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PRIMARY HEALTH CARE INITIATIVE: THE NIGERIAN EXPERIENCE (A REVIEW)

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ABSTRACT

This paper critically reviews and examines the Primary Health Care initiatives in Nigeria. The international conference on Primary Health Care held in Alma Ata in 1978 was convened in response to an international sense of despair over the widespread inequality in health and health care that afflicted all the nations of the world. However, over the years and particularly during the first decade after the Alma Ata conference, it became clear that in the African region in which Nigeria is a part of, no major improvements in health has been realised despite the policy changes which has been instituted. This paper therefore, is an attempt to highlight what PHC services are within the context of Nigeria's health policy and to know how the people in different communities prioritize these services when health care providers come their way. It is strongly believed in this analysis that an in-road into the ranking of PHC services by the rural dwellers is important for arriving at better initiatives for overall health care development in the country. It also reviews the journey so far in Nigeria and efforts made by Government agencies to promote healthcare in Nigeria.

INTRODUCTION

The issue of primary health care has become a global issue and its target is to get health care to all whether rich or poor, developed or developing etc. It is also a response to the call for a better health care for all.

ORIGIN OF PRIMARY HEALTH CARE

The international conference on Primary Health Care held in Alma Ata in 1978 was convened in response to an international sense of despair over the widespread inequality in health and health care that afflicted all the nations of the world. The conference was attended by 134 member states of the World Health Organization and 67 representatives of the United

Nations Organizations, specialized agencies and Non-Governmental Organizations. The main documentation of the conference was titled “Primary Health Care”.

The conference responded with a call for a radical change in the content and design of health services so that there will be equity in the health services through **Primary Care**. This had an immediate effect on the World Health Organization’s global strategies and has dominated its policies and strategies ever since (WHO, 1978).

However, over the years and particularly during the first decade after the Alma Ata conference, it became clear that in the African region, no major improvements in health has been realised despite the policy changes which has been instituted.

OBJECTIVES OF THE STUDY

The central focus of this paper relates to the extent to which primary health care has impacted people and to critically examine the problems people encounter in healthcare and how healthcare policies affect them. The objectives of this paper therefore include:

1. To examine primary health care policies in Nigeria
2. To investigate the impact of such policies
3. To make recommendations that would enhance effective health policies on the people.

LITERATURE REVIEW

WHAT IS PRIMARY HEALTH CARE?

According to the sixth pronouncement of the Alma Ata conference in 1978, Primary Health Care is defined as “essential health care” based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the communities through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self reliance and self determination (World Health Organization, 1978). In other words, primary health care is an approach to health beyond the traditional healthcare system that focuses on health equity producing social policy. Primary health care forms an integral part, both of the country’s health system where it is the main focus, and the overall social and economic development of the community.

Primary health care is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process (Mwanzia, 1994). The rest of the national health system supports and reinforces this effort which is made first at the community level.

PHC, according to the Alma-Ata declaration cited above, was aimed at addressing the main health problems in the community, providing promotive, curative, and rehabilitative services. Eight services were identified as the main focus of PHC as follows:

1. Promotion of nutrition
2. Provision of adequate supply of safe water
3. Provision of basic sanitation
4. Maternal and child care including family planning
5. Immunization against the major infectious diseases
6. Prevention and control of locally endemic diseases
7. Education concerning the prevalent health problems and the methods of their prevention and control.
8. Approximate treatment for common diseases and injuries.

It is evident from the foregoing therefore, that PHC embodies the basic needs approach, and the approach of the 60s was a development away from hospitals towards health centres and sub- centres using auxiliary personnel. PHC however, is a shift towards the front-line of day-to-day activities carried out within the community.

FEATURES OF PRIMARY HEALTH CARE

The following are features of primary health care which have been picked out by the definition given by the World Health Organization.

- a. An element of health system
- b. Focus on priorities

- c. Scientific basis
- d. Culture sensitivity
- e. Equity
- f. Community participation
- g. Sustainability
- h. Sustainability and self-reliance (Marafa, 2007).

GOALS OF PRIMARY HEALTH CARE

The ultimate goal of primary health care is better health for all. World Health Organization has identified 5 elements to achieving that goal and they are;

1. Reducing exclusion and social disparities in health (universal coverage reforms).
2. Organizing health services around people's needs and expectation (service delivery reforms). Primary Health Care is intended to reach everybody, particularly, those in greatest need; to reach the home and family level, not just health facilities.
3. Integrating health policies into all sectors (public policy reforms).
4. Pursuing collaborative models of policy dialogue (leadership reforms).
5. Increasing stakeholder participation.

BASIC PRINCIPLES OF PRIMARY HEALTH CARE

1. Equity – health care resources should be accessible and affordable to all i.e. there should be a decentralization of health services, drugs should be made available at all levels and at low cost. Equitable distribution of health care to meet the main health problem of the people irrespective of sex, status, gender, caste, colour, social class, rural/urban location. There should be universal coverage of the population, with care provided according to need.

2. Community participation – it is a process by which individuals and family assume responsibility for their own health and those of the community and develop the capacity to contribute to their/the community development. It involves community participation in planning, organization, operation and control. Without it, primary health care will not succeed. Community participation help to address the health needs of the people ensures social responsibility, sustainability, cost sharing, enhancement of knowledge etc, which is, making full use of local and other available resources and the appropriate education of the community. Community participation in the development of services promotes self reliance and reduces dependence.
3. Health workforce development and integration of health services – it is defined as coordination of primary health components into a whole programme and made available at all times including referrals which advantages include; ensuring use of all resources and removing all areas of wastage, ensuring sustainability of programmes, ensures bye pass phenomenon; reduces opportunity costs and enhances client confidentiality i.e. adequate numbers and distribution of trained physicians, nurses, community health workers, and allied health professions supported at the local and referral levels. Services should be effective, acceptable, affordable and manageable; it should also be promotive, curative and rehabilitative.
4. Self reliance and Use of appropriate technology – it involves the use of technological methods or scientifically sound system maintained by the community. It can be in terms of human resources (community health aid), money (to ensure financial backing), and materials (physical facilities, drugs) etc. medical technology should be provided and should be affordable, accessible, feasible and culturally acceptable. Self reliance ensures affordability, sustainability, acceptability and authenticity (Marafa, 2007).
5. Intersectoral collaboration – recognition that health cannot be improved only by the formal health sector but also by other sectors. It involves co-ordination with other sectors such as agriculture (food security), education, finance, communication (concerning health problems and methods of solving them), housing, public works (ensuring an adequate supply of safe water and basic sanitation), rural development,

industry, voluntary organization etc. There should be a working relationship to ensure overall human development, economic development and affordability (Marafa, 2007). It means that approaches to health should relate to other sectors of development.

COMPONENTS OF PRIMARY HEALTH CARE IN NIGERIA

Primary health care is made of the following components;

1. Immunization – to prevent infectious diseases like yellow fever, tuberculosis, meningitis, pertusis etc
2. Maternal and child care
3. Essential drugs should be available and affordable at all levels
4. Food and nutrition – family's food should be adequate, affordable and balanced.
5. Education – people should be informed of health problems and methods of prevention and control
6. Illness and injury – adequate provision of curative services for common ailments and injuries should be made by the community.
7. Water and sanitation – a safe water supply and the clean disposal of wastes are vital for health.
8. Vectors and reservoirs – endemic infectious diseases can be regulated through the control or eradication of vectors and animal reservoirs (Marafa, 2007).

PRIMARY HEALTH CARE POLICIES IN NIGERIA

During the 1975-1980 period (Nigeria's Third National Development Plan), there originated some concerted efforts to meet the World Health Organization's (WHO's) standard of 1 doctor-10,000 population ratio. The needs in the health sector led to the establishment of Federal and State health institutions and the training of middle-level personnel; also there was the establishment of Basic health Services Scheme (BHSS) and the establishment of Primary health care (PHC) as the centrepiece of health development in

Nigeria (Akande, 2002). Part of the fundamental principle underlying the national health policy in Nigeria to achieve health for all Nigerians is based on the national philosophy of social justice and equity (FMH, 1988).

Primary Health Care Service became a dream come true for the first time in Nigeria in 1975, when Yakubu Gowon, Nigeria's leader announced the Basic Health Service Scheme (BHSS) as part of the Third National Development Plan (1975-80). The objectives of the scheme were to increase the proportion of the population receiving health care from 25 to 60 percent, correct the imbalances in the location and distribution of health institutions and provide the infrastructures for all preventive health programmes such as control of communicable diseases, family health, environmental health, nutrition and others and establish a health care system best adapted to the local conditions and to the level of health technology (Sorungbe, 1989). According to Akande (2002), the basic plan for the implementation of the scheme was to build in each local government area a comprehensive health institution that would serve as the headquarters of the services, four primary health centres and 20 health clinics. This was called a basic health unit designed for a population of 150,000. The health clinics were to be the most peripheral health facilities, each serving a population of 2,000. The aim was that a primary health centre would serve as a referral centre for four health clinics and serve a population of 20,000, while the comprehensive health centres, and the four health clinics would serve a population of 50,000, with mobile clinics from the primary health centres.

In August 1987, the Federal Government launched its Primary Health Care (PHC) plan, which President Ibrahim Babangida announced as the cornerstone of health policy. Intended to affect the entire national population, its main stated objectives included accelerated health care personnel development; improved collection and monitoring of health data; ensured availability of essential drugs in all areas of the country; implementation of an Expanded Programme on Immunization (EPI); improved nutrition throughout the country; promotion of health awareness; development of a national family health program; and widespread promotion of oral rehydration therapy for treatment of diarrheal disease in infants and children. Implementation of these programs was intended to take place mainly through collaboration between the Ministry of Health and participating Local Government councils, which received direct grants from the Federal Government.

Of these objectives, the EPI was the most concrete and probably made the greatest progress initially. The immunization program focused on four major childhood diseases: pertussis, diphtheria, measles, and polio, and tetanus and tuberculosis. Its aim was to increase dramatically the proportion of immunized children younger than two from about 20% to 50%

initially, and to 90% by the end of 1990. Launched in March 1988, the immunization program by August 1989 was said to have been established in more than 300 of 449 LGAs. Although the program was said to have made much progress, its goal of 90% coverage was probably excessively ambitious, especially in view of the economic strains of structural adjustment that permeated the Nigerian economy throughout the late 1980s.

The government's population control program also came partially under the PHC. By the late 1980s, the official policy was strongly to encourage women to have no more than four children, which would represent a substantial reduction from the estimated fertility rate of almost seven children per woman in 1987. No official sanctions were attached to the government's population policy, but birth control information and contraceptive supplies were available in many health facilities.

The Federal Government also sought to improve the availability of pharmaceutical drugs. Foreign exchange had to be released for essential drug imports, so the government attempted to encourage local drug manufacture; because raw materials for local drug manufacture had to be imported, however, costs were reduced only partially. For Nigeria both to limit its foreign exchange expenditures and simultaneously to implement massive expansion in primary health care, foreign assistance would probably be needed. Despite advances against many infectious diseases, Nigeria's population continued through the 1980s to be subject to several major diseases, some of which occurred in acute outbreaks causing hundreds or thousands of deaths, while others recurred chronically, causing large-scale infection and debilitation. Among the former were cerebrospinal meningitis, yellow fever, Lassa fever and, most recently, AIDS; the latter included malaria, guinea worm, schistosomiasis (bilharzia), and onchocerciasis (river blindness). Malnutrition and its attendant diseases also continued to be a refractory problem among infants and children in many areas, despite the nation's economic and agricultural advances.

Among the worst of the acute diseases was cerebrospinal meningitis, a potentially fatal inflammation of the membranes of the brain and spinal cord, which can recur in periodic epidemic outbreaks. Northern Nigeria is one of the most heavily populated regions in what is considered the meningitis belt of Africa, stretching from Senegal to Sudan and all areas

having a long dry season and low humidity between December and April. The disease plagued the northern and middle belt areas in 1986 and 1989, generally appearing during the cool, dry harmattan season when people spend more time indoors, promoting contagious spread. Paralysis, and often death, can occur within forty-eight hours of the first symptoms. In response to the outbreaks, the Federal and State Governments in 1989 attempted mass immunization in the affected regions. Authorities pointed, however, to the difficulty of storing vaccines in the harsh conditions of northern areas, many of which also had poor roads and inadequate medical facilities.

Beginning in November 1986 and for several months thereafter, a large outbreak of yellow fever occurred in scattered areas. The most heavily affected were the states of Oyo, Imo, Anambra, and Cross River in the South, Benue and Niger in the middle belt, and Kaduna and Sokoto in the North. There were at least several hundred deaths. Fourteen million doses of vaccine were distributed with international assistance, and the outbreak was brought under control.

Lassa fever, a highly contagious and virulent viral disease, appeared periodically in the 1980s in various areas. The disease was first identified in 1969 in the northeast Nigerian town of Lassa. It is believed that rats and other rodents are reservoirs of the virus, and that transmission to humans can occur through droppings or food contamination in and around homes. Mortality rates can be high, and there is no known treatment.

The presence of AIDS in Nigeria was officially confirmed in 1987, considerably later than its appearance and wide dispersion in much of East and Central Africa. In March 1987, the Minister of Health announced that tests of a pool of blood samples collected from high risk groups had turned up two confirmed cases of AIDS, both HIV Type-1 strains. Subsequently, HIV-2, a somewhat less virulent strain found mainly in West Africa, was also confirmed. In 1990 the infection rate for either virus in Nigeria was thought to be below 1% of the population.

Less dramatic than the acute infectious diseases but often equally destructive were a host of chronic diseases that were serious and widespread but only occasionally resulted in

death. Of these the most common was malaria, including cerebral malaria, which can be fatal. The guinea worm parasite, which is spread through ingestion of contaminated water, is endemic in many rural areas, causing recurring illness and occasionally permanently crippling its victims. The World Health Organization (WHO) in 1987 estimated that there were 3 million cases of guinea worm in Nigeria--about 2 percent of the world total of 140 million cases- -making Nigeria the nation with the highest number of guinea worm cases. In affected areas, guinea worm and related complications were estimated to be the major cause of work and school absenteeism.

Virtually all affected states had campaigns under way to eradicate the disease through education and provision of pure drinking water supplies to rural villages. The government has set an ambitious target of full eradication by 1995, with extensive assistance from the Japanese government, Global 2000, and numerous other international donors.

The parasitic diseases onchocerciasis and schistosomiasis, both associated with bodies of water, were found in parts of Nigeria. Onchocerciasis is caused by filarial worms transmitted by small black flies that typically live and breed near rapidly flowing water. The worms can damage the eyes and optic nerve and can cause blindness by young adulthood or later. In some villages near the Volta River tributaries where the disease is endemic, up to 20% of adults older than thirty are blind because of the disease. Most control efforts have focused on a dual strategy of treating the sufferers and trying to eliminate the flies, usually with insecticide sprays. The flies and the disease are most common in the lowland savannah areas of the middle belt. Schistosomiasis is caused by blood flukes, which use freshwater snails as an intermediate host and invade humans when the larvae penetrate the skin of people entering a pond, lake, or stream in which the snails live. Most often, schistosomiasis results in chronic debilitation rather than acute illness.

FEATURES OF PRIMARY HEALTHCARE SERVICES IN NIGERIA

In Nigeria, Primary Health Care is provided by Local Government Areas through health centres and health posts and is staffed by nurses, midwives and community health workers, health technicians and few doctors. The services provided by Primary Health Care

include; prevention and treatment of communicable diseases, immunization, maternal and child health services, family planning, public health education, environmental health and collection of statistical data on health. The Primary Health Care is headed by a co-ordinator who reports to a supervisory councillor who in turn reports to the Local Government chairman. The Primary Health care helps to enhance maximum benefit of the principle of decentralization of the health sector.

TRENDS IN HEALTH CARE IN NIGERIA

Whereas traditional medicine continued to play an important role in Nigeria in the 1990s, the country made great strides in the provision of modern health care to its population in the years since World War II, particularly in the period after independence. Among the most notable accomplishments were the expansion of medical education, the improvement of public health care, the control of many contagious diseases and disease vectors, and the provision of primary health care in many urban and rural areas. In the late 1980s, a large increase in vaccination against major childhood diseases and a significant expansion of primary health care became the cornerstones of the government's health policies.

Nonetheless, many problems remained in the 1990s. Sharp disparities persisted in the availability of medical facilities among the regions, rural and urban areas, and socioeconomic classes. The severe economic stresses of the late 1980s had serious impacts throughout the country on the availability of medical supplies, drugs, equipment, and personnel. In the rapidly growing cities, inadequate sanitation and water supply increased the threat of infectious disease, while health care facilities were generally not able to keep pace with the rate of urban population growth. There were several serious outbreaks of infectious diseases during the 1980s, including cerebrospinal meningitis and yellow fever, for which, especially in rural areas, treatment or preventive immunization was often difficult to obtain. Chronic diseases, such as malaria and guinea worm, continued to resist efforts to reduce their incidence in many areas. The presence of acquired immune deficiency syndrome (AIDS) in Nigeria was confirmed by 1987 and appeared to be growing.

Government health policies increasingly had become an issue of policy debate and public contention in the late 1980s. The issue emerged during the Constituent Assembly held in 1989 to draft a proposed constitution. The original draft reported by the assembly included a clause specifying that free and adequate health care was to be available as a matter of right to all Nigerians within certain categories. The categories included all children younger than eighteen; all people sixty-five and older; and all those physically disabled or handicapped. This provision was, however, deleted by the president and the governing council when they reviewed the draft constitution.

FUNCTIONS OF PRIMARY HEALTH CARE

Primary Health Care (PHC) by policy arrangements is within the purview of Local Government, based on the residual operation of Local Government Authority. Primary health structures are unarguably the first points of call for the sick and injured persons. They undertake mild healthcare cases like treatment for malaria, fever, cold, nutrition disorder, among others. They are especially for milder health problems and health education. They also handle infant, maternal and pregnancy matters.

Other health issues in their care are family planning and immunization (Badru, 2003). Finally primary health centres emphasize health care and are involved in record keeping, case reporting and patients referral to higher tiers. Primary health centres are known within the system by content of health centre, maternity home/clinic and dispensaries. Primary healthcare centres refer complicated cases to secondary general hospitals. According to Medical and Dental Council of Nigeria (MDCN) in Badru (2003), primary health centres are also to undertake such functions as health education, diagnosis and treatment of common ailments, through the use of appropriate technology, infrastructure and essential drug list.

SOME ACHIEVEMENTS IN PRIMARY HEALTH CARE

Nigeria has made remarkable achievements in Primary Health Care, immunization coverage rates have increased from below 50% to over 70% in most areas of the country. Maternal and Child Health care services have also improved and are accessible to more communities; Safe Motherhood initiatives have gained momentum in most areas of the country.

The role of Traditional Birth Attendants (TBAs) and Community Health Workers (CHWs) has been recognized as an important one and more have been trained to conduct safe deliveries and improve the health status of their communities.

At least one health centre or health post can be found in most communities i.e. basic health care has been made available to the communities through the Primary Health Care system.

PROBLEMS IN THE IMPLEMENTATION OF PRIMARY HEALTH CARE IN NIGERIA

The Primary Health care system in Nigeria has not really benefited the citizens due to the following reasons;

the relatively notable problem of maldistribution of health personnel and facilities between rural and urban centres and the budgetary allocation to health at all levels of government are believed to be crucial factors, among others, still militating against the reality of PHC scheme in Nigeria.

A critical look at the National Programmes on Immunization (NPI) in 2005, for instance, shows that there was more success in the urban areas than the sub-urban and rural areas because there are more health infrastructures to sustain the programme in the former than in the latter. The success rate was 25% for urban children and 7% for the rest (CBN, 2005; Owumi, 2002). No wonder Nigeria has one of the highest rates deaths of under five children (0 to 5 years) in the world, that is, 178 per 1,000 births (CBN, 2005; Owumi, 2002).

Poor level of health awareness among the people especially in the rural areas, high rates of illiteracy, traditional conservatism and resistance to new ideas, deep rooted traditions, customs and beliefs and patronage of traditional healers. There is also shortage of trained health and medical personnel as well as their uneven distribution i.e. there is too many of the health workers are concentrated in the urban areas to the detriment of the rural areas. Another major challenge faced by the Primary Health care system in Nigeria is the deterioration of government and other health facilities, low salaries and poor working conditions for health workers which has resulted to the mass exodus of the health workers to other nations of the world especially the United States of America, United Kingdom and India.

Another major challenge faced by the Primary Health care system in Nigeria is the issue of poor transportation. There are inadequate vehicles to perform basic health tasks especially in the rural areas; this leads to poor services especially immunization services. In most cases, the few available vehicles are used for other purposes other than what they were originally intended for. There may also be underuse of available facilities due to difficulty associated with transportation and communication. Accessibility may also be a function of topography and weather.

Another major challenge faced by the Primary Health care system in Nigeria is the problem of finance. The money allocated to primary health care services is not usually enough. There is also the problem of over dependence of Local Government Areas on federal and state allocation; this is because most of the Health centres do not generate revenue that can sustain their activities.

There is also low level of community involvement in the Primary Health care system in Nigeria. Most times, it may depend on the lackadaisical attitude of the people, attitude to work by health workers (constant absence) or that those at the helm of affairs do not want to involve the local people. This has really led to the backward growth of the Primary Health care system in Nigeria.

Leadership problems are another problem faced by the Primary Health care system in Nigeria. Leaders do not care about what is happening in the system and those who care do not know what to do about the problems and those who know what to do about the problems do not have the financial capability to carry out reforms. There is also general misuse and abuse of scarce resources. There also lack of understanding between decision makers and Primary Health Care workers resulting in poor quality services.

CURRENT GAPS IN THE PRIMARY HEALTH CARE SYSTEM IN NIGERIA

The following are currently the areas that are lacking behind in the Primary Health Care system in Nigeria;

The Primary Health Care system in Nigeria lacks specialized medical services such as radiotherapy, orthopaedic procedures and surgeries. Also some of the health workers are

untrained while the trained ones lack the modern concept of the Primary Health Care system practice. This has reduced the efficacy of the Primary Health Care system in Nigeria.

Community participation is a process by which individuals and family assume responsibility for their own health and those of the community and develop the capacity to contribute to their/the community development. Community participation help to address the health needs of the people ensures social responsibility, sustainability, cost sharing, enhancement of knowledge etc. This community participation is lacking in the Primary Health Care system in Nigeria and it has reduced the success of the system.

Most people are not aware of some available services in Primary Health Care system because serious awareness has not been created for the program and the ignorance of the people about these services has led to underuse of services. For instance, maternal and child health services are underused in the country especially in Northern Nigeria.

The challenges along the pathway of the scheme in Nigeria can be summarized as follows: poor accessibility to the few health facilities in both urban and rural centres, Inadequate balance between curative and preventive health services, Inadequate support infrastructures like pipe-borne water, electricity, etc.

Beyond the limitations highlighted above, critical observers in recent times have argued that the scheme still suffers from inadequate awareness and mass mobilization for increased involvement of the citizenry in PHC activities. Till now for instance, a greater proportion of the rural population in many communities do not seem to know what PHC is all about, nor are they aware of the various services under the PHC scheme (Metiboba, 2005; 2009).

RECOMMENDATIONS

There is no uniformity in the ranking, organization and service utilization of PHC services in most communities in Nigeria. The pattern is likely to be the same in the urban centres because most of our cities have become receiving ends of ceaseless migrants from the rural areas (Metiboba, 2009). One major conclusion that has been reached from this review is that every community will want to opt for a PHC service whose end they are able to see more clearly and utilize more to advantage, among several alternatives.

It is therefore recommended to government and all stakeholders in the health industry to endeavour to first clearly understand the needs and aspirations of their target population before delivering any health service to them. This is because it is abundantly clear that every

community has its unique health needs and preference. Both health providers and consumers should work together as partners in progress and treat one another as rational beings.

It is also recommended that PHC policies should be tailored to the recommendations of the Sustainable Development Goals as a guide to reach more people with the needed health care service.

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