Chapter 1

ROLES OF MANAGEMENT IN THE SUSTENANCE OF A COST EFFECTIVE PRIMARY HEALTH CARE PROGRAMME FOR THE PREVENTION OF DISABILITIES IN NIGERIA

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Introduction

Management has become a household concept in recent times in almost all spheres of human activities – at home, at work, even at play. It is a common occurrence to hear "things have failed due to bad management". This and other similar statements point to the fact that man is in search of something that is lacking and that thing is "the ability to get things done". The importance of management therefore came as a result of the need to get things done with increased efficiency taking available resources into consideration.

The health sector is not left out in this quest. It has become more essential in the health sector because of its multidisciplinary nature both in the health sector and work output. This is in addition to the fact that most of the professionals in the health sector get to management position more on the job (through promotion to the highest cadre with its attendant responsibilities) rather than through training. Also, most of the professionals saddled with managerial responsibility in the health sector find themselves implementing a programme they did not take part in planning. This often leads to confusion, arising from trying to completely separate the responsibility for planning from managerial performance. This is because all managers irrespective of their levels do plan.

Consequently, the importance of management is nowhere better required than in the case of some underdeveloped or developing countries. Review of this problem in recent years by economic and development analysts has shown that provision of capital or technology does not ensure development. The limiting

factor in almost every case has been the lack of quality and vigour on the part of managers. An excerpt from the Nigeria's 4th National Development Plan of 1981 to 1985 corroborates this fact. It states that "poor management leading to inefficient utilization of resources has been identified to be a serious handicap to the efficient delivery of health care in Nigeria".

The worldwide acceptance of Primary Health Care (PHC) as the key to the organisation of more relevant and effective health care system after the 1978 Alma Ata Conference has made management even more important not only in the health sector but also in supporting services. Sequel to this acceptance was the adoption of management techniques, which resulted from the belief of member states of the World Health Organisation (WHO) that better management of health services is essential if higher standards in the National Health Care delivery system are to be achieved. This management technique they agreed would differ from state to state because of the differences in the already existing health care systems.

Nigeria, one of nations that accepted the PHC concept implements it as a strategy to make essential health care accessible to the entire population. This is in line with the then Federal Government of Nigeria's adoption of Health For All scheme by Year 2000 (HFA 2000) which formed fundamental objective of the state policy.

What is the history of health development in Nigeria? What are some problems associated with the health sector? When did Nigeria start the PHC programme and how is it run? Does management has any role to play in running it? These and other questions are what this chapter attempts to answer.

Definition of Primary Health Care

Primary Health Care (PHC) as defined in the Alma Ata Declaration of 1978 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 and through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contract of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitute the first element of a continuing health care process".

The Alma Ata s statement goes on to emphasise the multi-sectorial nature of PHC, the pre-requisite of community participation in planning, organisation, operation and control, making fullest use of local, national and other available resources and the appropriate education of the community. Self-reliance in the statement implies taking initiatives, determining what can be done without external resources when appropriate and deciding when to seek external support for what purpose and from what resources. Self-reliance is not synonymous with self-sufficiency as it is unattainable.

PHC is intended to:

(a) reach everybody, particularly those in greatest need;

(b) reach to the home and family level; it is not limited to health facilities;

(c) enable members of the community to take up the responsibility for their own health.

For effective implementation of PHC, there are five concepts that have been identified as prerequisite. These are:

(1) universal coverage of the population, with care provided according to need.

(2) services should be promotive, preventive, curative and rehabilitative.

(3) services should be effective, acceptable, affordable and manageable.

(4) communities should be involved in the development of services so as to promote self-reliance and reduce dependence.

(5) approaches to health should be related to their sectors and development.

To achieve these, eight activities were identified as the main focus of PHC. These activities are also referred to as elements of PHC. These are as follows:

i promotion of nutrition.

ii.. provision of adequate supply of safe water and basic sanitation.

iii. maternal and child care including family planning.

iv. immunization against the major infectious diseases.

v. prevention and control of locally endemic diseases.

vi. appropriate treatment for common diseases and injuries.

vii. education concerning the prevalent health problem and method of their prevention and control.

viii. provision of essential drugs.

In Nigeria, mental and dental health have been added to the list. Taken together, elements of PHC fall unto three main interacting areas of activity, namely:

1. co-ordination and collaboration with other sectors, for example, agriculture, water and sanitation, community development, roads and transport, education and others.

2. establishing firm roots within the community with active involvement and participation of the people to encourage self-reliance.

3. wholehearted support for formal health system with regard to training, logistics and referral problems.

PHC is both an approach as well as a concept. As an approach, PHC places emphasis on comprehensive (curative, preventive, promotive and rehabilitative) health care, which should be developed with the population even in the remotest areas of the country. As a concept, PHC places emphasis on several health related activities (such as nutrition, sanitation, housing, safe water supplies, agriculture and so on) many of which are outside the traditional responsibilities of the Ministry of Health. Furthermore, PHC will be successful only if it is integrated into the socio-economic development of the population, with maximum individual and community self-reliance and participation.

How PHC Evolved

Primary Health Care emerged as a result of the sequence of events and developments in the health care system. At the time of their independence, some Third World countries had inherited a health system largely intended to care for

the colonial administrators, the military and the civilian elite. The large bulk of the population had to make do with whatever form of health care was available, largely in the private sector, the traditional systems and home remedies. The concept of health centres had evolved in the fifties and in some countries, early developments in preventive promotive medicine had taken place. At independence, national leaders in all countries had made a commitment to better health for their people. Consequently, early developments in the health infrastructure took place along two main paths namely:

(a) along conventional lines – development in hospitals was associated with improvements in the quality of care and the development of centres of excellence as was the case in India, Indonesia and most of south-east Asia and Nigeria.

(b) building of health centres and their satellite centres including health posts as in Tanzania, Zambia, and some countries of sub-Saharan Africa.

Unplanned provision of health infrastructures together with trends of administration inherited from the past soon led to several disparities. First, there arose the disparity between expenditure and needs. This was because in most countries more than three-quarters of health budget was being spent on hospitals which were mainly urban and catered for diseases whereas the need was for prevention, improved nutrition, personal hygiene and environmental sanitation. Preventive services like the under-fives' clinics and ante-natal care did not receive much emphasis in national health plans.

Secondly, there was the disparity between resource allocation and population distribution. Most of the health personnel and capital resources remained sequestered in the urban areas catering for the elite even though the population was largely rural, or lived in urban squatter areas. A large share of the annual recurrent expenditure went into servicing capital resources.

Thirdly, disparity arose on account of rapid population growth and the accompanying growth of services. Because of the hospital oriented and hence capital intensive model of health infrastructure which was adopted, the growth in services was of necessity slow. Moreover, health planners came under pressure because of the overcrowding of hospital services which lacked the necessary epidemiological insights to notice the worsening state of services in semi-urban and rural areas.

Owing to some of the listed disparities, there occurred several problems having to do with:

i uneven distribution of health care facilities and in many countries expansion centred in urbanised areas.

ii absence of regional networks with proper referral links.

iii lack of specific definitions of promotive, preventive, curative, rehabilitative and supportive functions for each level of care resulting in misuse of complex facilities for primary care.

iv staffing – lack of appropriately trained personnel aggravated by misadministration and a combination of education and specialisation that is inappropriate for the tasks performed.

v general lack of encouragement for management training at all levels and lack of definition of roles and career structures.

vi lack of simple low-cost materials and methods designed for and adapted to local conditions.

vii maintenance – mixed equipment and material drawn from different sources were often without backup or spare parts – repairs, replacement and so on.

viii not only limited resources but also from poor coordination of different sources of funds – inappropriate allocation, lack of incentives for cost containment and control, and insufficient attention to the interrelationship between investment and running cost with too much emphasis on investment cost.

The foregoing brought about a rethinking on emphasis and principles should be in health development. Consequently, there was a widespread agreement that a better balance is needed between facilities at various levels, typically consisting of the sub-centre (or clinic/dispensary), the health centre, and the district/rural

hospital. The limited coverage offered by hospitals in any event makes it absolutely essential that a halt be placed on furthering the development of large hospitals so as to allow for rapid expansion of a network of primary care institutions.

As a result, a different approach to provision of health care was sought for. Towards the Sixties, the concept of Basic Health Services (BHS) emerged. Adequate coverage with simple preventive/promotive services like under-fives' clinics, antenatal care, immunisation, care during labour and so on were the main objectives of BHS. Such care did not require highly skilled personnel nor expensive technology but the services continued to remain largely institutionalised, and in many countries health centres and sub-centres ended up providing ambulatory curative care. This led to the World Health Organisation instituting the Executive Board Study on BHS in 1973 which focussed on the deficiencies of the existing health system and on the lack of health services for the overwhelming majority of world's population.

The convergence of new thinking in human development and alternative strategies in health planning together with several country experiences evolved into the Primary Health Care approach set out in the Alma Ata Conference in 1978.

Concept and Principles of Management

Management has existed ever since man was organised into communities. It is sometimes thought of as an invention of the 20th century but this is not so. Wherever and whenever people have worked together in groups – for whatever purpose – there has been management. Although management is so old and universal, it has no agreed single definition, instead there are many to choose from.

Perhaps the shortest definition one could come across has to do with the following:

Management as Getting Things Done

This definition is based on the principle of commitment to achievement, that is, commitment to purposeful action, not to action for its own sake. To stress this, this definition can be rephrased as management as saying what one wants to be done, and then getting it done. In other words, management sees first that objectives are specified and then those they are achieved. An objective is the

intended result or achievement or accomplishment of an activity or programme. This means setting a goal, a purpose or a target. This objective should state what is to be accomplished, how much of it, where it is to be done and when it is to be completed. In addition, an objective must be clear, specific, realistic (feasible) and measurable. This makes it possible to evaluate an objective. One is in approaching and reaching the set goals (objectives). Effectiveness here is the degree to which a stated objective is being achieved. Also, a clear statement of objective enables one to decide how to achieve it, that is, stating the end helps the means. An example of an objective is "To increase the proportion of children fully vaccinated with potent vaccines by first birthday in Ibadan from 20% to 80% by the year 2000 at the rate of 20% increase annually.

Management as Getting Things Done Through People

This definition's emphasis is on "getting things done through people" which shows that people are the most important resource or means for getting things done. Manpower however is not the only resource needed to achieve stated objectives. Other resources are material, money and methods. This definition should not be read to mean only that someone (a manager) commands and others (people) execute although this happens in practice.

Another useful definition of management is:

Management as The Efficient Use of Resources

The key concept in the above definition is efficiency which is concerned with the balanced use of resources, that is, the achievement of desired result with less effort using minimum resources and minimum wastage. Firstly, balance among different types of manpower is required. For example a teacher would not be able to teach unless someone opens and prepares the classroom. This is what is called division of labour: work must be shared by, or divided among a number of different categories of technically skilled people. When this principle is correctly applied and work is divided or distributed among members of a group, the group becomes a team. The team approach is the way that management attempts to bring about balance among the different professionals concerned. It must be noted that balance should also be maintained between other types of resources. Often when resources normally used to provide services become scarce or too expensive, different resources or different balance of resources may be used to produce the intended results. For example, when purchasing food for a hospital kitchen, the cheap produce in season can be substituted for the other similar or

expensive food if it provides equal nourishment. One particular type of substitution of resources is labour substitution. An example is the use of volunteers or auxiliaries for specified tasks formerly done by professionals. In addition, there is another definition of management which brings together many of points in the three definitions already considered. It states that:

Management as Making Efficient Use of Resources and Getting People to Work Harmoniously Together in Order to Achieve Objectives

As has been mentioned, one of the advantages of stating objectives is that it helps in deciding HOW to reach them, that is, the activities needed to achieve objectives effectively and the methods and organisation needed to ensure that people work harmoniously towards realizing the objectives while using resources efficiently. This means that work activities should be so designed and directed as to support each other towards the achievement of objectives. It also implies that working relations should contribute to the success of each activity and so to the general effectiveness.

The last to consider is:

Management as Decision-Making

This stresses the most important element of management which is decision-making. A decision is a choice between two or more courses of action. In management terms, a decision is an answer to a question about possible courses of action which could be stated as Yes, No, More, None. The requirements for decision making are:

i information and decision rules.

ii well identified decision maker or body to whom the authority and responsibility for making decision concerned has been clearly assigned.

iii communication, that is, ensuring that the decision once made is known to all concerned – between those who make decision, those who implements and those affected by it.

iv decision should be timely or well timed for it to be useful, that is, it should meet the needs of the moment and should not be unnecessarily delayed.

Definition, Causes and Prevention of Disabilities

What is Disability?

Disability can be defined as any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being. Disability reflects disturbances at the level of the person, concerning customarily expected activity, performance and behaviour e.g. inability to walk or awkward inefficient gait, communication problems due to speech disturbances or hearing loss, difficulties in self care and daily living activities such as bathing, dressing, feeding, strange behaviour, mobility problems due to blindness or physical impairment.

At this point, there is a need to differentiate between disability and handicap. Handicap is a disadvantage for an individual resulting from an impairment or disability that prevents or limits the fulfillment of a role that is normal (depending on age, sex, social and cultural factors) for that individual. Handicap reflects consequences for the individual – cultural, social, economic and environmental – that stem from the presence of an impairment a disability.

Types of Handicap:

(a) orientation handicap – individual's inability to orientate himself in relation to his surrounding;

(b) physical independence handicap – reliance on aids and assistance of others in self care and daily living activity;

(c) occupational handicap – problems with employment, domestic role, play or recreation;

(d) social integration handicap – problem or difficulties in participation in social life; and

(e) economic self – sufficiency handicap – inability or restricted ability to sustain socio-economic activity and independence.

Impairment on the other hand is any loss or abnormality of psychological, physiological/anatomical structure or function. In principle it reflects disturbance at the level of the organ. Examples of impairments are loss of a leg or part of it,

stiffness of joint, hearing loss, visual disturbance due to cataract to mention a few.

Causes of Disabilities

Things that responsible for disability can be grouped under congenital or acquired classifications. Congenital causes comprise those occurring pre-natally and peri-natally such as poor nutrition of young girls, diseases in pregnancy, use of drugs during the first three months of pregnancy while acquired causes are those which occur after delivery and in the course of life like accidents, diseases, drug ingestion to mention a few.

Prevention of Disabilities

Prevention of disability can be defined as all measures aimed at:

1. preventing the occurrence of impairments (primary or first level).
2. preventing, limiting or reversing disability caused by impairment (secondary or second level), and
3. preventing transition of disability to handicap (tertiary or third level).

Primary Level of Prevention: This includes general education, health education, hygiene and sanitation, vaccination/immunization, legislation, improved nutrition and health care.

Secondary Level of Prevention: This comprises early detection and treatment of diseases and disasters.

Tertiary Level of Prevention: This comprises therapeutic measures including surgery, physiotherapy, occupational therapy, speech therapy, training in self-care, provision of technical aids, social and vocational counseling and guidance, vocational training, provision of education and suitable jobs, education of public to improve attitude and behaviour towards the disabled person and elimination of physical barriers.

It is important to point out that the secondary level of prevention and especially the tertiary measures overlap with those utilised in rehabilitation. These are used to prevent, reduce/reverse disability when it is and to rehabilitate the disabled person when disability is established and irreversible.

should recognize areas of constraints and uncertainty, (ii) distinguish clearly between those areas he can do something about and those he cannot, (iii) do whatever he can to reduce their effects on his team's performance in the immediate future, in the longer term and (iv) accept those he cannot alter and take them realistically into account in planning, scheduling, processing and in setting objectives and work goals.

Also the type of leadership employed is a critical factor for success in pursuing any objective through. Without effective leadership both individuals and groups are likely to feel directionless, dissatisfied and demotivated. The kind of leadership style to be chosen for sustaining a cost effective PHC programme should relate to performance where specific core duties are particularly well defined and accomplished to the prescribed standards in a certain order, in a short time; and a directive management leadership style. Similarly this kind of leadership style can be engaged where the personnel are lacking in experience or knowledge, where tasks are open ended with a competent and balanced personnel and time is available an open, consultative democratic leadership would be required.

(ii) **Using Objectives to Achieve Goal:** In sustaining a cost-effective primary health care programme in Nigeria, managers of such programmes should bear in mind that relevant, achievable objectives are the basis of meaningful planning. This is because it is imperative for aims to be defined, to focus on the purpose of what is being done and relate all activities to expected results. An approach to work planning through objectives should be concerned with such things as identifying areas which need priority attention, setting and monitoring performance targets and objectives in each area which will keep individuals on course to achieve specific work goals, measuring performance using indicators set to see whether what is set out to achieve is accomplished, using results of monitoring by feedback to tell people what they have achieved and to set new goals; or to assess why goals were not achieved and then take action to ensure future success. To achieve the above, objectives must be well formulated, that is, written down in clear unambiguous language, be specific in defining the area of responsibility referred to and the result to be produced, define a quantitative goal wherever possible and aim for measurable results and be keyed to a given time schedule.

Using objectives successfully in the sustenance of cost-effective PHC programme therefore implies that appropriate monitoring is

essential. It gives the opportunity to identify and resolve problems, modify goals or bring in additional resources to achieve objective. It also ensures that team members are on course and are motivated to continued effort. It gives feedback about progress, gives praises, offers improvement counselling or arranges for training where appropriate and re-discusses the goals to clear up any misunderstanding by mutual agreement. This review may be done every month, three month or six month interval depending upon particular tasks involved to get desired results.

(iii) **Programme Design:** This is another important factor in roles of management in the sustenance of a cost effective PHC programme in Nigeria. It should be ensured that greater flexibility is built into both project implementation, plans and budgets so that deficiencies in design and approach can be corrected as they appear. Also mechanisms for regular review and replanning should be built into the design. The manager of PHC programme should ensure that middle government officials both at federal and state levels are encouraged to participate in activities. Their involvement is important to the maintenance of political support for a project's goals. There should be close monitoring of projects so that implementation problems are identified early. In addition, short-term consultants should not be allowed to have the prime responsibility for project designs. This is because various steps in pre-project planning and design require continuity and familiarity with the community which short-term consultants do not do often.

(iv) **Cost and Government Financing:** At the planning phase, more rigorous financial analysis should be done alongside thorough cost analysis. This is important because provision of such cost data on PHC components, service and service delivery strategies would help in choosing most effective options.

In addition, community finance schemes should be thoroughly studied before application. Such studies would provide adequate information on services which communities are willing to pay for and to determine whether full or partial cost recovery is to be expected. It is based on the fact that realistic assumption can be made.

(v) **Community Participation:** The programme manager need to identify those elements of PHC for which community participation is most

essential. This would motivate the community. Based on the funding. The guidelines for community participation should be prepared so that careful planning and budgeting could be done while planning. It is important too develop specific indicators for measuring progress. For example, number of heads of households who are currently clearing drains in their surroundings. The manager in order to sustain a cost effect PHC programme in this area should make efforts to establish more conclusively whether or not community participation is critical for the success of some programmes in improving health and sustaining improvements. Some advantages this will offer are that (i) it gives planners a better understanding of local values, knowledge and experience; (ii) wins community backing for project objectives and community help with local implementation and helps to resolve conflicts over resource use.

(vi) **Community Health Workers (CHWs):** To run and sustain a cost effective PHC programme, the manager should consider using existing health care agents to deliver PHC services where the community is depended upon to finance CHWs. This will not only minimise duplication but also reduce programme costs. This is necessary because most communities have established traditional health care providers who already provide curative care. This is critical to obtaining community support because they are accepted as credible sources of care. It may therefore be worthwhile if the manager can experiment with upgrading curative skills of these health care agents, train them to deliver preventive care and then provide the financial support they need to deliver preventive services.

(vii) **Preventive Services:** There is a need to make use of some educational techniques. The systematic use of mass media can be stepped up to generate support for efforts of CHWs and other health care agents and also to increase the community's receptivity to preventive medicine. This should improve knowledge and understanding in that facts would be known, values and analysis of benefits and costs of alternative measure will be known. It also ensures that information will be available to inform public and private choices.

To sustain a cost effective programme, programmes seeking community financial support should adopt new strategies by concentrating on the establishment of curative and preventive services in high demand, and then gradually introduce a wider range preventive of preventing services. Accepted preventive intervention which benefits are perceived immediately should be emphasized. Following these steps can ensure that the quality of services would improve as would popular interest and support of health care programme.

(viii) **Management and Support:** To sustain a cost effective PHC programme towards the prevention of disability in Nigeria, the manager should see to it that fewer services in the early period of implementation is provided. This is to enhance the likelihood that intervention can be delivered and will be successful as specific well defined PHC projects with limited goals, objectives and selected interventions of proven effectiveness have the best chance of becoming established. In addition, he should embark on programme experimentation to help identify effective clusters of services that PHC programmes can deliver and later augment. Training programmes should also be embarked upon giving special attention to management and planning. He should also experiment with the use of private sector distribution systems for moving drugs and other supplies. This will reduce burden of supplying, operating and maintaining costly vehicles on the government.

(ix) **Management of Manpower:** Managers have often been defined as people who get their work done through people. Since people are the most important resource, the manager should understand factors which motivate individuals at work like recognition, growth or advancement, the job itself, responsibility and achievement. This emphasis the importance of open and honest communication.

To ensure the sustenance of a cost effective PHC programme in Nigeria, the manager should ensure that people under him know clearly what is expected of them, discuss goals and changes which affect them rather than presenting them without consultation, give people a sense of belonging by building a team climate in which there are no people who are in and others who are out, show individuals that their contributions and roles are recognised and valued by giving praise or thanks appropriately, ensure that staff are capable of tasks assigned them, ensure that staff are properly equipped and equipment are maintained, keep available resources at the level needed for the individual to perform. In

addition, he should monitor and summarise progress regularly giving constructive feedback about its performance, defend his team against outside attack, he should also maintain harmony, face up to and resolve conflict positively. He must foster a constructive open climate in which his team can express ideas and feelings without fear but with mutual trust and a sense of common purpose.

One important fact to note is that in an attempt to run and sustain a cost effective PHC programme, the manager would have conflicts to handle. Conflicts could be destructive or constructive depending on how it is handled, the PHC manager should acquire conflict management skills. Positive conflict properly handled leads to greater understanding and openness, reduced tension, better relationships and more trust within the team. Any conflict can become destructive if it becomes personal, drags on too long, becomes too intense or too frequent. Negative conflict breeds mistrust and hostility.

Positive handling of conflicts involves looking for solutions not for somewhere or someone to blame and avoid turning confrontation or conflicts into win or lose situation. The manager should encourage his team to air their differences openly and fully in a purposeful way and advantages are that people are more likely to channel their energies positively than into disputes with one another. They should be encouraged to have common interest in finding solutions and work together, get to know each other better and tolerate each other's point of view. The original source of conflict may then become relatively unimportant.

The PHC manager can pre-empt harmful conflict if he constantly checks the balance of roles in his team and watches as for anyone who is miscast, involves his team in making decisions that affect them and ensures that each person knows what is expected of him and has clear goals with avoidance of win or lose situations thereby preventing the build up of resentment. Also, the PHC manger should have control over his team as well as maintain discipline so as to sustain a cost effective programme.

(x) **Supervision:** For the sustenance of a cost effective management of PHC in Nigeria, there should be adequate supervision. This should be done regularly and on fixed days. There should be checklist for supervision of various sections of the programme like drug supplies, record keeping of attendance etc.

(xi) Information: Information is an important aspect of sustaining a cost effective PHC programme. There should be proper dissemination of information to make decision making. The statistics department should be manned by experts so that the information could be readable and consistent.

Conclusion

In concluding this chapter, it would be imperative to highlight the lessons learnt. It was found from the above discussion that the scarcest resource is frequently not money but administrative capacity, that political pressures make policy particularly difficult. In view of this, government and managers should think carefully about what they do and how they do it. The what comes in setting priorities, coordinating, resolving conflicts and creating responsible regularity and enforcement institutions. The how is in terms of developing legislation and administrative structures providing needed skills, ensuring funding, implementing decentralisation and delegation. Also, it was observed that policies or programmes are most effective when they aim at underlying causes rather than symptoms, concentrate on addressing the problems for which the benefits of programme are greatest, use incentives rather than regulations where possible and recognise administrative constraints. Therefore as a result of this, adequate attention should be paid to the planning, implementation and ultimately the evaluation stages. Unless planning and implementation go together, proper planning may be marred by improper implementation just as ill planning may mar activities of virile health services.

Effect of policy on the management of a cost effective PHC programme is another. From the discussion, it is obvious that unless there is a rolling plan to sustain a management strategy for a period of time there will always be a problem. This is because frequent changes in policy may completely mar a well articulated PHC programme.

It was also observed that absence of rudimentary information leading to ignorance poses a serious impediment to finding solutions. Therefore decision makers need better information about social preferences and health processes. It became glaring that most of the PHC programmes set unrealistically high standards which they failed to achieve. These should be replaced with achievable standard for effectiveness.

Based on all these, PHC can therefore be seen as a cost effective programme in which problems are solved at local level. However, if this is to work, it must be accomplished by transfer of finance. Otherwise a policy vacuum

might be created where the centre sheds responsibilities and local agencies are ill equipped to take them up.

An overview of the Nigerian PHC programme therefore has adequately demonstrated the importance of roles of management in the sustenance of a cost effective PHC where planning on the drawing abroad looks adequate with a promising implementation tendency. But because lack of adequate management which probably results from lack of people with adequate management skill especially the resources management skills, the tempo with the PHC began could not be sustained if Nigeria is taken as a case study especially when it comes to prevention of disabilities.

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