

Rural Health Care in Nigeria: The Case of Uvuru Health Center

Gavina C Ihunnah

A thesis submitted in partial fulfillment of the requirements for the degree of

Masters in Public Health

University of Washington

2022

Committee:

Daniel A. Enquobahrie

Stephen Bezruchka

Amy Hagopian

Program Authorized to Offer Degree: Department of Health Systems and Population Health

Copyright 2022
Gavina C Ihunnah

University of Washington

ABSTRACT

Rural Health Care in Nigeria: The Case of Uvuru Health Center

Gavina C Ihunnah

Chair Supervisory Committee:

Daniel A. Enquobahrie

Department of Epidemiology

Rural communities in Africa have challenges in providing rural healthcare services. With over 200 million people, Nigeria struggles to provide primary health care needs to its teeming population. Although the late Prof. Olikoye Ransome-Kuti, Health Minister of Nigeria, established primary healthcare following the Alma Ata declaration of 1978, Nigeria's rural healthcare is still a mirage. There is no access to adequately functioning immediate health care for numerous individuals and communities in Nigeria with inadequate personnel, medical equipment, and dilapidated infrastructure. Uvuru is a community in southeastern Nigeria with a health center, Uvuru Health Center (UHC), established in 1967. Functions of the health center have not been assessed or evaluated since its inception. Therefore, it is essential to determine the healthcare needs of the Uvuru people and the health center's role in addressing these needs. We conducted a study that employed a phenomenological framework to capture individual experiences using in-depth and semi-structured interviews. We recruited participants using a snowball selection method. We identified 12 potential participants; 11 responded and agreed to the discussion. Interviews were conducted using telephone, zoom platform, and text messages. Questions were based on participants health care related experiences and observations.

Responses to initial and in-depth, probing, follow-up questions were recorded. Three people coded the data. We produced 136 codes that were condensed into the following six themes. (1) UHC seemed to be abandoned by the government, and its current ownership and financial status are obscure and contested. (2) Corruption at the level of the government has led to deteriorated infrastructure, looting, and unpaid labor of health workers. (3) The political insurgency in the area has created an atmosphere of fear for personal safety and undermined the facility's security. (4) The low level of political power among the Ibo people (Uvuru Health system users) has contributed to long-term poverty. (5) Private practitioners across the community are happy to provide services at high prices and have captured most of the market share (and are reluctant to support the public sector facility). (6) There are glimmers of hope in the local Uvuru Development Union (UDU) and the Uvuru community members, which are stepping up to improve the situation. Our research indicates that engaging community members may shed light on the state of health centers and relevant deficiencies of their function. Further, it can enhance building of a coalition needed to rehabilitate and revitalize the centers. These efforts can advance rural health in low-resource settings.

Keywords: Rural Health, Gaps, Healthcare, Evaluation, Assessment, Community

Rural Health in Nigeria: The Case of Uvuru Health Center

TABLE OF CONTENTS

Abstract	
Abbreviations	2
Definition of terms	3
Background	4
Methods	7
Results	10
Discussion	29
Acknowledgment	36
Availability of Data & Materials	37
References	38
Table 1: Codes and Meaning	43
Table 2: Information on Data Collection Tools	45
Appendix A: – Interview guide	46
Appendix B: - Ethical approval	47
Appendix C: - Pictures	48

Abbreviations

UHC: Uvuru Health Center

PHC: Primary Health Centers

IPOB: Indigenous People of Biafra

Definition of terms

Igbo man: an expression used to describe the Igbo people from southeastern Nigeria. The term

Igbo man incorporates both men and women of Igbo land

Ofo na Ogu: The Igbo collective will of honesty on which the Igbo man stands to demand a right

Abigbo: Local song peculiar to only Mbaise people in Imo State, Nigeria

BACKGROUND

Rural healthcare in disadvantaged African societies has well-documented challenges (Adedeji 2021, Ihunna 2008, Okoli et al., 2016). With over 200 million, Nigeria is the most populous nation in Africa. According to Bassey-Akamune & Ilomuanya (2017), about 70% of the Nigerian public live below the poverty line, while 30% live in extreme poverty. The National Bureau of Statistics (NBS) released the 2019 poverty and inequality report in Nigeria, highlighting that 40% of the total population, almost 83 million, live below the Country's poverty line of N137,430 (\$381.75) per year, while 48% of the total population live in the rural area (World Bank, 2020). Despite considerable resources in Nigeria, its rural community health care systems still suffer gross neglect, lack of resources, struggles to survive, and deliver less than optimal healthcare to its population (Ntoimo et al., 2019).

Nigeria adopted Primary Health Care (PHC) centers in 1985 based on the Alma Ata declaration of 1978 to emphasize preventive medicine and healthcare services (Aregbesola & Khan 2017). In the 1980s, the management of PHC was up to the local government's administration, the weakest level of government. The military takeover in 1993 rolled back all the giant strides recorded under the then Minister of Health, Prof. Olikoye Ransome-Kuti. The current state of the PHC system in Nigeria is appalling, with only about 20% of the 30,000 PHC facilities across Nigeria working (Aregbeshola & Khan 2017). In addition, findings indicate that PHC centers have left communities vulnerable to diseases (Adedeji 2021, Alemu 2019, Okoli et al. 2016, and Ihunna 2008). This, in effect, defeats the aim of establishing PHC centers to improve health in rural communities.

Nigeria's problem of economic instability has its foundation in the prolonged military rule witnessed since its independence in 1960 and its first military coup d'état in 1966. The

military brought with them corruption as they used intimidation and fear to prevent the people from legitimate agitation for their rights (Osoba 1996). The result is a long succession of military dictatorship and pervading corruption in all fabrics of the society. The effects continue today with a high poverty rate, unemployment, inflation, dilapidated public infrastructure, and preventable illnesses leading to higher morbidity and mortality. Communities in some regions of Nigeria, such as in southeastern Nigeria, are particularly vulnerable.

The Igbos of southeastern Nigeria were devastated by the civil war between 1967-1970. Following the war, Igbos now face challenges of marginalization from the Nigerian government (Okwuosa et al., 2021). The marginalization led to agitations that continue to put them at a more economic disadvantage, as in the present case of the Indigenous People of Biafra (IPOB). There is deterioration in rural health care among communities in Igbo land with no established system of rehabilitating or reviving PHC, which is critical for health care delivery. For these reasons, the Igbos, including those living in Uvuru, engage in many self-help projects to solve their health problem and improve their health outcomes.

Uvuru is a community of more than 26,000 residents in southeastern Nigeria's Aboh Mbaise local government. The inhabitants speak Igbo and are called Ndigbo. The people of Uvuru are subsistence farmers and local traders. They have weak political representation in government.

Uvuru Health Center (UHC), the primary health care center for the Uvuru community, was established in a central location in August 1967. The Mbaise General Hospital that serves the whole Mbaise region is in poor repair suffering from government neglect. Its midwifery school is closed, little or nothing goes on in the compound, it lacks resources, and lack of

supplies cripple services to the community. Therefore, 30 minutes from the UHC via road, the hospital is no alternative to UHC.

Despite well-recognized security issues, incessant transfers of staff, stunted growth, dilapidated infrastructure, low supplies, low clientele, and inadequate services, no recent study was conducted to evaluate the problems of UHC, information that could help inform potential solutions. The last evaluation happened in 1967 at its inception. Therefore, the current study objectives included achieving a better understanding of the healthcare needs of the Uvuru community and an assessment of the role of UHC in addressing the health needs of Uvuru community members. An indigene of Uvuru initiated this study through The Kindred Mutual Foundation (KMF), a non-profit organization based in Washington State, United States. KMF has a long-term objective of identifying strategies, partnerships, and resources to create a change that will lead to improved health outcomes and community satisfaction within the Uvuru community. Study findings will contribute to this effort.

METHODS

Study Context and Setting

The study involves health care needs and services of the rural community of Uvuru in southeastern Nigeria, and Uvuru Health Center established to address them. Uvuru is in Aboh - Mbaise local government area in Imo State, Nigeria. Uvuru has ten clans and five autonomous communities. Two clans make up one autonomous community. All the clans share the Uvuru Health Center, which is the focus of this study.

Study Design and Study participants

This qualitative research study utilized in-depth and semi-structured interviews conducted among members of the Uvuru community. We employed a phenomenological approach to characterize the lived experiences of Uvuru members using the Uvuru Health Center. A total of 12 individuals identified using snowballing method were approached to participate in the study. Of these, we could not reach one, despite multiple efforts, and 11 participated. About 45% of participants were recruited through a traditional leader of the Akpotu-Egbelu community, while 55% were recruited through connections with the Kindred Mutual Foundation (KMF). About 98% were indigenes, while 2% were people working within the Uvuru community and have contact with the Uvuru Health Center through their positions. The interviews were voluntary and conducted after verbal consent, and participants were free to stop the discussion at any time or not answer any questions. We submitted an IRB application to the Human Subject Division of the University of Washington and received IRB approval (exemption # 00012929). We also received International Human Subjects Approval in the research country – Nigeria (see Appendix B).

Data Collection

Data was collected using telephone conversation (N-8), zoom call (N-1), or text messaging (N-2). We dialed the telephone numbers of Uvuru indigenes who answered from their homes. Due to the time difference between Washington State and Nigeria, most calls happened early morning or late at night to get someone at home. Only identified individuals, not family members or others nearby, participated in the conversations. Most interviews (95%) faced numerous interruptions due to network problems and distance. All discussions were in English.

We developed an interview guide (Appendix A) to structure interviews. An interview guide facilitated the conversation but was not strictly relied on, depending on how the conversation continued, and participants responded to the prompts during the interviews. The interview guide had open-ended questions for community members, workers, and local leaders. The questions were structured to provide an avenue to express participants' experiences, thoughts, or assessments without limitation and to use probing and follow-up questions to help participants remember their stories and experiences. The first interview occurred on November 28, 2021, and the last interview occurred on March 13, 2022. All the participants' self-reported demographics were declared final due to cultural considerations. In Mbaise, asking people for personal information, especially age, may be disrespectful. Cultural issues of age are touchy and highly regarded. We did not report data that will likely identify participants. The data reached saturation with initial interviews. We did not conduct pilot testing. The total phone and zoom interview duration were 390 minutes (approximately 6.5hrs). Each discussion ranged between 30 and 60 minutes except for text messages.

We transcribed each interview, requested emails from each participant, and sent transcripts to each participant who provided an email - 6 participants received emails, two used

text messages only, and three used phone and text. Participants who provided emails had the opportunity to make edits before confirming the contents' accuracy. The average length of the transcripts ranged from one page to 21 pages.

Coding and Data Analysis

Each interview was independently and manually color-coded to elicit themes. We labeled participants' statements, sorted labels based on relationships, and synthesized the pieces by putting them together. Based on this process, theory-developed themes emerged. We described major themes and presented supportive participants' quotations. Participants' quotes were identified by number (e.g., CMI or CM6). All analyses were conducted using Microsoft Excel.

RESULTS

Study Participant Demographics

Study participants' data collection is in Table 2. Participants were between the ages of 34 and 74 years. Three were females, and 8 were males. The ages of male participants ranged from 34 - 74 years. In comparison, the ages of female participants were 38 – 57 years. The average age for both male and female participants was 50 years. All participants had completed high school. The average years of residence of participants in Uvuru were between one year and 17 years. The average years of working at the Uvuru Health Center for the two participants who worked there were seven years. The participants represented the Uvuru Community (comprised of five autonomous communities and ten clans), Uvuru Health Center workers, and Uvuru Health Center management. While all participants described Uvuru as one community comprised of independent communities, more participants were from the Akpotu Egbelu Uvuru autonomous community.

Codes

Table 1 shows the Codes. Many codes identified were sorted into categories to generate themes. Some of these codes appear below.

Management: The management code came up several times during discussions. The confusion of not knowing who was responsible for the direction of the UHC caused community members to accuse the local government of not doing its job. The local government accused the State government of the problems on the ground.

Corruption: Officials were accused of keeping funds for themselves and allowing the UHC to suffer. There is an agreement that corruption is deep in the Country. Uvuru community members

still believe that the UHC should receive help despite the corrupt practices of the officials.

However, that did not happen

Insecurity: The insecurity issue (at the UHC, State, and Country) was recurrent. Newspapers and television announcements are replete with armed robbery, kidnapping, local thievery, separatist movements, and religious fundamentalist activities leading to loss of lives, injury, and lack of sense of security.

Limited political power: The Igbos have poor representation in the government, leading to limited political power. This has prevented Mbaise from making substantial political gains. Although singing their local songs, Abigbo, helps them express themselves, sometimes in the form of a piece of recorded music, not everyone understands the language (Iwuoha, 2020). This has prevented the group from communicating better about their plight and convincing more people to believe in them to vote for political representation.

Private Hospitals: In Nigeria, there are frequent scuffles between the government and the people because the government controls most public establishments (e.g., Schools and hospitals). Sometimes, employee unions in these establishments drag issues with the government leading to strikes and unpaid workers. The private establishments use these opportunities to hike prices. More people died during the strike because they could not afford private hospitals.

Development Union: In Uvuru, the spirit of self-help is evident among the Igbo community. Communal ethic has led them to come together under the Uvuru Development Union (UDU) umbrella to work together and provide essential security, protection, and support for their local institutions.

Thematic Overview

The codes were condensed into six themes that will be discussed below, along with the identified problems and participants' relevant responses.

Theme 1: The Uvuru Health Center seemed to be abandoned by the government, and its current ownership and funding status is in the contest and obscure.

UHC was established in August 1967 by the federal government to bring health to the doorsteps of rural communities. Funding for it comes from the federal government. Its management belongs to the local government, but the state (regional government) seems to define management activities, making it hard to know who is responsible for its management. This doubt in ownership creates confusion among the community, as expressed by some participants:

CM1 - Uvuru health center is a prime example of past public and community partnerships. When those clinics were set up, it brought the local government, the community, and those supposed to serve under one forum. It did work earlier on but is also an example of the current problems on the scene in Nigeria.

Another participant explained the issue of ownership and the lack of funding for the Center, which led him to start building another center to provide his people with the needed help.

CM10: The health center is supposed to be funded by the local government. So, I need to find out if, actually, they are receiving the fund and it's being misappropriated or no fund is coming from the government, from the local government, I need to find out. That information I don't have now. And I'm yet to know what is the government supposed to provide for the health center and what is the community supposed to do. That I also need to find out. So, the overall state of the health center, it needs serious attention. Serious attention. If it was functioning well, if it was functioning well, I wouldn't have thought of building another one.

A big part of the ownership problem is identifying the funding source for the Center and the role of each level of government. The next participant expresses frustration by saying the following:

CM2: But that's the way the state government is doing things that when the allocations come

from the federation account, the state government seizes all the money and just gives them money for salaries and begins to determine priorities for them so that they are not very much in control of their finances and whatever they can do, they do so we also try to lobby the state government directly except that there is politics, politics, I do not know whether it is service in our Country today or just a means of some people improving their own individual economies, I don't know. I am not a politician

The confusion over responsibility for affairs of the health center is leading to neglect of the Center as it falls into severe disrepair. People are afraid to speak up for fear of intimidation, intensifying the problems. This participant states:

CM2: State government, local government, my dear, unless you want to develop a headache if you plan with them. I don't plan with them, I'm not planning with them, All I can do is to plead, If they intervene, I say a good prayer to God for answering, if they don't, I say it is normal now, it is new normal. The government doesn't intervene so.

One of the participants described how the government confuses the public with bogus announcements that are only real in newspapers, radio, and television but are not seen on the ground. The participant said:

CM6: The truth of the matter is that these government people, they don't look into. You will see so many things on paper that they have done that, they have done this but when you actually go on ground for monitoring or evaluation, you will not see anything there, and nobody will ask them anything

The above statement illustrates the community's dilemma and the hope that the government will deal with the people's issues in a more straightforward way. Citizens seem to track the flow of the funds allocated to the UHC:

CMI: Within their budget, they have to be able to find something to help those communities. If there is a project budget, if you look at the extent of the problem in that one place, many other communities' situation has the same issues. Okay Federal Govt gives allocation to Aboh Mbaise LGA every month, okay, so if you decide to gobble the money, you should be able to carve out 10 % of this project budget, 20% as participation of the LGA.

Meanwhile, another participant believes that establishing the UHC was a partnership between the people and the government because the people donated a large expanse of land to benefit the community. This participant argued:

CM9: *No, the area the local government is using is a very large expanse of land. It seems that their attention is shifted. It's a very large expanse of land so they are using some of the land. When you go there, the nurse that is in charge. When you ask her, she says this is what the government wants, that's what we are doing. Nobody is responsible again. They are answering government establishment by mouth.*

Community Member 8 said the health Center had been there for a long time, claiming it was established in the eighties; however, the health Center was established in 1967. The participant notes the importance of the health Center as the only government health service presence in the community.

CM8: *Okay, this much I know about the health center, it has been in existence for a very very long time. In fact, it was established in the eighties, and in the early eighties, it was about the only health center in the whole of Oke-Ovoro clan. Oke-Ovoro clan is bigger than Uvuru.*

Theme 2: Corruption at the level of the government has led to deteriorated infrastructure, looting, and unpaid health workers

This theme describes the rift between the government and the people and the lack of accountability and transparency. There is increasing dissatisfaction among the people towards the government. This participant describes the situation as follows:

CM1: *The problems generally in Imo state, and I will say in Nigeria, consists of a number of factors – the poverty level has increased, and there has been no investment in communities so that people are able to provide for themselves. There is very high unemployment of young people, and there is high level of corruption in society, so the most pressing is that the jurisprudence in the Country is almost at Zero, where people are not held accountable for bad things that they do. The police is very corrupt*

The next participant shows exasperation in the way the government pilots the affairs of the people by saying:

CM2: *I do not know whether it is service in our Country today or just a means of some people improving their own individual economies, I don't know. I am not a politician. They look very healthy whereas the people they are supposed to be servicing are quite unhealthy and poor.*

The corruption in Nigeria dates to Nigeria's colonial years and British rule. A

series of coup d'état followed the first democratically elected government in 1960. Since then, Nigeria has had many military rulers, and the same corrupt practices have continued within the political class spreading out into every facet of the society, with evidence of profound corrupt practices documented by (Osoba 1996, Fitzgibbon & Mojeed 2015). This participant captures the gravity of the problem by stating the following:

CM6: The government in Nigeria is fantastically corrupt, the allocations have not been given to these facilities to improve some of the facilities The truth of the matter is that these government people, they don't look into. You will see so many things on paper that they have done that, they have done this but when you actually go on ground for monitoring or evaluation, you will not see anything there, and nobody will ask them anything. That is the situation we find ourselves. As I talk to you, the government is not doing anything to improve the lot of our people in respect to primary health care improvement.

The practice of corruption is more of a norm in Nigeria. The corrupt practices have led to owing staff salaries, waning motivation to work, the ongoing strike by workers, poor infrastructure maintenance, and obsolete equipment at health centers. Evidence of this is shown in the statement below:

CM7: Some of our staff are not being paid for over one year now. Somebody like me, I have been receiving half salary without any explanation since February. We are only about three people. Only about two people are coming to work. Others are at home relaxed. The reason is that the government is not paying, most of them are not receiving salaries. So, when somebody is not receiving salary, nothing is of interest to the person, nothing to motivate the person to continue working.

CM4 upholds the same view of receiving salary by saying

I would be happier if my salary is paid when due, incentives and promotions given to other health workers are given to me, and basic amenities provided for my healthcare.

The non-payment of workers' salaries is a chronic problem. Nigerian workers are known to embark on strikes due to non-payment of wages (Adeloye et al., 2017). The Nigerian health care sector embarks on strike with the hospital doors closed, a boost to the private sectors and a disadvantage to the poor who cannot afford private hospital payments. The Academic Staff

Union of Universities (ASUU) has been on strike since February 2022 (as of July 21, 2022). The government has yet to settle with them. This participant's quotes capture the dangers of strikes on health institutions. The participant does not understand why workers in a health institution should be on strike.

CM11: The time was a strike, yes, calling it strike that time but no matter the strike, someone supposed to be there, in case of emergency but I didn't see anybody ask me before they use motor and transfer me to Coronata hospital I deliver my son. And she went further to state, as no matter strike, no matter no strike, as far as is a health, somebody supposed to be permanent there.

The next participant laments the government's ineptitude by saying:

CM9: From the government system of administration which is not functioning, I say it is not functioning because when I go to that place, I shed tears too much...If you see that place, it looks like a deserted area, so bushy, nothing at all, nothing is going on there. The government have chosen to establish some other little little things around that place. So, what that place was meant for, what it was meant for, is not what they are doing. And the land is wasting over there. The land, a very large area of land is being wasted now... The building which you see now is dilapidated, is the residential area of health workers

Yet further description by participant CM10 stated the unkempt nature of the Center by stating the following:

CM10: So, the place is not clean, it's very filthy, it's like an abandoned property. The whole compound filled with grasses, bushes, rodents, insects, you know, it's just in a mess... So, the overall state of the health center, it needs serious attention. Serious attention!

Another participant narrated the extent of stealing that has reset the progress of the Center and other community assets by stating the following:

CM1: There is thievery as a daily occurrence. The secondary school had an incident where things that were built for them walked off overnight. The problem with the health center, their Generator stolen, the solar panels taken, pretty much everything of value there has walked away.

With the normalization of corruption as a way of life among the ruling class (Osoba,1996), it is challenging to navigate the Nigerian civil service, where people now expect gratifications before doing their regular duties. Murtala (2018).

Theme 3: The political insurgency in the area has created an atmosphere of fear for personal safety and undermined security at the facility

The political unrest in southeastern Nigeria following the arrest of the Indigenous People of Biafra leader (IPOB) continues to spill uncertainty and fear. The Igbos of southeast Nigeria believe they are marginalized and formed the indigenous people of Biafra (IPOB) as an instrument to make their voice heard. The leader of this movement is under arrest (as of July 21, 2022). Since his arrest, political unrest in the southeastern area continued. Any day the IPOB leader appears in court, activity is limited in the southeast. This limits socio-economic activity and depletes the economic growth of the Igbos. Anyone who disregards this order faces the danger of death. People are fearful, and the imposed 'holidays' continue to create more economic hardship for the southeast as they agitate for the release of their leader. When we traveled in October 2021 to Nigeria, we observed this stiff political situation and noted a lot of fear and uncertainty among the people. https://www.youtube.com/watch?v=uscte_Codc8.

The political insurgency undermines the progress of the facility in many ways. One of the participants stated that security is generally an issue in Nigeria. At the same time, staff at the Center proclaimed that thieves came to the Center and removed its generator. In addition to the Center's dilapidated buildings quarters, the team admitted that it is an unsafe area to live in because there is no security in the area. Wild animals and sometimes kidnappers stalk the site.

A government representative, when asked about the Security of the Center; - said,

CM5: In our last meeting with the Governor of the State, the issue of security came up. The Governor noted that each community should provide its own protection until the ban on employment is lifted. The participant admits that with a prohibition on work, the government could not employ anyone to provide security because of a lack of funds. The participant acknowledges that security is a big issue. If we do anything at the health center without protection, it's no use because the thieves will come and cart it away.

The participant admits that with a prohibition on work, the government could not employ anyone to provide security because of lack of funds. The participant acknowledges that security is a big issue.

From the statement above, it shows that the state left security issues in the hands of each community to provide, and the next participant acknowledged the security problem by saying:

CM1: Security is a problem generally in Imo state, and I will say in Nigeria. There is a failure at the governmental level to provide adequate security to communities. Like Imo state needs to get their acts together. It's not just in Uvuru this is happening. if you go to Orlu today, it is horrible what is going on, then you extend it to places like Abia state, horrible things are going on everywhere. But it is just a failure of leadership

The participant continues by saying,

Everything is murky, needs clarity, needs actual project planning, and centers on responsibility. Who is going to do what? If such issues can be identified with certainty and then with some improvement in security situation at home. If there is a buy-in into this security stuff, the health center is the only one in Uvuru, they have one secondary school, they have one community bank. These are just basic community institutions.

Although this government failure is expressed, participant CM1 voiced enthusiasm for the community's self-help efforts. Uvuru people are working together to provide security for themselves by connecting with those in the diaspora – their sons and daughters living in different places through emails, phones, zoom, Instagram, Twitter, and Facebook.

CM1: So, on a good note, Uvuru people in the diaspora want to tackle the security problem in Uvuru.

The idea should be a welcome development to the community and staff who have expressed fears by saying:

CM7: The main problem we have at Uvuru is security and accommodation.

Another community member believes Uvuru Development Union (UDU) leadership is working on putting a permanent stop to the lack of security by recruiting some young men who will work

in concert with the local police to help keep the peace in the local community. Here is the quotation:

CM2: We are getting a permanent answer to that security challenge. Yes, I've written to the inspector general of police, I've written the commissioner of police Imo state, I've written to the area commander of the Police for Aboh Mbaise – Ngor Okpala, I'm establishing what we call Uvuru native Police, yes, just last Saturday we recruited the first 40 personnel of that local police. They will be trained over about ten weeks by the Nigerian Police, but we will be maintaining them, and we have the structure to retain them. Already we've raised N12.+ million as our take off. They will provide uniforms, offices, motorcycles, and cars and keep them so that there are lines of security. We will formally launch them on December 26, and the state govt is behind us. We will post security personnel round the clock in the secondary school and at the health center.

In bolstering the earlier quote, another participant enunciated the effort employed in setting up the security outfit by stating the following:

CM6: As I talk to you now Uvuru Security Outfit is being formed. As I talk to you, they have recruited more than 73 young Uvuru youth that will be able to man some strategic physical infrastructure owned by Uvuru people and as I talk to you, this Saturday, the president General will fly in from Lagos to have meeting with other president generals of the autonomous community on how to consolidate on that.

CM6 further admits that the lack of security at the Center makes him unhappy by adding:

CM6: There is no security there. You know in everything, security is important, so these are the major three things that I am not happy about it. Not giving us the things, we intend to get from the facility.'

The participant believes in the collective will of the community and its action through self-help.

The next participant confirms that security will help bolster people's confidence in using the health center by stating:

CM11: Okay, so they need to have security there all the time to prevent kidnappers or anybody coming to harass people that are there, and if they provide security, then people can live in there and provide care to the community members.

Theme 4: The low level of political power among the Igbo people (Uvuru Health system users) has resulted in long-term poverty.

The Igbo community is known for self-help in projects, but poverty disarms people and makes them vulnerable to various risks, including a low political will (Adibe 2017, Okwuosa et al. 2021). The complaint of marginalization leads to agitation under The Indigenous People of Biafra (IPOB), a separatist movement in southeastern Nigeria. Activities of IPOB prevent people from attending their regular businesses, causing them to lose money and plunging them into deeper poverty. On Mondays, everyone sits at home, and there is no attempt to buy, sell, or travel from one place to another. Most establishments open on Mondays, including UHC, for immunizations of children and other services. Women bringing children for vaccination are scared to go to the clinic, leaving a child without needed vaccination and vulnerable for life. Workers are also afraid to come to work on Mondays leading to heavy economic losses within the southeast zone. With such fear and harassment, people are scared to operate and secure their daily bread leading to deeper poverty among the Igbos. In bolstering this point, while lamenting the helplessness of the community, this participant states:

CM1: It would have been best if the local govt should at least provide direction. See how bad the roads are, see how wrong everything is. We have no clue what the provincial govt is doing. Local schools are challenged the same way these local clinics are challenged.

Participant CM10 levies the blame solely on the government by saying:

CM10: The real problem is the government; there's no other person to take the blame because it's their responsibility, that is their responsibility- the local govt. Is the government, you know? But now, especially the Igbos, we do a lot of self-help. It depends on who the community leader is or his passion.

Participant CM9 concurs:

CM9: Now, I want the govt to run that place very well. They should be fully responsible for direction and the administration for the place. But, if they want to hand it over strictly to the community, one should be able to be responsible for the administration of that place. So,

there's a local saying we say in my place, that goes like this 'a goat that is owned by the public, is owned by no one'. So, the govt should be waking up to take full responsibility, full charge for the administration of that place. I will be happy about it. If the govt will hand over to the community to take over, I will be happy about it. I know fully that the govt will not even listen to that, but I have partially told them the other time.

The next participant showed exasperation and declared the Country was in deep trouble. The participant's statement shows community members find it disturbing to work with the government and the dwindling negotiating power of the community members, which keeps the people in dependent and power-less positions with the government rather than at par as representatives of the Uvuru people. Under such a low position, Uvuru representatives cannot negotiate to improve the UHC.

CM2: Our Country is run down generally so what we are doing is community efforts. To try and give our people whatever we can put together.

Yet another participant adds to the above and admits to the under function of the government, narrating the misuse of the Center by the government and portraying the helplessness of the Uvuru people in confronting the government's method of running the business of UHC by saying the following:

CM9: from the government system of administration, which is not functioning, I say it's not functioning because when I go into that place, I shed tears too much. Why I shed tears is this, the hospital that that place is meant for, but it's not all that it is using for, for it. I'm talking to you honestly before God and man. If you see that place, it looks like a deserted area, so bushy, nothing at all, nothing is going on there.

But participant CM1 said his people could achieve success if people could function by the rules and employ transparency and accountability:

CM1: If Uvuru people were to be successful, it needs to be sustained. It calls for employing people, it calls for transparency, accountability, somebody needs to be held accountable. The participant sums up by saying, success begets success.

The view of these participants points to the need for the community to witness some success in projects in the community, including having Uvuru people in government represent the Uvuru

people's interests and upgrade their political representation. Such success stories can spawn more success, as noted by this participant.

Theme 5: Private practitioners across the community are happy to provide services at high prices and have captured most of the market share (and are reluctant to support the public sector facility).

Community members have had to turn to private-sector health care providers in their quest to receive proper treatment as the health Center is not providing the needed services. One participant said:

CM6: I didn't get any attention. The drugs that were there were expired. Am telling you! And then, it has been long we used chloroquine here to cure malaria. I did not get any help; I did not get any help. So, I now went to a nearby hospital, a private hospital called Orient hospital around that place. So, what I have been saying and that is how it is, is that, that facility now is lacking a lot of infrastructure as to the mandate it was supposed to be giving to the people

Another participant noted a private hospital helped save her life and that of her unborn child after going into labor after the participant came to the health center and waited for more than two hours. Her family moved her to a private hospital to deliver her baby after no one at the health center offered to answer her any questions and help.

CM11: I went there to deliver my son. I was there more than two hours during that time, nobody asked me what am I waiting for, till my mother-in-law make a call to my husband to find a motor to transfer me to another private hospital to deliver, because of that day was There's no work that time yes, there's no work that time That time was a strike, yes, calling it strike that time but no matter the strike, someone supposed to be there, in case of emergency, but I didn't see anybody ask me before they use motor and transfer me to Coronata, I deliver my son.

Private practitioners seem to benefit from the ineffectiveness of the health Center. The incapacity boosts the private sector market share. Participant CM1 reported an amicable discussion between them and a private practitioner turned sour, highlighting the private sector's

unwillingness to partner with the public sector. When asked if they think private practitioners are a problem to the growth of the Center, CM1 replies: -

CM1: YES, Yes Yes, because I can say that the one private clinic - Dr. Private, he has a clinic with two locations there somewhere. He is the one, one time I went home. I visited him, told him what we were trying to do, that it will actually be a boost to his clinic because any of the cases that is bad will automatically end up in his clinic, and that we would want to even extend help to his clinic in view of the ones that would come there that can't afford anything, and I also talked to him and say eventually even implement a voucher system where by the very poor ones can come to your clinic, give you a voucher and we redeem that voucher because we want them to get treated and anytime you see our voucher, you know it is as good as money because we can't give anybody voucher without backing it up. So, the conversation went very well and everything, but after I came back, I've been trying to contact him and talk to him, I have not been able to get him on the phone And I explained all the advantages, and I made a point of letting him know that This is not a competition to what he is doing but actually an added resource to what he is doing. He has not been able to communicate anymore. It didn't hit me at first. Then I started to think this thing through so I said, maybe, he sees this as competition, maybe he doesn't like the idea

Another community member added to the description of activities of private establishment by stating:

CM8: But at a time, when she was due, it was the only thing she ran to that could offer midwifery services, she went there and she almost lost the baby because there were no enough nurses, no enough equipment, to take care, to give good delivery, but they managed to deliver the baby but she has to be moved to a private hospital with my own intervention, so that is the direct experience I can say that I have had there.

This participant noted that improving the health Center is essential as people cannot afford the private hospitals because of high prices; the participant continued by adding:

CM8: It will greatly improve the health condition of the people. People really need it; they really need it. Because they can't afford private clinics because of the poor remuneration, and they cannot afford it. So, the health center is very primary to their health function. . It's pretty helpful because these mothers can't afford the private health care for their antenatal, and the health center becomes very handy with maternal health.

Another participant lamented the helplessness of the community members; as a result of inadequate staffing and the nonfunctioning of the health center. Community members had to carry their loved ones to private establishments to receive care

CM9: *Everything constructed there, but the job is not there because, when they are not in consonant with what they need, you still have to go to other places. The general hospital is at the local government headquarters. It's about 10 kilometers away. So that's the truth Each of the persons carry along to the private hospitals. Everything constructed there they have to go to other facilities private hospital. It is now the duty of the person to carry their loved ones to any of the private hospitals. Everything constructed there but the the job is not there because when they are not in consonant with what they need, you still have to go to other places. The general hospital is at the local government headquarters, it's about 10 kilometers away*

This participant is not the only one who had a brush with private hospitals. Most community members had no choice but to patronize them or resort to self-medication, misuse of drugs, turn to quackery or stay home and get sicker.

CM10: *So, the health center is like providing no service. I can say no service. People don't patronize it again. Not because they don't want to, but the basic things needed to attend to the rural people are not there. Sometimes they don't find any nurse; they don't find any nurse there in the health center. So, people resort to self-medication and some quack chemist. There are lots of them here, people who dispense medicine.*

The next participant captures the consequences of those actions by saying:

CM10: *Here in the village, every presentation of sickness is termed, typhoid and malaria. So, most times people have even kidney issues at the early stage and it is not detected until it goes bad. People are hypertensive, it's not detected until they die, and when they die, they say it is the SPIRIT that have killed the person. So, most times even as I came home, I always come with BP medication. Each time I come use BP monitor to check people. Out of 10 people you check in the village, more than 40% will have raised BP and they don't know.*

Another participant narrates an ordeal at the UHC while not getting treatment until they went to a private hospital to receive treatment.

CM6: *One of the reasons why we have high death rate here is because we don't have any good hospital here. No government hospital here in Uvuru. The only place you can get government hospital is at the Local government, the local county here.at Aboh Mbaise. And that hospital is as good as the health center...But it is far from Uvuru here, it is up to like 30 – 40 minutes' drive from Uvuru here. Bad road can even extend the time to. That hospital is as good as the primary health center, nothing is happening...if one has a serious emergency case here, that patient will die; I'm telling you That is just the truth; I'm being very blunt to you. That is just the truth.*

Theme 6: There are glimmers of hope in the local Uvuru Development Union (UDU) and the Uvuru community members, who are stepping up to improve the situation

During the interviews, participants showed enthusiasm for reviving UHC while soliciting help from anywhere it could come. The participants note that UHC means a lot to them and will work hard to restore it. Here is one statement from a participant:

CMI: So, on a good note, the Uvuru people in Diaspora want to tackle the security problem in Uvuru head-on. I believe they have raised well over six million naira in the last few months to start employing people with some experience in law enforcement and align themselves with the local police post in Uvuru. Uvuru people from across the world are donating to this venture. Now that was last year, this year alone, for this Security thing, in the two months that they started this program, they have already raised six million naira. Our people love progress. Success beget success

Another participant believes in the self-help approach of the Igbo community and narrates how that can be leveraged.

CM2: We create platform, we solicit funds, we put down what we need and we solicit. so, people whatever they have they contribute. There is no family in Mbaise, that does not have either palm plantation or wild palm that has been handed over from generation to generation. So, we go to the traditional rulers and say for instance, every March of every year, no family harvests their palm fruits. The community harvests all the palm fruits and then sell, and the money, we raise up to sometimes, two-million-naira, or one million-plus naira.

On the issue of security, the above participant states that, the UDU, is working hard to address the situation.

CM2: We're getting a permanent answer to that security challenge. I'm establishing what we call Uvuru native police, yes just last Saturday we recruited the first 40 personnel of that local police. They are going to be trained over about 10 weeks by the Nigerian Police. but we will be maintaining them and we have the structure to maintain them. We've already raised 12 point something million naira as our take off fund. The local police will be formally launched December 26, and the state government is behind us.

Another participant who showed much enthusiasm in working for the progress of the Uvuru community states:

CM6: Yes, I must tell you now that the present Uvuru community development Union, just did their election this Christmas, and the leadership of Uvuru has changed. As I talk to you now

Uvuru Security Outfit is being formed. As I talk to you, they have recruited more than 73 young Uvuru youth that will be able to man some strategic physical infrastructure owned by Uvuru people and as I talk to you, this Saturday, the president General will fly in from Lagos to have meeting with other president generals of the autonomous community on how to consolidate on that.

When probed on issues of partnership and working with groups outside Uvuru community, the participant added:

CM6: Yes, yes, I must tell you that Uvuru as a community will be ready to partner with anybody that would come and try to help. I assure anybody that is coming to help that there is also what we call the Self-Help Development Trust Fund that we are trying to raise. I know that if there is anybody that will come to our rescue, it's going to be an opportunity for us to sit down and talk and look at the areas where people will want to come help and improve some things and then too, we will also pick up our own aspect of the challenge and also try to make things happen. I am assuring anybody that will come, or would want to help us. We are not going to leave 100% of the responsibility to that person; I know Uvuru will help.

The next participant promised commitment so long as the community rehabilitates the UHC.

CM8: Well em I'm willing to give up, for me, I'm going to give up a lot of things just to make sure that that place is equipped, is upgraded, the building is renovated, they add more staff to it, more qualified nurses' midwives, doctors. I'm willing to give up my time if I have to station more in the village to make sure that that place is put in order. I'm willing to stay here and forget whatever remuneration I want, I'm a business man. I'm willing to give up part of my business time. If I have to be part of any supervisory or any role to play, I'm willing to give up my private time because I'm a business man.

To the above participant, committing to this venture through collective effort can transform the UHC into an acceptable health care delivery unit for the community members. The participant stated:

CM8: What I want to happen is, I want the Center to be looked into in terms of the facilities upgraded. First of all, if possible, renovate the existing building, add more structures, you understand, provide more beds, more facilities for those who are coming in for health care needs. Then put a resident doctor there. I want the place functional; They have a good water supply, but I don't think it is still functional, upgrade it or build a new one and make sure there is enough water because water is health you understand because it promotes the cleanliness of the place, to flush the toilets, use it to clean up the whole place because, you need everywhere to be clean because, that is the first sign of healthiness, cleanliness. So, I need that place to be upgraded so that it can be looking clean and sharp then get the right personnel.

The participant continued by highlighting their confidence in people of his age group who are willing and ready to transform the Center. When asked if other people are thinking similarly, he stated:

CM8: Yes, yes, yes there's a lot, a lot, I'm telling you, a lot of people, especially in my age bracket, we are concerned. Several times I belong to several groups; I have a lot of friends, we always share many facts about the situation of health center, but sometimes we are helpless because it requires a lot of money to do these things, and we might not have such funds.

The willingness of the Uvuru community members is evident in another member's statements:

CM9: But this health center is serving the entire clan, the entire five autonomous communities. In my own little thing, I will do my best. Then, I will still make sure that I gather other people, gather the entire community, reach out to the officials of the community then, we begin think of what to do. As at now, individually and, collectively, we can inform the people now, everybody, to make sure that we resuscitate that place and make sure it takes its pride of place. That is all I can say about that.

The desire for Uvuru community members to have a functional health center led one of the participants to start erecting a whole new building for the community as a Health Center. The member stated:

CM10: Now last 6 years, I started building a health center to add to donate to my community. Yes, I finished the building and there are this people in the US I contacted, Advocates for World Health. The guy is in Florida; they're in Florida; in fact, they are in Tampa in Florida. So, I called him; I sent them mail to equip the hospital, they gave me list of used items they want to donate. So, we started talking and everything, in fact, my wife had to come to Florida to meet with them. During the process, I sent ten thousand dollars to them, being the cost of housing of those items they needed to send to us.

So, the overall state of the health center, it needs serious attention. Serious attention. If it was functioning well, if it was functioning well, I wouldn't have thought of building another one. I wouldn't have thought of building another one because what made me, I say, okay, let me build it and see if I can see some friends to work with me and see if I can be providing, to be funding it, you know, that was my idea, you know. And with that equipment they planned to give me from the US would have made it the best primary health center in Nigeria because the list of the equipment they sent to me was mind-blowing.

But this participant did not see his desire for the community to pass because the pieces of equipment never came to Nigeria. This is what he said about that:

CMI0: I don't know because, I tried with, you know, here, I'm in Nigeria. We communicate through emails and through phone calls. At a time, they are not responding. So, when I made contact with somebody, the person told me, that because of time we have allowed, we might not get any of the money back or whatever. So, I don't know, I don't know how they operate, it's an NGO, so, I don't know, so maybe, we can still try again and see what can be done.

As demonstrated by this effort, the Igbos engage in many self-help projects to solve their health problem and improve their health outcomes (Okwuosa et al., 2021). It is vital to acknowledge that this is a work in progress.

Discussion:

In this study, we investigated the healthcare needs of the Uvuru community and the role Uvuru Health Center plays in advancing the health of the Uvuru community. Findings support the need for a thorough evaluation of the Uvuru Health Center and the need to rehabilitate the infrastructure, install updated equipment, eliminate corruption, and provide steady leadership with adequate funding. In addition, our findings indicate the critical role Uvuru community members can play in improving their health outcomes and that of their neighbors.

This research highlighted a health center that has not received any assessment or evaluation since its inception in 1967. Findings show that Uvuru Health Center is in dire need of rehabilitation, similar to previous reports in the literature on other comparable centers (Aregbesola & Khan 2017, Olufemi 2019, Inungu & Minelli 2021). The Center cannot provide reliable care to communities unless it upgraded on all fronts. The current picture of the Center spells dysfunction, abandonment, and misery that dampens the spirit of community members instead of an uplifting spirit that gives hope.

Community members showed exasperation with the government's position of ownership of the Center yet refusal to fund the Center. The compound's buildings, clinic, and living quarters show gross signs of dilapidation (see photographs in Appendix C) and corroborate findings in the literature of other comparable centers (Adedeji 2021, Ntoimo 2019, Ihunna, 2008, and Okoli et al. 2016). The compound is large, as stated by the participants, but there are no conventional means of securing it to avoid unregulated entry in and out of the premises.

Therefore, as observed by some participants, the UHC will benefit from an improved security outfit to protect life and property and instill confidence in workers and community members that they can move freely without harassment from thieves or kidnappers. On the positive side, the

Uvuru local police established by the UDU is an encouraging step to promote community watch and security that allows participation by community members. Providing dedicated lines to disseminate or report suspicious activities in the community would be helpful.

The ingrained corruption in the government (federal and local) creates a challenging atmosphere. With the normalization of crime as a way of life among the ruling class (Osoba1996), it is challenging to navigate the Nigerian civil service, where people now expect gratifications before doing their regular duties (Murtala, 2018). Corruption has eroded trust in the government, disproportionately impacting the poor and vulnerable. The poorer population is powerless to complain while bearing the brunt of corruption. Increased costs make it difficult for the poor to access health services, education, and justice. It is essential to work to strengthen communities and promote values that shun and expose corrupt practices or risks of corruption. Communities must demand accountability and transparency starting from local leadership and maintaining values that extend to state and federal levels of leadership.

Nigeria's political instability is a setback to Nigeria's progress. Persistent agitation from workers employing strike actions to get messages across to the government pulls back improvement in the Country's economy. Federal, state, and local governments appear nonchalant as negotiations break down one after the other. However, when public institutions are on strike, the private systems benefit more by setting high prices. This makes health care services inaccessible to those with limited resources. The spiral effect impacts the poor in rural communities who cannot patronize government establishments. Some participants noted that this results in high morbidity and mortality.

Although numerous challenges exist, building confidence and working within familiar community groups may create opportunities to mobilize grassroots resources to bring lasting

change. The confidence-building activities of the local Uvuru Union (UDU) and their efforts to rebuild the Center and provide their community with basic health needs are welcomed. So far, UDU has shown a glimmer of hope by organizing itself to tackle security issues in Uvuru and provide stability for a functional Uvuru Health Center. Therefore, working to build partnerships and coalitions will be essential for all stakeholders willing to see improved health outcomes in rural communities (Oyekale 2017, Stoto & Atkins 2019, O'Sullivan et al. 2021, Sibiri 2020). Study participants' firm belief is that if they work together and with some help, they will achieve the type of functional health center that will provide improved health outcomes for them and their neighbors despite the present political situation (Joe-Ikechebelu et al. 2020, NHC 2014, Inungu & Minelli 2021).

It is not only in Nigeria that rural health is in jeopardy. Other countries in sub-Saharan Africa, like Ghana and South Africa, experience similar hardships. In Ghana, the Project manager of the United Nations Office for Project Services (UNOPS), Herbert Appiah, reports that most health centers lack essential health care equipment, and personnel may turn patients away. Some health posts are themselves very dilapidated. These make it challenging for health care to reach the region's most vulnerable. (Ghana | UNOPS 2020, April 22). This published work further mentions the poor condition of the roads as preventing community health volunteers and coordinators from reaching patients for home visits.

In rural South Africa, there is evidence of a lack of access to quality comprehensive care despite government investment in programs to strengthen the health system (Gumede et al., 2021). The article further stated that about 15% of poor rural households in South Africa live more than an hour away from the closest clinics and equally noted that transportation is expensive and unreliable with poor road conditions (Gumede et al., 2021). Although these

countries appear to have similarly poor rural health care systems, like Nigeria, the types of challenges differ. For instance, Nigeria battles corruption as a prime problem in its development, and Ghana and South Africa have been successfully walking out of corruption challenges. According to Transparency International - the global coalition against corruption -Nigeria scored 24 out of 100 in the Corruption Perception Index (CPI, 2021), while Ghana and South Africa scored 43% and 44%, respectively. On the other hand, Nigeria has more population, resources, and workforce to tackle its problem than any other Sub-Saharan country, including Ghana and South Africa. Therefore, specific solutions to address rural health care delivery challenges must consider the different local contexts that communities face.

Several strengths of the current study deserve mention. The willingness of Uvuru community members to share their experiences freely and the rich data collected from each of them are significant strengths. Each member could relate to the Center uniquely, expressing different perspectives and enriching the information collected about the UHC. All participants willingly gave interviews and expressed patience with internet interruptions to reconnect and continue. Only one participant was not reachable.

The many visits from 2018 -2021 by the research team, an inspection of the facility, and interactions with the clinic staff created a rapport that helped with the interview process and corroboration of participants' versions of the interviews. Researcher's affiliation with the kindred Mutual Foundation (KMF) and familiarity with the terrain, language, and culture helped a lot with this research.

On the other hand, several limitations of the study deserve mention. These include-distance. Even though the study involved a short site visit, limited time, lack of funding to conduct a more thorough and comprehensive assessment, and the volatile political situation in

southeastern Nigeria at the time of visit was challenging. Other limitations of this study include:

- lack of personal observation of participants' reactions and demeanor during interviews. We relied heavily on the verbal/text communication of recruited participants and their perseverance throughout the interview process while talking with someone they could not see in most cases, except for one zoom call (Fitzgibbon & Mojeed 2015, UNOPS 2020, Challenges Abroad n.d).

One of the significant limitations during data collection was connectivity issues. The time difference (9 hours in the winter and 8 hours in the summer), internet problems, and power issues (e.g., to charge phones) led to challenges. This study was a one-time cross-sectional assessment of the health situation in Uvuru and the functions of the Uvuru Health Center; as such, we did not conduct an assessment of activities over time. The lack of longitudinal assessment is a limitation.

Several recommendations can be put forth to address noted challenges of the UHC and improve the health of the Uvuru community. First is involving stakeholders in the UHC's rehabilitation process through their local leadership. When working with local communities, it is better to work with a supervisor who will communicate with them in the language they will understand. That will help reduce anxiety and encourage them to be more involved and feel like part owners of the project while contributing their quota to decision-making. An oversight committee needs to be constituted to monitor the implementation of a rehabilitation project. The oversight committee liaises with involved entities (including non-governmental organizations) to ensure transparency and accountability. When non-governmental organizations embark on foreign assignments, there should be a way to monitor the progress or lack of progress of such tasks. This is even more important in corrupt societies. It is essential to be careful and define agreements so everyone understands what to expect.

Other measures include using a written memorandum of understanding (MOU) to set expectations for projects and assign roles and responsibilities. The MOU will enable various stakeholders to understand the project's seriousness and deliver within the stipulated time frame. The oversight committee also works within the MOU. To minimize resource wastage, instituting a cost-reimbursement system to account for project expenditures after an initial seed funding will be helpful. This system will ensure that project expenditures reimbursed after the fact were allowable, verified, and in line with budgeted amounts, performance targets, and deliverables. Monthly financial and performance reporting mechanisms for ongoing projects or phases must be in place until completion. Accountability and transparency help keep everyone in check.

An approach that encourages others to partner with the community by involving them in outreaches will be advantageous. The district receives information on the activities or projects through outreach programs, celebrates gains, and builds relationships as the community embarks on projects and completes them. Celebration of profits will help boost the effort to do more and achieve more. It is critical to determine the best methods of rewards and encouragement in consultation with other stakeholders and to recognize donors and people who paid extra prices to achieve projects. Sharing the experience with other communities and being ready to support them in their path to improving their health is of mutual benefit. Finally, consistent and rigorous evaluation of progress is necessary to identify projects that are not going as planned and help them receive timely attention.

The research effort in this study motivates the assessment of other community health centers similar to the UHC. These efforts can inform health centers' challenges and provide opportunities to rehabilitate them. In sum, we found that years of neglect, difficulties in management, poor funding allocations, and lack of stability and security affected the function of

UHC and caused the Uvuru people to seek services elsewhere. Despite that, Uvuru people are ready to improve their health outcomes through partnership and coalition of willing individuals and groups. Future studies and interventions are needed to continue to strengthen UHC and make it more viable.

Acknowledgments

I thank Uvuru community members for their willingness to participate in this research and answer questions from someone they did not see. I appreciate the Kindred Mutual Foundation for providing the basis to undertake this research. I thank my committee for their time, patience, guidance, and support throughout this process.

Availability of data and materials

The data is available from the corresponding author on reasonable request.

Conflicts of Interest: The authors declare they have no conflict of interest

Funding: The authors received no funding for this work.

References

- Adedeji, T. (2021, August 12). Group bemoans poor state of primary health centers in Imo. *Newsmond*. <https://www.newsmond.com/group-bemoans-poor-state-of-primary-health-centers-in-imo/>
- Adeloye, D., David, R. A., Olaogun, A. A., Auta, A., Adesokan, A., Gadanya, M., Opele, J. K., Owagbemi, O., & Iseolorunkanmi, A. (2017). Health workforce and governance: The crisis in Nigeria. *Human Resources for Health*, 15(1), 32. <https://doi.org/10.1186/s12960-017-0205-4>
- Adibe, J. (2017, July 12). Separatist agitations in Nigeria: Causes and trajectories <https://www.brookings.edu/blog/africa-in-focus/2017/07/12/separatist-agitations-in-nigeria-causes-and-trajectories/> Accessed May 28, 2022.
- Alemu, Z., G. (2019). Poverty in Nigeria: A multidimensional approach. AfDB Working paper No 327, Abidjan, Cote d'Ivoire: African Development Bank <https://www.afdb.org/en/documents/working-paper-327-poverty-nigeria-multidimensional-approach> retrieved May 21 2022
- Aregbeshola, B. S., & Khan, S. M. (2017). Primary Health Care in Nigeria: 24 Years after Olikoye Ransome-Kuti's Leadership. *Frontiers in public health*, 5, 48. <https://doi.org/10.3389/fpubh.2017.00048>
Retrieved May 21, 2022.
- Bassey-Akamune, F. U., & Ilomuanya, M. O. (2017). Short-term medical mission: Serving the underserved patients in south southern Nigeria. *Journal of Public Health and Epidemiology*, 9(2), 24-30. <https://doi.org/10.5897/JPHE2016.0896>

Challenges Abroad. (n.d.). 3 key issues affecting public health in Peru.

<https://www.challengesabroad.com.au/blog/3-key-issues-affecting-public-health-in-peru/>

Data Bank|World Development Indicators (WDI). (2022). The World Bank Group

<https://databank.worldbank.org/source/world-development-indicators>

Federal Ministry of Health. (2019). Nigeria Health Facility Registry (HFR).

<https://www.hfr.health.gov.ng/>

Fitzgibbon, W., & Mojeed, M. (2015, February 10). Files open new window on \$182-million Halliburton bribery scandal in Nigeria. Retrieved from

<https://www.icij.org/investigations/swiss-leaks/files-open-new-window-182-million-halliburton-bribery-scandal-nigeria/> Accessed May 28, 2022.

Gumede, D.M., Taylor, M. & Kvalsvig, J.D. (2021). Engaging future healthcare professionals for rural health services in South Africa: students, graduates and managers perceptions. *BMC Health Serv Res* **21**, 220. <https://doi.org/10.1186/s12913-021-06178-w>
Accessed July 10, 2022.

Ihunna, O. I. (2008). On the poverty of health politics in Africa: Are governments doing enough? Health knowledge and belief system in Africa Edited by Toyin Falola & Matthew M. Heaton. Chapter 18, p. 299. Carolina Academic Press. Durham.

Iwuoha, E A (2020). Abigbo song of Mbaise: An analytical survey of its National significance. *Pan African Journal of Humanities and social sciences* 2 (1)
<https://doi.org/10.5281/zenodo.3895313> Retrieved May 21, 2022.

Inungu, J. N., & Minelli, M. J. (2021). Defining Rurality: Rural public health challenges. In J.N. Inungu & M. J. Minelli (Eds.), *Foundations of rural public health in America*, (3-12).

Jones & Bartlett,

https://books.google.com/books?id=AN0PEAAAQBAJ&source=gbs_navlinks_s

IPOB Sit-At-Home Order: Residents comply in Abia, Anambra, Imo, Ebonyi, and Enugu Delta.

https://www.youtube.com/watch?v=uscte_Codc8 Accessed May 28, 2022.

Joe-Ikechebelu, N., Osuorah, C. D. I., Nwankwo, B. E. Ngene, W., & Nwaneli, E. I. (2021).

Evaluation of social determinants of health (SDH) in communities across the southeastern region of Nigeria. *Anatolian Journal of Family Medicine*, 3(1), 10-16.

<https://doi.org/10.5505/anatofm.2019.40085>

Murtala, S. (2018). Ethical implications of collecting brown envelope by Nigerian Journalists.

International Journal of Management and Applied Sciences 4 (2)

http://www.iraj.in/journal/journal_file/journal_pdf/14-440-152301587866-70.pdf

Retrieved June 19, 2022

National Health Act. (NHC, 2014). Explanatory Memoranda.

<https://www.publichealth.com.ng/wp-content/uploads/2017/10/National-Health-Act-2014-Explanatory-Memoranda.pdf>

Ntoimo, L.F.C., Okonofua, F. E., Igboin, B., Ekwo, C., Imongan, W. & Yaya, S. (2019). Why

rural women do not use primary health centers for pregnancy care: Evidence from a qualitative study in Nigeria. *BMC Pregnancy and Childbirth*, 19, Article 277.

<https://doi.org/10.1186/s12884-019-2433-1>

Okoli, U., Eze-Ajoku, E., Oludipe, M., Spieker, N., Ekezie, W., & Ohiri, K. (2016). Improving

quality of care in primary healthcare facilities in rural Nigeria: Successes and challenges. *Health Services Research and Managerial Epidemiology*, 3.

<https://doi.org/10.1177/2333392816662581>

- Okwuosa, L., Nwaoga, C.T., & Uroko, F. (2021). The post-war era in Nigeria and the resilience of the Igbo communal system. *Jamba: Journal of Disaster Risk Studies*, 13(1), a867. <https://doi.org/10.4102/jamba.v13i1.867>
- Olufemi, J. (2019, November 7). The Premium Times. Nigeria budgets N2000 for the healthcare of each citizen in 2020. <https://www.premiumtimesng.com/health/health-features/361373-nigeria-budgets-n2000-for-the-healthcare-of-each-citizen-in-2020.html>
- Osoba, S., O. (1996). Corruption in Nigeria: Historical Perspectives. *Review of African Political Economy*, 23(69), 371-386. <https://www.jstor.org/stable/4006378>
- O'Sullivan, B. G., Couper, I., Kumar, P., McGrail, M. R. (2021). Editorial: Effective strategies to develop rural health workforce in low and middle-Income countries (LMICs). *Frontiers in Public Health*, 9, 702362. <https://www.frontiersin.org/articles/10.3389/fpubh.2021.702362/full>
- Oyekale, A. S., (2017). Assessment of primary health care facilities' service readiness in Nigeria. *BMC Health Services Research*, 17(1), 172. <https://doi.org/10.1186/s12913-017-2112-8>
- Sibiri, E. A., & Uzobo, E. (2020). Needs assessments for effective development in the rural areas of the Niger Delta Region, Nigeria. *KIU Journal of Social Sciences*, 6(2), 63-73. <https://www.ijhumas.com/ojs/index.php/kiujoss/article/view/848>
- Stoto, M. A., Davis, M. V., & Atkins, A. (2019a). Beyond CHNAS: Performance measurement for community health improvement. *EGEMS*, 7(1), 45. <https://doi.org/10.5334/egems.312>

Stoto, M. A., Davis, M. V., & Atkins, A. (2019b). Making Better use of Population Health Data for Community Health Needs Assessments. *EGEMS*, 7(1), 44.

<https://doi.org/10.5334/egems.305>

The World Bank (May 28, 2020). Brief: Nigeria releases new report on poverty and inequality in Country

<https://www.worldbank.org/en/programs/lsm/brief/nigeria-releases-new-report-on-poverty-and-inequality-in-country> Retrieved May 2022.

Tolley, E. E., Ulin, P. R., Mack, N., Robinson, E. T., & Succop, S. M. (2016). *Qualitative methods in public health: A field guide for applied research* 2nd ed., Jossey-Bass

Tong, A., Sainsbury, P., & Craig, J (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*; 19(6), 349-357. Printed 06/18/2022.

Transparency International, The global coalition against corruption (January 25, 2022). 2021 corruption perceptions index reveals a decade of stagnating corruption levels amid human rights abuses & democratic decline in Sub-Saharan Africa.

<https://www.transparency.org/en/press/2021-corruption-perceptions-index-press-release-regional-a> Accessed July 10, 2022.

United Nations Office for Project Services (UNOPS), (2020, April 22). *Bringing medical help to rural communities*.

<https://www.unops.org/news-and-stories/stories/working-towards-a-healthier-future-for-ghanaians/bringing-medical-help-to-rural-communities>

United Nations Development Programme (2022) Health Development Index

<https://hdr.undp.org/en/countries/profiles/NGA>

Table 1: Codes and Meanings

Recommendation	REC	Abuja	ABJ
Uncertainty	UNCTYNTY	Journalism	JNLST
Communications	COMM	Distraction	DSTR
Competition	COPTN	Local government Area	LGA
Anger	ANG	Snowballing	SNB
Hopelessness	HOP	Summary Transcript	SUM TRSPT
Job satisfaction	JBS	Deterioration	DTRN
Poverty	POV	Infrastructure	INFR
Security	SEC	Reproducible	RPD
Accommodation	ACC	Template	TPL
Strategically	STR	Replicate	RPL
Corruption	COR	Collective Responsibility	CRP
Uvuru Health Center	UHC	Complaint	CPLT
Uvuru Community	UVU	Protest	PRO
Self-Help	SLH	Training	TRN
Unemployment	UNEM	Fear	FRS
Vigilante	VIGL	Stolen	STOL
Stealing	STL	Maintenance	MTN
Maternity Services	MTS	Pressure	PRES
Diaspora	DIA	Fundraising	FUDR
Leadership Failures	LDFR	Generational Wealth	GRW
Contribution to Success	CTRBTN2SUCS	Agriculture	AGR
Empathy	EMP	Mbaise	MBSE
Negativism	NEG	Community Effort	CEF
Commitment	COMTMT	Solicit Funds	SOL
Clarity	CRTY	Platform	PLTF
Consistency	CSTCY	Emergency	EMG
Stability	STB	Services	SVCS
Investments	INV	Restatement	RSTMT
Responsibility	RSP	Distance	DIST
Agreement	AGR	Expectation	EXPTN
Planning	PLNG	Dilapidated	DILP
Aboh-Mbaise	ABHMBSE	Healthcare	HCARE

Codes and meanings

Rebuilding	RBLG	Resources	RSR
Improvement	IMPV	Hazards	HAZ
Intervention	INTV	Reconciliation	RECN
Autonomous	AUTM	Gratitude	GRT
Stakeholders	STK	Healthcare	HCARE
Punitive Measures	PNTM	Jurisprudence	JURIS
Population	POP	Police	POL
Selfish	SFSH	Residents	RES
Name	MNE	Market Square	MKTSQ
Thank God	TGD	Stolen	STOL
Time Introduction	TME CONSTR	Greetings	GTNS
Introduction	INTR	God	GOD
Expectation	EXPTN	Apology	APLG
Partnership	PTS	Time	TME
Coalition	COLTN	Work	WRK
Users	USR	Indigenous	INDG
Government	GOV	Uvuru Development Union	UDU
Management	MGT	Affirmation	AFFRM
Control	CTRL	Working	WRKG
Benefits	BNF	Mission	MISN
Meaning	MNG	Covid Woes	CVD WOES
Location	LOC	Visiting	VST
Overview	OVW	Several Times	SEVTMS
Problems	PBL	Gains	GNS
Needs	NDS	Surprise	SURP
Rural Communities	RCOM	Promise	PRMSE
Meeting	MTG	Health	HLTH
Information	INF	Critical Indicator	CRIT IND
Traditional Rulers	TRD RLRS	Determinant	DTM
Affordability	AFFORD	Nation	NATN
Challenge	CLNGE	Society	SOC
Interview Request	INTW RSQ	Research Questions	RSQ
Communication Method	COMM MTHD	Thieves	TVS
Follow up	FLWP	Medicine Store	MDS
Kidnappers	KNP	Farmers	FRM

Table 2:*Information on Data Collection Tools*

Participant	Mode	Length of time in minutes	Language
CM1	Zoom	60	English
CM2	Phone	33	English
CM3	Text Messages		English
CM4	Text Messages		English
CM5	Phone & Text Messages	27	English
CM6	Phone and Text Messages	40	English
CM7	Phone Credit	30	English
CM8	Phone Credit	30	English
CM9	Phone credit	60	English
CM10	Phone credit & Text	55	English
CM11	Phone credit	55	English
TOTAL		390 Minutes (6.5 Hours)	

APPENDIX A:**INTERVIEW GUIDE**

Community members

- Tell me about Uvuru Health Center
- Tell me about an experience you had with the Center
- Tell me how you care for your sick ones
- What do you do if the Center does not meet your needs?
- Tell me in your own words what you will call satisfactory healthcare here at Uvuru
- Tell me what you think you need here

Workers at the Center

- You seem happy; tell me about your work here at Uvuru Health Center
- How long now have you been serving Uvuru people
- What is a typical day like for you?
- Tell something about what you will call a problematic day
- What will improve your job here at Uvuru
- Tell me more about what you need to enhance your work here

Executive Members

- Uvuru Community has ten clans. Tell me about your clan
- Tell me about the Community Health Center
- What are you most happy about at Uvuru Health Center?
- Tell me what you are most unhappy about Uvuru Health Center
- Tell me what you are willing to give up to make the health center the place to be
- Tell me what you would want to change in the Center

APPENDIX B: ETHICAL APPROVAL

IMO STATE UNIVERSITY TEACHING HOSPITAL

E-mail: imsuthorlu@yahoo.com
Phone: 063520194



UMUNA,
P.M.B.R.
ORLU, IMO STATE,
NIGERIA.

OUR REF: _____ IMSUTH/CS/321

YOUR REF: _____

DATE: 2nd Sept., 2021

Gayina Chinyereze Ihunnah
Department of Health Systems and Population,
School of Public Health,
University of Washington.

**ETHICAL APPROVAL FOR YOUR RESEARCH WORK TITLED:
"UTILIZATION AND SUSTAINABILITY OF UVURU HEALTH
CENTRE MBAISE."**

With reference to your letter dated 27th August, 2021, I wish to convey Management's approval for you to conduct the above study.

We hope that the outcome of the research will be useful to the hospital community. A hard-bound final copy of the work should be submitted to the hospital as complimentary copy at the end of the study and for a possible joint publication in a reputable journal with our institution.

Note: You are expected to pay a sum of ₦10,000.00 (Ten Thousand Naira) only as research fee and return the pink copy of the receipt to the Ethical Committee Secretary, before research commencement.

Thank you.



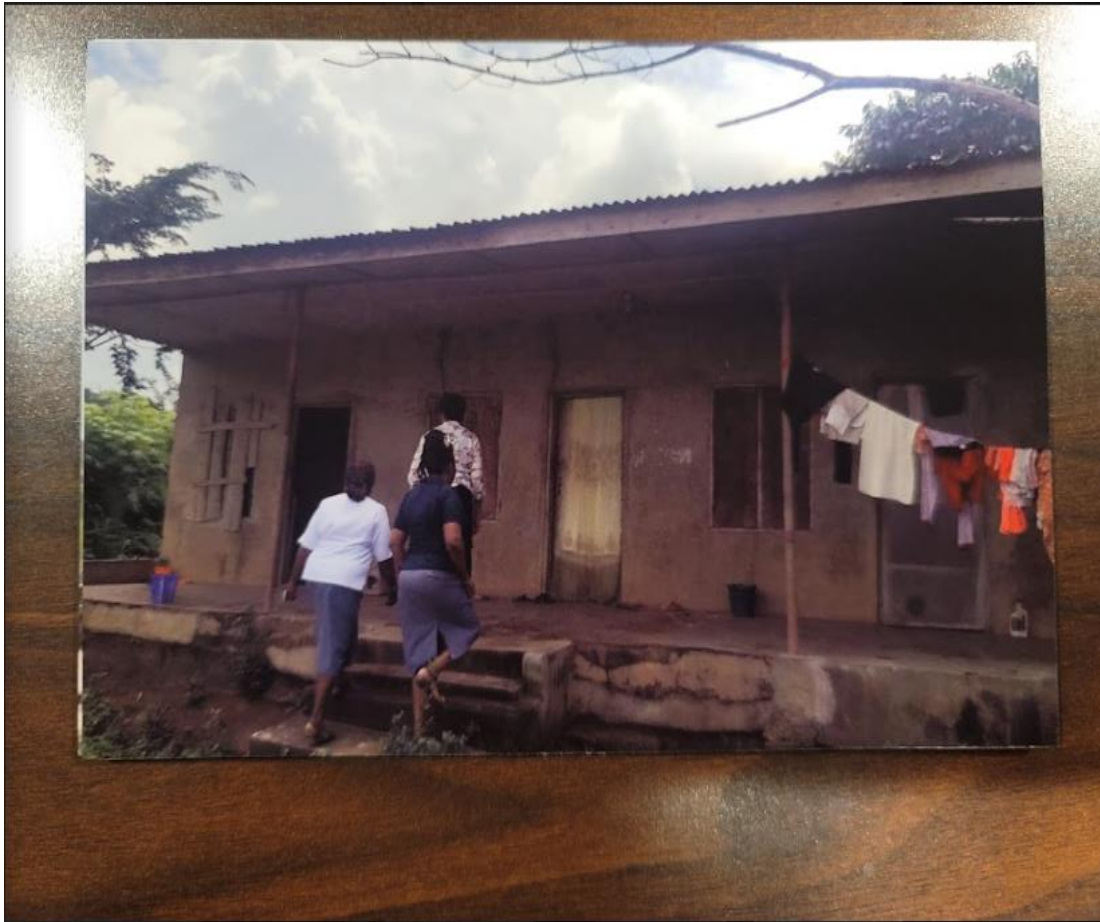
Dr. Ibezim E.O. MBBS, FWACS, MPA
Lecturer/Consultant Radiologist
AG CMAC IMSUTH, Orlu.

APPENDIX C: PICTURES

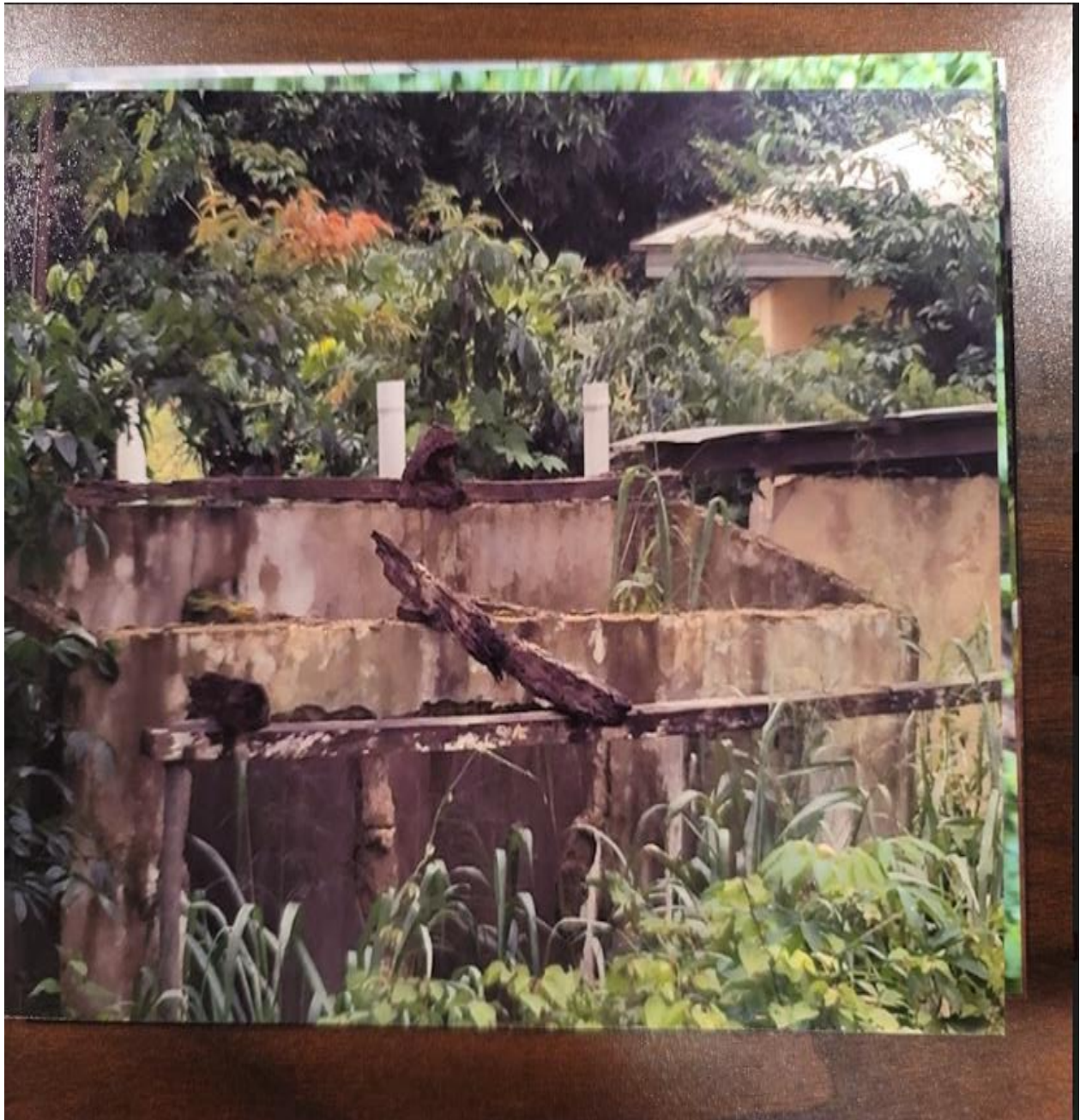
Climbing the Staircase to the Uvuru Health Centers Reception



Dilapidated Health Workers' Building



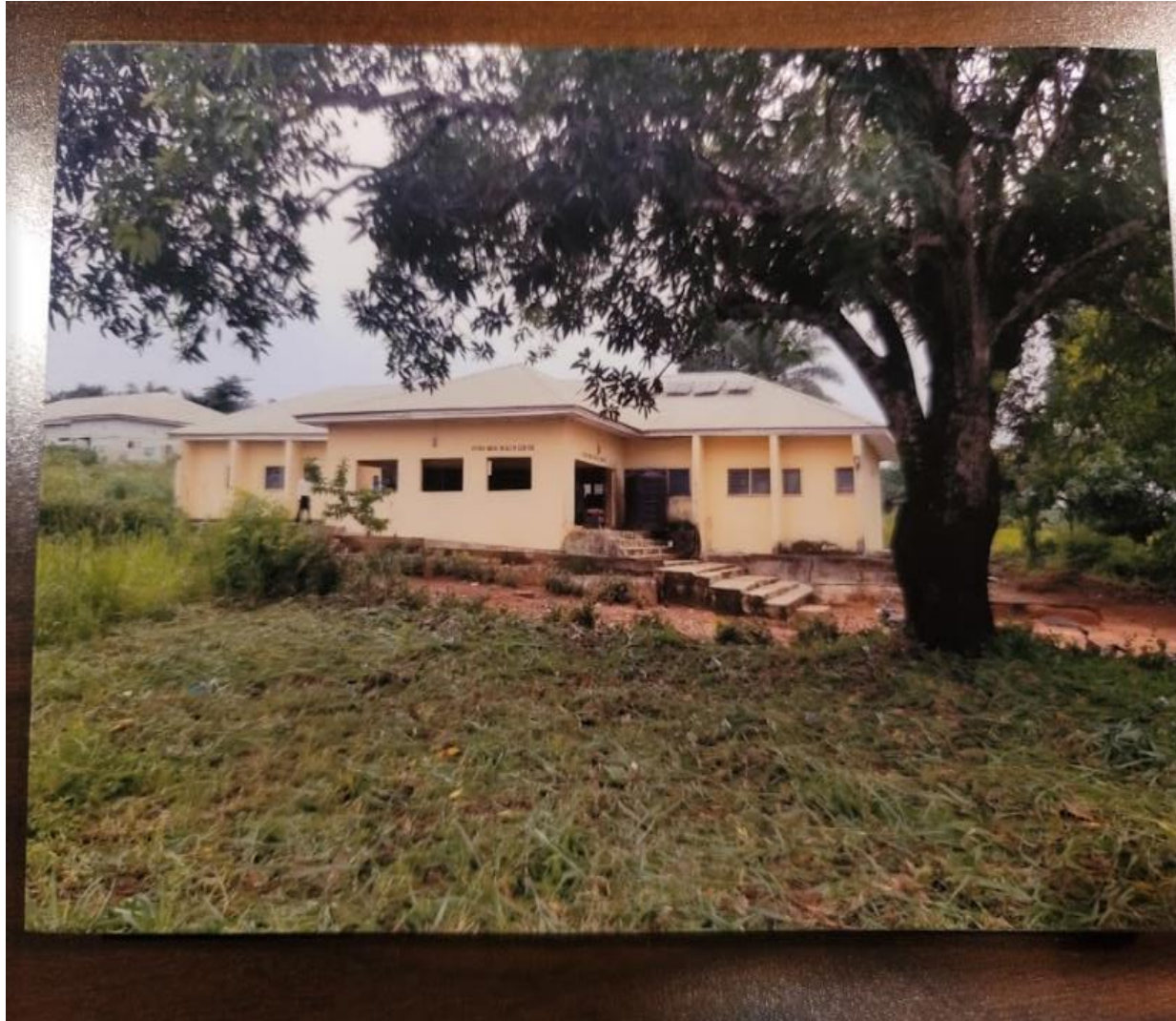
Dilapidated buildings at Uvuru Health Center



One of the many dilapidated buildings at the Uvuru Health Center



Full View of Uvuru Basic Health Center



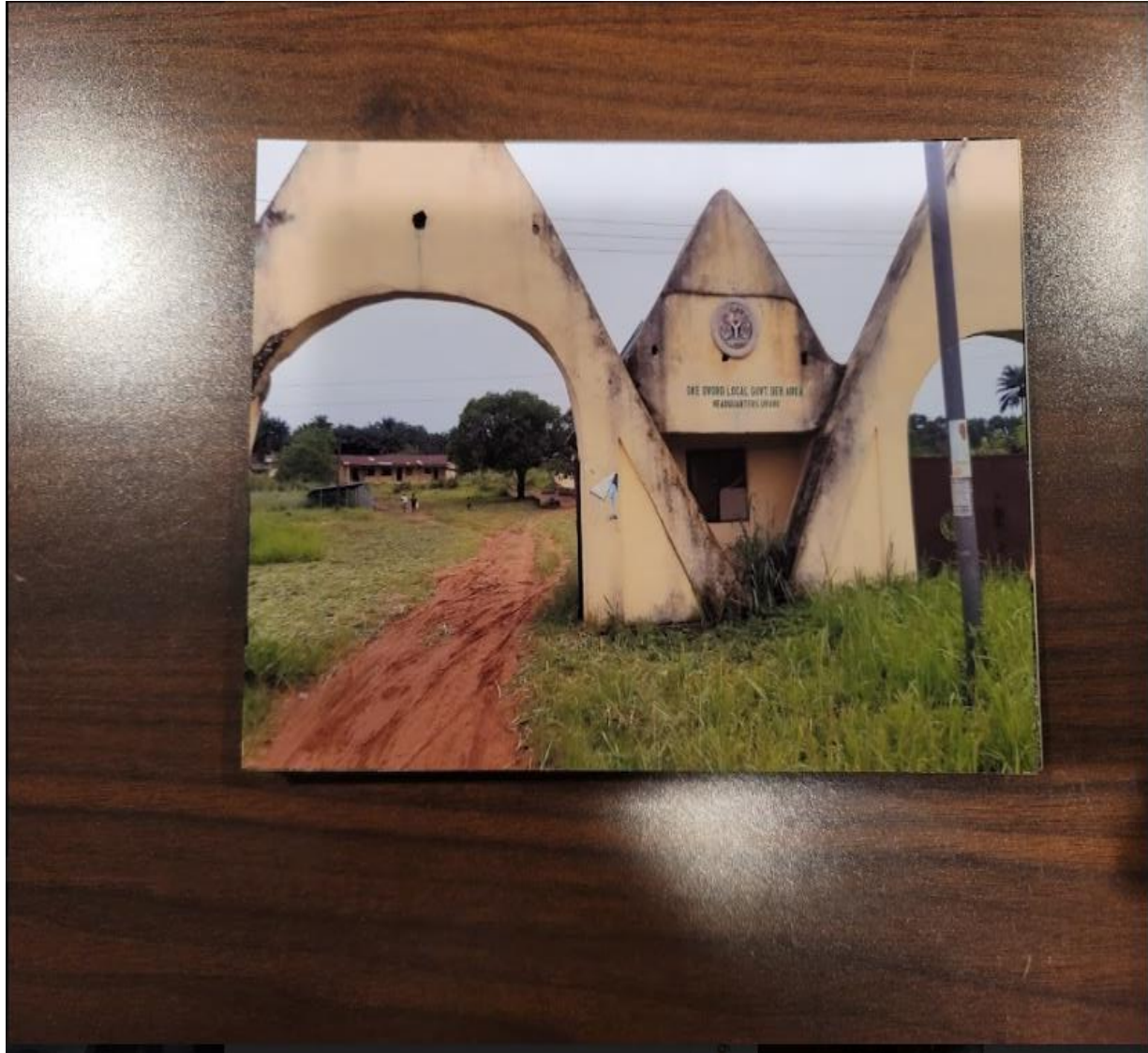
Staff and students provide Health Education and Immunization Services to mothers at the health Center.



Unkempt Compound with Deteriorating Infrastructure



Entrance to the Uvuru Health Center Compound from a Major Road



Lying in Ward at the Uvuru Health Center

