Abstract

The paper examines the primary health care delivery in Nigeria. Existing literature reveals that primary health care was established to cater mostly for those in rural areas where improved facilities are almost nonexistent. This implementation was in line with Alma Ata Conference of 1978 in which Nigeria was a signatory among the 187 countries accepting the primary health care for all citizens of the world. It is expected to fulfill four basic conditions of viable health care plan of accessibility, affordability, continuity and quality of services. Thereafter the aims, objectives and the component of primary health care as well as its functions are examined. The paper also discusses the problems hindering the effectiveness of primary health care in Nigeria, among which are lack of political will and commitment by the three tiers of Governments in Nigeria, federal, state and local government. Inadequate funding, poor staffing, lack of supervision and monitoring, corruption etc. Base on these, suggestions are made on how it can be more effective in the Nigeria society.

Introduction and General Overview

Primary health care is an integral part of the health care system that was imported into this country (Nigeria) by the colonial masters. Existing literature reveals that as a result of the shortcomings of the western medicine and its attendant’s implications for health care in the developing countries with particular reference to Nigeria, the situation has not been favourable.

Eguagie (2005) and other studies have reported that facilities were “almost non existent in the rural areas”. This ugly situation led the then Director General of the World Health Organization (WHO), Mahler to propose the primary level health care approach to integrate at “the community level all the elements necessary to make an impact upon the status of the people” (WHO 1975, Adetoro 1989). For him, the goal is an acceptable level of health evenly distributed throughout the world’s population (Mahler 1975). This is expected to yield health for all by the year 2000 (Jegede, 2002). The programme was expected to meet four basic conditions of viable health care plan of accessibility, affordability, continuity and quality of services. The emphasis was to educate the people on ways of preventing diseases with the provision of a health care system based on the spirit of self-reliance and self determination. In the words of Alma Ata (1978) the concept of PHC is cited in Lucas (2006):

“primary health care is 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 reliance and self determination. Source WHO (1978).

This familiar definition of PHC encapsulates its fundamental concepts and provides guidance on its implementation. It includes the seven key elements that characterize PHC as stated by Lucas (2006) (see table 1)
Table 1: Seven Features of Primary Health Care (PHC)

<table>
<thead>
<tr>
<th>No</th>
<th>Features of PHC</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>An element of the Health system</td>
<td>Primary health care... it forms an integral part both of the country's health system and it is the first level of contact of individuals, the family and community with the national health system.</td>
</tr>
<tr>
<td>2.</td>
<td>Focus on priorities</td>
<td>Essential Health care...</td>
</tr>
<tr>
<td>3.</td>
<td>Scientific Basis</td>
<td>Based on scientifically sound...</td>
</tr>
<tr>
<td>4.</td>
<td>Culture Sensitivity</td>
<td>Socially acceptable methods and technology...</td>
</tr>
<tr>
<td>5.</td>
<td>Equity</td>
<td>Made universally accessible to individuals and families in the community...</td>
</tr>
<tr>
<td>6.</td>
<td>Community participation</td>
<td>Through their full participation...</td>
</tr>
<tr>
<td>7.</td>
<td>Sustainability and self reliance</td>
<td>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.</td>
</tr>
</tbody>
</table>


Adeyemo (2005) and Ademuwagun et al. (2002) reported that there are (10) components of primary health care. They include:

i. Education concerning prevailing health problems and the methods of preventing and controlling them;
ii. Promotion of food supply and proper nutrition;
iii. Adequate supply of safe water and basic sanitation;
iv. Material and child health care including family planning;
v. Immunization against the major infectious diseases;
vi. Prevention and control of locally endemic diseases;
vii. Appropriate treatment of common diseases and inquiries;
viii. Provision of essential drugs;
ix. Community mental health care; and
x. Dental health

It is worthwhile to mention that various studies have reported that the principle upon which the primary health is founded, is that health is a fundamental right to be enjoyed by the people in all walks of life in all communities. However the authors view is: How realistic is the laudable objectives of the primary health care services in Nigeria? It was initially said that by the year 2000 the health of the people would have been improved by more than 80% through the PHC. In other words, more than 80% of the population would have good health status. But this goal has not been achievable even in 2009.

The aim of this paper is to examine the role of primary health care in the Nigeria health care delivery system and raise other issues pertaining to primary health care. After the introduction and overview presented in this section, the rest of our discussions will be structured as follows: Section (2) discusses the sociological role of primary health care in Nigeria; Section (3) provides the need to reform primary health in Nigeria; Section (4) highlights the functions of the primary health care services delivery. In section (5) we state the conclusion and recommendation.

Sociological Role of Primary Health Care

Primary health care was established essentially to bring health closer to the people at the community through their full participation. Adeyemo (2005) reporting W.H.O. (1987) specified the aims and objectives of primary health care as follows:

i. To make health service accessible and available to all people wherever they live or work.
ii. To tackle the health problems causing the highest mortality and morbidity at a cost that the community can afford.
iii. To ensure that whatever technology is used must be within the ability of the community to use effectively and maintain.

iv. To ensure that in implementing health programme, the community must be fully involved in planning the delivery and evaluation of the services in the spirit of self reliance

In sum PHC is essentially aimed at:

i. Promoting health
ii. Preventing disease
iii. Curing disease
iv. Rehabilitating people to live full and normal lives after an illness or disability.

According to the Nigeria Constitution of 1999, the federal, state and local government shall support in a coordinate manner a three tier system of health care, viz

a. Primary health care for local government
b. Secondary health care for state, local government
c. Tertiary health care for federal government

Simply put, primary health care shall provide general health service of preventive, promotive, curative and rehabilitative nature for the population as on the entry point of the health care system.

The Need to Reform Primary Health Care in Nigeria

It has been observed that primary health care services are bedeviled with a number of problems. This has accounted for the non attainment of health for all in the year 2000

Table 2 shows the Nigerian PHC System with Respect to PHC Target for 2000AD

<table>
<thead>
<tr>
<th>PHC component</th>
<th>c/o Target achieved as at December 1992 (this fig. Declined drastically since then)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.P.I coverage</td>
<td>54.4%</td>
</tr>
<tr>
<td>Antenatal care</td>
<td>48.4%</td>
</tr>
<tr>
<td>Nutritional status/pregnant women</td>
<td>34.4%</td>
</tr>
<tr>
<td>Attendance at delivery</td>
<td>52.3%</td>
</tr>
<tr>
<td>Contraceptive prevalence</td>
<td>38.0%</td>
</tr>
<tr>
<td>Access to health services</td>
<td>43.3%</td>
</tr>
</tbody>
</table>


Table 3: Health/Personal Requirement Need and Gap

<table>
<thead>
<tr>
<th>Category</th>
<th>No available</th>
<th>Location</th>
<th>No needed</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>1</td>
<td>Nil</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>CHO</td>
<td>2</td>
<td>HQ</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>S/N/M</td>
<td>6</td>
<td>NQ/HF</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>S/N</td>
<td>6</td>
<td>HQ/HF</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>S/N</td>
<td>6</td>
<td>H/Facility</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>CHEW</td>
<td>11</td>
<td>HQ/HF</td>
<td>18</td>
<td>7</td>
</tr>
<tr>
<td>EHO</td>
<td>5</td>
<td>HQ/HF</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>MRO</td>
<td>2</td>
<td>HQ/HF</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td></td>
<td>67</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: Oladipo (2006)

As indicated in table 3 the number of health personnel i.e. category of different profession required fall short of the ones available, whereas the total No of personnel was put at 67 but 9 were available while the gap stood at 28. In view of the population that is much; more health personnel ought to have been provided to this effect. It can be observed that some of the targeted beneficiaries of health services were not serviced. Even where they are available the concentration is in the urban to the neglect of rural areas.
Eguagie 2003 and Adeyemo (2005) reported another problem of transport in their studies. It was found that workers have not enough vehicles to perform their task especially in rural areas. The irregular accessibility to many parts of the communities owing to natural topographical conditions such as excessive flooding during raining season, hilly and mountainous terrain of the landscape has also been reported by other studies.

The problems of finance and the level of community involvement in PHC management are other matters for concern. There is evidence of low community participation. The general misuse and abuse of the scarce resources, human, material and financial by some political and administrative leadership is also a problem.

Similarly lack of continuity of local government area, leadership poses another problem. This has accounted for inconsistencies in health policy decisions.

If the primary health care is to function to meet its objective, there is the need for a quick reformation by federal, state and local governments towards a change of attitude in all spheres. Lucas (2006) has asserted that there is the need to tailor the training of health professionals to meet the needs of health services in developing countries (Ramsome-Kuti, 1990). The most recent World Health report deals with the global crisis in human resources for health (WHO, 2006b), also the authors are of the view that there is the need to train health personnel who have a thorough understanding of PHC and can make their delivery of health care compatible with the philosophy enunciated at Alma Ata conference.

Functions of the Primary Health Care Services Delivery

According to Adeyemo (2005) the primary health care system also gives recognition to local people with little or no formal education who could be trained to perform some basic health services. In other words the use of traditional birth attendants or midwives (TBA) or traditional healers is indispensable in the villages. The community health workers are being made use of as key factors in the delivery of preventive health care. They perform the basic functions such as:

i. Delivery of high quality basic first aid;
ii. Recognition of signs and symptoms of more serious conditions;
iii. Delivery of babies under more hygienic conditions;
iv. Educating their fellow villagers in understanding the disease process in their community.

Complementarily, the PHC system employs the concept of village health committees usually composed of local residents chosen without regard to political affiliations, sex and age

Recommendation and conclusion

This paper is of the view that if primary health care delivery is to achieve its aims and objectives that led to its establishment globally, the following suggestions should be implemented. The federal, state and local governments including other stakeholders should observe the following:

The three tiers of government should increase their allocation to health sector. The local government should be more inward finance generating to boost the health sector within their jurisdiction to avoid the dependence on the federation account in financing health programmes.

The living standard of the people in the rural areas should be improved in all spheres of life. Also intensive and effective health education should be put in place to sensitize the people in order to avoid such disease as malaria, typhoid and other infectious disease.

The issue of poor leadership and political instability has been responsible for unsuccessful implementation of most government policies and programmes on health care delivery. In other words if there is good leadership and political stability, it will provide an enabling environment for the implementation of PHC programme. This will help to address abandoned projects in the health sector by successive governments.
The Role Of Primary Health Care In Nigeria. Health Care Delivery Systems: Problems And Prospects

There is the need for adequate supervision, monitoring and evaluation of programmes in order to ensure that wastage, abuse and misappropriation of funds are avoided. Also adequate manpower should be provided.

The Nigeria health policy makers should give adequate attention to the training of more rural health workers to urban centres. Also more monetary and other fringe benefits and incentives should be provided to prevent the high turn over of health workers.

In conclusion, the primary health care was established as a result of the inadequacies and the shortcomings of western medicine and the implications of this for the health condition of the people in the developing countries. The programme was expected to fulfill four basic conditions of viable health care plan of accessibility, affordability, continuity and equality of services. The problem confronting its effectiveness and suggestions on how to improve the services of the primary health care have been examined in this paper.

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