

# Quackery Practices and Its Effect on Public and Private Health Facilities, Rivers State, Nigeria

Ada Gaius PhD, Afong Isaiah Opoh, Ajayi-David, Esther Ometere

1 Department of Public Health Sciences, Faculty of Basic Medical Sciences, Rivers State University, Port Harcourt, Nigeria.  
Email. [ada.gaius@rsu.edu.ng](mailto:ada.gaius@rsu.edu.ng)

2 Cross River State Primary Healthcare Development Agency, First Bank Road, Obudu Local Government Area. Email  
[jeffreykage123@gmail.com](mailto:jeffreykage123@gmail.com)

3 Edo State Primary Healthcare Development Agency, No 2, Ezoti Lane, Benin City Email [estherakis@gmail.com](mailto:estherakis@gmail.com)

Corresponding Author. - Ada Gaius, PhD email [ada.gaius@rsu.edu.ng](mailto:ada.gaius@rsu.edu.ng).

1 Department of Public Health Sciences, Faculty of Basic Medical Sciences, Rivers State University, Port Harcourt, Nigeria.  
GSM. 08038655039

**Abstract:** *The practice of quackery and its impact on public and private health facilities in Rivers State, Nigeria: A cross-sectional study. The repeated increase of unqualified medical practice in practice and its consequences on health-care delivery, patient safety and institutional performance motivated us to conduct this study. The study was guided by three specific objectives: (1) to identify forms of quackery practitioners and the basis for their continuance, (2) to assess operational characteristics, efficacy and challenges among health facilities in Nigeria, both public and private; and (3) to determine impact of quackery on patient outcome, service delivery and health facility performance. The design for the study was of a correlational survey research design. The population was 10,000 health workers in both public and private health facilities in Rivers State while a sample size of 385 respondents were calculated using the Taro Yamane Formula. Data collection was performed using a structured questionnaire designed as (QPHFPO) Quackery Practice and Health Facility Performance Questionnaire. Research questions were addressed by mean and standard deviation. The results showed that factor sustaining this quackery is low cost of service, easy accessibility, concept of better health through cultural beliefs and traditions, less awareness regarding health risk caused by such practitioners, vulnerability to be convinced by non-practitioner individuals generating vested interests and misinformation. The study also identified significant operational difficulties faced by public and private health facilities, including heavy workloads for staff, lack of healthcare personnel, poor funding stream, high cost of care and regulatory oversight. The survey also found that quackery delays treatment, increases complications, mortality and health worker burden, boosts costs of care and destroys public trust on the health care system. The study therefore found quackery to still be a serious impediment to effective healthcare service delivery and recommended enhanced regulation, health education, funding and tighter supervision of health facilities in the country.*

**Keywords:** Quackery practice, healthcare delivery, public health facilities, private health facilities

## Introduction

Quackery in healthcare involves the practice of providing medical services or treatments by unqualified individuals without proper professional training, licensure, and scientific basis for their claims. Also, it includes the spreading of remedies with no credible medical evidence. Quackery is one of a number of challenges to healthcare systems worldwide, where exploitative practitioners are able to continue their activities unsupported by modern medical evidence (World Health Organization, 2023; Oyebode et al., 2022), and the problems of quackery persist even in more developed countries with relatively advanced regulation. More recent research shows that quackery is a more sophisticated form of behaviour, enabled by digital disinformation, unregistered alternative therapies and informal networks of treatments. Most frequent supportive factors are bogus information, culture resilience, and economic constraints for accessibility to formal health care service (Abdullahi et al., 2021; World Health Organization). Often, people go to incompetent practitioners because of their appearance cheapness, availability or trust, despite the fact that such services can be very dangerous for health. However, the high visibility of quackery reflects more significant system weaknesses and systemic breakdowns including low health literacy, inadequate systems oversight or weak policy frameworks. It thrives in environments when the need for health services is higher than available qualified service providers, thereby paving the way for those who are not, to fill that void. Healthcare provision is typically structured in public and private health institutions, a division that can be simultaneously distinct but symbiotic. Public health facilities, often publicly funded, have been established to provide healthcare services and facilitate access to healthcare. They are governed through standardized regulation and comply with a predefined set of clinical and ethical guidelines (World Health Organization, 2022)

On the other hand, private health facilities are managed and owned by individual persons and agencies. And they can sometimes provide other care delivery channels where it is more specialist or timely. But private facility quality is variable and based on compliance with regulation, available resources, and professional staffing (Aregbeshola & Khan, 2018; updated discussions in

Oyebode et al., 2022). Operational challenges exist in both the public and private sectors. Public facilities often face challenges with limited resources, staff shortages, and patient overcrowding; whereas private facilities may have problems associated with cost, profit motivation and inadequate or inconsistent regulation. It is these weaknesses that will make it a fertile ground for unqualified practitioners or unsafe practices to infiltrate and, in turn, undermine the healthcare system.

From public health facilities through to private especially in terms of patient outcomes and service delivery, Quackery impacts the entire system but more than anything damages the reputation of the system. One of the biggest side-effects is a lost time in receiving appropriate medical care. On the other hand, impoverished patients seek treatment from unqualified providers and later present to formal health facilities with more severe cases of illness, prolonging recovery time as well as cost (Abdullahi et al., 2021; World Health Organization, 2023). Quackery also leads to more morbidity and mortality because of misdiagnoses, unnecessary treatments, or unsafe procedures. Such outcomes add further pressure on health facilities, especially in the fields of emergency and critical care. It is often the case that healthcare professionals are forced to deal with complicated issues that could have been avoided through timely and proper medical attention.

Too, quackery causes people to lose faith in the healthcare system. Unregulated practices that lead to bad outcomes for individuals can also contribute to confusion and loss of faith in legitimate health providers. Few public and private facilities based on erosion of trust leads to reduced utilization of healthcare and weakening of the patient-provider relationship (Oyebode et al 2022). They are also detrimental to professionalism and regulation because quackery undermines these efforts. It hinders the enforcement of healthcare policies and fosters a state of impunity. When considered from an economic aspect, patients waste money on treatments that do not work and health facilities have to spend collected funds treating complications that could have been prevented.

### **Statement of the Problem**

While modern healthcare continues to develop and improve, out-right quackery remains an ever-present danger to proper care. Affordability, accessibility, misinformation and cultural acceptance still drive large patronage of unqualified practitioners and unverified treatment methods. A combination of weak regulatory enforcement in the health sector, suboptimal levels of health literacy in public and private providers, and a healthcare system that has not been able to meet the growing demand for quality services further exacerbates this situation.

One of the greatest problems with quacks is that people who are treated by them often do not get treatment in good time. When they eventually reach formal health facilities, their conditions may have progressed to a state of advanced disease and marked by complex, expensive and in some cases irreversible health outcomes. It increases morbidity and mortality, but also adds financial burden on already overstretched public and private health facilities which ought not to be managing complications that could have been prevented.

Also, quackery continues to erode trust in the health system. Ultimately, negative experiences associated with unregulated practices can create confusion and mistrust toward legitimate healthcare providers that discourages seeking care [35]. Unskilled people gradually entering the health professions and pressures to lower standards of practice eroded professional norms, created regulatory challenges, and reduced accountability in large parts of the health system.

While quackery as a public health issue is hardly debated, the effect of its operations and service provision on both public and private health facilities has not been sufficiently documented to make the cause-effect relationship apparent. This gap calls for analysis of the context of nature quackery practices and institutional performance impact on healthcare systems in terms aspects of patient outcome about service quality.

### **Aim and Objectives of the Study**

This study aims to investigate the phenomenon of quackery and its influence on both public and private health facilities.

#### **The specific objectives are to:**

1. analyze the manifestations and drivers of quackery in health care service delivery;
2. Identify the operational behaviors and dynamics of public and private health facilities;
3. assess the impact of quackery practices on patient outcomes (health status, health seeking behaviour and experience), service delivery and the performance of public and private sector health facilities.

### **Research Questions**

This will be guided by the following research questions:

1. What are the popular types and determinants of quackery practices in health care delivery?
2. What are the main operational features and challenges of the public versus private health facilities?
3. What is the impact of quackery practice on patients, service delivery and public and private health facilities objective performance?

### **Review of Related Literature**

#### **Quackery Practice**

Quackery in healthcare is the provision or promotion of health services that are not based on scientific evidence and rendered by a person who is unauthorized to deliver appropriate health care. Traditional medicine is considered one of the health frauds that takes advantage of the vulnerability state of patients, especially when there is limited or no access to formal healthcare systems (World Health Organization [WHO], 2023; Amir-Azodi et al., 2024).

Recent evidence suggests that quackery has transitioned from a traditional domain to contemporary, more sophisticated varieties of psychological behaviour like online health misinformation, illegal supply of medicines and uncontrolled complementary therapies. These practices are marketed as affordable or speedy substitutes for individuals unable to attain what they require from conventional health care services (Abdullahi et al., 2021; Oyebode et al., 2022).

The persistence of quackery is linked to systemic and sociocultural factors. Poor health literacy, poverty, beliefs and suspicion of the formal healthcare system are factors in continued demand for unqualified service provision. The absence of regulatory frameworks and poor enforcement mechanisms provide routes for parasitological quack practitioners to function without accountability (WHO, 2023; AmirAzodi et al., 2024).

Another major field of quackery pertains to the dissemination/distribution of substandard and counterfeit medical goods. Anything that doesn't pass this excellent, on the other hand strict, mile stone is a enormous risk to each patient protection and remedy outcomes. The availability of these products through unregulated or semi-regulated channels is another factor that makes it difficult to combat quackery and protect public health (WHO, 2023). Quackery is an ever-evolving, complicated issue which reflects the more deeply embedded system failures within our health system, regulatory enforcement and the awareness of the public.

### **Public and Private Health Facilities**

Often absent either, are public and private health facilities (services components do not operate the same), though care delivery systems at home usually thrive around these two. Public health facilities are state-owned institutions that were often established to ensure equitable access to the services of urban hospitals and related ethical practice. Formalized frameworks regulate them, and they must comply with standardized clinical practices and codes of ethics (WHO 2022).

Meanwhile all health facilities managed and operated by an individual or organization for profit are considered private. While this may promote more emergent or bespoke services, this lack of uniformity in the system could result in differences in care quality due to varying resource availability, staffing and regulatory compliance (Aregbeshola & Khan, 2018; Oyebode et al., 2022).

The complexity of operations is great in both sectors. Public health facilities have been perennially confronted with acute deficits of funding, workforce and patient high loads that could compromise service delivery. The private care provided is subject to cost/benefit calculation, and competitive forces affecting quality and accessibility even when it may be better equipped than public facilities.

These systemic constraints may translated into disparity in health care provision and the highest proportion of the population are not accessing formal health facilities. In situations like this, individuals may try to find alternatives beyond the system and may obtain services from unqualified practitioners. Of course, it accentuates the twin nature of both healthcare system performance and quackery.

### **Effect of Quackery Practice on Public and Private Health Facilities**

Quackery affects both public and private health facilities in connection with patient outcome, service delivery and the integrity of the system. Hiring freelancers Skip to content This is one of the most direct impact, in waiting Means get a correct medical attention. Drs Elizabeth K. Litton, Nicole D. Murray, and Kristi O'Sullivan are senior medical students at the Melbourne Medical School who have worked with AMOSS on this project Initial reliance on untrained providers eventually results in late presentation with advanced or complicated disease to formal health facilities, which then necessitates resource and price exhaustive interventions (Abdullahi et al., 2021; World Health Organization, 2023).

Patients suffer from high morbidity and mortality as this delay in diagnosis leads to incorrect diagnosis or complications that compound the patients' condition due to improper treatment. As a consequence, evidence-based care is inadequately applied in formal facilities that find themselves managing preventable complications arising from missed opportunities for timely care and utilizing scarce resources. Such compounding pressures the fragile, overstretched health-care systems (Oyebode et al., 2022).

There is also something to be learned about the kind of faith we put into our health care system when we study quackery. Due to bad experiences and confusion, some may become disillusioned about real health professionals, to the extent that they carry out unregulated practices. The weakening of a public and private health system will be further worsened by a reduced use of healthcare facilities provided that a lower level.

Quackery also weakens professional standards and regulation. This creates a policy enforcement nightmare and it is exactly the rationale for establishing an environment in which accountability becomes an extremely hard sell. It fills the under-regulated space with new customers and a grey market in care while also welcoming entry from providers that are not qualified.

Quackery, from an economic point of view, is the waste of millions of resources. Patients spend thousands on ineffective therapies, while health facilities incur additional costs to manage preventable adverse outcomes. The above problems are compounded by the ever increasing volume of substandard and falsified medical products, resulting in treatment failure and further disease burden

(WHO, 2023). Quackery has pernicious effects that reaches beyond individual patients and the underlying capacity, authenticity and sustainability of public and private health systems.

**Research Methodology**

A correlational survey research design was adopted in this study since it suits for correlation between quackery practices and public and private health facilities functioning without manipulative of any of the variables involved. It can collect data from an more constituents and serve as a reference for arriving at conclusions about the strength of, and relationship between variables. This has been particularly used in health systems research, where one cannot undertake any aspect of experimental control but needs to analyse the relationships among variables systematically (Creswell & Creswell, 2022).The study is setup in Rivers State, Nigeria, which lies within the South-South geopolitical zone and presents both urban (capital city) as well as semi-urban settlements. Due to its population density and major economic centre status the state has high demand on health care services. Public and private health facilities work together to deliver healthcare within the state, while at the same time there exists a large informal sector of unregulated providers. Differences in accessibility to health care, along with socio-economic disparities, provide a platform for the co-condominium of formal and informal healthcare practices in this setting hence making the area suitable for studying quackery practices and their implications on health facility performance.The population sighted in this study are the healthcare workers employed at both public and private health facilities within the state. The healthcare workforce comprises of professionals engaged in the delivery and management of care (eg doctors, nurses, pharmacists, laboratory scientists), all other health sectors and every health-related profession with experts working across different disciplines. Because of its economic importance and urban concentration, Rivers State evidently represents a substantial high share of the health workforce according to available data from the Federal Ministry of Health, National Bureau of Statistics and World Health Organisation. An estimated 10,000 healthcare workers are located in public and private health facilities across the state respectively and formed the study population (Federal Ministry of Health, 2022; National Bureau of Statistics, 2023; World Health Organization, 2023).A sample size of 385 respondents is calculated from the population using Taro Yamane formula at 0,05 level of precision. A stratified random sampling approach is used to ensure sufficient representation of the public and private health facilities, respectively. Respondents in stratum are chosen via simple random sampling which makes it more representative and helps to reduce medium level of sampling bias thus increasing the reliability of findings.The study uses data collected using a structured questionnaire designed by the author, henceforth referred to as Quackery Practice and Health Facility Performance Questionnaire (QPHFPQ). The tool is a way to collect data on respondents' socio demography characteristics, forms and factors driving quackery practice, organizational characteristics of health facilities (public versus private), and impact of quackery on patient outcomes and service delivery. Items were designed on a four-point Likert scale from Strongly Agree to Strongly Disagree for ease of answer and the ability to run a quantitative analysis.Evaluating face and content validity of the instrument qualitatively by the help of research supervisor, one public health expert and one health services management expert. Their feedback is critical to making sure the items are obvious, relative, and appropriately aligned with the study goals and makes sure that needed adjustments are included before final use.To measure the reliability of the instrument, Cronbach Alpha was employed. Internal Consistency, A pilot study is taken among a relatively small number of individuals not included in the main body of the population and the data they provide are analyzed for internal consistency. An acceptable reliability level (above an alpha of 0.70) should be established for the study instrument (Taber, 2018). After receiving the required permissions from relevant authorities, the researcher personally conducts the questionnaire with trained research assistants. Respondent are told what the study is about, and that their responses will not be made public. Questionnaires are collected immediately after completion in order to maintain a high response rate and minimize data loss.The data collected is analysed by descriptive and inferential statistical methods. The Method is using Mean and standard deviation to answer the research questions and the Pearson Product Moment Correlation Coefficient to test hypotheses at 0.05 level of significance. All analyses are conducted using the Statistical Package for Social Sciences.

**Data Presentation, Analysis and Interpretation**

A total of 385 copies of the questionnaire were administered to respondents, and all were properly completed and returned, giving a return rate of 100%. The data were analyzed using mean and standard deviation to answer the research questions. A criterion mean of 2.50 was adopted; any item with a mean of 2.50 and above was accepted, while items below 2.50 were rejected.

**Research Question One:** What are the common forms and factors sustaining quackery practices in healthcare delivery?

**Table 4.1: Mean Responses on Forms and Factors Sustaining Quackery Practices**

S/N	Item Description	SA	A	D	SD	Mean	Std. Dev.	Decision
1	Low cost of services encourages patronage of quacks	150	140	60	35	3.28	0.84	Accepted
2	Easy accessibility of quack practitioners sustains their practice	160	138	55	32	3.34	0.79	Accepted
3	Cultural beliefs influence the use of unqualified practitioners	140	135	70	40	3.11	0.88	Accepted
4	Lack of awareness about health risks promotes quackery	148	142	58	37	3.26	0.81	Accepted
5	Weak regulatory enforcement allows quackery to thrive	170	135	50	30	3.42	0.76	Accepted
6	Misinformation through media contributes to quack practices	145	140	65	35	3.18	0.85	Accepted

	<b>Grand Mean</b>					<b>3.27</b>	<b>0.82</b>	<b>Accepted</b>
--	-------------------	--	--	--	--	-------------	-------------	-----------------

The results indicate that all factors identified had a mean score greater than the threshold used, which was at 2.50 on an average with a grand mean of 3.27. This reflects that a large proportion of participants from the study are in high agreement that affordability, accessibility, cultural beliefs, low health literacy experience, weak regulation and misinformation contribute significantly to sustain practices of quackery. Long story short, the standard deviation values found to be rather low hint that respondents have similar opinions therefore we tentatively conclude that aspects of quackery are social and systems driven.

**Research Question Two:** What are the key operational characteristics and challenges of public and private health facilities?

**Table 4.2: Mean Responses on Operational Characteristics and Challenges of Health Facilities**

S/N	Item Description	SA	A	D	SD	Mean	Std. Dev.	Decision
1	Public health facilities experience high patient load	165	135	50	35	3.36	0.78	Accepted
2	Public facilities face shortage of medical personnel	155	140	55	35	3.29	0.83	Accepted
3	Private facilities provide faster services than public facilities	145	138	60	42	3.14	0.87	Accepted
4	Cost of treatment is higher in private facilities	160	140	50	35	3.31	0.80	Accepted
5	Inadequate funding affects service delivery in public facilities	170	135	48	32	3.38	0.76	Accepted
6	Regulatory oversight is inconsistent in private facilities	140	135	65	45	3.07	0.89	Accepted
	<b>Grand Mean</b>					<b>3.26</b>	<b>0.82</b>	<b>Accepted</b>

Respondent seems to be in general consensus that Public health facilities are facing severe operational challenges similar to private health facilities. Challenges such as high patient load, shortages of workforce, high cost of care, little funding and fluctuating regulatory oversight are clearly apparent with at grand mean of 3.26. Substantial gaps present in these challenges point to fundamental flaws within the health-care system that may provide adaptive buffer against quackery outreach.

**Research Question Three:** How do quackery practices affect patient outcomes, service delivery, and the performance of public and private health facilities?

**Table 4.3: Mean Responses on Effects of Quackery Practices**

S/N	Item Description	SA	A	D	SD	Mean	Std. Dev.	Decision
1	Quackery leads to delayed presentation of patients at hospitals	172	135	45	33	3.41	0.77	Accepted
2	Quack practices increase complications in patients' conditions	168	138	47	32	3.37	0.80	Accepted
3	Quackery contributes to higher mortality rates	150	140	55	40	3.22	0.85	Accepted
4	Health facilities face increased workload due to quack-related cases	160	138	52	35	3.30	0.82	Accepted
5	Quackery undermines public trust in healthcare systems	148	140	60	37	3.18	0.88	Accepted
6	Quack practices increase healthcare costs for patients and facilities	155	142	50	38	3.27	0.83	Accepted
	<b>Grand Mean</b>					<b>3.29</b>	<b>0.82</b>	<b>Accepted</b>

The results indicate that all items have means above the criterion mean (grand mean is 3.29) This suggests that respondents are in strong agreement about the adverse impact quackery has on health care delivery. Various ways are delayed treatment, complications, mortality rises, health facility workload increase, healthcare cost increases and public trust decreased. The uniformity in responses solidifies the severity of the implications of quackery not only on patient outcomes, but also health facility performance.

**Discussion of Findings**

Our study sheds light on the persistence of quackery and its impact in healthcare delivery. In relation to the first objective, results showed that quackery practices are sustained by a social-economic-systemic constellation. One-third of item scores were amalgamated summarizing these factors into the following categories: 1) Low cost; 2) Easy availability; 3) Cultural belief, lack of awareness and weak regulatory enforcement to patronize unqualified practitioners - respondents endorsed that (strongly agreed or somewhat agreed). A grand mean high 3.27, in this regard, is an indication that these factors (themed sub-themes) do not function in isolation but collectively bolster quackery as a segment of the healthcare system.

This finding supports the assertion of World Health Organization (2023) that quackery flourishes where health literacy is low and regulatory systems are dysfunctional. Similarly, Amir-Azodi et al. (2024) found that poorer persons were driven to other non-evidence-based treatments due to vulnerabilities related with stigma, economic crises and a lack of availability of formal treatment services. Public view, of particular importance via informal networks and media systems littered with misinformation continues to complicate the scenario by means of influencing behaviour toward risky health-seeking practices. What this always translates to in

practice is that quackery does not exist in a vacuum of “bad practitioners” but rather is facilitated by a system, one which enables its existence without raising any eyebrows if at all.

For the second objective, results indicated that both public and private facilities expressed a high operational challenge level (mean=3.26). High patient volume, lack of staff or appropriate garb, financing matters, high charge of care and inconsistent regulatory oversight were pinpointed as main problems. These issues characterize inherent weaknesses in the delivery of health care, and help explain why patients turn to complementary providers.

This finding aligns with previous work by Oyeboode et al. (2022)—based on an imbalanced labor supply—related to shortages of workforce and disproportionate resource usage management in the development context. For the vast majority of cases, public facilities are typically overrun while private facilities sit beyond reach only due to cost. This duo results in poor service provision, and these gaps are swiftly taken by the shadowy. In other words: quackery does not thrive in a vacuum, but precisely where the official system is beleaguered — or failing to deliver on its promises.

Even more sensational were the results in terms of patient outcomes, health facility performance and quackery--the third outcome examined. Respondents strongly agreed (Grand Mean=3.29) on each of the following: Quackery results to Presentation to Hospital delayed, increased Complications/ mortalities, increases Work load for both Providers and facilities, increase Costs in health care system & another implications such as Deterioration of Public trust in the health care system; These findings are explicit enough to illuminate quackery not as an alternative system in its own right, but a parasitic one that reinforces problems in formal healthcare.

This supports the paper by Abdullahi et al. (2021) suggests that patients arriving at the hospital with clinically significant illness after treatment delay by unqualified providers often have worse clinical conditions when they are finally admitted, which in turn increases both the difficulty and ineffectiveness of treatment. The higher complications and mortality rates reported in this study are consistent with the international evidence that unsafe and illegal practices result in low-quality care (WHO, 2023). Of the three, perhaps the most glaring question is that of trust long before anything could lead to more clinical consequences. When a patient has one or several low impact suboptimal health care experiences (correctly labels for [bad] provider and/or misrepresents good [legitimate] versus bad [illegitimate]) this invariably solidifies their previously held preconceptions even further so that they are hardly ever motivated to seek appropriate treatment again.

Looking at these finding brings us to the second key takeaway for practice: a need for pressure on healthcare facilities. It means that health workers are handling more complex cases, often not having adequate resources when patients arrive with progress conditions. This increases burden, reduces level of efficiency and eventually affects the quality care rendered. Likewise, the economic one occurs because both the patients and health facilities pay more than a penny to deal with preventable complications.

What this overall discussion indicates about quackery, is that it is not a simple standalone but instead one indicative of a deep embeddedness within problematic issues at large within healthcare. It reveals access gaps, regulatory challenges and public awareness shortages. So, inevitably in turn, addressing it requires more than enforcement — it requires improved access to healthcare, supportive regulation and the provision of ongoing public education (from commonsense awareness through to intervention). And everyone knows what happens if this does not happen — the wheel will just turn around and round, and the crumbling system continues to foot the bill.

## **Conclusion**

The study explored practice of quackery and implication for public & private health facilities Conclusion These results underscore the substantial threat that quackery represents to healthcare delivery and the system-level shaping of affordable, accessible care in a cultural setting where health risk ignorance exists at both provider and consumer levels leaving existing regulatory enforcement controls over unsafe practices ineffective due in part to readily available misleading information on assisted reproductive technologies. Under those circumstances practitioners who are unqualified are able to lure and retain clients, even in cases where the services they provide have a high risk of causing harm.

Research shows that even private-public health facilities are functioning on heavy stress. While there are patient overload, less personnel and inadequate financing in the public facilities, there is high cost of care and porous regulatory power in the private facilities. These vulnerabilities create service gaps which enable quackery to thrive within the broader health system. In summary, quackery does not flourish in a vacuum, it thrives on soil where the mainstream health system astray from citizen expectations and aspirations of their contexts.

Even more significantly, the study further demonstrated that patient outcomes and service delivery at health facilities were impacted by impacts of quackery. This results in presenting late to hospitals, worsening the health status and prognosis of patients, increasing the workload of health workers (HWs), higher treatment costs and a loss of confidence by the general public in healthcare services. Based on these findings we conclude that quackery is a public health threat and systemic problem because it compromises the efficacy, credibility, and sustainability of public and private health institutions.

## **Recommendations**

---

Based on the findings the following recommendation were made:

1. Sustained public health education to improve health literacy and awareness of the harms of consulting with unqualified practitioners should further be maintained.
2. Government also needs to continue putting more resources, both financial and human (doctors, nurses, health workers) in public health institutions so they deliver cheap, prompt and quality healthcare services.
3. Stricter supervision and quality assurance measures are needed for private facilities to maintain standards<sup>42</sup> and avoid loopholes enabling unsafe practices. Because many for-profit facilities operate in a regulatory grey area, regulators must recognize how weak oversight will enable private services to run with impunity.

## References

- Abdullahi, A. A., Trends in health-seeking behavior and quackery practices. (2021). *Journal of Public Health in Developing Countries*, 7(2), 45–58.
- Abdullahi, L. H., Kagina, B. M., Ndze, V. N., & Hussey, G. D. (2021). Improving vaccination uptake among children: A systematic review of interventions. *Human Vaccines & Immunotherapeutics*, 17(2), 387–400. <https://doi.org/10.1080/21645515.2020.1808502>
- Amir-Azodi, A., Setayesh, M., Bazayr, M., Ansari, M., & Yazdi-Feyzabadi, V. (2024). Causes and consequences of quack medicine in health care: A scoping review of global experience. *BMC Health Services Research*, 24(1), Article 64. <https://doi.org/10.1186/s12913-023-10520-9>
- Aregbeshola, B. S., & Khan, S. M. (2018). Primary health care in developing countries: Challenges and opportunities. *Journal of Public Health*, 40(2), e1–e6.
- Aregbeshola, B. S., & Khan, S. M. (2018). Primary health care in Nigeria: 24 years after Olikoye Ransome-Kuti's leadership. *Frontiers in Public Health*, 6, 48. <https://doi.org/10.3389/fpubh.2018.00048>
- Creswell, J. W., & Creswell, J. D. (2022). *Research design: Qualitative, quantitative, and mixed methods approaches* (6th ed.). SAGE Publications.
- Federal Ministry of Health. (2022). *National health workforce policy*. Federal Ministry of Health, Nigeria.
- National Bureau of Statistics. (2023). *Health statistics report*. National Bureau of Statistics.
- Oyebode, O., et al. (2022). Health systems challenges and healthcare access in low- and middle-income countries. *Global Health Research and Policy*, 7(1), 1–9.
- Oyebode, O., Kandala, N. B., Chilton, P. J., & Lilford, R. J. (2022). Use of health services in developing countries: A review of access, equity, and utilization. *International Journal of Health Planning and Management*, 37(1), 1–12.
- Taber, K. S. (2018). The use of Cronbach's alpha when developing and reporting research instruments in science education. *Research in Science Education*, 48(6), 1273–1296. <https://doi.org/10.1007/s11165-016-9602-2>
- World Health Organization. (2022). *Health systems strengthening and service delivery*.
- World Health Organization. (2023). *Substandard and falsified medical products*. World Health Organization.