REFORMING PRIMARY HEALTH CARE IN AKWA IBOM STATE

UDOH N. B.
Department of Community Medicine University of Nigeria Teaching Hospital Enugu.
(on in-service training from Akwa Ibom State Civil Service)

INTRODUCTION:

Society and all social systems are dynamic which means that changes occur continuously. Some changes occur spontaneously while others are planned and executed. Planned changes, or reforms, occur in all sectors of life, the aim usually being to improve efficiency and performance in the system so that society could be better served. Since health is now regarded as a central focus in the overall developmental efforts of human societies, planned changes in the health sector occur very rapidly [1]. These changes have engendered profound impacts on the health of nations, leading to visible improvements in the quality of life. Primary health care is one such planned change. Since its definition and adoption in 1978 [1], primary health care, where properly implemented has led to tremendous improvement in the health status of various communities as shown by drops in maternal mortality, infants mortality and other indices used in assessment of the health status of communities. It has not been a smooth sail for primary health care in Nigeria, and by extension, Akwa Ibom State. In the hay days of the programme, for example, immunization coverage country wide, as at 1990 was 65% [2]. Recently, coverage is said to have dropped to just 13% [3]. At a stage, things took such a dramatic turn that an assessment by some workers indicated that primary health care has completely collapsed at the local government level [4]. For the drift not to continue, primary health care at the local government level, which itself is a reform, has to be reformed. In this article, we discuss reforms in general, in the health sector in particular and suggest measures to reform primary health care in Akwa Ibom State.

2. DEFINITIONS

2.1 REFORM

A reform is a change made to a social system or an organization to improve or correct it[5]. It is planned change deliberately instituted by people to achieve certain results.

2.2 PRIMARY HEALTH CARE

The Alma-Ata declaration of 1978 defined primary health care as "essential health care, based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the Community through their full participation and at a cost that the Community and the country can afford to maintain at every stage of their development in the spirit of self determination" [6]. As it was conceived, primary health care is the first level of contact of individuals and families with the country's health system. It is based on the principles of intersectoral collaboration, appropriate technology, community participation and equitable distribution. Components approved at the Alma-Ata Conference included health education, adequate supply of good water and sanitation, adequate food supply and nutrition, immunization against preventable diseases, control of locally endemic diseases, treatment of common diseases and injuries, maternal and child health including family planning and provision of essential drugs. Components later included in the list are mental and dental health. The sector charged with implementation of primary health care in Nigeria according to the National Health Policy is the Local Government Council [7].

Correspondence: Nestor B. Udoh, Senior Registrar, Department of Community Medicine University of Nigeria Teaching Hospital Enugu.

2.3 PRIMARY HEALTH CARE SECTOR REFORMS

Reforms occurring in the primary health care sector are primary health sector reforms. Health sector reforms are broad based, purposeful and sustained fundamental changes in function, structure and performance of the health system in order to deliver efficient, qualitative, affordable, accessible and effective health care services to the population to ultimately improve the health status of the people [8].

3.0 AREAS COVERED BY REFORMS

For any reform to be meaningful, it must cover a broad range of areas. Some of these include human resources training and orientation, infrastructure, finance, nformation management, quality monitoring, general administration, legislation, health policy formulation, public-private mix, among others.

4.0 DYNAMICS OF REFORMS

As already stated, a reform is essentially a planned change. Kurt Lewin in his field force theory has explained that planned change is always bound to meet with forces pushing for the change and forces pushing against the change, in other to words resistance [9]. Such forces could be internal or external. Resistance to change could arise when people do not like the change, when they fear that it may alter their consolidated benefits or their power base and in particular when the change is introduced by those they do not like.

5.0 STRATEGIES IN HEALTH SECTOR REFORMS

Many strategies have been adopted by health planners in implementing reforms in the health sector. Some of these include decentralization of services, free health services to target groups, for example pregnant women, introduction of user fees, cost recovery schemes, health insurance, development and use of paradigms, research and human resources development, introduction of new technologies, introduction of new management techniques, policy formulation and development of health infrastructure.

6.0 REFORMING THE HEALTH SECTOR IN AKWA IBOM STATE

Not all the strategies adopted for implementing reforms as enumerated above will be discussed in searching for ways of reforming primary health care in Akwa Ibom State. All are important but some are more fundamental than others. It is pertinent, however, to ask certain fundamental questions to guide us as we move towards reforms. First, where are we now? Second, where do we want to be and finally how do we get there?

6.1 WHERE ARE WE NOW?

It will be superfluous to consider all the components of primary health care individually in determining where we are in their implementation. Certain selected indices give a clear picture of the present state of primary health care implementation in any community. We shall consider only three of such indices.

Maternal mortality and infant mortality are two such indices, and their reduction have been listed among the United Nations millennium development goals [10]. Maternal mortality rate is one of the most sensitive indices of development in any community, and in Nigeria, ranges between 750 1000/100,000 women [11], [12]. Infant mortality rate is no less sensitive. It is a measure of the effectiveness of health services as well as the socio-economic development of a country, and in Nigeria, it ranges between 80 110/1000, which is up to 10 times greater than that of industrialized countries[13]. Immunization coverage is said to stand at 13% in Nigeria currently, as mentioned before. We note, regrettably that most of

the factors in our environment responsible for the high maternal and infant deaths are preventable and responsive to simple measures such as supply of good drinking water, environmental sanitation, good nutrition, health education, immunization and provision of infrastructural facilities that improve the standard of living of the Community [13].

6.2 WHERE DO WE WANT TO BE?

The path had already been charted by Ransome Kuti, former health minister when he wrote: "MY vision for the future is clear: I look forward to the day when, for all time, the fear of ill-health will be removed from our homes and villages by the availability of health services that are accessible, affordable and acceptable to every Nigerian" [14]. When this shall have happened, we shall witness drops in maternal mortality and infant mortality that reach levels that have been attained by the United States of America and Britain. Routine immunization coverage, too, would then stand at 100%.

6.3 HOW DO WE GET THERE?

To get to that destination is not easy and requires carefully planned and executed changes in the health sector. Inevitably, we shall go back to some of the components of PHC to see how we can use them as vehicles.

6.3.1 HEALTH EDUCATION

Health education is so important that it is the first of the components of primary health care as approved by the Alma-Ata Conference. The fact remains that health Education, when effectively delivered, has the potential for saving many more lives than any one research discovery, even in the foreseeable future [15]. In Akwa Ibom State, the University of Uyo has graduated many nurses from the state Civil Service in health education at Bachelors degree level. Unfortunately, most of these nurses are structurally unemployed because the health services management board is spending more time trying to determine which nurse is a graduate nurse and which is a nurse graduate. Our suggestion is that since their qualification is too potent to be wasted, such nurses should be identified and deployed to head health education units in all local government PHC units. Also, each general hospital should have a health education department where these nurses should be deployed to work full time, with one of them as head.

6.3.2 WATER SUPPLY AND SANITATION

The efforts of the present administration in providing potable water, especially in the urban areas is commendable. This should continue, because up to 80% of all human diseases are water borne, and with good water supply alone, these will be preventable [16]. Refuse disposal is an expensive business, and in some developed countries, governments spend as much as 20% of their revenue on refuse disposal. Sanitary inspectors were a feature of public health activities in the olden days. Existing staff of health units in local government councils should be reoriented to perform this function, and new ones should be recruited and trained. Sanitation courts should be established in each local government to back their activities and prosecute offenders who refuse to abate nuisances.

6.3.3 MATERNAL AND CHILD HEALTH

Free medical services to target groups, as we have mentioned, is a potent strategy in health sector reforms. It was therefore sweet music to the ears when the Commissioner for health announced that pregnant women and children under 5 years will enjoy free medical services [17]. Later on, disabled and aged people should be included.

6.3.4 IMMUNIZATION

Routine immunization, especially at the peripheral centres in the local governments should be strengthened. Policy makers should not believe that the 'fire-brigade" circus shows called "immunization

Days" are any thing near solving the problems of preventing immunizable diseases in the Community. They only help to line the pockets of some corrupt officials. Vehicles, motorcycles, bicycles, cold boxes, vaccine carriers should be provided in adequate quantities, and the cold chain should be maintained at all times.

6.3.5 PROVISION OF ESSENTIAL DRUGS

Health services without drugs easily lose credibility. It should be ensured that the drug revolving fund programme, recommended at the Bamako initiative [18] is revived and implemented in all local government councils. This will ensure adequate and uninterrupted supply of good quality drugs in the primary health care system.

6.3.6 STAFF TRAINING AND DEPLOYMENT

Since primary health care is a specialized area of health, it was realized that a new cadre of staff whose training was oriented towards service in the rural communities was needed. This led to creation of schools of health technology in the country to train community health extension workers. Public health nurses and community health officers were trained in University teaching hospitals. Syllabuses were drawn for training of volunteer village health workers and traditional birth attendants at local government levels.

But so far, no co-ordinated attempts have been made to train medical doctors to take charge of primary health care at the local government level. This has left a yawning vacuum in the leadership of primary health care at this level, with the result that every Tom, Dick and Harry is now struggling to be designated a primary health care (PHC) Co-ordinator. At the inception of PHC in Nigeria, it was recommended that "existing LGA health departments can be restructured by assigning a medical officer of health to be the PHC Co-ordinator. If this is not possible, a senior Community or public health worker can be designated PHC Co-ordinator [19]. For the avoidance of doubt, a medical officer of health is a doctor with postgraduate qualification in public health such as a masters degree (MPH). An example was Dr. Isaac Ladipo Oluwole who was only appointed the first African medical officer of health for Lagos in 1936 after he went back to Glasgow to obtain a Diploma in Public health [20]. The story of his exploits in that office has been well told [20], to the extent that today he is recognized as the father of public health in Nigeria. We shall not enumerate the function of a medical officer of health here but this can be found in laws of Akwa Ibom State [21]. It will be obvious from here that such functions can only be effectively performed by someone with the requisite training. We note that a competent council can appoint its own medical officer of health. In Akwa Ibom State, all councils are competent, and can easily do this. What needs to be done is a legislation to compel each council to, first, appoint a medical doctor to head its health department. Thereafter, the Ministry of health should arrange with departments of Community medicine in some Universities to train these doctors to obtain an MPH to enable them function as medical officers of health and PHC Co-ordinators. This will end once and for all the unnecessary bickering currently going on as to who heads the PHC departments at the local government level. This is what obtain in areas where PHC has taken root, particularly in Western Nigeria, where the best indices in primary health care in the country are recorded. Once such structures backed by law are laid, it should not be subject to changes at the whims and caprices of policy makers who feel that doctors are only useful working in hospitals where diseases are treated. Infact, a well developed PHC system manned by a doctor trained in the field results in the reduction on incidence of preventable diseases, thus reducing the work load of doctors in hospitals and decongesting these secondary health care outlets.

6.3.7 **CONCLUSION**

Political will and commitment for PHC at the highest policy making level is of utmost importance for putting the system in place and on a sound footing. All the suggestions made here to improve and reform primary health care in the state are not utopian, and can be achieved with time, especially given the enormous material and human resources available in the state. The caveat, however is that people with the requisite training should be deployed at all levels of the system to give the necessary direction.

REFERENCES

1. *World Health Organization. Alma-Ata declaration for primary health care WHO health for all series No. 1, 1978.*

2. *Federal Ministry of Health, Nigeria. Multiple Cluster Surveys. Lagos FMOH 1990.*

3. *National Population Commission (Nigeria) Nigeria demographic and health survey 2003.*

4. *Olumide, A. E., Obionu, C. N and Mako, V. I. An assessment of the quality of PHC in Nigeria. In: Ogbalu, M. M. (Ed) Primary Health Care: A mass oriented health system. Amawbia. Lumos (Nig) Ltd. 2004 p. 156*

5. *Oxford Advanced Learners Dictionary of Current English. 6th Edition 2001.*

6. *WHO (1978). Health for all series No. 1*

7. *Ogbalu, M. M.: Primary Health Care, a mass oriented health system. Amawbia Lumos Nig. Ltd, 2004*

8. *Longe, A. R. J. and Idris, J. Ongoing health sector reform in Lagos State, Nigeria. Special publication of the Nigerian Network on poverty reduction, reproductive health and health sector reforms. Intelfit Africa training centre, Lagos. 2004 p1*

9. *Lewin, K. Field force theory in social science: selected theoretical papers. New York. Haper Brothers 1951.*

10. *United Nations Millennium Development goals. Page 1 of 1 2005 http://www un.org. Millennium goals 1*

11. *Lucas, A. O. and Gilles, HM. Family Health. In: A short textbook of public health medicine for the tropics. London, Arnold. 2003 p. 320.*

12. *Onadeko, M. O. Maternal and Child health state in Nigeria. WHO/FMOH 2003.*

13. *Obionu, CN. Primary Health Care for Developing countries. Enugu. Delta publications. 2001 p. 126 137.*

14. *Ransome Kuti, O. O. vision of the future. In: Strengthening Primary Health Care at the Local Government level Lagos. FMOH 1990 p. 161.*

15. *Parks textbook of preventive and social medicine. India. M/s Banarsidas Bhanot. 17th edition 2002 p. 622.*

16. *Duncan, J. K. W. Water supplies and Health of Africans. IN: Sofoluwe, G. O., Schram R. and Ogunmekan, D. A. Principles and practice of public health in Africa, Ibadan. University Press. 1996 p. 146*

17. *Emah, O. J. Commissioner for Health in a speech, Akwa Ibom State Branch of the Nigerian Medical Association Meeting. August 2006*

18. *Obionu, C. N. Provision of essential drugs. IN: Primary Health Care for Developing countries. Enugu. Delta Publications. 2001 p. 213*

19. *Ransome Kuti, O., Sorungbe O. O. A., Oyegbite, K. S., Bamisaiye, A. Strengthening Primary Health Care at the Local Government level, The Nigerian experience. Lagos FMOH 1990 p 32.*

20. *Schram, R. A. history of Public Health in Africa. In: Principles and practice of public health in Africa. Volume 1 p 32*

21. *Laws of Akwa Ibom State and certain Federal enactments. Uyo, Ministry of Justice Volume 5 P 329-359. 2000.*