack of political commitment that has led to an inadequate and inefficient financing, a shambolic distribution of the health workforce, weak and dilapidated infrastructures (Abosede and Sholey, 2014; Aigbiremolen et al., 2014), substandard drugs and equipment among other highlights. Fundamentally, these setbacks are with regard to Nigerian leaders’ preference and patronization of foreign medical outfits which of course had become detrimental to health institutions in the country (Adebayo, 2020; Eme et al., 2014). Indeed, the dichotomy between the medical choices open to the country’s leadership and the ledger accounts for the poor healthcare system in Nigeria. What’s more, the menace of the Covid-19 pandemic has further accentuated this reality and has exposed the aftermath arising due to the disdainful neglect of the country’s healthcare system by poor leadership whose actions have affected the impoverished and the wealthy alike. As such, this paper through its recommendations, avow the urgent need for the rehabilitation of the Nigerian healthcare system towards curbing the current pandemic.

In a wider context, the poor leadership style of Nigerian leaders since independence has affected the political, social, economic and health sectors; the dilapidation of the latter leading to an increased mortality rate in Nigeria. Thus, there is the need to grow the economy through the exploitation of the natural resources and investing the wealth in critical sectors of health and education. According to Obi-Ani (2010), an ailing economy is dreaded by those aspiring to assume the realms of power; especially as the economy of any nation is the hub upon which its entire government machinery is hinged. Contrarily, this dread has not been exhibited by Nigerian leaders who since the country’s independence have shattered the hopes of its citizens with gross corruption, tribalism and nepotism (Achebe, 1983). Similarly, the elite group produced by the country’s colonial rulers, having no revolutionary bent, replicated this same colonial violence (Njoku, 2014). As a result of this replication, citizens have become disenchanted
especially considering the country's health sector which has not received adequate attention despite the numerous budget channeled to it (Eme et al., 2014; Emuakpor, 2010; Ochulor, 2011; Ogbeidi, 2012). Thus far, various scholars have focused on corrupt leadership practices of Nigerian leaders without a detailed and in-depth study on the nexus between the health sector and this failure. It is this obvious gap in scholarship that this present study sets out to fill.

2. Methodology and data collection
This paper examines the nexus between leadership failure and neglect in the healthcare system in Nigeria. The historical methodology was adopted in order to interrogate the various healthcare policies adopted by the various administrations since independence of 1960. It traced the different healthcare plans instituted by various regimes. There have not been conscientious efforts to understand the reasons for the failure of the system before adopting new plan. Thus, each plan has been haphazardly implemented, leaving a weak foundation. A new administration usually jumps to the next stage, creating yawning gaps that need to be addressed. The research surveyed the attitudes and feelings of the citizens towards the health institutions and poor working conditions in Nigeria healthcare system.

The data for this study were collected through the use of primary and secondary sources. The primary sources for this research include interviews, telephone conversations and online messages. The respondents were free to express themselves without any form of intimidation. The secondary sources of this study were collected through newspapers, magazine and online materials. These were deployed in the analysis and interpretation of the subject of discourse.

3. Nigerian government since independence
The exit of British overlords in 1960 witnessed the rise of expectations from Nigerian citizens especially as the country's economic, social and political sectors were drastically affected by decades of European imperialism. Nationalists who eventually took over governance did promise a bright future for all Nigerians. This is a situation where colonial exploitation would be replaced with ample rewards for hard work and unrestricted opportunities would be provided for individual citizens to attain their legitimate economic and socio-political aspirations (Njoku, 2014). Citizens were also promised an adequate standard of living together with a low percentage of mortality rate. In view of this, a majority of citizens began to “dream” of a life that would be strikingly similar to that of Europeans; as the expectation coupled with the huge resources of the country would be put to purposeful use for an overall improvement in living standards (Njoku, 2014). However, these hopes and promises never materialized as the country continues to wallow in dire economic straits. With recourse to this gap between hope and its fulfillment, Achebe surmises that the trouble with Nigeria is mostly as regards its poor political leadership; one that is marked by the replication of colonial violence. Building on the thoughts of Achebe, Patterson (2016) opines that leadership failure occurs as a result of selfishness, errors, mistakes, ignorance, lack of expertise, flawed communication, and a deliberate neglect. Largely, this sums up the challenges confronting Nigeria as a nation.

Having gained independence, a legitimate and meritocratic acquisition of power through an effective population census and a flawless election became the key ambitions of the nascent republic. Yet from 1962 to 1965, the country was marked by election crises that bequeathed untold deaths, injuries and hatred. Hence, this demonstrated a leadership failure that catapulted the country into anarchy that albeit paved an inroad for the first military coup of 1966 which enthroned Aguiyi Ironsi (Meredith, 2011; Obi-Ani & Obi-Ani, 2016). This coup was soon to be followed by the revenge coup of July 1966 which witnessed the mass massacre of the Igbos residing in the North (Meredith, 2011). With recourse to this, anarchy became a mainstay in the country and this led to the controversial seizure of power by General Yakubu Gowon. What is more, if the failure in leadership featured as the bane of the hitherto July 1966 coup, Gowon’s leadership proved far worse, arising due to its inability to avert the historic thirty months civil war coupled with a sit-tight posture in which he refused to relinquish power to civilians.
In the same vein, the leadership of Murtala/Obasanjo was not marked by a tenderhearted approach. More so, such words as truculence and insensate best describe Major General Buhari’s leadership popularly known for its civil service charge dubbed “War Against Indiscipline” that retrenched, jailed unjustly, restricted press freedom and executed, without conviction, thousands of alleged law defaulters (William, December 11 P William, 2019). What is worse, this tenure was a haven for notorious drug peddlers. Similarly, subsequent political leaders boarded the lethal train of Buhari’s thorny and iron-fisted regime that was rooted in a Machiavellian statecraft (Niccolo, 2003). For instance, Ibrahim Babangida’s leadership in 1985 initially remained unconcerned during one of the country’s foremost religious scourge in Northern Nigeria. Also, bloodletting violence between Muslims and Christians in Plateau state in 2004 eluded the attention of the government during Obasanjo’s tenure.

With regard to Nigeria’s health sectors, in 1984, the first HIV case was recorded but was taken less seriously until it affected a horde of Nigerians. Likewise, in 2014, the Ebola virus was reported but was also taken lightly not until eight deaths were recorded (Adelakun, Shikyil and Olowu 2017). This apathetic attitude was also displayed with the outbreak of Lassa fever which according to Adelakun, Shikyil and Olowu (2017) ravaged hundreds. Other indications of the culture of hesitance that characterize Nigerian leadership, include the 2011 Boko Haram rampage in Northern Nigeria that beclouds the nation till date, and the countless herdsmen-farmers clashes in Benue, Kaduna and Enugu States where many of the victims lack basic necessities such as access to schools and adequate medical care.

Additionally, the leadership failure in Nigeria since 1960 is reflected in wrong and inconsistent policies championed by corrupt leadership. Crain Briton, one of the prominent scholars of revolution, opined that inconsistent policies constitute the hallmark of “ancien regime” and a failed leadership: a fact that necessitates its eventual overthrow. In the same vein, in their Why Nations Fail, (Acemoglu & Robinson, 2012) reflect that nations fail because their states fail, and by “state” the authors imply the modus vivendi of leadership that is anchored on policies and practices. To this end, the study of the policies of respective Nigerian leaderships since 1960 reveals that 70% of such policies instituted were wrong and inconsistent, amongst which include the unitary policies of Aguiyi Ironsi; the structural imbalance and the 3Rs policies of Yakubu Gowon that was sustained by Murtala/Obasanjo regime (Obi-Ani, 2009); Shagari’s Housing Programme; Buhari’s “War against Indiscipline”; Babangida’s Structural Adjustment Program; Obasanjo’s Niger Delta Development Commission Yar’dua’s Amnesty Policy and Buhari’s “Below the Change” policies, all of which though laudable have not achieved any purpose because these policies become moribund upon the end of a tenure.

According to Ogbeidi (2012), corruption has destroyed ‘most of what is held as cherished national values’, which have long become an issue of trivial importance since Nigeria’s attainment of independence (Korikuye, 2017). More so, Lewis (1996) in his From Prebendalism to Predation asserts that: “Public and private resources, wielded as state assets, come under the discretionary control of political elites and public office holders and thereby serves as a conduit for private accumulation.” As regards this, corruption in Nigeria that is being fertilized by nepotism among other things remains the sole reason behind the woeful neglect of the welfare of citizens. It is also with this in view that Ochulor (2011) highlights the unsteady power supply in Nigeria as an indicator of her failed leadership. Amongst the setbacks that are consequent of this tyrannical mode of leadership is the neglect of the country’s healthcare system. With emergencies like the Covid-19 pandemic, the need to cast a historical glance on Nigeria’s healthcare System becomes imperative.

4. Nigeria healthcare system: from 1960 to the Covid-19 pandemic

The aphorism that health is wealth is germane. Thus, a nation that neglects its health sector is bound to face huge challenges as a healthy citizenry most often approximate to a dedicated workforce. This accounts for the reasons many countries pay special attention to the training, retention and remuneration of their healthcare personnel. Therefore, let us consider the Nigerian
healthcare sector since independence in 1960. Since 1960 onwards, the healthcare system of Nigeria has not been given priority. For instance, the health policy promulgated in 1954 gave birth to National Health Service. The health policy envisaged rural hospitals with 20–24 beds; to be supervised by a medical officer who would ensure that dispensaries, maternal and child welfare clinics and sanitation works were adequately provided (Emuakpor, 2010). However, this target was not met by 1975. By 1975, at the inception of the Third National Development Plan, it became obvious that not much had been done to achieve the goals of the Nationwide Health Care Services Policy. It was such that General Yakubu Gowon lamented that development in the health sector was yet to be marked by any spectacular achievement during the past decade (Emuakpor, 2010). Albeit, from 1975, new plans were nurtured as regards the improvement of Nigeria’s Healthcare system; hence the system was placed in focus when in 1978 (Abosede and Sholeye, 2014), the global target of “Health for All” was declared by the World Health Organization (Fran, 2007; World Health Organization, 1978). In a tireless pursuit of the global health target, the Primary Healthcare (PHC) was adopted and accepted universally to be the sine qua non to healthcare development (Abosede and Sholeye, 2014).

Primary health care, as defined in the Alma Ata declaration is the, “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; 1–2). In the light of this, Nigeria, contemporaneously, began to initiate major attempts towards perfecting her primary healthcare system. Historically, these major attempts fall into three categories each with its own chequered performance. The first attempt occurred between 1975 and 1980 with the introduction of the Basic Health Services Scheme (BHSS) by the Federal Ministry of Health through the Basic Health Service Implementation Agency. The BHSS provides for the establishment of three levels of healthcare facilities: Comprehensive Health Centers (CHC) to serve communities of 5000–20, 000 persons; Primary Health Centers (PHC) to serve communities of 5000–20, 000 persons; and Health Clinics (HC) to serve communities of 2000–5000 persons (Emuakpor, 2010). The strategies for the realization of BHSS include the promotion of community mobilization, the involvement of other sectors, functional integration and the strengthening of managerial processes. Unfortunately, this modest health policy vision failed at implementation on the grounds of poor community participation, faulty citing of health facilities, stolen equipment, lack of political commitment as well as inadequate orientation and distribution of the health workforce (Eme et al., 2014; Adebayo, 10 April 2020; Aigbiremolen et al., 2014; Abosede and Sholey, 2014). Consequent upon this, the primary health quality indicator and coverage remained frail and thereby led to the District Health System of 1986–1992. It is crystal clear that Nigeria healthcare plan is haphazardly implemented, thus leaving a weak foundation. Without getting the Primary Healthcare right, it jumps to the next stage, creating yawning gaps that need to be addressed before a holistic healthcare system could emerge.

The District Health System (1986–1992) began with the development of “Project Formulation Documents” or Action Plans that were funded by the Federal government in 52 selected pilot local government areas. Through this scheme, each local government area was given a minimum of 7 PHCs and 30 HCs with at least one CHC at the apex of the healthcare services; while larger LGAs were given at least 12 PHCs and 50 HCs that fed into one or more CHCs (Emuakpor, 2010). This system was strengthened by Bamako Initiative activities in 1988 during which PHC facilities had seed drugs that enabled them to operate drug revolving funds jointly administered with their community development committees. Yet similar to the first effort, the District Health System experienced only but partial success with similar hackneyed factors that undermined BHSS: poor involvement, poor funding, lack of appropriate infrastructure, equipment (Eme et al., 2014; Adebayo, April 10; Adebayo, 2020) and substandard drugs and materials. More so, the paucity of basic health statistics and inequitable distribution of manpower and poor logistics persisted (Abosede and Sholey, 2014; Aigbiremolen et al., 2014). Thus, the inability of DHS to achieve
a complete success ushered in the third and current effort. In stages of development, the mastery of every stage is imperative. Half measures cannot lead to an enduring next phase. This is the crux of Nigeria’s Healthcare challenges which require dispassionate reappraisal before a sustainable healthcare system can be achieved.

Furthermore, the National Primary Healthcare Development Agency (NPHCDA) established in 1992 was the third attempt to perfect and systematize basic healthcare system. Aside the announcement of its establishment, no obvious contributory step was taken until the turn of the democratic era when efforts were commenced towards its implementation beginning first with the institution of Ward Health System (WHS) in 2001 which utilized, among other means, the electoral ward (with a representative councilor) as the basic operational unit for primary healthcare delivery (Abosede and Sholey, 2014; Aigbiremolen et al., 2014). What is more, the Ward Minimum Health Care Package (WMHCP), which outlined a set of cost-effective health interventions with significant impact on morbidity and mortality, was also developed; and among its packages were the Integrated Management of Childhood Illnesses (IMCI), Integrated Maternal, Newborn and Child Health (IMNCH) services, etc. Other sub-NPHCDA efforts that were intermittently conceived and pursued through the years till present times include the Reactivation of Routine Immunization, Polio Eradication Initiative, Midwives Service Scheme (MSS), Primary Healthcare Reviews, Integrated Primary Healthcare Governance, strengthening of the National Health Management Information System (NHMIS) and the bi-annual Maternal Newborn and Child Health Weeks (MNCHW), etc. (Abosede and Sholey, 2014; Aigbiremolen et al., 2014). Despite these facilitations, the NPHCDA, till date, alongside Nigeria’s Revised National Health Policy (Nigeria Federal Ministry of Health, 2004) and the state of Primary Healthcare System are yet to achieve perfect success stories and this is with regard to colossal neglects. Consequently, this neglect led to mortality rate being one of the highest in the world and averagely in Sub-Saharan Africa. The issues accounting for this high mortality rate are: (a) weak health systems; (b) all time low immunization coverage; (c) secondary health facilities in prostrate conditions; d. outdated and non-functional diagnostic and investigative equipment in tertiary institutions; (e.) prevalence of fake and adulterated drugs; (f.) public expenditure in health less than 8 USD per capita, as against 34 USD recommended internationally; private expenditure estimated to 70% with most of it from out-of-pocket; (g) absence of partnership between private and public health sector; (h) mismanagement of limited health resources and (i) a poor coordination of international community donors.

Nonetheless, irrespective of the obvious decay in the healthcare system in Nigeria, the situation has not improved especially with respect to effective implementation and funding. Between 2003 and 2005, correlated records on Health Development efforts indicated that Federal, State and Local governments accounted for 12%, 8%, and 4% respectively (Uzochukwu et al., 2015). More so, the total government’s health expenditure, as a proportion of the Total Health Expenditure, was estimated at 18.69% in 2003; 26.40% in 2004 and 26.02% in 2005 respectively (Soyibo et al., 2009). Basically, what these reveal is that the federal government’s capital expenditure as regards the health sector has dwindled over the years. In the Abuja Declaration, which Nigeria and 43 other African countries signed in 2001, a commitment to spending 15% of annual budgets on public health were made; however, this has not been achieved over the years (Obansa & Orimisan, 2013). Additionally, up to the year 2020, the budgetary allocation for health still remains below the 15% expenditure that was signed by the Nigerian government in the Abuja Declaration (Yanusa et al., 2014). Even in the face of this, Nigerian leaders continued to squander large fortunes on foreign medical treatment for its officials. According to the Nigerian Health Sector Market Study Report (2015: 15) “Nigerians spent an estimated 260 USD million on medical bills in India alone in 2012 and 40% of all visas to India were for medical reasons. The Nigeria Medical Association (NMA) estimates that Nigeria spend 500 USD million to USD one billion on medical tourism per year.” Against this background, AbuBakar et al. (2018) noted that in 2013, Nigerians spent 1 USD billion on foreign medical trip with a majority being Nigerian politicians. Similarly, the BBC (June 7, BBC, 2016) also reported how the Nigerian President, Muhammadu Buhari traveled abroad to treat an ordinary ear infection. It is being suggested that the huge medical bills incurred by Nigeria for its
political leaders abroad could be utilized in addressing its health infrastructural deficit. Many
Nigerian trained medical doctors and nurses are being enticed by Western countries with good
remuneration and better working conditions. Some doctors in Nigeria are frustrated by epileptic
power supply and lack of modern medical equipment. The political leadership appears indifferent
to the parlous medical situation because of the ease with which they travel abroad for medical
checkup for themselves and members of their immediate families. In 2017, President Muhammadu
Buhari spent more than 100 days in a London hospital. Perhaps, the Nigeria government does not
see the president’s hospitalization outside the country as a national security risk. There also
appears no jolt of conscious local patriotism among the political elite that allows its symbol of
sovereignty, the president to be treated outside the country. The clarion call for revitalization of
healthcare system in Nigeria is predicated on such embarrassing situation whereby our scarce
foreign exchange is expanded on medical trips abroad for government officials and businessmen
who could afford it. The issue is that Nigeria has both the manpower and resources to maintain
world class hospitals but inefp political leadership and crass corruption have vitiated them. The
coronavirus pandemic is a wakeup call on Nigerian leaders to urgently address the dilapidated
healthcare system or else perish because of lack of foresight when world-wide health crisis might
force other countries to close their borders to medical tourists like Nigerian officials.

Summed up from (Uzochukwu et al., 2015) and verified through Anonymous in Budget Office of
the Federation, Federal Ministry of Finance (11 April 2020).

Unfortunately, in the same period, studies conducted on sudden deaths by Olayinka et al. (2013)
(SD) revealed that out of 48 cases, 35.5% was by communicable diseases, 60% by non-
communicable diseases while the overall adult mortality reported on CD cases was 718. In 2011,
following the need to tackle rising health challenges, the Nigerian Center for Disease Control
(NCDC) was established. But up to 2016 government’s funding of the health sector still lagged
behind. More so, from 2016 to 2020, the trend remained static and even in some instances
deteriorated. For instance, in 2016, only N155m naira out of N251m naira was released to NCDC
and during this period, 1,166 Nigerians died of Cerebrospinal Meningitis (Chidebe, April 4, Chidebe,
2020). What is more, in 2017, the NCDC was given N782m out of N1.5billion budget whereas
N1billion was recorded to have been spent by the president on foreign medical trip abroad in 2017
(Mbamalu, Oyebade and Oyedoyin, February 17, Mbamalu et al., 2017).

By November 2018, the act establishing NCDC was signed into law by President Muhammed
Buhari (Obi-Ani et al., 2020,6). This happened following Bill Gates’ criticism of Nigeria’s poor
funding of her primary healthcare system. Yet in the same year, despite Gates’ criticism, only
N654m was released out of a total proposed budget of N1.9b by NCDC (Chidebe, April 4, Chidebe,
2020). In 2019, it was hoped that funding for the health sector will improve dramatically but
stunningly, the year marked the worst budgetary allocation to NCDC with an N224m release out of
an N1.4b budget. Similarly, in the face of the COVID-19 Pandemic, only a meager amount was
released to the NCDC despite donations made by individuals, international organizations and other
world governments to Nigeria. Consequent upon this, Covid-19 testing laboratories and centers
were sparsely distributed. In a country with a population of over 200 million, as of 17 April 2020,
the country had only 169 ventilators serving an estimate of 1,266,440 persons per ventilator
(Maclean and Marks, April 18, Maclean & Mark, 2020). More so, 70% of ward health centers are
severely outdated, dilapidated and short of essential and affordable drugs with a lot of epidemiolo-
gical cases gaining momentum. A careful computation and summary of NCDC’s weekly epidemi-
ological reports from January 1 to April 5 (14 weeks) indicate as follows in Table 1 and Table 2.

5. Compiled from NCDC’s weekly epidemiological reports (1st January - 5 April 2020)
The above tabled information reveals that there were millions of undetected and unreported
cases; thus, HIV cases which currently rank in millions as well as COVID-19 cases which record
a swooping 2,170 cases, as at 1 May 2020, are not included.
Table 1. As demonstrated in Table 1, from 2009 to 2013, no Nigerian health budget was neither up to 6% of its total budget nor 1% of its GDP.

| Year | GDP (NGN billion) | Total Allocation Budget | Allocation to Health (NGN billion) | % of GDP | % of Total Budget | Total Release | % of Released | Amount Utilized |
|------|-------------------|-------------------------|------------------------------------|---------|-------------------|--------------|--------------|----------------|
| 2009 | 25,102.44         | 3557.7                  | 154.6                              | 0.6     | 4.3               | 48.6         | 89.2         | 24.5           |
| 2010 | 30,980.84         | 4427.2                  | 164.9                              | 0.5     | 3.7               | 33.6         | 58.8         | 32.8           |
| 2011 | 36,123.11         | 4971.9                  | 266.7                              | 0.7     | 5.4               | 38.8         | 61.2         | 26.0           |
| 2012 | 42,132.16         | 4877.2                  | 282.8                              | 0.7     | 5.8               | -            | -            | -              |
| 2013 | 63,50.00          | 4920.0                  | 279.2                              | 0.4     | 5.7               | -            | -            | -              |
|                  | Lassa Fever | Cholera | Acute Flaccid Paralysis | Cere-spinal Menin | Measles | National sentinel influenza | Yellow Fever | Monkey pox |
|------------------|-------------|---------|-------------------------|-------------------|---------|----------------------------|--------------|-------------|
| Suspected Case(s)| 4410        | 635     | 1131                    | 201               | 9753    | 186                        | 456          | 9           |
| Confirmed Case(s)| 964         | 0       | 0                       | 0                 | 37      | 52                         | 52           | 2           |
| Death case($)    | 125         | 23      | 0                       | 3                 | 39      | 0                          | 0            | 0           |
| TOTAL            | 5499        | 658     | 1131                    | 204               | 9829    | 238                        | 508          | 11          |
6. Covid-19 pandemic: a wake up call to a revitalized healthcare system in Nigeria

The interconnected nature of the world is increasingly obvious for both the positive and negative. The internet, mass media and social media make the news of scientific inventions, political unrest and natural disasters filter into the remotest part of the world in a matter of hours. The mobility of man is faster today than in previous known history of mankind. Thus, the outbreak of a flu in one part of the world might be disseminated to the rest of the world in a matter of days. This makes it necessary for nations to take proactive measures to guard against being convulsed by upheavals. Thus, political unrest in Tunisia turned into the Arab spring in 2011, impacting far-flung countries such as Egypt, Libya, Yemen and Syria. In 2014, the world was gripped by Ebola epidemic which originated in the Democratic Republic of Congo but quickly spread to many parts of the world before being curtailed. Though the news got to Nigeria, the reactions of the Nigeria health authority was lethargic. The Nigeria government did not restrict travels from endemic countries until a vigilant medical doctor, Stella Adadevoh detected an index case of a Liberian citizen on a visit to Lagos, Mr. Sawyer. It was only on her insistence to quarantine Mr. Sawyer and alerting the Federal ministry of health that mitigated the disaster (BBC New, 2014). Thus, when the news of the Covid-19 coronavirus emerged from China, many people had expected the Nigerian government to restrict flights from countries where the virus was ravaging.

Invariably, there was no lesson learnt from the Ebola epidemic. It was not until the index case of an Italian visiting Lagos tested positive on 28 February 2020 that a general outcry by citizens that government should restrict flights or quarantine anybody coming in from coronavirus pandemic ravaged countries of Europe should be enforced (Obi-Ani et al., 2020, 2). The Buhari presidency did not act with the speed expected in such life-threatening situation. Eventually, on 29 March 2020 President Buhari in nation-wide broadcast banned international flights into the country and lockdown Abuja, Lagos and Ogun states for a period of one month. His action was like bolting the stable after the horse has gone. The process of decision making is at a snail pace. Major decisions await the imprimatur of the president. A sluggish bureaucracy that lacks precedents but at every emergency awaits the approval of the chief executive is inimical to the good health of the nation.

It has been alleged that part of the delay in closing the Nigerian borders was to await the return of President Buhari’s daughter from London. Assuming this allegation is correct, whereby state policies are implemented based on the whims of the leader, or what suits the first family, little wonder the healthcare system is in a chaotic condition. This allegation is plausible since the president’s daughter shortly after her return and self-isolation (Ogundipe et al., 2020), the Nigerian borders were closed. Laws in Nigeria are for the weak and powerless. The powerful members of the ruling class observe the laws mostly in breach. At the height of Covid-19 pandemic National Assembly members returning from Europe flaunted the protocol to be tested or quarantined at the airport. Health officials at Nnamdi Azikiwe Airport, Abuja, were frustrated that the president’s chief of staff Abba Kyari, had to appeal to the Senate President to plead with his colleagues to observe the protocol to little avail. Indeed, Abba Kyari contracted Covid-19 during his official visit to Germany which eventually led to his demise.

Following countless criticisms by Nigerians against the languid attitude of the country’s apex leadership, the presidency thereupon decided to demonstrate efficiency via his decision to import supposedly Chinese medical experts and equipment (Atoyebi et al., April 4, Atoyebi et al., 2020). It is important to note that although manpower and financial deficit in Nigeria may have informed Buhari’s decision, as proposed by some analysts (Agency Report, 4 April, Agency Report, 2020; Yakubu, April 8; Yakubu, 2020); yet the central question revolves around why the presidency would have to seek succor from China. More so, despite the fact that the presidency’s intention was hid from the general public but leaked to the Nigerian Medical Association (NMA), an action that garnered criticisms (NMA, 9 April 2020) and opposition parties like Peoples Democratic Party (PDP) the presidency still proceeded adamantly to implement its decision. These oppositions were against the background that instead of importing Chinese medical team, Nigerian doctors ought to have been given better opportunities and reinforcements. Other quarters also expressed their cynicism by affirming that the importation of
Chinese medical experts was exclusively for the elites who could afford them; while citizens who had contracted the virus were left with inadequate medical care.

Furthermore, legislators, state functionaries, LGA functionaries, etc., are also not exempt from these corruption allegations as they similarly exhibited leadership failure in the past, with only a few exceptions. According to Baiyewu (February 18, Baiyewu, 2020a), as of 5 February 2020, while the news of Covid-19 pandemic had circulated to all nooks and crannies of the world, Nigerian legislators, rather than budget for the fortification of Nigeria’s Primary Healthcare system, were busy making financial arrangements for the latest version of about 400 Toyota Camry cars. This was considered, by citizens, to be heartless and inconsiderate of their representatives. Worse still, despite the opposition by concerned Nigerians and by the Socio-Economic Rights and Accountability Project (SERAP) these legislators proceeded to spend N5.04 billion on official cars, each costing an estimated 35,130 USD (Olasunkanni, February 24, Olasunkanni, 2020; Baiyewu, March 27; Baiyewu, 2020b). Largely, what can be gleaned from the above is that the legislature is in cahoots with the executive in squandering the country’s meagre resources on themselves. To rationalize their tomfoolery, the law makers claimed that the contract for the cars had already been concluded before the pandemic erupted; however, this paper proposes that sensitive legislators would have also halted the deal due to the emergency situation and that the timing of the arrival of these cars is inauspicious. Fundamentally, this depicts the apt description of the Singaporean former president who surmised that African leaders ostentatiously exhibited their wealth while attending meetings at the United Nations General Assembly. In his words: “The poorer the country, the bigger their hired Cadillac” (Yew, 2000, 364). This assertion is further buttressed by the fact that from the time of Mansa Musa till date, African leaders are yet to desist from self-aggrandizement and misappropriation of public funds.

7. Implications of Covid-19 pandemic on the poor healthcare system in Nigeria

The law of karma is a natural law of cause and effect which infers that every action elicits a reaction. Following this line of thought, corollary karmic consequences in Nigeria, with relation to the deliberate abandonment of the nation’s primary healthcare system, have been self-evident with malaria fever killing more people than Covid-19 pandemic. This karmic backlash, emanating from the lack of political will on the part of the elites to address the primary healthcare challenges, underscores the need to revitalize the healthcare sector before it is too late. The lockdown and cessation of routine activities with its concomitant cataclysmic consequences as regards income reduction, escalation of hunger, boredom, rise in suicide, upsurge in insecurity, paranoia, buttresses the need for local production of drugs, medical equipment such as ventilators, surgical masks and even vaccines to treat epidemic and pandemic diseases.

At the international scene, the coronavirus engendered lockdown has caused a meltdown of global economic activities of which Nigeria’s major export of crude suffered huge losses. Consequently, this decline in economic activities has led to a drastic fall in revenues accruing from oil sale in oil-dependent nations like Nigeria; thereby plunging the country into economic recession (Emefiele, 2020). At the domestic scene, the shutdown has two repercussions: economic difficulties such as hunger and business closure, with its attendant frustration marked by a rise in suicide cases, and the cessation of notable social events such as religious events due to social distancing. It is against this background that this paper postulates that had Nigeria fortified her medical system and cultivated appropriate leadership measures, a complete lockdown would not have been so excruciating.

The prolonged lockdown was distressful to both individuals and businesses. The promised palliative by the government was not forthcoming. Many artisans that depended on daily wages were worse off. The lockdown prevented them from performing their daily vocations, thereby denying them means of sustenance. While government paid salaries of public servants, private business operators could not pay their staff and some were retrenched. All these brought hardship to many people. In Lagos, area boys, putative name for hoodlums started to harass residents. Those well-to-do, in other to avoid these hoodlums breaking in their residence, usually brought
food items in front of their houses which these area boys, collect during their raid in the night, thus sparing the complaint ones and subjecting the not so wealth to all manners of molestation including rape. More so, in Enugu, Abia, Imo and some other Eastern States, news is also replete of burglary and robbery amidst other insecurity issues (FM Radio Nigeria, Enugu). What is worse, aside from inflicting harm dispossessing citizens of their foodstuff and money, this study affirms that these social dislocations may create instability unless Nigeria evolves a kind of social welfare scheme of the unemployed and other vulnerable members of the society.

However, it is important to note at this juncture that of the 150 deaths recorded in the country so far from the coronavirus cut across the rich and poor in the society. Evidently, this is another implication of leadership failure that is worked with the poor healthcare system. Currently, the number of positive cases was approximately 4,641 infections with 150 deaths as of 12 May 2020 (NCDC page, 12 May 2020, Vanguard, 12 May 2020). Indeed, the coronavirus pandemic is a wakeup call for Nigerian government to revitalize its hospitals and healthcare system, as the flu has forced the rich to stew in their own juice with world-wide ban on flights which prevented few rich Nigerians from seeking medical care abroad. The casualties of the rich and powerful Nigerians that succumbed to Covid-19 include Abba Kyari (Fabiyi, Alagbe and Aworinde, April 18, Fabiysi et al., 2020), and Senator Rose Oko who died in the UK (Olasupo, March 24, Olasupo, 2020). It is possible that if these leaders had encouraged state-of-the-art hospitals while in office, their lives and those of fellow compatriots could have been spared the affliction of the virus or survive the disease.

8. Conclusion
The coronavirus pandemic exposed the underbelly of Nigeria’s healthcare system. The rot has been visible over the years, yet no remedial steps had been taken to address them. From lack of basic equipment in hospitals, to lack of essential drugs in the shelves and epileptic power supply and poor remuneration of medical personnel, the deterioration had persisted. General Sani Abacha in his famous coup d’etat broadcast of 1984 summed Nigeria’s hospitals as mere consulting clinics. Yet, government after government have refused to address the pathetic situation. Many Nigerian doctors have agonized losing patients due to lack of appropriate equipment, fake drugs and electric power going off in the midst of major operation in the theater. This has forced many health workers in Nigeria to migrate to Europe, United States and Saudi Arabia under better conditions of service than is obtainable in Nigeria. The saying that health is wealth and a healthy nation is a wealthy nation makes little or no meaning to government officials in Nigeria. Virtually all top government officials and their family members are routinely sponsored abroad for medical checkup at government expense. That accounts for the reason they pay scant attention to public healthcare system in Nigeria.

The Covid-19 pandemic should have marked the critical juncture in Nigeria healthcare scheme. This is the moment the country ought to turn the corner for good. But like every other issue afflicting Nigeria, once the emergency abates, the health challenges confronting the country will be swept under the carpet. The coronavirus should awaken in the government the need for health security. There is urgent need to produce locally most of the drugs required in Nigeria in partnership with big pharmaceutical companies. If there is a global lockdown, closure of borders around the world for one year, the drug supply chain will run dry. The political leadership lacks every sense of patriotism otherwise Nigeria with its huge population and resources should have at least ten state-of-the-art referral hospitals manned by qualified Nigerians. It is scandalous that President Musa Ya’aradua died in a Saudi Arabia hospital in 2010 while in 2017, President Buhari spent over three months in a London hospital receiving treatment. Despite all these, there is no single referral hospital that can handle whatever health challenge of a Nigeria president without rushing abroad. Recently, President Donald. J. Trump contracted coronavirus and within three days of admission in their military hospital, he regained his health. Nigerians and indeed the political leaders spend over 1 USD billion dollars annually on medical bills abroad. Even the inconveniences of rushing a sick person abroad for medical check should no longer be a status symbol.
Nigeria's healthcare policies are germane. From the primary healthcare to secondary and tertiary healthcare schemes are all in place. But they are malfunctioning. There are areas of life that should not be politicized. Healthcare sector should not be associated with quota system, favoritism and corruption. Every personnel from cleaners to consultants must be on merit. Any compromise in healthcare could lead to loss of life. But a hospital administrator sees the position as an opportunity to employ his relations in positions they are least qualified. This is the bane of Nigeria. Again, most public officials are law breakers in Nigeria. A situation whereby senators and other government officials returning to the country, refused to be tested for Covid-19 at the airports and quarantined, to say the least is embarrassing. It took more than a month after the first index case was detected in Lagos for the federal government to close the borders and implement lockdown in parts of the country. What is worst being that some government officials charged with distribution of palliatives to the indigent, saw it as an opportunity to enrich themselves. Nigerians want to profit from fellow compatriots' distress. The coronavirus pandemic is an opportunity to revitalize our healthcare system. We may not be so lucky next time.

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