Primary Health Care in Nigeria

STATE OF THE ART

Edited by

E.A. Oke
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Published by the Department of Sociology
University of Ibadan
Ibadan
Nigeria

Published by
©Department of Sociology,
Faculty of Social Science,
University of Ibadan,
Ibadan.
Nigerian.

First Published 1993

ISBN: 978-32524-1-0

Production by
Cadalad Nigeria Limited
P. O. Box 20133, U. I.., Ibadan

Contents

Thanks to Dr. E. A. Oke, Immediate past Head, Department of Sociology and Dr. A. N. Isamah, the current Head of the Department and Dr. B. E. Owumi, the Coordinator for their support in making this publication a reality and finally to our wives Mrs. Lola Oke and Mrs. A. E. Owumi for their moral support and understanding.

We hope that this book will stimulate further workshops and discussions and eventually enhance participation in and utilization of PHC services.

November 1993

Dr. E. Adewale Oke
Dr. Bernard Owumi

Introduction

Primary Healthcare has become the cornerstone of the Nigerian Healthcare system since the Alma Ata declaration of 1978 and the inception of Prof. Olikoye Ransome-Kuti as the helms man of the health ministry during the Babangida's administration (FMOH 1988). The Alma Ata declaration actually drew the attention of the world to the inadequacies of the western healthcare structures and facilities in the maintenance of the health needs of the people of the world and the third world societies in particular. For instance research (Rifkin & Walt, 1986) and field experience (Ityavyar 1987) have shown that technical, curative interventions were expensive and limited in coverage and impact and that preventive measures might improve more lives at a lower cost. Again the ever rising cost of technical care was made available for mainly the rich and the middle income, urban people leaving those with low incomes mainly in the rural areas without any access to health services. These drawbacks gave the impetus for the evolution of the PHC strategy as a better approach for the extension of the frontiers of healthcare.

It should be noted however, that the concept (primary healthcare) is not actually new in the Nigerian context except in terms of phraseology. Nigeria had earlier established the basic healthcare services scheme (BHSS) as a strategy for healthcare development which has a primary orientation (Third National Dev. Plan 1975-80; Oyeneye, 1985), but for financial, manpower, political, planning and implementation pitfalls among others the programme did not see the light of the day (Oyeneye, 1985; Ityavyar, 1987). The "popularization" of the PHC strategy by the Alma Ata declaration sort of rejuvenated the interest of the Nigerian government to this approach of healthcare delivery which emphasizes preventive, non technical and people oriented.

Up till the moment, a huge amount of resources have been expended on the implementation of the scheme in the face of a number of problems mitigating the realization of the noble efforts of the government at extending the frontiers of healthcare delivery. Given this back-

ground, the department of Sociology, University of Ibadan thought it worthwhile to execute a training programme to keep the executors and implementors of the programme abreast with the concepts, principles and problems of implementing the PHC programme and how to resolve the health problems of the majority of the population.

The papers which have been presented here are therefore meant to highlight the activities of the executors of the programme as well as the policy makers and suggest possible strategies for making it more effective. It also attempt to rekindle and awaken, and inform the Nigerian public of the primacy of the programme in our health quest. The basic theme that runs through or forms the bedrock of analysis is the primacy of the PHC. Consequently, this piece is considered a major handbook for every Nigerian concerned with health matters.

The first two papers (Chapters one and two) give a vivid account of the evolution and essence of PHC in Nigeria pointing out the pitfalls of the western healthcare model. This is closely followed by chapter three which examines the principles of PHC to facilitate implementation of the programme at the local level. Chapter four critically analysizes the Nigerian healthcare system from the colonial times and questions the western approach of healthcare development. Given the existing pattern the author doubts the suitability of the programme for the poor except indigenous methods are galvanized.

Chapter five discusses the strategies for community participation in PHC from the participatory rural appraisal model. This model stresses the utility of the "locale" in programme development and management for optimal benefit. Chapter six examines the place of traditional medicine in PHC. The paper tries to establish the presence of traditional medicine within every culture and the primacy of traditional medicine within the structure of PHC that stresses accessibility, affordability and acceptability which are the hallmark of traditional medicine. Closely followed by this, is voluntary Healthcare workers and the success of PHC which is the theme of chapter seven. This piece examines VHW and attempts to suggest how it can enhance the success of PHC within the Nigerian economy that is market oriented.

Health services utilization form the basis of the next two chapters (chapters eight and nine). While chapter eight examines the influence of man and culture on PHC and by extension Health behaviour chapter nine discusses psychological determinants of health patronage in Nigeria.

Arising from the above patterns, the problems of PHC management

in Nigeria were thus examined critically; chapter ten attempts a general analysis of problems associated with PHC in Nigeria while chapter eleven examines the constraints of PHC relying heavily on an evaluation of EPI component of the PHC programme as a basis for assessing the art.

The role of the local government and efforts made at this level to realize the target of health for all by the year 2000 is examined in chapter twelve. Chapter thirteen examines the importance of developing the human resources of a community by governments and how alternative sources of fund for development can be sourced through proposal writing techniques, while the last chapter examines these independent sources of financing PHC.

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1

The Theory and Evolution of Primary Health Care in Nigeria

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Nigeria's health sector has been undergoing a momentous and remarkable change in the past six years largely because of the vision of the incumbent Honourable Minister of Health and Human Services, Professor Olikoye Ransome-Kuti. The years have witnessed a dramatic and perceptive shift in the orientation of health care programmes from curative to preventive care.

In order to bring about this shift, the Nigerian authorities for the first time in the history of the country, conceived, adopted and are doggedly implementing a national health policy. The goal of the policy is to enable "all Nigerians to achieve socially and economically productive lives, while the cornerstone of this policy is primary health care. The implementation of this policy has equally been made possible through an unprecedented financial, technical, logistical and other forms of support from international organisations. Second, several health personnel needed to provide service at the primary health care level have been trained at the Schools of Health Technology built for this purpose in the country. Third, steps are being taken to sustain, on a longer-term basis, the primary health programmes. To this end, the responsibility for providing primary health care is now vested in the Local Government Authorities while a special agency is being established by the Federal Government to help sustain the momentum which it had built up for this approach over the past six years.

The policy and programmes initiatives on primary health care have attracted both praise and condemnation in various quarters. There are, on the one hand, those who commend the present administration for

addressing the priority needs of a vast proportion of Nigerians for the first time since the attainment of nationhood. Yet others are wont to criticize these new initiatives for a variety of reasons. In my view, these divergent viewpoints on the efforts of the present administration provide the basis for a deeper understanding of the evolution and theory of primary health care. This is because they represent the two competing theoretical approaches toward the promotion of health care in the context of a developing country. Let us for a moment explore the standpoints of these approaches.

Critics of the current emphasis on primary health care are usually drawn from among those who strongly subscribe to the orthodox approach toward the provision of health care in the context of developing country. The orthodox orientation is anchored on the belief that the development and promotion of health care could readily be achieved if formally trained physicians and other high level health personnel assume a pivotal role, and secondary and tertiary health facilities are opened in sufficient number to provide total coverage for the population. This was the dominant perspective since the attainment of political independence and it remained in force until the last six years. To wit, the Fourth National Development Plan, 1980- 1985 which was the last to be proposed before the onset of this administration intones:

> critical shortages exist in the essential categories of health manpower, including personnel in the development and maintenance of medical, paramedical and preventive services. As shortage of doctors continues to be a major problem. Whilst, the target set by the WHO for this part of the world is a doctor/population 1:22,000,.recorded in 1972. To achieve the WHO target, we need more than double the present number of doctors by 1980.

The document further states:

> IN RECOGNITION OF THE HIGHLY STRATEGIC ROLE OF DOCTORS IN THE HEALTH CARE DELIVERY-SYSTEM and the current critical shortages of this personnel in most parts of the country, steps will be taken in the plan period to undertake accelerated expansion of medical colleges and associated facilities for clinical training. This exercise will be carried out within the framework of the expansion programmes of universities and will SEEK TO ESTABLISH appropriate ratios in the enrolment be-

> tween the faculties of medicine and other faculties, adequate account being taken of the general manpower needs of the country. The objective of this policy will, however, seek to ensure substantial increases in annual admission level of 3,000 for the whole system by 1980.

The orthodox orientation, therefore, prompted a huge investment in the training of physicians, the establishment and rapid expansion of secondary and tertiary health care facilities in the country, all of which underscored the strong emphasis in the curative as opposed to the preventive approach. For many in this school, the emphasis on the curative approach was synonymous with DEVELOPMENT and/or adequate provision of health care for the population.

Despite the huge investment in the training of high level health manpower such as physicians and in the establishment as well as expansion of secondary and tertiary health care facilities, well- informed observers were wont to demonstrate that the promotion of the physical, social and mental well-being of a vast proportion of Nigerians remained an illusion for a variety of reasons. First, it became self-evident that the sophisticated health facilities on which so much had been invested remained inaccessible to rural dwellers where the majority of the people live. Besides, the investment could not be justified as several facilities were usually not in full operational state as the equipment were often in the state of disrepair for a variety of reasons. Second, the high level health manpower on which so much hope was placed were also often not accessible to the majority in the population because of their preference for practice in urban centres. Third, there was evidence to suggest an inverse relationship between the epidemiological reality and investment in health care programmes. While the population suffered mainly from parasitic and infectious diseases which could be prevented, the pattern of investment in health care programmes was attuned to curative programmes, demonstrated by the emphasis on the establishment and expansion of secondary and tertiary health care facilities and high level health manpower.

In realization of the failure of health care programmes to address the needs of the people at the grassroot level led other observers to call for a decisive shift from a system of care which is anchored on the orthodox approach to one which emphasizes primary health care.

> Primary health care is essentially 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 and country can afford to maintain at every state 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 functional and main focus, and of the overall social and economic development of the community. It is the first level of contact 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 constitutes, the first element of a continuing health care process.

In essence, the raison d'etre for the theory of primary health care in the country is informed by the foregoing. It's origin can, however, be traced back to the introduction of the Basic Health Services Scheme in the early seventies. The Scheme did not have the necessary political and material support for take-off and soon became moribund. Consequently, successive administrations continued to pay lip service to the promotion of the Scheme. It is the present administration that has attempted to nurture and institutionalize the concept of the Scheme in the context of primary health programme. Whether the Scheme or primary health programme will be sustained may well depend on the orientation of the next administration. My hunch at this point is that primary health care will face serious challenges in the years ahead if we are to judge by past experience with innovative programmes which are implanted in our society. Whatever be the case, I hope that my hunch turns out to be an illusion.

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2

The Essence of Primary Health Care (PHC) in Developing Society: The Nigerian Experience

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INTRODUCTION

Certain suggestive relationships between socio-cultural, environmental and personal factors which relate to and influence the utilization of health and medical services by various individuals and groups have been identified by a number of students of social professions (Rosenstock, 1966; Kasl and Cobb, 1966; Lerner and Ander, 1963; Kegies et al, 1965; Hertman, 1974.)

These students have also stressed the fact that those having closest access to health and medical services are actually ;the segment of the society who have the least need for health education and public health services from the standpoint of relative socio-economic position. The segment who have the greatest need have the least access to these services — these are the ruralists and the illiterates who form the bulk of a developing society, perhaps, more than 80% of such society particularly, our own society. This paper focuses on Nigerian Society specifically the essence of the PHC in Nigeria.

In order to reach the vast majority of the population, there was a need to adapt the philosophy, the style and actual practices of health and medical services to suit the need of our people so as to provide maximum health services and achieve health for all Nigerians by the end of this century, hence a reformulation of "The National Health Policy and Strategy" otherwise referred to as "The Fundamental Principles underlying the National Health Policy" (Ransome-Kuti, 1988) it states:

> The National Health Policy is based on the National Philosophy of social justice and equity. A health system based on Primary Health Care.... shall be the key to the development of the National Health Policy. Emphasis shall be placed on the preventive and promotive measures which shall be integrated with treatment and rehabilitation in a multidisciplinary and multi- sectoral approach involving effective community participation. That Primary Health Care shall be scientifically sound implies that all health practices and technologies both orthodox and traditional shall be evaluated to determine their efficacy, safety and appropriateness.

The goal of the National Health Policy in this sense is to establish a comprehensive healthcare system which is promotive, preventive, restorative and rehabilitative to all Nigerians within the available resources so as to achieve socially and economically productive lives.

The Need And The Implementation Of Primary Health Care In Nigeria

The introduction of the PHC was informed in part by the realization that the western orthodox medical care did not serve adequately the need of the citizens. This does not mean that the orthodox medicine has not achieved much, in fact, it has a significant impact on the health status of Nigerians. However, it is obvious that the services were actually designed for only a small segment of the society.

The history of the orthodox medicine in Nigeria reveals that initially it was designed to serve the interest of the church missionaries and their converts and later the interest of the colonial government, targeted at European population, and later extended to the Nigerians working for the colonial government (Adetoro, 1989). Adetoro reported that even today, only 35% of Nigerians are served by western orthodox medicine.

It is not surprising therefore that the services were mostly located in the urban centres where the Europeans and the Nigerians working for them often resided. The Federal Ministry of Health (FMOH) is well aware of this fact, in the formulation of the National Health Policy (1988) it noted:

> The public health services in Nigeria originated from the

> British Army Medical Services Government during the colonial era. Government offered to treat the local civil servants and their relatives and eventually, the local population living close by Government Stations.

This pattern persisted even after the independence. Hospitals were built in urban centres throughout the country mostly to cure or treat diseases and little or no concern on preventive medicine and preventive measures.

This system came under severe attack, scholars (Mojekwu, 1978; Aghayere, 1986; Lesi, 1978; Onadeko, 1978; Pearce, 1980; Olumide, 1982 etc.) revealed that most of the deaths in our country were preventable, they are caused by preventable diseases, the origin of which could be traced directly or indirectly to socio-cultural and environmental factors (Oke and Yoder, 1989). This position is summarized by the FMOH (1988) as follows:

> The health services of Nigeria have evolved through a series of historical developments including a succession of policies and plans which had been introduced by previous administrations. The health services are judged to be unsatisfactory and inadequate in meeting the needs and demands of the public as reflected by the low state of health of the population.

It is apparent from the above that the orthodox medical service was far away removed from the needs of the bulk of the population, it is also obvious that it was not intended for the general population, as such, there was a need to evolve a system that would cater for all the citizens — the PHC.

The inception of the PHC can be traced back to 1986 when the Federal Government established 52 model PHC in selected Local Government Areas (LGAs) throughout the country. By 1987, the number has increased by 31 (Adetoro, 1989).

The model project was designed as a prototype from which subsequent projects would be developed or improved upon. Although it was obvious that the Federal Government has decided to embark or implement fully the PHC programme, the success of the prototype has stimulated the government and have given the Ministries of Health (Federal and States) and all participating agencies/organizations much confident to pursue the programme vigorously. Today, PHC is an household word in Nigeria and its impact is felt throughout

country. Let us discuss a few of the projects which help to strengthen components of the PHC. These include:

(1) EPI (Expanded Programme on Immunization)

(2) Control of Diarrhoeal Diseases

(3) Control of Malaria and

(4) Continuing Education

EPI

Perhaps the most component of the PHC that has the greatest impact on Nigerians is the EPI. The Programmes is targeted at children between 0 to 2 years of age and women of child-bearing age (15 — 49 years of age). EPI prevents the six most deadly childhood diseases, namely, Tuberculosis, Diptheria, Whopping Cough, Tetanus, Polio and Measles.

All the LGAs provide immunization services. The number of immunization administered has generally risen each year since 1986 (CCCD, 1991) which results in higher proportions of immunized individuals (target groups) against the six diseases. The CCCD reported, for example, that 700,000 doses of measles vaccine were given in 1986 compared to 2.5 million doses in 1990, 2.6 million doses of DPT were given in 1986 compared to 7.2 million in 1990.

It is the ambition of the Government to eradicate all these diseases within a reasonable time. The target coverage for 1990 was 80% of the population which the Government claimed it has achieved although a field report actually shows 76.6% coverage (See Table 1).

The country was divided into five zones (see the table referred to above). It is interesting to note that Zone C which is made up of Abuja, Katsina, Kwara, Niger and Sokoto has exceeded the target with 84.7% coverage while Zone C which is made of Bauchi, Borno, Gongola, Kano, Plateau has the least coverage (68.1%). The reason for the disparity is not clear but we noted that Zone C might have received more attention. We observe that aside from the active involvement of the UNICEF and the Ministries of Health, other agencies and organizations, such as the CCCD, the HEALTHCOM, ADDR, IDRC — have worked extensively in the zone by way of formative and baseline studies seminars, workshops and intervention programmes.

Table 1: Immunization Coverage By Antigen 12-23 Month Cohort On Crude Data

Up to 2 Years of Age, by State, February 1991

State	Bcg	Bcg Scar	Dpt1/ Opv1	Dpt3/ Opv3	Meas- les	Full Vacc	Card Reten- tion
Akwa Ibom	97.6	90.0	97.4	89.0	93.8	88.5	93.8
Anambra	99.5	93.2	99.8	94.7	93.7	89.8	99.0
Benue	95.7	90.0	93.6	74.0	78.5	67.0	86.1
Cross River	99.0	96.2	97.6	85.2	86.1	80.4	93.3
Imo	90.1	79.7	88.1	78.2	76.2	69.8	76.7
Rivers	96.7	91.4	94.5	83.5	86.1	79.4	90.0
Zone A	95.9	90.1	94.8	84.4	85.6	79.1	89.8
Bendel	79.0	68.8	73.7	52.7	53.7	46.8	56.6
Lagos	96.7	77.5	95.0	86.1	77.5	73.2	84.2
Ogun	98.5	85.5	98.5	87.5	88.0	85.0	93.0
Ondo	99.5	85.1	98.6	90.9	92.3	87.5	89.4
Oyo	99.0	93.8	98.5	89.2	89.7	84.8	96.2
Zone B	95.2	82.1	93.7	82.5	81.9	76.9	83.9
Abuja	100.0	97.7	100.0	100.0	100.0	100.0	99.6
Kaduna	100.0	97.5	100.0	94.1	94.1	91.6	97.5
Katsina	89.6	83.4	88.4	65.4	75.8	61.6	74.4
Kwara	100.0	90.6	100.0	100.0	100.0	100.0	99.9
Niger	99.0	85.6	97.4	83.0	92.3	82.7	86.7
Sokoto	99.0	86.5	98.4	91.1	92.3	88.9	89.4
Zone C	97.3	90.2	96.7	86.8	90.3	84.7	91.3
Bauchi	99.0	93.2	97.6	83.5	89.8	80.1	89.8
Borno	98.1	91.5	98.3	87.4	95.1	85.9	97.1
Gongola	97.1	91.3	96.2	83.7	87.5	80.3	86.5
Kano	89.9	79.7	89.4	58.0	73.9	51.7	79.7
Plateau	89.7	81.4	85.8	63.7	73.0	58.3	76.5
Nigeria	95.5	87.5	94.4	81.1	84.7	76.6	87.7

Criteria: Measles > 36 weeks; DPT1/OPV1 > 6 weeks;
Intervals between repeat doses > 21 days.

Control of Diarrhoeal Diseases

Diarrhoea, particularly childhood diarrhoea poses the greatest threat to the survival of children under the age of five in our society (Oke and Yoder, 1989). In 1989 alone, there were 213,638 cases of reported diarrhoea resulting in 855 deaths (Nigeria Bulletin of Epidemiology, 1991). And yet this disease can easily be managed or prevented. The plan therefore is to reduce diarrhoea incidence by improving water and sanitation, prevent dehydration and malnutrition through home treatment that focuses on early use of home fluids such as sugar-salt-solution, proper feeding and by treatment of dehydration at health facilities with ORS (CCCD, 1991).

Home fluid-treatment is fairly accepted throughout Nigeria. The CCCD reported that since 1987, 349 professionals have received training in the clinical management of diarrhoea. The clinical training programme has been reviewed and updated and agreement has been reached with the WHO on a cooperative activity with regard to improve pre-service training materials for our medical students.

MalariaControl

The responsibility of control or management of malaria rests essentially with the National Malaria and Vector Control Division. The technical committee meets semi-annually and reviews malaria therapy efficacy, studies and other research data. The monitoring of malaria resistance is carried out by the National Malaria Surveillance Network which consists of multi disciplinary teams from our universities. In addition, the CCCD has helped in developing a new malaria training module for mid-level and peripheral health workers which was pretested in Niger State and has been approved for use throughout the country.

The HEALTHCOM has also introduced a series of intervention programmes in Niger State to improve the health of school pupils and the general community by the provision of potable water and improved personal hygiene. Parents were persuaded through multiple communication channels to take a child with fever to the nearest health facility within 24 hours for diagnosis and treatment. The importance of completing the three-day medication even though the fever may disappear in two days was stressed. Parents were taught that a fever

caused by mosquitoes is very dangerous but it can be treated with chloroquine. The use of chloroquine for treatment of malaria fever was recommended by the Federal Ministry of Health and promoted by the HEALTHCOM.

The impact of the intervention was monitored through a reporting form distributed to health centre staff (Yoder and Oke, 1991). Although it is difficult to quantify the impact of the intervention at present, it is obvious that there is a significant improvement in the management of malaria — this will be more apparent in the near future if the programme can be sustained.

Continuing Education

A major but often overlooked aspect of the PHC is the continuing education. The only well organized programme known to me is the Niger State Continuing Education Programme established in 1989 at the Minna School of Health Technology.

The CCCD reported that nine modules for training LGA Managers in priority child survival and managerial topics were adapted to Nigeria circumstances. Already, LGA Managers from the State have been trained in the Programme and positive impact has been demonstrated.

More of such programme should be established to accelerate the achievement of the PHC objectives. There are other components of the PHC that are not discussed here due to lack of space and time — they include; water and sanitation, personal hygiene, school health, guinea worm prevention, nutrition and home accidents. These are also declared priority of the Federal Ministry of Health with regard to PHC.

Conclusion

The Federal and State Ministries of Health and all the collaborating organizations/agencies are actively engaged in PHC intervention. The basic strategy of the intervention is to involve communities in the planning, implementation and evaluation of the programmes. These interventions are based on community perceived and expressed needs as identified through formative research, informal and formal baseline studies and a series of consultative meetings with appropriate agencies and authorities.

The PHC has been an exciting experience in this country. Nigerians

have been able to identify with it, they are involved in the planning and execution of the intervention programmes and obviously, it has improved their health status although in some of the programmes, this is very difficult to quantify. For example, the impact of PHC Project on immunization coverage in Niger State by the HEALTHCOM was initially difficult to assess with the data available partly because of the strategy of the Federal Ministry of Health to plan annual special immunization days. This did not allow accurate measurement of the level of acceptance and internalization of the programme. There is also the problem of accuracy of the available data. Nonetheless, the assessment of the project by personnel from the Ministries of Health was remarkably consistent with regard to the achievement of its objectives. We have similar information from different parts of the country.

It is apparent that much has been achieved but there is much to be done to sustain the present achievement, improve upon it and go forward. Much improvement is needed in the provision of health and social facilities, there is also a need for provision, of more facilities for continuing education for health workers and intensification of basic health education for all Nigerians.

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3

The Application of the Fundamental Principles of Primary Health Care at the Local Government Levels in Nigeria

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Introduction

Since the Alma Ata declaration in 1978, Primary Health Care (PHC) has been adopted in many countries of the world as the key to the development of health care programmes. It has also been widely accepted as the means of attaining health for all by 2000 (WHO, 1978). PHC is defined as an essential health care that meets the needs of the majority of the people in any community at a cost that is affordable to them. It includes not only the services provided at health centres, clinics and dispensaries but also what individuals and families can do to promote and maintain their health. (WHO, 1978).

In Nigeria, the first serious attempt to implement PHC even predates the Alma Ata declaration. In 1975, the Basic Health Service Scheme was launched by the then government of General Yakubu Gowon as part of the Third National Development Plan (1975-80). The programme was aimed at increasing the proportion of the population receiving health care from 25 to 60%. However, the programme failed to reach this target mainly because the principles of PHC were not adopted during the implementation. For example, the community did not participate; in the planning and implementation of the programme. In addition, large quantities of sophisticated equipment were purchased and imported into the country contrary to the principles of self-reliance and use of appropriate technology (Ransome-Kuti, 1988; Alakija, 1986).

A second attempt was made to implement PHC in the country in 1986 when the then Minister of Health, Professor Olikoye Ransome-Kuti launched the programme. Although some problems were encountered, at the initial stage, a lot has been achieved since the inception of the programme in the country. For example, the strategy for implementing the programme has changed. Local Government Areas (LGAs) are now the foci of most PHC activities. For this purpose, 52 LGAs were selected and designated models for PHC programmes.

Component of PHC

Ideally, the contents, or components of the PHC should be determined by the main health problems common in the community. However, the World Health Organization (WHO) (1978) recommends that PHC should include at least the following components:

(a) Education concerning prevailing health problems in the community;
(b) Promotion of food and adequate nutrition;
(c) Supply of adequate potable water and basic sanitation;
(d) Provision of maternal and child care including family planning;
(e) Provision of Immunization services against major infectious diseases;
(f) Treatment of common diseases and injuries;
(g) Promotion of mental health;
(h) Provision of essential drugs;
(i) Control of local endemic disease.

Fundamental Principles Guiding Implementation Of PHC Programmes

As mentioned earlier, PHC seeks to meet the health care needs of as many people as possible at the lowest possible cost. In order to reach this goal, the implementation of PHC must be guided by the following principles:

1. Involvement and participation
2. Use of appropriate technology
3. Inter-sectoral co-operation/collaboration

4. Use of local resources.

These principles are fundamental in the sense that they determine the outcome of the PHC programme.

Involvement and Participation

By participation, we mean that the person, group or community for whom the PHC programme is being planned actively works with the health worker in planning and implementation of the programme. Participation of the beneficiaries of a PHC programme is crucial for four main reasons.

The first is based on the principle of civil responsibility. According to the WHO (1978) people have a right and duty to participate either individually or collectively in the planning and implementation of their health care. Secondly, if people participate, they are likely to be interested in helping themselves and feel committed to take necessary action to improve their health. Thirdly, participation ensures that the PHC services meet the real and not the perceived needs of the people. Finally, it facilitates self-reliance of the benefiting group or communities.

Having discussed the importance of participation, the next logical issue is how to ensure that beneficiaries of PHC programmes at the LGA levels participate in planning and implementation of the programmes.

The following suggestions are practical ways of facilitating community participation.

1. Keep people *informed* about the programme being planned. This can be done by meeting and discussing with community and opinion leaders.
2. *Encourage suggestions* to be made, either directly or through representatives, e.g. a planning committee.
3. Mutually set out specific *tasks and responsibilities* for all those involved.
4. *Acknowledge* and *praise* all those involved in the programme.

Use of Appropriate Technology

Technology is simply the means by which people utilise the environment to satisfy their needs and wants. It involves among others:

1. The production of tools or materials and,

2. The creative capacity to improve the materials.

The technology or method used in PHC service delivery should mesh with the cultural and resource patterns of a given community in order to maximise benefit and minimise disruptions. In PHC, a good example of appropriate technology is the local production of sugar-salt-solution as an oral rehydration drink instead of importation of expensive mixture from pharmaceutical companies. For a technology to be appropriate, it must be:

1. Scientifically sound;
2. Adapted to local needs of the population; and
3. Simple and can be easily maintained by the people.

Intersectoral Co-operation

As shown in the components, PHC seeks to provide comprehensive or holistic care to people. In order to reach this goal, all sectors or departments must co-operate, therefore, all hands must be on deck for health.

For example, at the LGA levels, there are many people drawn from various departments who make significant contributions to the promotion of PHC services. Such persons include agricultural extension workers, social welfare officers, community development officers, school teachers etc.

All persons whose work contribute to the health of the people should, therefore, be involved in as much as possible in planning the programmes.

Ways of ensuring co-operation of all Sectors/Departments of planning PHC programmes at the LGA Level

1. Formation of a committee involving representatives of all the key sectors. Meetings should be held regularly and roles and responsibilities of each sector mutually agreed upon should be spelt out.
2. Good interpersonal relationship and effective communication skills are also crucial.

Use of Local Resources

In planning PHC programmes at the LGA level, emphasis must be placed on use of locally available resources in the community. Em-

phasis should be on use of local resources because:

1. It saves money.
2. It promotes self-reliance of the community.
3. It facilitates use of appropriate technology.
4. It fosters pride in people who are able to help themselves. This pride will further encourage them to try to solve more problems using their own efforts.

However, although it is best to implement PHC programmes using resources from within benefiting communities, sometimes all resources needed may not be available in a community because the programme may be too big for the resources available. Also the problem may be difficult to solve.

Under this condition, it is necessary to look outside for such resources. Most times the community members are not aware about the place to obtain the resources. They need to be linked-up with such external resources. Resource linking is the process of bringing together an external resource to a community in need of resource (Brieger, 1978).

Ways of effectively linking up communities with external resources

1. Provide background information about
   - Names of the agencies, organizations or individuals that have the resources
   - Description and type of resources provided by the agencies
   - Location of the resource agency
   - Special requirements, if any, the agency demand before giving resources (WHO, 1988).
2. Encourage community members to visit the agency. This will enable them learn the skill of resource linking.
3. Encourage the community to make the decision whether to accept or reject the resources, i.e. the community should be encouraged to make informed decision.

Having discussed the principles guiding PHC programmes at the LGA level, it is necessary to highlight the processes involved in planning and implementing and evaluating the programmes.

Outline of Planning and implementation of programmes at the Local Government Area Level Using a PHC Approach

There are three components of the programmes, namely planning, implementation and evaluation.

1.Planning

(a) *Entry into the Community*

Meet the leaders of the community to inform them about the programme and enlist their support and co-operation.

(b) *Identify needs*

Sometimes the felt needs of the people do not coincide with those of the LGA, government or funding agencies. Yet, we must be sensitive to the needs of the people otherwise they may not be motivated to actively participate in the programmes been proposed.

(c) *Priorities the needs*

Rarely do communities have only one felt need. More often that not their needs are numerous. Given the fact that community resources are limited these needs must be prioritised. The community should be encouraged to start with their most important felt need.

(d) *Set goals/objectives or targets*

Objectives need to be set to keep the programme on track and to help in evaluation.

(e) *Identify resources*

Look inwards to determine locally available resources and if need be, link-up the community with external resource.

2.Implementation

(a) Commence work on the programme as planned

(b) Monitor progress in order to ensure that programme is implemented as planned. Also, identify problems impeding progress.

(c) Feedback outcome of monitoring into on-going programmes.

3.Evaluation

(a) Review programme after completion to determine:

— the extent to which set objectives have been accomplished

— Lessons learned in order to avoid reinventing the wheel.

The community members must be encouraged to actively participate in all these phases of the programme.

Conclusion

Primary Health Care is the bedrock of the health care system in Nigeria. PHC is rooted in the philosophy of equitable access to health care since its main goal is to meet the essential health care needs of the majority of the population at a cost they can afford. This goal can be attained only if the fundamental principles guiding Primary Health Care are put into consideration during the planning and implementation of the programme.

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4

Primary Health Care: the Grassroot Means of Minimal Healthcare Services: How Realistic?

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Introduction

It is of great interest, but also of great concern, that until more than three decades of Nigeria's independence, health is only being perceived as 'primary' to the citizens of the nation. It is of great interest because it requires a need to study why the situation is what it is. It is also of great concern because the different governments have only believed in actions that could make Nigeria 'catch up' with the erstwhile colonial government and other developed nations. Such actions have been tantamount to chasing shadows. These actions might be connected with the fact that planners and policymakers are not genuinely interested in the welfare of the majority of the people.

Anyway, the Babangida's regime has declared its intention to democratize both the political and the health institutions. The latter is equal to the agreement with the Alma Ata declaration of 1978 which states that:

(i) health is a fundamental human right and that health involves 'a state of complete physical, mental and social wellbeing....'

(ii) health would be made available to the people based on the principles of equity and social justice;

(iii) the planning and implementation of healthcare would involve the participation of all the people, individually and collectively;

(iv) there is political commitment and will to ensure health for all by the year 2000;

(v) 'health is wealth' implying that health is related to all aspects of national and community development such as promotion of food supply and proper nutrition; adequate supply of water and basic sanitation; industry; education; housing; animal husbandry and so on;

(vi) cheap, socially acceptable methods and technology which are scientifically sound would be accessible to individuals and families in the community.

Our task in this paper is to examine the possibility of realising these laudable ideas.

To achieve this task, we have to first examine the structural context within which Primary Health Care (hereafter referred to as PHC), as stated above would exist. Interestingly, PHC aims to structurally transform this existing social structure as the objectives imply. Consequently, the most important point to observe is that the basic tenets of the PHC have a lot in common with that of the Structural Adjustment Programme (SAP)[2]. These basic tenets include:

— equity and social justice
— political commitment and will
— community participation and involvement
— intersectoral action and;
— the use of appropriate technology through self-reliance.

SAP and PHC

It is very important to state that the Structural Adjustment Programme implied above is far above the economic adjustment being attempted by the Babangida regime.[3] The political, economic, educational and other institutions are seen as a structural whole all of which have to change from their existing orientation. This is what becomes fundamental to PHC. A total transformation of the social structure is required since it cuts across the entire social fabric. Paragraph 18 of the Alma Ata declaration states, in part, that:

> '... Health activities should be undertaken concurrently with measures such as those for the improvement of nutrition..., increase in production and employment, and a more equi-

table distribution of personal income; anti-poverty measures; and protection and improvement of the environment.'[4]

The aim, therefore, is to close the gap between the "haves" and "have nots", and "achieve more equitable distribution of ... resources..."[5]

The idea of closing the gap between the rich and the poor, especially within nations, means the building of a new social arrangement. This is to be achieved through the participation of majority of the people in the affairs of the nations, including health. This is the original definition of democracy which most Third World nations should aspire to achieve.[6] Building new social arrangement also requires the need to draw closer to the exploitation of the physical environment. It implies that the principle of self-reliance and self-determination.[7] Like democracy both SAP and PHC agree that the existing type of development orientation is undesirable. The argument is that developing nations have not managed their resources well — a resultant effect of the inequalities perpetrated by the ruling elites. This has led to the existing debt-burden which these nations now shoulder.[8]

To reduce this debt-burden, developing nations must be self- reliant; reduce inequalities between the "haves" and the "have nots" both in the urban and rural areas; encourage social justice; involve most people in governance and so on. In short, the conditions that led to SAP also informed PHC. These are, indeed, good ideals that nations should aspire to achieve. But how can these be realised with the continued existence of the old social structure? In other words, to realise the ideas and ideals of PHC as the grassroot means of minimal health care services, the transformation of the social structure is inevitable. But who would embark on this task? The success of whoever attempts to carry out this task is dependent on the extent to which those who occupy the present position are ready to relinquish their position and priviledges. Consequently, an analysis of the existing social structure as it affects the health institution becomes important. This would expose the need for PHC and the extent to which it is possible for the system to come to reality.

Nigeria's Health Institution in Perspective

Prior to the establishment of Western medicine, traditional medicine- defined by the World Health Organization as 'the total combination of knowledge and practices, whether applicable or not, used in diagnosing, preventing or eliminating a physical, mental, or social disease

and which may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing[9] constituted the means by which the different communities took care of their health and health-related problems. The colonial intervention was with the aim of 'modernising' these practices. The modernisation process involves the importation of the highly technological and differentiated medical system in Western Europe, especially Britain, into Nigeria. Missionary groups were the first to encourage 'modern' medicine in West Africa, followed by the colonial government (with its application under the military regiment).[10]

Generally, emphasis was laid on the construction of teaching, general, and specialist hospitals located in major towns. The training of medical doctors was also preferred to auxilliary training school which graduates students as medical assistants. The students have started realising the new status which they would acquire at the exit of Europeans. Medical Schools were "modelled on institutions in home countries of the colonial government(s) and their intellectual traditions, with very little adaptation to African socio-cultural tenets....".[11] The students, when they graduate, preferred to work in the urban centers than in the rural areas.

At independence, these practices continued and the new governing elites did not give due consideration to the management and administrative capacity of the country. They created and expanded institutions with loans borrowed abroad from both private and commercial sources. Since the Europeans (colonialists) did not understand the indigenous traditional medicine, they found no need for it.[12] The new medical doctors, realising the importance of this to their new statuses, found it irrelevant. This is because they would have had to be competing with the 'unlearned' medical practitioners — who ironically nurtured, brought them up with traditional medicine. Their newly acquired position have to be enhanced. Especially because they were few in number, foreign experts were employed in the hospitals. Sophisticated equipments including drugs were imported.[13] All these led to the debt-burden already mentioned above. Unfortunately the situation, till today, has not essentially changed. Obafemi Awolowo University Teaching would soon launch its multi-million Naira fund.

In spite of all the debt aimed at improving the health status of Nigerians, health facilities are still very inadequate; only a few people can afford the available services; there is an inbalance in the distribution of personnel and facilities to the urban and rural areas; the em-

phasis of European medicine has no bearing with the indigenous structure-curative rather than preventive health system is encouraged and so on.[14] It is not therefore surprising that health-status of Nigerians is very poor. There are still no enough medical personnel. There are 6,200 Nigerians per doctor in 1986; 99,000 people per dentist; 24,300 per pharmacist; 1,950 per nurse; 2,340 per mid-wife and there are 1,100 people per hospital bed.[15] Life expectancy at birth is still one of the lowest in the world at 51. Infant mortality rate is 100 per 1000 and maternal mortality is around the same range as at 1980 (a situation that has not changed significantly today).[16] All of these resulted because of the type of health care system in Nigeria. Most important is the nature and content of medical education which has continued to affect the status of health in Nigeria. Brew-Graves summarised these to include.[17]

(a) absence of national health manpower policies which has led to the disparity between procedures and the employers of health care;

(b) many doctors trained for years at public expense have left for non-African countries;

(c) curriculum are essentially foreign-based and highly- structured;

(d) training has been hospital-based and, essentially, clinical-oriented and ignored culture and socio-economic background;

(e) the training is discipline-oriented and departmentally organised rather than competency-based, problem-oriented and inter-disciplinary;

(f) teaching rather than student responsibility for learning is emphasised;

(g) there is no team approach;

(h) the products of the medical institutions are uninterested in rural areas; and

(i) the products are unsympathetic, gains-oriented and lacked leadership.

All of these have existed since 1948 when the first College of Medicinewas established and even, in some cases, before then. They all continue to exist today. A practice — more or less a way of life — is expected to change within 14 years (from 1986) through the Primary Health Care System. It is, infact, supposed to be a revolutionary transformation. Attitudes of medical doctors, nurses, mid-wives as well as rural dwellers have to change within this period. The content of medi-

cal education and its practice, especially private medical practice must change significantly.[18]

Primary Health Care means building a new health institution on a new foundation. It implies a reconceptualisation of what health is. It has to be seen, in the words of Lambo, 'as a whole, as part and parcel of a culture, its boundaries and its principles being studied more than its incidentals'.[19] Health is no more to be conceived as disease for which preventive and curative methods of care are being found. It now implies the standard and style of living of people because:

> The real *per capital* income of the individual, his standard of education, and his access to food and potable water contribute more to (his) health than the number of hospital beds, doctors, and nurses... Health is therefore a composite to which all national socio-economic activities, including the prevention and care of disease, contribute.[20]

Hence, it is not only the health institution that requires a change in orientation nor is the ministry or committee (in whatever form) that should implement PHC. All the societal institutions are involved and must be transformed. The present distribution of resources and ideas in the rural and urban areas has to change in favour of the former. Those 'who have' must be ready to loose part of what they have to the 'have nots'. Indeed, a new era of governance is required — a new and 'truly revolutionary national ideology from which inspiration and motivation for true and socially relevant development could be derived'.[21]

PHC involves the use of indigenous natural and human resources. This can only be achieved through the decentralisation of political responsibility and obligation to allow for full participation of all members of the community. The implication of this is not only the involvement of people but also the use of traditional herbs and traditional doctors which and who are socially acceptable. Unfortunately, PHC expects that 'traditional workers and traditional birth attendants', should be 'trained for and attuned to PHC', *only 'where applicable'*[22] (my emphasis). In this wise, one can allege that PHC is only a half-step taken in the right direction but not a full-step. "Scientifically sound and socially acceptable methods of technology....." as well 'the spirit of self-reliance and self- determination' become contradictory. PHC, as it is, encourages the persistence of the top-bottom development strategy. The grassroot (bottom) are not likely to take active par

ticipation – a situation which negates the essence of PHC. We shall elucidate on this later. Let us very briefly examine how the structure of PHC is being established in Nigeria.

The Establishment of PHC in Nigeria: 1986—1992

It has been variously argued that the first attempt at establishing PHC in Nigeria was in 1975, during General Gowon's government.[23] Though this might be assumed as the foundation on which present efforts are being based, PHC was not the national policy nor was it the cornerstone of Nigeria's healthcare delivery system. It was not until 1986 when an articulated national policy based on PHC as its cornerstone was promulgated.[24] In fact, the attempt during Gowon's regime validates the fact that SAP and PHC have a lot in common. It was during the later part of Gowon's regime that the debt burden actually started getting out of hand. However, the regime was, probably, not bold enough to implement the SAP as it ought to. This same argument goes for the governments after this until during Babangida's regime. At least for this, this regime has to be commended. It is the first time in the nation's history that a government would profess such a radical idea. It is radical in the sense that it is a departure from the existing norm and also because it cares (or attempts to care) for the majority of the people. Like the transition to grassroot democracy however, the implementation, or rather genuineness, becomes questionable.

There is already an inconsistency in the implementation of the PHC which resulted from the lack of consistency in the transition programme. For example, the plan once described by Dr. Ogundeji, the B Health Zone co-ordinator, in a paper presented in 1987 and another paper which gave the same plan as Ogundeji's by Kayode Oyegbite, special assistant to the Minister of Health has changed.[25] The change resulted from the creation of more local governments in 1991. Formerly the number of health committee was between 10 and 20,000. The upper limit now changed to 500 due to the establishment of more wards. This problem appears trivial, at least on paper.

More important is the fact that the implementation process involves the local governments which would be strengthened to take care of such health matters. The Ministry of Health plans (and already in the process) to set up Village Development Committees (VDCs) with em-

phasis on health. The councillors in different wards are to help in achieving this aim. The committee should not be more than 500. Amongst these, they would select their own Voluntary Health Worker (VHW) who would be trained in simple ways of solving identified problems 'preach the gospel of PHC', supportive referral system are also being put in place at both the state and local government levels. Other activities in process include the training of PHC personnel, the Expanded Programme on Immunization; treatment of common minor ailments, control of communicable and endemic diseases, family planning, nutrition programmes and environmental sanitation.[26]

Assessment and Conclusion

So far, it could be observed that the Ministry of Health is still the only department involved in the Primary Health Care System. According to Dr. Ogundeji, inter-sectoral collaboration is still very difficult. When meetings are to be held with other ministries, the people who represent the various ministries are not the ministers and not even the Director-Generals if they send any representative at all. His conclusion is that each department still guards its power jealously.[27] Hence the management of PHC is bound to have major problems since present situation goes contrary to its focus.

Health activities *cannot* 'be undertaken concurrently with measures such as those for the improvement of nutrition, particularly of children and mothers; increase in production and employment, and a more equitable distribution of personal income, anti-poverty measures, as is being seen in Nigeria now is not structural. Hence, its role as a transforming institution becomes impossible. In so far as health is not reconceptualised as progressive improvement in conditions and quality of life, health for all by the year 2000 is unrealistic!

One can therefore assert for Nigeria. as Samba did for Gambia, that:

> 'As a slogan (sic), I think Health for All by the year 2000 is already succeeding. It has galvanised local and international opinion. But whether or not the objective it expresses will be achieved depends on the degree of local and international commitment.[28]

which, for now, is close to zero.

Furthermore, the attitudes of traditional healers are only to be modified ir order to discourage traditional healing practices. for ex-

ample, Dr. Ogundeji pointed out that traditional healers would be encouraged to replace their equally effective drugs with 'Westernised' ones. This is in line with PHC recommendation but which negates the idea of self-reliance and self-determination. In so far as this is the case, health for all by the year 2000 is only a mirage. This is because 'the concept of health cannot be based on thin or elaborate abstractions, irrelevant to the overall needs of the society and divorced from the natural objects of its interests..... Health must spring from the people — a truly dialectic purpose, it must draw from its tradition....'[29] A situation where the ideology, planning, and implementation comes from above is also a major problem.

Consequently, there is the need to give important considerations to the study of the existing traditional health care system. What this requires is that medical doctors, nurses, midwives, students in medical and paramedical profession as well as the ruling elites should come down from their 'high pedestal' to learn and identify with the traditional healers. These are to be re- evaluated for implementation. Though this may take a long time and hardwork, we should learn from Wande Abimbola's observation that the Chinese continued to use their traditional medicine but also intensified research to explain their mode of action.[30]

The choice of VHW through councillors is also a problem. Money politics has continued to be the basis of elections in Nigeria. In this situation, councillors are more interested in their 'pockets' than what they can do for the people (the people have been bribed before, any way). Therefore, one cannot but doubt the success of PHC in their hands. In addition, the fact that politicians are apt to choose who voted for them as VHW would affect the success of PHC. The process of choosing the VHW is very crucial to the success of PHC. Where the person (or people) the community prefer(s) is not taken, it may lead to the failure of the programme.[31]

Closely related to this problem is the fact that it is not easy to change people's attitudes. Yet medical doctors and students and even the community members have to change their attitudes. To date, the norms and values in relation to expectations from politicians; to the divergent perception of life among the rural and urban dwellers; and even the trained VHW has to change. In case of the latter, for example, it has been found out that most health workers might have been taught some things but their belief might hinder the implementation.[32]

Finally, as a matter of emphasis, the political transition which

Nigeria is undergoing does not show that there are principled dedicated, visionary and innovation leaders. What most of them are interested in is how to recoup the money they invested in elections, and more. Consequently, one cannot but be pessimistic about the success of the PHC which devolves on the councillors at the ward level. The realisation of health for all by the year 2000 is dependent on the realisation of representative grassroot democracy not based on money politics. Unfortunately the latter is the case. What hope is left for the PHC? Poor people in slums and villages cannot do it by themselves. This would only amount to telling them "to lift themselves by their own bootstraps and forgetting that most of them are barefoot anyway",[33] politicians are, in most cases, out of the point; influential elites are wary at doing such things; educated elites think more of themselves; whither Primary Health Care?

There is however, a ray of hope. The Christian Health Association might help out but definitely not traditional health practitioners; other non-governmental organisations may also help but not in so far as it threatens their existence-profit. The Nigeria social structure really needs a shake-up. But by who?

Footnotes.

1. We have used this in the context of the Alma Ata Declaration, 1978 '... bringing health care as close as possible to where people live and ;work ...' and involving all aspects of human activities. See Alma Ata 1978: Primary Health Care (World Health Organisation, General, 1978).
2. It is important to point out that SAP predates 1986. The late years of General Gowon's government; Murtala-Obasanjo's regime, Shagari, and Buhari-Idiagbon regimes; all attempted to implement the programme. It is only that they are interested in implementing part of the programme. See, among others, Ben Turok (ed.) *Debt and Democracy* (London: Institute for African Alternatives, (1991)
3. See Onimode, B. 'The Political Economy of Privatisation in a Depressed Economy' in *Privatization of Public Enterprises in Nigeria* (Nigerian Economic Society, 1988).
4. Op. Cit.
5. Ibid. Paragraph 17.

6. We have discussed this somewhere else under Olutayo, A.O. 'Surviving within Democracy: The Case of Local Government in Nigeria' at a Conference on Democracy Organised by the Department of Classics, University of Ibadan and the Classical Department Association of Nigeria. June 1992. (It is likely to come out in a published form under another topic).

7 Our idea of the principle of self-reliance seems a little bit deeper than what is implied in the definition of PHC approach (Alma Ata Op. Cit. Para. 1). We do believe, however, that the words 'scientifically sound' means a long-term process of transforming indigenous medicine. This ought to start immediately. In other words, 'scientific' understanding of 'traditional health care' should start now and be encouraged.

8. We should mention here that the process actually began during the colonial period. This and the people to whom governance was handed over to led to the existing situation. See Ekeh, P.P. *Colonialism and Social Structure* (Inaugural Lecture, University of Ibadan, 1980); see also Olutayo, A.O. 'The Development of Underdevelopment: Rural Economy of Colonial South Western Nigeria'. An Unpublished Ph.D. Thesis, October, 1991; Julius Ihonvbere (ed.) *The Political Economy of Crisis and Underdevelopment in Africa: Selected Works of Claude Ake* (Nigeria: JAD Publishers Ltd. 1989).

9. World Health Organisation: "African Traditional Medicine". AFRO Technical Report Series, No. 1, 1976.

10. Tola Olu Pearce 'Social Change and the Modernisation of the Medical Sector' in Simi Afonja and Tola Olu Pearce (ed.) *Social Change in Nigeria* (England: Longman Group Ltd. 1984).

11. S.H. Brew-Graves, 'Medical Education, Health Care and Development in Africa' Paper Presented at the College Lecture, College of Medicine, University of Ibadan, July 26, 1990 (Dr. Brew-Graves is the WHO Representatives and Resident Programme Coordinator in Nigeria).

12. Also important is the fact that colonies were seen as avenues for trade. See, among others, Walter Rodney, *How Europe Underdeveloped Africa* (London: Publishing House, 1972).

13. Alubo, S.O. 'Debt Crisis, Health and Health Services in Africa'. Social Science Med. Vol. 31, No. 6 pp. 639-648, 1990; Pearce, Op. Cit.; also in 1982, Federal Government Officials prefer to go

abroad for Medical Care, September 6, *Daily Times.*

14. Ibid. See also Ogundeji, M.O. 'Primary Health Care in Nigeria: Achievement since Inception and Prospects for the Future', Paper presented at a Seminar/Workshop on Community Mobilization and Training for Primary Health Care Workers, 14th Sept. 1987.
15. Aregbeyen, J.B.O. "The Imperatives of Preventive Health Care in Nigeria" in Proceedings of the National Conference of the Ibadan Socio-Economic Group in Development Strategies in 21st Century Nigeria. July, 1991.
16. World Development Report 1991: The Challenge of Development (Published for the World Bank by Oxford University Press, 1991).
17. Op. Cit.
18. See for example Roemer, M.I. 'Private Medical Practice: Obstacle to Health for All' in *World Health Forum*, Vol. 5, 1984.
19. Lambo, T.A. 'Politics, ideology, and health', *World Health Forum*, Vol. 1 (1, 2) 1980 p. 6.
20. Samba, E.M. "Primary Health Care: unknown, pitfalls, and hazards', *World Health Forum*, Vol. 2 (3) p. 359, 1981.
21. Lambo, Op. Cit. p. 6.
22. Alma-Ata Op. Cit. para. 22.
23. Op. Cit. (Ogundeji, M.O. and Pearce).
24. See the 'Foreword' to the Federal Ministry of Health: The National Health Policy and Strategy to Achieve Health for all Nigerians, Lagos, 1980 by Prof. Olikoye Ransome-Kuti.
25. Ogundeji, M.O. (Op. Cit.) and Oyegbite, K.S. 'Overview of Primary Health Care in Nigeria', n.d.
26. Our source of information is Dr. Martins O. Ogundeji, Zonal Coordinator of B Health Zone (comprising of Delta, Edo, Lagos, Ogun, Ondo, Osun and Oyo) in an interview held with him on the 17th of August, 1992. All the information with regards to the establishment of PHC in Nigeria emanated from him. The critique is ours.
27. This is one of the pitfalls Gambia experienced. PHC started in 1978 at the Gambia. See Samba, E.M. Op. Cit. pp. 358- 363. On page 361 he states: 'In my own opinion, management was the most critical factor in the success or failure of PHC. At the central level we had an interministerial committee, whose meetings were

initially well attended. As the honeymoon came to an end, different, often conflicting, priorities emerged. Attendance at the meetings became poorer as time went on. Other ministries became less cooperative; some were down-right obstructive....' See also, on the problem of management especially at the political level, Muriel Skeet, 'Community Health Workers: promoters or inhibitors of Primary Health Care? *World Health Forum, Vol. 5, 1984 pp. 291-295.*

28. Samba, E.M. Op. Cit. p. 362.
29. Lambo, Op. Cit. p. 6.
30. Wande Abimbola 'Traditional Medicine in Nigeria: The Journey so Far', Paper Presented at the Pre-Fair Seminar Organised by the NTA Channel 7, Lagos. Feb. 26, 1988.
31. Skeet, M. Op. Cit. and also Ratnaike, R.N. O'Neil, P. and Chynoweth, R. 'Village Health Workers and Malnutrition: A Project that failed'.
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5

Strategies For Community Participation In Primary Health Care Programme: The Participatory Rural AppraisalApproach

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> "Frequently, beneficiary knowledge of the local situation will prevent wasteful and inappropriate schemes designed by ignorant outsiders".
>
> Cow and Morss (1988)

Introduction

So much has been written already on Nigerian local government since the reform of 1976. The reform attempted to make local government the most important organ of the Nigerian administrative system. The reform defined, in clear terms, the structure and functions of the local government. Adequate constitutional guarantees were also put in place to protect the local governments. Of course, statutory allocations both from the Federal and State governments, were made available to them.

Staff training also received a boost through special grants. These enabled local government officials to attend workshops and seminars on different areas of the local government functions.

In spite of all these, development at the grassroot has remained rather low. There are, in fact, some who argue that local governments have failed to live up to expectation. These critics have suggested further reforms to make local government more relevant at the grassroots. To some extent, these critics are right. But what is required to make local government more relevant is not another wholesale reform.

Rather, local government functionaries should be encouraged and exposed to more training opportunities to make them more innovative in carrying out the responsibilities assigned them to make life more meaningful for the majority of people living in their constituencies.

This short paper addresses the issue of Community Participation in Project Planing and Implementation at the local level. The intention is to introduce participants to Participatory Rural Appraisal (PRA) which I consider a very good strategy for promoting participation in the planning and implementation of Primary Health Care Programmes at the local level. This approach is considered useful because most of the local government areas in Nigeria are rural. A very large proportion of Nigerians live in these rural areas where the need for effective health care services is felt most.

Primary Health Care

Primary Health Care is now firmly established in Nigeria as the strategy for providing health care for the entire population. According to the 1978 Declaration of Alma Ata, Primary Health Care is defined thus:

> Primary Health Care is essential health care based on practical, scientifically sound and social 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.
>
> It forms an integral part both of the country's health system, of which it is the central function and main process, and of the overall social and economic development of the community.
>
> It 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 the people live and work, and constitutes health care process.[2]

Five main universal principles underline the Primary Health Care strategy. These are:

— equitable distribution

— community participation
— a preventive/promotive approach
— appropriate technology; and
— a multisectoral approach.

Since 1985 when the present military administration came into power, a lot resources has been committed to the health sector. The Federal Government allocated huge sums of money to the States to rehabilitate general hospitals which form an important component of the P.H.C. The teaching hospitals under the control of the Federal Government also received special grants to improve their services. The training of the different cadres of health workers also received a boost as seminars and workshops are organised to provide them with requisite skills necessary for the operation of the P.H.C. system. All these show the commitment of the government to the P.H.C.

Attempts at ensuring community participation in the P.H.C. has succeeded in some areas. But to a large extent, community participation remains problematic because of the attitudes of health professionals. Often, health professionals assume that they are in position to assess the health problems, needs and priorities of the people in the community. They blame the people for their poor health and formulate policies and strategies without the input or participation of the people. This not only negates one of the basic principles of P.H.C., it also undermines the progress of the programme at the community level. The present state of affairs need to be redressed to encourage community participation in PHC.

Community Participation and Planning Process at the Local level:

Contributing to a workshop organised for local government officials by the Faculty of Social and Management Sciences, Ogun State University in 1985, I wrote inter alia:

> The analysis of the present situation at the local level is basically that the bureaucrats and professionals monopolise the planning process and decision-making structure thereby alienating the citizens. The planning strategy being adopted is simply one in which the planners plan for the people and not with the people. This strategy not only negates democratic political processes, it also makes the citizens hos-

tile to government projects designed to serve them and enhance their living conditions. (Oyeneye, 1985).

This situation has remained very much the same till today. While it is true that many local governments across the country have strengthened their public relations machinery to enhance public enlightenment to support their programmes and have always extended their hands of goodwill to the people, community participation has remained low. The failure of these efforts suggest the need to further search for approaches that could be used to enhance community participation in project training and implementation at the local level in Nigeria. It is in this context that I find Participatory Rural Appraisal (PRA) relevant as a tool that may be used to promote community participation in PHC at the local level.

Participatory Rural Appraisal Approach (PRA):

What is PRA? When, where and how did it originate? What is the importance of PRA to local government functionaries? When and where is the approach?

Participatory rural appraisal originated in the late 1970s in Chang Mai and Kohn Kean Universities in Thailand. It emerged as an alternative to the conventional 'top-down' approach to rural development.[4]

The idea of PRA arose due to the disillusion of development experts regarding the long delays and huge expense incurred in conducting formal surveys to generate data for policy formulation. Not only do these formal surveys result in the collection of too much data, it has also been found that quite often, the data collected are irrelevant. The publication of the results are usually late and inappropriate with too little or no participation by the local people. It is the need for more qualitative, in-depth information and insights from the local people rather than mere quantitative data that gave birth to PRA.

As an approach, it enables government officials, professionals and consultants to learn from and with rural people, directly and face to face. It also enhances their understanding of the perception, priorities and needs of the rural people.[5] Thus, PRA challenges the prevalent notion among professionals and development administrators that the rural people are ignorant. Secondly, it encourages participation and empowerment of the people in the analysis of problems and the formulation of possible solutions. This, indeed, is an essential requirement for successful development within the context of grassroot development

which is the cornerstone of the present administration.

Participatory Rural Appraisal is used mostly in the developing countries. Usually, it is used in solving problems at the local level, but some development administrators have used it to find solutions to urgent urban problems. PRA has been used mostly in the agricultural field. It has also been used for solving problems in health, nutrition, economics, energy and forestry.

This approach has been found very useful when exploring an area to learn about the key problems or when planning for research or development projects (Explanatory PRA). The approach is equally useful when dealing with conflicting differences between different groups (Conflict Resolution PRA).

Practitioners of PRA used several techniques which include the following:

- direct observation
- participant observation including being taught and participating in village activities
- secondary data review
- informal interviews
- group interviews
- wealth ranking
- stories and case histories
- workshops and brainstorming
- group walks
- participatory mapping and modelling
- time lines and trends
- rapid report writing in the field.

This list is by no means exhaustive as there is a basket of different techniques. The techniques or a combination of any of these techniques used by practitioners depend on the problem at hand. Let me elaborate on each technique.

Direct Observation: This involve looking first-hand at the conditions, the agricultural, health, nutrition, economic practices, the people, their relationships, the problems etc.

Participant Observation: This requires the actual involvement of the professionals in the different activities of the people in the com-

munity under consideration.

Secondary Data Review: This involves learning from existing official records, maps, photographs, survey documents and census reports.

Informal Interviews: This is usually conducted among key informants in the community such as village heads, opinion leaders, religious leaders, school teachers, retired civil servants and all those directly affected by the problems being examined.

Group Interviews: This may be focus group for the investigation of interest groups or specialist attitudes. It may also be open groups workshops for general discussion and/or feedback. This is useful for collecting vital information.

Wealth Ranking: This is the process of discussion with informants about the nature of poverty and wealth in their area as seen by them. This is usually followed by a process of ranking households in that area based on the criteria provided by these informants (who actually do the ranking exercise). The greatest advantage of wealth ranking is that it generates useful insights into local perceptions of wealth and poverty rather than an imposition and application of criteria developed by outsiders. It is also very useful in identifying target groups that need attention. Above all, wealth ranking can promote sustainable rural development since the programmes and/or projects emanating from it (wealth ranking) will be perceived as just and equitable in the eyes of the people in the community concerned.

Stories and Case Histories: This relates to the report of the PRA exercise. It concerns the record of interesting stories told during interviews and the description of households with unusual or interesting situations.

Workshops and Brainstorming: This is normally conducted to discuss problems and to analyse the possible options for solving the identified problems.

Group Walk: This simply refers to the group walk round the community for direct observation of the conditions of the people and the community in general.

Participatory Mapping and Modelling: This refers to maps made by the people on paper, the floor or the ground. It could be used for showing numbers and locations of people, natural resources and social attributes etc. as indicated below:

People — census type information on all the people in the community.
— compilation of community register
— social groups (clan, ethnic etc.)

— key informants
— Health specialists (TBAs etc.)
— handicapped
— children who do or do not attend school
— pregnant women
— the sick by types of disease, by location and social group.
— household characteristics.

Natural Resources:
— land use pattern
— location of the different community resources.

Social attributes:
— ownership of assets, wealth/well-being status.

Facilities
— water supplies
— community facilities — school, churches, mosques, shrines etc.
— Post Office, Chemists, health posts, Family Planning Centres;
— Paths, roads etc.

Hazards:
— pollution
— flood
— prohibited areas
— accident spots
— pests etc.

Participatory mapping and modelling is useful in several ways — starting point of entry with community thus establishing rapport, collection of demographic data, identification of vulnerable groups, awareness and planning by the community and participatory location of facilities.

Time Lines and Trends: These relate to major changes in the past such as incidence of disease, trends in epidemics, changes in the environment and changes in access to services. This technique helps people to analyse and make sense of what has occurred. It also helps in conflict resolution and in building on previous successes/failures.

Planning and Implementing a PRA:

Having examined, albeit briefly, some of the different techniques used in PRA, an attempt is made in this section to show how a PRA is planned and implemented. For the purpose of illustration, we shall focus attention on a health problem — widespread or guinea-worm in an area of a local government. It is this health problem that has neces-

sitated the planning of the PRA.

The following steps will be taken:

(i) Composition of a PRA team;

(ii) Initial preparation — liaison with the local government headquarters and the Chiefs in the area(s) affected by the disease;

(iii) Consideration of types of information required;

(iv) Consideration of people to be seen/identified for relevant information;

(v) PRA techniques to be used.

Composition of a PRA Team:

A PRA team should not be too large if it is to be effective. Membership should not exceed ten; and these must be people who are sufficiently knowledgeable about the problem under consideration. In the case of the guinea-worm, a PRA team of seven members is considered adequate. The membership will include a doctor with special interest in community medicine, a PHC Officer, Parasitologist, Laboratory Technologist, Community Development Officer, Budget and Planning Officer and an Administrative Officer who will coordinate the activities of the team. Key informants from the area under consideration will also be included.

InitialPreparation:

The administrative officer is expected to gather relevant documents for the other members of the team and also make preliminary contacts with relevant bodies informing them about the composition of the team, its purpose and the need for their cooperation in executing the team's task. The appropriate village heads should also be informed about the formation of the team and its purpose. The officer is also expected to fix the date and place of the first meeting. It is normal to have the meeting in the area/village that is plagued with the disease.

Types of Information Required:

For a PRA to achieve the desired results, the team members must consider and carefully identify the various types of information they need from the area/village under consideration. This should be done before the first meeting. With particular reference to the guinea-worm

problem, the underlisted baseline information are considered relevant:

- secondary source of data for the past history and the socio-cultural, economic and political development of the area;
- the prevalence of the disease in the area;
- the type and number of household affected;
- the sex distribution of those affected including children;
- level of education, type of occupation and income levels of those affected;
- sources of drinking water and nutritional behaviour of the people;
- location and number of modern health facilities available in the area including the number of personnel, equipment in use and supply of drugs;
- other sources of health care delivery such as chemist shops and traditional medical practitioners;
- when the disease was first noticed in the area;
- what the people consider to be the minor-major causes of the disease and the possible immediate solutions.

The People to be seen:

The first people to be seen by the PRA team are the heads of the villages afflicted by the disease. Others include: school teachers, retired civil servants, religious leaders, opinion leaders and those afflicted by the disease as well as a handful of those not affected in the various age-groups and occupations.

PRA Techniques to be Used:

In view of the type of information required and the problem under consideration, a combination of eight techniques is considered adequate. These will include:

- direct observation
- the use of key informants
- ranking
- informal interviews
- group interviews
- mapping

— workshops and brainstorming
— report writing

The first PRA techniques to be adopted will be the direct observation of the entire area/village through which the PRA team members will gain firsthand information about the people, the economy, social, cultural, spatial and other ecological aspect of the area/village. This method will generate additional information that will supplement some of the information gained through secondary sources about the area/village.

While going round the area/village for observation, members of the team will also hold conversation with different people aimed at learning about the area/village. The use of conversation will be complemented with the identification and informal interviews or key informants such as school teachers, retired civil servants, opinion and religious leaders in the area/village.

Group interviews are also one of the methods to be used to obtain information from those affected by the disease and other members of their households. Another group in the area/village where there has been no incidence of the disease will also be interviewed for comparative purposes.

Ranking method will be used to elicit information on the most serious health problem and the type of health facilities — modern or traditional, commonly used in the area/village.

The use of mapping method is meant to show the extent to which the people in the area/village know the incidence of the disease. In doing this, the people will be asked to use a stick to draw the map of the area on the ground showing those villages where people are badly affected. The justification for this, is to show areas, where the disease clustered and in need of urgent attention.

Workshop and brainstorming will provide the forum for all the heads, the opinion leaders, the educated, some of those affected by the disease and the PRA team to meet for further interaction. Here, the people themselves will be expected to examine in detail the problem of the guinea-worm in the area and the appropriate measures necessary.

Finally, a report will be written on the field so that appropriate government authority, as well as the villagers, can go into action immediately. This report will be jointly prepared by the team and the people of the area/village.

Discussion

It must be admitted that the PRA approach takes quite some time to learn and somehow difficult to do well. But given its inherent advantages, functionaries at the local government level responsible for the design and implementation of PHC programmes should develop interest and readily take to it. PRA is not only time-saving but also efficient in information gathering. PRA will encourage participation of the local people in the process of development since local insights are usually sought not only in the gathering of information but also the design, implementation and sustenance of projects. In a way, PRA empowers the rural people and increase their commitment to programmes and projects designed for their benefit and well-being.

It is important at this juncture to draw attention to some basic requirements in the application of PRA. First, practitioners of the approach must be willing to share some of their powers with the people.

At the local level, functionaries will need to share their powers with the rural people to encourage them to participate in government programmes. This is very important if the conventional 'top-down' approach to development is to be reversed. Within this context, practitioners of PRA must be humble and show basic respect for the rural people. They must also show keen interest in what the rural people know, say and do. It is certainly out of place for practitioners to regard the rural people as ignorant rural dwellers who have no contribution to make in matters affecting their well-being and the environment in which they live.

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6

The Place of Traditional Medicine in Primary Health Care

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The Place of Traditional Medicine in Primary Health Care

There is a general concensus among social scientists that within every culture, there are means with which the health problems of the people are maintained. This belief thus suggests that the culture dictates the cause of disease and the course of action taken. For instance Pearce (1982:15) observed that all cultures evolve methods of dealing with ill-health, discomfort and maintenance of health. Similarly, Lambo (1961, 1966) noted that his experience of non literate societies have demonstrated the influence or importance of cultural factors in the management of the patients. To him it is culture which determines the acceptability, the success or failure of a give therapeutic orientation. This position supports Unschuld's (1976) observation that "were ever" western medicine was introduced and no matter how urgent the need for its immediate application was felt to be, it was never a question of its filling a medical vacuum." This picture was succintly put by Pearce (1982) she noted that the vast territory to be known as Nigeria under the Britain in 1914, after the unification, had developed various specialist among different ethnic groups to handle their health problems.

These specialists were known as traditional or native healers with their various local names that suited the different cultures. For instance the Yorubas recognised them as *babalawos*. The Ibos *dibia*, the Hausa *Boka* while the Urhobos *Oboh*. Who are these people and what form

of medicine do they practice in the community?

Traditional Medicine And The Practitioners

The conception of traditional medicine varies amongst authors and even between ethnic group. In other words, there are as many definitions of the art as there are researchers. According to Ataudo (1985), traditional medicine is the medicine of the people by the people and for the people which has been practiced and handed down from generation to generation. Similarly, the World Health Organisation (WHO, 1976) defines it as the sum total of all knowledge and practices, whether explicable or not used in diagnosis, prevention, and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation down from generation to generation whether verbally or in writing. In other words, traditional medicine is an art which depends on available resources of nature.

There are also different areas of specialization or proficiency. Let us take the case of the *Okpe* people of Delta State, for an illustration.

There are two major groups of healers among the *Okpe* people of Delta State — The *Edjele* (witchdoctor) and the *Oboh* (the Ordinary doctor). This classification is based on the belief that the *edjele* could be able to resolve problems (ailment) with witchcraft undertone as it is with the Babalawo of the Ibadan Yorubas (Maclean 1971:18) while the *Oboh* who only rely on his natural knowledge in "herbs and barks" of plants to handle problems cannot resolve witchcraft related problems.

It should be noted, however, that the above classification is not to suggest that witches are traditional practitioners instead it reveals the fact that there are traditional practitioners who in addition to their skill in the natural methods of healing have witchcraft powers that they utilise in the management of illness. It also suggests that the belief in witchcraft as a potent source of disease/misfortune and consequently illness management is well developed and entrenched in the culture of the Okpe people. This observation agrees with what other researchers (Lambo 1966; Erinosho 1978; Oyebola 1980 and Odebiyi 1980) view that ill- health may be due to a number of sources or causes — naturally, supernatural or mystical and considering the fact that most problems/ailment in the developing world are more magico- religious in nature — (Ackerknecht 1946), there is a need therefore to develop traditional medicine.

A closer analysis of the above classifications of the two major group of practitioners reveals the following:

(i) The general practitioners who perform general services regardless of the problem of the patient. They have a wide knowledge of herbal medicine as well as being able to divine the cause of the problem, just as the Yoruba babalawo (Oyebola 1980) including rendering of ordeal services.

(ii) The second group are the Oraclemen/women whose role is strictly divination. Theirs is to locate the cause of the problem, without which no meaningful solution can be obtained. The average Okpeman believes this because illness is seen to be mostly the handiwork of evil machination and surreptitious in nature.

The traditional Birth Attendant constitutes another group of practitioners among the Okpe people. They are very knowledgeable in parturitional services. These include the preparation of waist and other prophylactics against evil persons or spirits during pregnancy and kids ailment and delivery among others.

(iii) The bone setters, traditional psychiatrists and masseus are the other categories discernable among the group. The bone setter is involved in the treatment of fractured bones while the psychiatrist handles mental cases. The masseues massage. To my mind, the bone setter performs in some if not all cases a service that has no alternative or equivalent source. They do not amputate patients. Similarly, the traditional psychiatrists have been acclaimed to be more effective in the management of mental patient than the so called scientific medicine (Lambo 1966). The point here is that there are some areas of proficiency where traditional medicine has leverage over western medicine. For instance Oyebola (1980) observed that traditional practitioners seem to cater for certain health needs of patients in the Yoruba cultural milieu (this is true for almost every culture in Nigeria) in which Western medicine falls short of expectation. An observation he made after discovering that in cities like Lagos and Ibadan where western medicine faciliities are available within easy reach of inhabitants a large percentage of the people still visit traditional proctitioners or have traditional medicine secretly brought to them when they are in the hospital. In other words, traditional medicine would continue to cater for some special needs because the culture defines the disease, and management pattern and the attitude of the people. This

is a purely socio-psychological syndrome which cannot be trampled upon in ailment management so there should be a way of identifying such areas of needs and developing them for a start.

These practitioners acquired their knowledge either through inheritance or apprenticeship or as a call by one spirit or the other. They practise this art as a hobby or as a form of communal service with little or no financial rewards to the people. This non financial ethos characterized the practice of traditional medicine till of recent. The art then was "pure" and efficacious because most practitioner's services were rendered to family and close community members while in others token were only given to the traditional practitioner after positive result of treatment have been obtained.

Unfortunately, these unparalleled services were administered by illiterate and old people who could not document what they did or knew consequently, some if not all died with a substantial part of their knowledge. It is in this realm that the development of traditional medicine has seen its greatest pitfall in this country because our government has been culturally enslaved to believe that what is western in origin is the best an nothing else.

The situation is gradually improving today, some of our traditional practitioners are now literate and collaborative in their attitude towards the practice of medicine. They have revolutionized the practice to one which shows that they (practitioners) are no longer a bunch of uneducated dirty and unorganized body to a fairly organised, less dirty and refined group consisting of full time practitioners with monetized services.

Primary Health Care And Traditional Medicine

Today, Primary Health Care is now the focus of the government. The reason being that the government has identified that the western medicine which is mostly centred on curative, capital oriented and, sometimes unaffordable cost is distant from the people and in order to 'carry' health to the door step of the people the primary orientation of medicine should be emphasised and pursued vigorously.

Primary Health Care as it is conceived in the Alma Ata Declaration of 1978 is essentially 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 and country can

afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

One vital point that strikes us from the above conception is the acceptability, accessibility, affordability and sustanability that it preaches. This vividly brings to mind Mallean Foets et al (1985) conception of the term PHC. PHC very often is characterized by a non specialized and easy accessible service. In their study conducted in Belgium they concluded that those services mostly consulted without referrals constitute Primary Health Care. Again, from our various development plans (first to the fourth national development plans) and execution of goals, have we demonstrated that we can sustain and provide for the needs of our population relying solely on the western model of medicine? The facts are there for all and sundry.

Research findings in Nigeria today reveal that about 75% of the population utilize traditional medicine due partly to the fact that it is highly accessible, affordable and acceptable to the generality of the population. In this light, it would not be wrong to conclude that traditional medicine can be equated to PHC in the Nigerian setting. Simplistic as this may sound, the integration and or recognition of traditional practitioners as a useful and relevant component of medicine at the local level of health management in the country is indicative of my conclusions. Today the traditional Birth Attendants are now being trained in an attempt to extend the frontiers of health care delivery in the country.

Going by the conception of PHC as stated above and given the role and nature of traditional medicine in our society, the primacy of traditional medicine within the overall healthcare needs, of the country cannot be over emphasised. The bulk of the rural poor and to a very large extent the majority depends on traditional healing systems. In fact WHO recognised that health for all by the year 2000 is an illusion without traditional medicine especially in the third world societies.

In conclusion I would urge government officials to ensure that local practitioners of the art in their domain be assisted to improve on their methods and be provided with some kits to enable the community from their services.

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7

Voluntary Healthcare Workers and the Success of PHC

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Voluntary Healthcare Workers and the Success of PHC

Voluntarism is a concept that is essentially rooted in the conception of the Primary Health Care strategy for the development and advancement of health for all people of the world and the developing nations in particular. The need for this strategy for extending the frontiers of health is premised on the inadequacies manifested by the existing healthcare structures world over. Researches and findings of scholars reveal that the present healthcare system which is technical, capital intensive, curative and modern is essentially elitist and unaffordable by a substantial proportion of the population (Rifkin and Watt 1986; Ityavyar 1987), while in the developing societies, the modern health care system is inadequate numerically and alien to the rural people. Based on these conclusions, the need for a re- examination and reorientation of the present structure as it obtains was inevitable to ensure that the health need of the people is adequately catered for. It is in the light of the above observation that the International Conference on Primary Healthcare was held in Alma- Ata in 1978 to profer solutions to the health problems of the world. It should be noted that this Conference was only the Climax of a Series of meetings aimed at addressing the health needs of the people of the world (W.H.O. 1978).

Healthcare

The Alma-Ata Conference declaration that health is a state of com-

plete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social good whose realization requires the action of many other social and economic sectors in addition to the health sector. Problematic as this conception may be, the scope of coverage makes health a non diagnostic and curative phenomenon. In other words, ill-health could be equated to poverty or absence of potable water, electricity, good food and not necessarily malaria fever. It is in consonance with this conception that the multi sectorial approach to the attainment of primary health care goal is meaningful.

The Conference declared:

> In addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sector; and demands the coordinated effort of all those sectors.

This is the more reason why nations of the world today have started to change their management of the health status of their citizen to the multi sectoral approach which stresses the provision of the basic facilities of life. For instance, self-reliance in food, provision of adequate potable water, good road amongst others as a basic target of the Nigerian government are a component or derived from the New World order that analysizes health from a wholistic point of view.

Such aphorism as

(i) illiteracy is a disease

(ii) poverty is a disease

are a testimony to the inevitability of the wholistic approach now in vogue.

Voluntary Healthcare Workers

Primary Healthcare as defined in the Alma-Ata declaration is basically healthcare based on practical, scientifically sound and *socially acceptable method* and technology made universally *accessible* to the individual, and families in the community and 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.

It should be re-called that the basic obstacles aforestated to the realisation of equitable and adequate healthcare world wide was the high cost, low strength of facilities and the alien ethos of the western services available particularly in the developing societies. In an attempt to ameliorate the existing conditions, it was necessary to:

> promote maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary healthcare, making the fullest use of *local, national* and other *available resources*; and to this end develops through appropriate education the ability of communities to participate. (FMOH, 1978).

Voluntary healthcare is thus premised on the cost reductionist and adaptation of healthcare management to the environment. In an attempt to realise the target of health for all by the year 2000, the participation of the people is inevitable. In line with this argument, voluntary healthcare workers (VHW) variously known as Community Based Assistants (CBA), Village Healthcare Workers (VHW), Community Health Officers (CHO), Community Health Assistants (CHA) and 'Barefoot doctors' in the case of China are considered crucial to the attainment of the ultimate goal.

This conception (VHW) is not actually new to the Nigerian society as far as health management is concerned. The Nigerian Community like any other has developed its own traditional system of healthcare before the advent of western medicine (Oyeneye 1985). This the people depended on and the practitioners, well recognised and respected by the community (Twumasi, 1988). The traditional healers were not motivated by economic gains or profit oriented, the art was practiced as a complementary service and humanitarian in ethos (Owumi 1989). Consequently, payment of services rendered were made post treatment in appreciation of the services. The traditional healers' services were thus a service to the community and mankind and not the gains expected. It is also possible to argue that the Primary Healthcare Scheme is also not new to the Nigerian Society since the Basic Health Service Scheme (BHSS) is structured along the same line (Oyeneye 1985).

The belief by researchers and world bodies that medicine and health management is environmentally and culturally based made the call for adaptation and involvement of the local people a genuine one to address the health problems of our people. To this end, the Nigerian

government has taken the initiative to set the pace in order to realise the goal of health for all by the year 2000.

The Nigerian Voluntary Workers Scheme

The structure in Nigeria is such that all levels of government are involved in the management of the scheme. The federal government initiated and executed the first pragmatic step towards extending the frontier of health care by creating the National Committee on Training of Traditional Birth Attendance (NCTTBA) in 1978. This Committee has in fact established strategies and guidelines for the training of TBAs and the role of the different tiers of government in the management of the primary healthcare scheme (Payne 1984). The product of this scheme were to work in their various communities as certificated TBAs. They are of course to be provided with some software to assist them in the dispensation of services. Apart from the training allowance and some kits; there is no provision for wages. This practice of training TBAs is also extended to other well intentioned persons who are concerned with the health problems of the people. Such people when identified are trained to work as voluntary health officers or community based attendants. For instance, in Akinyele Local Government Area, about four hundred village health workers have been trained to assist in the management of health problems in their various communities.

There is no doubt that the scheme is a noble one and if well managed would lead to the realization of the target of health for all by the year 2000 especially as many people would now be accessible to health officers at the local level with the existence of voluntary healthcare workers.

The basic obstacle to the realization of accessibility of health care to the generality is the low degree of commitment of the voluntary workers to the scheme. In a situation like ours, where the economy is "harsh" and the survival of the citizenry depends largely on how economically productive they are, the sustenance of health for all by the year 2000 based on voluntarism seems an illusion. This is due to the fact that nothing is actually expected from the government for services rendered to the community. As such voluntary workers are likely to have lukewarm attitude towards the management of the scheme. In places where similar schemes have succeeded, for instance, Peoples' Republic of China, participants are part of government and the nature of the economy encourages the approach (Teh Wal Hu 1981).

Another major problem which faces the success of the scheme is the orientation of the average Nigerian to healthcare delivery. Basically Nigerians see healthcare in terms of curative rather than preventive which is the focus of Primary healthcare. In this regards, the average village patient is likely to be less confident in the activities of the voluntary health worker. Again, the non-availability of essential first aid drugs due to the poor state of the economy would greatly affect the workability of the scheme under the present situation.

All these problems notwithstanding, if the local government on whose shoulder primary healthcare rest can dispense substantial amount of fund to its implementation and monitoring, the healthcare status of our people would come near enough to the ideal of health for all by the year 2000.

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8

Culture, Man, and Utilization Pattern of Primary Health Care (PHC) and its Implications For Developing Societies

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Introduction

The primary objective of this paper is to highlight the interrelationship between culture, man and utilization of the PHC facilities in developing societies. The paper was to be addressed to the developing societies wherever they exist, this is rather a very wide scope, in order to keep the discussion focused and manageable, I have deliberately decided to concentrate on Nigerian society and rely heavily on Nigerian materials.

I assume that participants in this workshop are already familiar with the concepts of "culture" and "man", but for the purpose of this paper, let us re-examine briefly the two. We shall start with the idea of man by asking what exactly is man?

The anthropologist is not totally concerned with the question, most of the answers will come from the philosopher and the social scientist interested in studyig the peculiarly human aspects of human behaviour. On the other hand, we cannot completely ignore the question even in some of its larger aspects. The evolutionary success of human line has been assured, at least in the past by a particular set of behavioural characteristics that constitute man's capacity for culture. Without culture, he is completely a helpless creature (Bleibtreu, et al 1971).

It is this point that must be kept in mind in an attempt to understand the basic nature of human being. We can simply say that man is a cultural being. What is edible and what is not? Which animals are

dangerous and under what circumstaces? Which animals can men hunt and by what means? Where can one get water when the familiar source is dry? Bleibtreu, et al (Ibid).

Unlike other animals, answers to there questions are not provided by 'instinct'. As individuals, men discovered important pieces of information either by accident or by trial and error. These facts enter into the tradition of the group to which the discoveries belonged. Verbal transmission to other members of the group made it unnecessary for vital bits of information to be learned anew each time their use could be of benefit.

In sum, culture is a most important factor that separates man from other animals particularly the primates. Culture in this sense encompasses language, means of making a living, arrangement of family life, the focus of loyalties and ways of perceiving the world, both the physical world and the world beyond. (Oke, 1987).

Furthermore, culture puts a control on man's drive it influences its eating habits, hours of sleep, display of emotion and sexual behaviour. It provides for reproduction, care of new family members and pattern of child-rearing Oke (ibid.). Although there is what can be regarded, as human culture, that is certain basic features which our species, the homosapiens share together, each human group has its own unique culture, its distinctive way of life or design for living which enables the individuals in the social group to adjust to the total setting.

Human behaviour therefore is a product of his culture and there is no way we can separate him from his culture. Human culture, among other features, is dynamic, that is, it is always changing. There are several ways in which these changes occur (Beals, 1971, Oke, 1987). These can be summarised as follows: 1) When new items are added or old items improved by invention; 2) When culture items are borrowed from other societies; 3) When culture items unsuited to the environment are abandoned or replaced by better ones and; 4) When items are lost because of failure to transmit them from one generation to the next.

It is now apparent that a given society's culture is bound to change over a period of time, modern scholars have recognized this fact, it is also apparent that contemporary medicine is a part of human cultural revolution (Hahn and Kleinman, 1983, Oke, 1992), this paper explores this premise in some details.

Today, it is widely accepted by various workers in the medical and social sciences that all communicable and infections diseases occasioned by faulty diet, clothing or housing are dependent upon sociocultural factors, even some organic diseases have at least indirect cultural origin.

In this sense, it could be suggested that man's physiological state is largely conditioned by sociocultural phenomena. By extension, it can also be suggested that utilization of medical facilities in this case, the PHC, is conditioned by certain sociocultural background factors which predispose the individual toward accepting the approach of professional medicine and hence increase or decrease the possibility of utilization (Suchman, 1972).

The fundamental postulate is a familiar one, that is, behaviour is constrained by the expectations and directives of the social groups which bear significance for the individual, Suchman (ibid.) observes:

> Medically relevant behaviour rather than being an exception, is for many important reasons, a type of behaviour on which the constraining mould of society rests heavily. Illness is a frequently recurring phenomenon, which generates fundamental concern and anxieties and which intimately involves many other people besides the sick individual. As a consequence, significant group norms and mores have evolved which strongly influence individual and behaviour in the health area.

Perhaps, the most important variable in the area of sociocultural characteristics is socioeconomic status. It has been one of the most important sources of social and medical differentiation especially in the advance societies. Almost all studies have shown that upper and lower social classes, however defined, have different values and norms and vary in both their health status and utilization of health facilities (Rosenstock, 1966, Oke, 1992; Foster, 1969; Otite, 1987 etc). The studies have revealed that modern health care services are used, for example, mostly by younger or middle aged people, by females, by those who are relatively better educated and having higher income.

Other scholars (Wolff, 1958; Weeks, 1958; stockle etal1963; Zola, 1966; Oke, 1977 etc) have also revealed an association of sociocultural

factors with the use of modern medical facilities. These factors include cultural and situational background, differential past experiences and differences in personality. Most of these findings are relevant to the situation in Nigeria with regards to the utilization of PHC facilities. None-theless, a most important feature which most studies have not adequately addressed or addressed at all is the factor of rural urban differences, a cultural variable although not quite unique to our society, but with a very pronounced impact. The guiding principle here is that settlement system is a sociocultural reality. I shall devote the rest of this paper to this variable.

Pattern of Utilization of PHC Facilities In Nigeria

A most striking feature of the PHC delivery system in Nigeria is the rural-urban differences. Recent studies and field observations (Iyun, Oke, Matanmi, 1987; Oke, Yoder, Oke Oladepo, Oyejide, 1991 etc) have consistently revealed that facilities and personnel are heavily concentrated in the urban centres even though the bulk of Nigeria population (80%) live in the rural areas. This disparity in the distribution of the facilities and resultant underutilization can partly be attributed to inappropriate health care organization. Let us talk on this briefly.

Accessibility And Availability of Facilities

It is obvious that the available facilities for delivery of the PHC are not adequate but the situation is worsened by mal- distribution, the rural population is at theloosing side,this fact is vividly expressed by Osuntokun (1973);

> . . . three fifths of the medical personnel are concentrated in 3 or 4 major largest cities in the country ... have more doctors than the rest of the country put together. Many Nigerians therefore from cradle to coffin would never have the benefit of modern medicine.

Today, the position has slightly changed, the introduction of the mobile clinic has brought health care services nearer to the rural dwellers. But most of the facilities are still located in the urban centres usually in the state and local Government headquarters. The question arises, how much distance is a rural citizen prepared to travel in order to utilize these facilities?

Certainly, he is not willing to travel a great distance. Field observa-

tions reveal that many of the villagers who have not used health facilities have not done so because of great difficulty of travelling to the centre where the facility is located. Some of the difficulties encountered include poor transportation (bad roads) to urban centres where facilities are mostly located. Some of the villagers cannot even afford the transportation cost. Some of them are confronted with the problem of accommodation in the city if they have to stay overnight.

This happens quite often since most of the public health clinics (except cases of emergency) are closed to the public too early. It is unlikely for these rural people to arrive in the city (from their villages) early enough to be treated the same day, as such, those who do not have relatives in the city with whom they can stay overnight are very reluctant to come to the city for health care.

The problem of accessibility can be considered further in terms of social distance between medical/health workers and the rural consumers. The rural people are generally poor. They are poorly educated and lack the ability to deal with or manipulate the health system to their advantage. Neither the health workers nor the rural consumers actually want to identify with each other, both are conscious of their social status and may unconsciously try to avoid each other.

The villager often express a lack of trust in the health worker and the health worker himself often complains of the rural consumer's ignorance and superstitions. The villagers are too sensitive about their inferior social position and such, they will come to the clinic as a last resort.

Man Power Distribution

Nigeria is faced with severe shortage of all categories of health manpower but the problem is worsened by mal-deployment of available trained personnel. The problem is further complicated by the fact that there is scarcity of health-professionals who personally identify with rural communities and who have strong commitments to its health needs. Many of the health workers are reluctant to serve in rural areas where they are most needed.

Most of these were recruited (as students) from urban areas, their background and value are generally middle class and urban oriented. They are being trained in Euro-American therapeutic tradition and are Western or urban oriented. They are not therefore often prepared to accommodate or tolerate rural and poor people. As a result, semi-

professionals are often found in rural Nigeria. Serious efforts should be made to sensitize students in our various health education programmes and medical schools to health needs of the rural people so as to cater for a large population of the country.

Priority Given to Curative Services

In the past, there was too much concentration on curative services throughout the country. In rural areas, the concentration was almost entirely on curative services. Health centres and dispensary services were often provided whereas, hospitals and specialized services are located in urban areas. Today, the position has improved, there is more emphasis on preventive health care. The position of PHC services both in rural and urban areas is now receiving government and public attention.

It is obvious, however, that the concepts of disease, illness and rehabilitation are not the same among the poor and rural illiterate as among the middle class urban people. The rural dwellers, generally are "crisis oriented", meaning that many of them do not seek medical help until incapacitated or until a symptom appears. It is further observed that the ruralist perceive the body as having a limited span of utility to be enjoyed in youth, and then with age to be suffered and endured. Middle class urban dweller on the other hand, generally think of the body as a "machine" to be preserved and kept in perfect running order.

These fatalistic attitudes of the rural dweller are often explained in terms of their inadequate knowledge of the Principle of infectious and communicable diseases. This is usually an excuse for the relative concentration of treatment services in rural areas with the argument that the rural dweller will never utilize a preventive/detection service. Whether the "culture of poverty" (assuming it actually exists) is applicable to Nigerian situation awaits further research. It is obvious, however, that various health authorities in the country seem to have bought the idea and thus meager services offered to rural Nigeria are mostly centred on treatment.

Conclusion

I have suggested that human behaviour is a manifestation of his culture, man is a cultural being, his behaviour is culturally conditioned.

Without culture, he is not different from other animals. It is therefore imperative for health workers who must deal with the dynamics processes who must deal with community health programmes to understand and appreciate the local culture or subculture for an effective health programme.

I have further suggested that settlement system is a cultural reality, hence utilization pattern is explained in terms of rural-urban differences, the manner in which health care is organized is actually the most important factor which affects the proper utilization of facilities, where availability of facilities/services does not guarantee adequate use without health professionals who personally identify with the (rural) communities.

The priority given to curative services is a deterrent to proper utilization. The PHC scheme is an attempt to offer balance health services at the grass-root, but the services have not reached most rural areas in the country. While efforts to improve curative service should not be abandoned, the rural people should be exposed also to preventive/detection services by means of health education programmes, provision of adequate facilities and health and medical practitioners who are socially accessible.

Finally, the quality of medical and health workers in rural communities needs much improvements. The poor image of the rural medical system can be attributed in part to inadequate number and quality of medical practitioners. While we realize that developing societies including our own society, are short of health manpower, it is observed that the problem is worsened by concentrating the very few well qualified once in urban areas and thereby leaving a large proportion of the population uncatered for.

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9

Psychodynamics of PHC consumation in Nigeria

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Introduction

During the first workshop organized by the co- ordinator for the same people, I happened to be one of the sessions chairman. Here, I asked the question as to why psychologists were not brought into the scene. This is because psychologists and psychology are meant to study analyse, interpret, predict and control human behaviour i.e. at the individual level. Psychology is interested in understanding the totality of human behaviour, like perception, attitude, interpersonal attraction, cognition, cultural influence etc.

Given this background, and the claim that PHC consumation is low in Nigeria (Jegede, 1992), one then begins to wonder why the low response to PHC strategies despite the heavy investment by the agencies and organizations concerned. Hence the need to present a psychological solution to the problem(s) at hand i.e. low level of PHC consumation.

Theoretical Background to Health Conceptualization

Psychology is very interested in conceptualization of terms and/or issues of concern. My attempt at addressing the issue at hand will follow this pattern as well. The WHO defines health as "a state of complete physical, mental and social well being and not merely the absence of disease and infirmity", but I share in Jegede's (1992) concern that this definition is limited in scope if we fail to incorporate psychological dimension. He posited that someone may have access to good medical

services, good housing etc. but can still be psychologically sick, as a result of his poverty level (not only in economic terms alone). The psychological elements involved here are attitude, perception, behaviour, interpersonal relationship, culture, social support, to mention just a few.

Perhaps, Ivan Illich's (1976) definition is more applicable here, and it states inter alia: "Health designates a process of adaptation. It is not the result of instinct, but of an autonomous yet culturally shaped reaction to socially created reality. It designates the *ability to adapt to changing environments, to growing up and ageing, to health when damaged, to sufferings and to the peaceful expectation of death.* Health embraces the future as well, and therefore includes anguish and the inner resources to live with it..." (emphasis mine). All the emphasised concerns link up with psychological dynamics mentioned earlier. In other words, people strive to achieve a psychological "homeostasis" i.e. an equilibrium, a balance between self and the environment (both internal and external). This balance is captured by the diagram below which is associated with health.

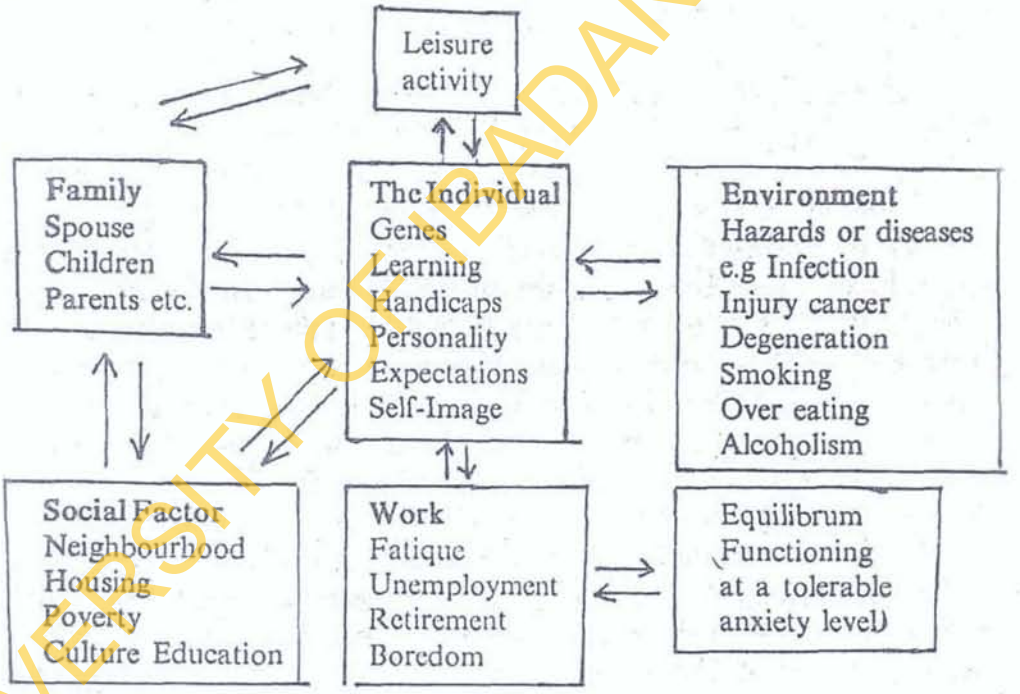

Fig. 1.1. Equilibria associated with 'health'
Source: Pritchard (1981)

Health care according to Pritchard (1981) is a response to this equilibrium and primary health care is the nearest contact between the individual and the health care service. According to him, primary health care should involve the following:

- health maintenance
- illness prevention
- diagnosis and treatment
- rehabilitation
- pastoral care
- certification
- *Research and data gathering*
- *Information dissemination and mass education*

(emphasis mine).

If we are to adopt these objectives then PHC must be made accessible, acceptable, identify needs and maximum and justifiable use of manpower and other resources.

Consumation of PHC in Nigeria

Since the inception of the present military administration in Nigeria in 1985, a huge sum of money and efforts have been committed and still being committed to PHC in the health sector. This is in form of rehabilitation of general hospitals (Oyeneye, 1992), training of health officers, purchase of essential drugs and so on. However, despite this commitment, there is low consumation in Nigeria (Agbonlahor, 1992; Jegede, 1992). For example, Jegede (1992) claimed that since 1977 when EPI was formally launched in Nigeria, coverage had been low, (10%). This he attributed to poor logistics. Not only this, improper understanding of people's perception of health related issues or behaviour can also be the problem. For example, it is how people perceive a problem that will inform what attitude to adopt or not as regard solving the "problem". Pritchard (1981) indicated that many health problems which individuals face are a reflection of their attitude to life and society, as well as their level of motivation at achieving a balance between these and their health status.

Another problem in PHC consumation is level of poverty in Nigeria. Generally speaking Nigeria is poor not only in monetary terms, but in all other spheres of human endeavour. A psychologically abused mind will not be motivated to seeking all other supposedly curable means to

its health problem. Motivation derives from deprivation and when there is deprivation, there will be need for seeking out means of restoring balance (homeostasis) which is brought about by the deprivation. However, there must be facilitating factors put in proper place(s) for the individual to attempt (be motivated) to seek "redress". Such facilitating factors include among others, concern by the appropriate authority (society & government agents), accessibility of the health ameliorating facilities (e.g. distance, cheap drugs, education) and acceptability by the people.

Another problem identified by Oyeneye (1992) is the poor attitude of health professionals, not only in their relationship towards the people in need but also, in their assumptions that they know the need priorities and health problems of the community. For example, they blame people for their poor health and formulate policies and "solutions" to their problems without adequate input or participation of those people. This is psychologically threatening in that there is the fear of an outsider usurping their "rights", customs, beliefs and values. They therefore respond with what is psychologically known as "rectance". This is the tendency to repel a threat or total refusal to abide by a simple request.

Another example concerning the attitude of health professionals can be drawn from a research by Balogun (1993) on Vesico Vaginal Fistula (VVF) patients. Many health assistants were reportedly "fired" by the authority at the VVF centre in Anua, Akwa-Ibom State for their "aggressive" and "non- cooperative" behaviours over a period of time. If you want to encourage an individual to "patronise your goods" you don't invite him/her with a frown on your face or a big stick in your hand for fear of being attacked. Such is the case of VVF patients and health attendants.

Finally, communication strategies being adopted by the agents concerned, though effective in some areas, still need an improvement for consumation of PHC to be totally effective. Psychology of communication concerns itself with the source, the target, the channel and the prevailing situation. The source of a message especially in the rural community is very important e.g. the community head, opinion leaders, age-group representatives, and any significant others within the community. The same goes for the contents of the message in terms of appeals, emotions, and the desired attitude change. All these must be channelled through a proper medium like radio, jingles, drama sketches, puppet shows, etc. Furthermore the intended target's

(audience) peculiar characteristics must also be taken into consideration e.g. age, sex, religion, culture, literacy level etc. Finally, the prevailing situation in the community (society or country) at the time of message dissemination is equally important if people were to listen and eventually be persuaded to adopt the intended message.

All these strategies, if at all they are being adopted, are not presently coordinated properly. Hence; the low consumation level because they still need to be convinced as to why their attitude/value or customs should be jettisoned for a foreign one. This points to a fact that a lot of research and documentation need to be done.

Suggestions for improvement

It is an established fact that psychology rely very much on facts and figures and a great deal of pain is taken in gathering these facts. A "venture" that is expected to change the total value orientation, cultural practices, attitudes, belief system and the social structure of an individual or group of individuals need to understand the individual or group inside out, and this can only be best achieved through research, data gathering and proper documentation. These can always serve as points of reference to check the "problem", how to solve it and progress made so far. As pointed out by Howie (1979), it is better for health practitioners to question what they are doing (which is, what we are doing already) and this is the starting point. According to Pritchard (1981) research can be done in three areas.

(a) Clinical i.e. adding to the sum of knowledge about the natural history, the diagnosis and treatment of illness practice (especially in the concerned community).

(b) epidemiological i.e. studies of larger populations.

(c) operational i.e. studying how health care is provided and how effective it is.

Another related solution to research undertaking is in treatment of specific problems identified during the research. One of such is the attitude of the people towards the "innovation" being introduced. A proper analysis of the attitude structure via its contents and value weights will help in modifying the approach in communication strategy and effective utilization of the aspect of PHC that is being introduced. One method of attitude change is that of self-persuasion (Balogun,

1990; Ugwuegbu, 1982). Here the individual is presented with attacking but subtle information that is self convincing about the desired attitude object. The product of attitude structure analysis is a proper understanding of the "psychology" of the people which will help in the communication strategies to be adopted.

On communication strategy, there is an encouragement if what is being done by BCOS, Radio O-Y-O and FRCN is anything to go by. There is effective utilization of local idols, message contents, theatrics, language etc. in disseminating information to the people about PHC programmes.

Another solution is in personnel training and re-training through induction courses, seminars, workshops and symposia especially on interpersonal relations and interpersonal communication. A Yoruba adage says that "if you want to catch a monkey, then you must behave like one". This further suggests that you must learn the monkey lifestyles and other related behaviours so as to properly fit into that culture. Maybe, this is why Oyeneye (1992) suggested Participatory Rural Appraisal Approach (PRAA) towards improving the consumation of PHC. As a health practitioner, you are not only expected to treat physically or physiologically but to treat psychologically by showing concern, feelings, understanding and care in the problem of the people in the community of interest. These will elicit a mutual rapport between you and the patients in order to get what must be done, done effectively.

It is one thing to crave for treatment, it is another thing for treatment to be available if and when it is needed. A "good' health programme is good to the extent to which it is made cheap in terms of cost and accessibility. A negative occurrence could be psychologically frustrating. It is like having a goal and placing blockades or obstacles in someone's path in order to get to the goal.

Added to the above suggestion is to put in place, other supporting facilities such as food, shelter and education. Without these, the individual may not be motivated to seek out the health facilities available. In fact he will resign himself to what is known in psychology as "learned helplessness" i.e. he has come to realize that there is no point in trying to "escape" from his problem, if he is sure of getting back at it since there is no supporting facilities (such as the ones mentioned) to help in consolidating on whatever gain he must have achieved in the first place.

Conclusion

Some of the identified problems and suggested solutions might sound as if they are not new, but if a good and effective PHC programme is the concern of the people, then the importance of these things would be realized. After all psychology is interested in knowing the totality of an individual's behaviour. Why would a behaviour be enacted? What would be responsible for such a behaviour? What things are possibly sustaining the behaviour? Can it be changed or eliminated? etc.

As suggested earlier, (Balogun, 1992, a, b) only through research and data gathering can we understand the people better. It is only research that can make us understand the needs and priorities of individuals or group of individuals and arrange them in order of importance. Thereafter, we can now talk of meeting these needs accordingly.

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10

Problems and Solutions to PHC Execution in Nigeria

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Problems and Solutions to Primary Health Care (PHC) Execution in Nigeria

What is PHC all about?

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 country 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 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.

The primary health care approach is essential to achieving an acceptable level of health throughout the world in the foreseeable future as an integral part of social development in the spirit of social justice and equality. Thus the goal of health for all by the year 2000 would be attained.

The components of PHC should ideally be

(1) education concerning prevailing health problems and the methods of diagnosing, preventing and curing them;

(2) promotion of food supply and proper nutrition, an adequate supply of safe water, and basic sanitation;

(3) maternal and child health care including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health and provision of essential drugs.

Problems in the Execution of the Scheme

PHC is the hub of the health system. Around it are arranged the other levels of the system whose actions converge on primary health care on a continuing basis.

(a) Planning

Planning for PHC has to be carried out in communities as well as at intermediate and central levels. The Ministry of Health or its equivalent's responsible for formulating National health policy, including primary health care policy and for promoting its adoption by the government strategies have to be devised to translate policies into reality. Training of personnel and management at all levels is indispensable to the planning process. Since the planning of primary health care involves political, social and economic factors, multi-disciplinary planning teams are needed, especially at the central level, including among others people with a knowledge of *economics, sociology, political science,* and *other social sciences.*

(b) Coverage and Accessibility

PHC aims at providing the whole population with essential health care. Population coverage has often been expressed in terms of a Numerical Ratio between services for providing health care and the poupulation to be served. For example, the number of hospital beds per unit of population, the number of doctors and nurses per unit population or the number of people for whom a health centre has been established.

It is necessary to relate the specific components of health care being provided to those who require them. For example, to relate the provision of child care to the total number of children in the community, female as well as male, in order to make sure that such care is in fact available to all children.

Accessibility

Accessibility implies the continuing and organised supply of care that geographically, financially, culturally and technologically are within easy reach of the whole community. *Geographical* accessibility means that the distance, travel time and means of transportation are acceptable to the people. *Financial* accessibility means that whatever the methods of payment used, the services can be afforded by the community and country.

Cultural accessibility means that the technical and managerial methods used are in keeping with the cultural patterns of community.

Financial accessibility means that the right kind of care is available on a continuing basis to those who need it, whenever they need it.

(c) Human Resources

People are the most important resource of any country, but all and too often this resource is not tapped. PHC however has to make full use of all available resources and therefore has to mobilize the human potential of the entire community. This is possible on condition that individuals and families accept greater responsibility for their health. Inadequate manpower vis a vis trained community health workers pose enormous problems hence their training and retraining should be based on a clear definition of the problems involved, the tasks to be performed and the methods, techniques and equipments to be used.

(d) Logistics of Supply

The logistics of supply include planning and budgeting for the supplies required, procurement or manufacture, storage, distribution and control supplies of the right quality and quantity have to be delivered to primary health care facilities at the right time to make it possible to provide services on a continuing basis.

(e) Physical Facilities

Physical facilities required may be simple but must be clean, they

should have spacious waiting areas, and clean toilets.

(f) Budgeting

Budgeting has to ensure the preferential allocation of resources to PHC starting from communities and progressing through the other levels. It consists basically of the allocation of communities and to supporting services of financial ceilings which are to be used for the particular purposes defined in the PHC programme. Much time and effort can be saved by the allocation of resources.

(g) Financing

Finance for health care may come from government taxation or from a social security system with contribution from individuals or employers or both or it may come from philantrophic sources. It is unwise for developing countries to rely solely on methods of financing health care that are current in more affluent countries. Every country has to evolve its own methods based on its own circumstances and judgement, analysing the experiences of others in the light of its own political, social and economic context. External financing may take the form of loans and grants from bilateral and multilateral sources and countries must weigh the advantages and disadvantages of accepting financial support from these sources.

Solutions to problems in execution of the scheme

Firm National commitment to primary health care is vital but it must be clear what this commitment entails. It has been shown that primary health care has a great variety of implications and consequently that go far beyond technical considerations. National strategies are therefore required that take into account all political, social and economic as well as technical factors that help overcome obstacles of any nature.

Mobilizing Public Opinions

One of the fundamental principles of primary health care is the participation of the community at all stages. For communities to be intelligibly involved, they need to have easy access to the right kind of information concerning their health situation and how they themselves can help to improve it.

Newspapers, Magazines, Radio, Television, Films, Plays, Posters, Community Notice Boards and any other means available can be used to secure people's enthusiasm and their willingness to get primary health care going in the right direction.

Legislation

Legislation will be required to facilitate the development of primary health care and implementation of its strategy.

International support

Primary health care involves a major re-thinking of ways of delivery health care. To make the community the focal point of the whole health system, to look for the relevant technology that countries and communities can accept and afford and to aim at the universal accessibility of health care is in many ways revolutionary. Primary health care will be more acceptable and easier to implement for all countries if they realise that others are successfully using this approach. For this reason, international political, moral, technical and financial support are important. The type of external support needed must be very carefully identified and coordinated by the receiving country itself. The government has the responsibility for defining areas for which external support is needed.

Financial support

Primary health care as envisaged above, especially during its evolutionary phase and particularly in developing countries requires considerable financial resources. As an expression of the international political commitment and support mentioned earlier, developed countries would do well to increase substantially the transfer of funds to the developing countries for primary health care. Flexibility in the use of these funds is important so that receiving countries can allocate them where they are most required.

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11

PHC: A Beautiful Concept Fraught With Constraints: the Nigerian Experience.

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Introduction

The issue of whether health is a right or not relates to the question of whether man should be viewed as an active participant in his environment or whether his action should be seen as a product of the interplay of prior and or more primitive structure acting on him (Wallace, 1969).

While the goal of health planning remains that of equalizing health access for all citizenry epidemiological evidence suggests that some strategies are more effective than others. Until recently, most post-colonial health effort was directed at building medical system and centres of excellence comparable to those obtainable in the Euro-American world, without paying much attention to the nature of the prevailing diseases in Africa (Third NNDP). This strategy was given impetus by national elites and in particular, Medical doctors whose scientific training and consequent denigrative attitude brought them on the path of confrontation with traditional healers.

Over the years, it has been realised that aside the issue of cost, and the fact that the illness behaviour of Africans goes beyond mere symtomological treatment; orthodox medicine was simply not available to vast majority of the population (olatunbosun, 1975). The official acknowledgement of this fact led to the 1978 Alma-Ata meeting to reassess strategies and the oft-quoted declaration which viewed health as a right and directed that it be made more accessible, affordable and socially relevant (Mosley, 1989). The strategy that was chosen to actualize this was christened Primary Health Care (PHC).

In its article VI of Alma declaration, the WHO defines

> 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 country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Furthermore, it notes

> It is the first level of contact 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 constitutes the first element of continuing health care process.

In the same work (Article VII, item 3) it spelt out the principles of primary health care which include:-

1. education concerning prevailing health problems and the methods of preventing and controlling them;
2. promotion of food supply and proper nutrition;
3. an adequate supply of safe water and basic sanitation;
4. maternal and child health care, including family planning;
5. immunization against the major infectious diseases;
6. prevention and control of locally endemic disease;
7. appropriate treatment of common diseases and injuries and
8. provision of essential drugs.

The present effort, is an attempt to examine the Expanded Programme on Immunization (EPI) — an off-shoot of PHC programme in Ekpoma, Edo State. Evaluation is a vital feature of any human endeavour as it not only shows the gap between what has been done and what is left, but also points out the way forward. This is the thrust of this study.

Method of Study

This work is based on the analysis of EPI Scheme in Ekpoma. The latter is the headquarters of Esan West Local Government area in Edo State. The study is purely exploratory and makes no attempt to test

any meaningful statistical relations. Nonetheless, it is our contention that studies of this nature are important because they depict the phenomenon under study as it is at any particular time, set the stage for larger works and are useful for planning and management.

The study is based on a sample of 50 women in Ekpoma, drawn from a list of 250 women. The women were contacted and from the figure, 50 of them qualified to be interviewed. All the 50 women have been living in Ekpoma for at least 6 years, had a child in the last 5 years and are between 15 and 49 years of age.

The respondents were asked a number of questions in the following broad areas: social characteristics, sources of PHC/EPI information, utilization of EPI services, knowledge of vaccine, causes, spread and prevention of the six deadly diseases covered by EPI.

The analysis of the results on the ages of the interviewees shows that the age category 26-35 years rank highest with a total of 56% of the women. This is closely followed by cohort 36-45 years with 28%, while categories 15-25 years and 46-54 years had 12% and 4% respectively.

The examination of the results recorded under educational attainment reveals that most women in the sample completed primary and had some secondary school education. This group recorded 42% of the sample, followed by those who completed secondary, those with HSC, OND and NCE certificate with a total of 26%. The category of those who had no schooling of any kind or had a stint in the primary school recorded 22%. The least figure of 10% was registered by those who had University degree and other equivalent qualification.

The number of co-wives respondents have also formed part of the areas examined. On the whole, the data reveal that 54% of the respondents have no co-wives, 36% claimed they had 1-2, 8% reported 3-4 co-wives, while 2% reported 5 co-wives.

Another variable considered is the length of marriage 68% of the sample reported that they have been married for a period of 1-8 years, 22% for 9-16 years, and 10% for 17 years.

RESULTS

Table I: Social Characteristics of Respondents

Table I

SN.	Characteristics	Subgroup	Distribution %
1.	Age	15-25	12
		26-35	56
		36-45	28
		46+	04
2.	Educational attainment	No schooling/Some Primary	22
		Completed Pry. and some Secondary	42
		Completed sec./OND/NCE	26
		First degree and above	10
3.	No. of Co-wives	NIL	54
		1-2	36
		3-4	08
		5+	02
4.	Length of Marriage	1-8	68
		9-16	22
		17+	10
5.	Occupational grouping	Trading	58
		Teaching/Admin.	26
		Farming	04
		Others	12
6.	Annual Income	0001-1500	06
		1501-3000	24
		3001-4500	32
		4501-6000	20
		6001+	18
7.	No. of Children	1-4	28
		5-8	70
		9+	2

The occupation grouping of respondents was also investigated. The data show that 58% of the respondents are traders. This is followed by

teachers and administrators (26%). Four percent are farmers while 12% are designated as others.

The annual income of respondents was also investigated. 32% of the sample reported that they earn above ₦3,000.00 but not more than ₦4,500.00. Twenty four per cent indicated that they earn between ₦1,501.00 and ₦3,000.00 and 20% above ₦4,500.00 but less than ₦6,001.00. Eighteen per cent reported getting more than ₦6,001.00 and finally, 6% indicated earning between ₦1.00 and ₦1,500.00.

By the way of finalizing this section, respondents were asked to state the number of children they have. The result shows that 70% of the sample had 5-8 children, 28% had 1-4 children while the remaining 2% had at least 9 children.

Respondents were asked whether they have ever heard about the PHC. Fifty six per cent of the sample claimed they have heard about it, while 44% reported the contrary. Furthermore, the 28 women who answered in the affirmative were asked to name the source from which they first heard about the PHC. Radio was mentioned as the commonest source (39%). This is followed by informal source, that is friends/specialists (25%). Five respondents (18%) reported that they first heard of it from the TV and lastly, another 5 interviewees named printed media such as Newspapers and magazines as their principal source.

In pursuance of our investigation in this area, respondents were asked if they have ever heard of the EPI Scheme. Surprisingly, all 50 women were not only familiar with the concept, but also demonstrated a good knowledge of what the scheme is all about. Again radio with 46% came out as the primary source of EPI information. This figure is again followed by friends/specialists (26%), 14% from TV, and another 14% from print media.

The third and final section in which respondents were interviewed relates to the utilization of EPI scheme and the knowledge of the causes, spread and prevention of the diseases. First, we asked all 50 women if they were innoculated during their last pregnancy. The responses show that only 12% were innoculated. The remaining 88% claimed they were not. Again, of the 6 women who were innoculated, only 1 knew the name of the vaccine she took, while 2 displayed a knowledge of what the vaccine was supposed to prevent.

Furthermore, 94% of the women took their last child for one innoculation or the other while 6% did not. It was difficult for us to keep track of the kind of vaccines received by the children since a good

number of them did not know the names of the vaccines they took. However, we tried to surmount this by asking them to state the number of times they took or have taken their children for innoculation. We augmented this by showing them a picture depicting children suffering from the six EPI deadly diseases. On the whole an average of three times per woman was established for all the innoculations. This result appears curious, especially as the women demonstrated adequate knowledge of EPI. In order to get to the root of it, respondents were asked questions relating to the causes, spread and prevention of the six deadly diseases. The result is shown in table II.

Table II
Knowledge Of EPI By Diseases

Name of Disease	Knowledge of Causation	Knowledge of Spread	Knowledge of Prevention
Tetanus	48%	12%	56%
Diptheria	20%	6%	2%
Whooping cough	44%	86%	26%
Smallpox	38%	52%	18%
Poliomyelitis	18%	4%	2%
Measles	30%	44%	10%

Beginning from the top, 48% of the sample reported that they knew the cause of tetanus, 12% knew how the disease could be spread, while 56% demonstrated some knowledge of how to prevent the disease. In the case of diphteria, 20% knew how it can occur, 6% knew how it can spread, whereas, only 2% knew how it can be prevented. Under whooping cough, 44% knew its cause, 86% knew of how it can be contacted, as against 26% who informed on how it can be prevented.

Knowledge about smallpox ranks high. 38% knew its cause, 52% knew of its prevention. In case of Poliomyelitis 18% knew its causation, 4% had knowledge of spread and 2% knew how to prevent the disease. Lastly, 30% of the respondents claimed knowledge of measles, 44% knew about its spread, while 10% reported knowledge of its prevention.

Discussion/Conclusion/Recommendation

In this section, we shall highlight some of the important findings of this work, we shall also attempt to point out the policy implication for PHC and suggest the way forward.

The analysis shows that most of the women in this study contracted early marriages, have a high procreation rate and do not space out their conception. This is supported by the fact that 64% of the sample did not read up to secondary class five. This is one area where those concerned with implementing PHC need to direct attention. The WHO (1989) reports that in Zaria, girls under 15 years of age have a maternal mortality that is nearly seven times as high as those of women in age category 20-24 years. Safe motherhood is an index of reproductive factors. Boerma, (1987) records that the maternal age, parity and unwanted pregnancy can mean the difference between life and death of a pregnant woman. It notes that women die more when they get pregnant at too early ages or too late in life.

The findings of average 5-8 children per woman calls to mind the issue of parity, child spacing and abortion. The WHO (1986) records that while information on parity is more difficult to obtain than those of age, several studies have nevertheless confirmed the increased risks of death associated with having many children. The importance of child spacing cannot be over- stressed. Child-spacing not only permits a mother to recuperate after child birth, but also eliminates competition for food among siblings. In the past, most African societies recognised this fact and recommended a period of sexual abstinence for suckling mothers, but it would appear that this practice is increasingly being neglected.

Abortion has also long been recognised as a major killer of women. This practice is outlawed in Nigeria either because of the social stigma associated with it, or the cost of procuring one from a medical expert, most women keep sealed lips about it while seeking aid from quacks. The result is that a good number of the cases never come before a medical expert until it is too late. The WHO (1986) notes that abortion accounts for 86% of maternal deaths in Romania, 64% in China, 29% in Ethiopia and 20% in Bangladesh. While the evidence from our sample does not tell us much about abortion, the ages of mothers, the number of years for which they have been married and number of children taken together point to the fact of early marriages, active

sexuality and by implication, early intercourse. Given the fact that not all relationships end up in marriages and the fact of the social stigma associated with having children out of wedlock, it appears that illegal abortion will continue to swell the rank of those women who die yearly as a result of becoming pregnant. This is one area where the practice of family planning can make the difference in the proportion of those women who die and those who live, since most deaths associated with reproductive factors are preventable. It will therefore help if those concerned with the implementation of PHC programme are aware of this gap and can step up family planning activities in this area.

The information collected under sources of PHC and EPI information shows some consistency in reporting. Radio was established as the principal source. This finding is apt considering the fact that radio comes in all shapes and sizes these days and there is also the relative ease of taking one anywhere. This is complemented by the fact that trading is the major occupation of the respondents.

The study reveals the importance of interpersonal communication channel as a source of information on the two related programmes. In specifying the role of specialists, respondents reported that those who give birth in hospitals are informed of immunization facility and were told when to bring their children. It is however, very doubtful if this information is available to traditional birth attendants as the only 3 women who gave birth in such homes claimed they received the information from friends.

This demonstrates that while specialists constitute an important sources of information on EPI activities, a gap still exists about knowledge of the programme itself. This appears to be the reason for the upsurge from 28% recorded by those who have heard of the concept of PHC to 100% under EPI. It would appear that those concerned with the implementation of PHC programme took the latter for granted and expected the rebound effect of perpetuating EPI activities to illuminate the philosophical status of PHC. This thinking is teleological and the fact that this has not happened amply epitomized the falsity of such an assumption.

The information on the utilization of EPI services reveals that a great deal of ignorance exists about the activities of PHC/EPI in this area. Most mothers demonstrated little knowledge of the causes, spread or prevention of the diseases EPI caters for. A closer examination reveals that mothers tended to exhibit more knowledge in ailments that have traditional history. Even here some mothers subscribed to the

fatalistic motion that diseases just happen. This observation has also been made by Ogunmekan (1982). It would appear that while specialists form a significant part of the PHC/EPI information network in this area, they are probably paying lesser attention to teaching mothers about the causes, spread and prevention of the six deadly diseases. This is further manifested in the number of women who were innoculated during their pregnancies Of the six women who were innoculated, four had educational attainment below secondary class five. Of the four, two knew what the vaccine they took, was supposed to prevent, while only one remembered the name.

The effects of income on utilization could not be directly measured as the women reported that they were not asked to pay for the services. This information is at variance with the fact that most respondents did not complete their children's innoculation dosage. We pursued this angle with the respondents and found that income indirectly manifested itself in the excuses they gave for not completing the dosage. Generally, such excuses vary from outright lack of money for transportation to distance or ease of transportation. Others are unnecessary delays at health centres, the number of people that are sick in their households at the same time and the after effects of innoculation on their children.

The real issue here is that of the nature of health services sought. It would appear that consumers consciously distinguish among services that are emergency or life-saving, curative, paliative and preventive; and that such label generally influence their attitude to health services. This observation led Bailey (1969), to conclude that unless preventive services are free, it is very doubtful whether demand for them can be stimulated. This study demonstrates that free services are not synonymous with high demand for health services. It would appear that when health services are oriented toward preventive services and are free consumers develop sloppy utilization attitude. This is reflected in the kind of excuses they gave for not completing the dosage stipulated for some of the vaccines.

A conscious effort is therefore needed by those charged with co- ordinating PHC/EPI affairs; to stimulate the utilization of those services. Such effort should be able to trace the presence of disease by drawing a comparison between an innoculation control group who is free of the disease and those who spurned innoculation and are currently affected.

The way forward

This study reveals a vast ignorance about PHC/EPI activities and a low level of family planning practice. This is probably accounted for by the issue of low educational attainment and the fact of their major occupation which takes them out of the house for most part of the day. The development of intervention to reverse this trend will have to take these salient facts into account. The way forward is for more family planning activities to be organised in this area. Emphasis should be placed not only on getting information across, but also on finding rationalization within the cultural context of users.

Efforts should be made to step up the FP/EPI campaign. Radio and informal source of friends/specialists have been found to the most effective in this area. This communication channels should be exploited. Local names which have relevance or reference point in users' cosmology should be given to the vaccines. Such names should then be translated in the various local dialects.

The use of poster in strategic places in the market, drama, cartoon and other forms of mass literacy campaign strategy should be employed. Examples of these will include enlisting the support of specialized agencies as 'Better Life', Religious Organizations, Social Clubs and Labour Unions. In addition, eminent personalities like traditional rulers and opinion leaders should be called up as to publicly address the issue.

More formal education, especially for female children is urgently needed. This can be be aided by the incorporation of sex education into the curricula of post primary education. The importance of female education is recorded by Caldwell (1981). More research into the cultural practices of the people is equally needed. Such investigation should be carried out with a view to identifying the areas that are likely to hinder PHC activities and to find ways of removing them. Another area where research will help is an inquiry into doctor/patient and nurse/patient relationship. It may well be what the observed hesitancy to complete immunization dosage has its roots here. If this is right, then the stage is set for the development of intervention that will improve the situation. For now the only area in which PHC has made impact in Ekpoma is on the EPI Scheme. Even this is not without its problems. We would rather have an amenable PHC that contributes minimally today and hope that the co-operation of all the social classes

in society will make the expected significant difference tomorrow.

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12

The Role of Local Government and the Community in the Attainment of Primary Health Care (PHC) Goal: The Nigerian Experience.

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1.Introduction

'Health is Wealth' is an old traditional axiom that has been scientifically proven to be a truism. In fact the philosophy implied by this axiom abound in various forms in most cultures that make-up the Nigerian nation. For example, a south- Western Nigeria folk singer once opined that of the three blood brothers, an individual should aspire to have in life – money child and good health, good health is the eldest of them all. There is therefore a logic in the conscious effort being made at every level of (any) society to ensure the acquisition of this 'wealth' that opens the door to other riches. However, it should be noted that despite its primodial position, evidence abound to show that health is dependent on social economic development and also contributes to it.

Despite this realisation however various historical realities have served to create gross inequality in the health status of people in society. This inequality has its roots in the political economy and status ranking in society. Basically, it has been proven that "the gap is widening between the 'haves' and the 'have-nots' in the developing world" Moreover, this gap is also evident within individual countries, whatever their level of development. This gap in social standards is being reflected in health status in society. There is therefore a widespread disenchantment with health care throughout the world. This is moreso

in developing countries where health resources are allocated mainly to sophisticated medical institutions mostly located in urban areas to the general neglect of the rural (disadvantaged) majority. The alienation implication of this is obvious. This situation, has further increased the contact gap between those providing medical care and those receiving it, with the disadvantage groups having little or no access to any permanent farm of modern health care.

2. The Primary Health Care

The realisation of the gross disadvantages of the hitherto existing arrangement, which have not only been distorted by the dictates of medical technology, but also by the misguided efforts of a medical industry providing medical goods to society, led to the introduction of Primary Health Care (PHC). It was introduced 'as a practical approach to making essential healthcare universally accessible to individuals and families in the community in an acceptable and affordable way and with their participation'. This approach evolved over the years and was formally concretised in the Alma-Ata declaration of 1978.

PHC, it is said, addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services which reflect and evolve from the economic conditions and social values of the country and its communities. It is recognised as an integral part both of the country's healthcare system and of overall economic and social development. In essence, it has to be co-ordinated on a national basis with other levels of health system as well as with other sectors that contribute to a country's total development strategy. Being part of total development strategy, it was noted that 'health activities should be undertaken concurrently with measures such as those for the improvement of nutrition, particularly that of children and mothers: increase in production and employment, and a more equitable distribution of personal income; anti-poverty measures; and protection and improvement of environment'.

From the foregoing, there is no doubt that PHC is very embrassive. Its basic components are: Health education on prevalent health problems; maternal and child health including family planning; environmental sanitation and the provision of safe portable water; control of locally endemic diseases; promotion of food supply and proper nutrition, immunization; treatment of common diseases and minor injuries; provision of essential drugs; and mental health. The overall

socio-economic development implication of these various components considered becomes imperative.

Given its grass-root nature, community participation becomes a sine-qua-non in the measurement of its success. In addition, the Alma-Ata Conference in noting the importance of full organized community participation also stressed the ultimate self-reliance; with individuals, families, and communities assuming more responsibility for their own health. This is premised on the axiom 'that the salvation of the people lies with the people in themselves. To facilitate community participation therefore, support were called for from groups such as Local Government Agencies, local leaders; voluntary groups, youth and women groups, consumers' groups, the Red Cross and similar societies, other non-governmental organizations and liberation movements as well as by accountability to the people'. The declaration also called for the support of administrators at all levels in order that PHC does not develop as an isolated peripheral action.

3. PHC: The Structural Arrangement

In order to ensure the realisation of its major goal of an acceptable level of health throughout the world, some structural arrangements were put in place. The arrangement which goes with the catch-phrase- "health for all by the year 2000" –will be briefly discussed below. Without necessarily challenging some of the premises and assumptions upon which the programme is based, we shall however assess the roles of two of the identified tiers in the attainment of the PHC goal – using some of the Nigerian experience.

At the lowest level of this structural arrangement for PHC is the Village Development Committee (VDC) on health. Its membership include the following: The Village Head or a responsible appointee as Chairman; the Primary School Headmaster in the community as Secretary or a literate person; representatives of religious groups; representatives of occupational/professional groups; representatives of Non-governmental Organisations (NGOs); representatives of youth/age group/Associations; and any other persons deemed fit.

The role of the Village Development Committee shall be to:

- identify health and health related needs in the community;
- plan for health and welfare of the community;
- supervise the implementation of developed health plans;
- monitor and evaluate the progress and impact of the implemen-

tation of health activities;

- select appropriate persons in the community for training as Village Health Worker (VHW);
- select appropriate Traditional Birth Attendants (TBAs) for training:
- supervise the activities of VHW and TBA;
- pay compensation, in cash or kind to the VHW for his work in the community;
- agree with the VHW the number of hours he shall work per day;
- establish a village health post;
- liaise with other officials living in the village to provide healthcare and other development activities;
- provide necessary support to the VHW for the purpose of Health Care Services.

In addition to the above functions; the Bamako Initiative (BI) - which is a follow-up action conference to Alma- Ata with particular reference to essential drugs - the VDC is expected to:

- set drug prices for the BL;
- manage drug revolving fund account;
- monitor drug usage;
- determine exemptions for drug payment;
- review monthly records of work for VHW and TBA;
- propagate the advantage of the cost recovery fund.

It is expected that for every 500 persons there would be a community development committee for PHC. With an operational directory which include meeting at least once a month, the indicator for the measurement of success at this community level is expected to involve, among others, the percentage of participating communities that have a *functional* VDC.

In between the VDC and the district level arrangement is the Health facility level committee (HFC) which is expected to oversee the functioning of health facility in the community. The District Development Committee (DDC) of PHC at the higher level is expected to perform functions similar to that of VDC. For specific mentioning however is the additional task of:

- raising funds for community projects where necessary;
- liaise with government and other voluntary agencies in finding

solutions to the health, social and other related problems in the district;

monitor activities at each levels of health facilities and VHWs.

Membership of the DDC is equally multisectoral to ensure the involvement of various groups in the district.

Following the DDC closely is the Local Government Area PHC Management Committee with the LGA Chairman as its head. It also include various other relevant personalities, groups, Associations as well as Head of Health related departments in the LGA (e.g. education, Agriculture/DRFFI; works, etc.). It is indeed an intersectorial committee.

Meeting at least once in a month, its functions are:

- to provide overall direction for PHC;
- plan to manage PHC services;
- identify training needs;
- approve local workshops;
- budget and manage finance;
- mobilize communities for effective participation;
- supervise the activities of LGA PHC Co-ordinator;
- designate persons to run the drug revolving fund and monitor progress;
- receive monthly reports from LGA PHC coordinator;
- liaise with governmental, NGOs and international agencies;
- monitor health activities and health facility and community levels.

With regards to the Bamako initiative, the role of LGA PHC is similar to that of the VDC level arrangement.

The grassroot arrangement highlighted above is supported by successive levels of referral facilities. Also, there are arrangements at state Ministries of Health as well as at the federal Ministry of Health (national) not only for co-ordination but also to supervise and provide technical and professional support. Given the decentralisation principle upon which this structural arrangement is based and relative to earlier arrangement, one cannot but agree that some progress has been made in the Nigerian case. The question however is what has been the impact of PHC programme in Nigeria, particularly for the pioneering LGAs?

4. Some Field Reports

Various field reports and isolated research outputs tend to give us the conclusion that PHC programme has been making steady progress in the face of some odds. of which finance is not left out. This is in addition to various success stories after told by Local Government Chairmen as regards their area of operation. Although such pronouncements often carry political overtones, we cannot totally rule them out as mere propaganda to catch votes.

As at October 1990, the Federal Ministry of Health provided some reports of which we present that of two Local Government Areas as typical success stories:

(a) Ife Central LGA(Now in Osun State)

- establishment of 5 operational health districts;
- establishment of 50 VDC;
- provision of operational bases in the districts for executing PHC activities;
- house numbering and distribution of home based records (establishing a system of record keeping);
- orientation of health staff towards the principles and concepts or PHC;
- training of over 200 TBA and VHW;
- operating of the revolving drug fund system.

(b) Idah LGA (Now in Kogi State).

The success story here include:

- distribution to and sale of drugs at health facilities level and by VHWs and TBAs;
- community mobilisation for health activities:
- extension of PHC service coverage to the remaining district of the LGAs;
- production of LGA maps;
- training of 249 VHWs and TBAs;
- upgrading of 4 district referral facilities;
- erection and equipping of a new LGA (drug) store.

Aside from these two (typical) examples, there are many strong indicators and media reports of growing acceptance and use of the various components of PHC especially the immunization (EPI) com-

ponent. There are figures and reports at various grassroot health centres confirming the utilization of EPI programme. Also, there are evidences to show that community mobilization for health activities in many communities in the country is succeeding as could be inferred from growing attendance at community health centres and even from the gradual emergence of private rural health clinics.

An additional prove (of growing success) can be cited in the case of Egbado North Local Government (ENLG) in Ogun State. We had a course to examine some components of PHC in the process of a rural development research in 1991. Here there were evidences that point to some steady progress of PHC programme. House numbering and home-based enumerations have reached advanced stage in the Local Government. Infact, it was the population figure provided by the PHC enumerators for Saala-Orile Community (ENLG) that formed the basis of the said research in the last quarter of 1991. During this period, we actually observed the activities of Ayetoro/Idofoyi/Sunwa health district. We were equally informed by Mr. M. A. Awaye (the then PHC district co-ordinator) of the said area, that there are functional PHC communities at the village as well as at the LGA level in the area. Besides, we attended, in an observer capacity, some of the training sessions for some VHWs at Ayetoro (LGA H/Q). In addition, we attended (also in an observer capacity) one of the meetings of the VDC at Saala-Orile and went further to visit two VHWs in the area.

With this seeming success story of the grassroot level, one may also need to mention that the Federal administration in Nigeria has also made provisions for complementary projects as well as the involvement of various health related departments in the country. It is along this line that we begin to appreciate the policy principle behind the establishment of bodies like Directorate for food, Roads and Rural Infrastructure (DFRRI); Better Life for Rural Women commission; Peoples Bank Project; to mention but a few. As should be evident from our discussions earlier, these various bodies are represented at various levels of PHC committee.

5. Some Comments

Without necessarily sounding alarmist however, the arrangement discussed above is not without some underlying structural problems which will no doubt mitigate the true success of PHC in Nigeria. Before rounding up this paper therefore, we shall offer some few comments

which we hope will be food for thought.

The first problem we see is inherent in the multisectorial composition of the various levels of the PHC. Much as this multisectorial development committee of PHC (at all levels) appears sound – because it involves all health and health related sectors – there is nothing to compel the parties in the committee to carry–out whatever decisions taken. For example, the DFRRI, although represented at the LGA PHÇ level is a body with its own independent programmes and policy directives. There is no legal basis for the synchronization of PHC programme with that of DFRRI. It is only assumed and expected that the co–operation will exist. Our field experience in the course of a Non–Governmental Grassroot Associations research in Sokoto State in 1990 is a good example in this respect. Complaints abound by various Community Development Association officials (at the LGA) that DFRRI undertake projects in their domain without their knowing. Often times such projects are cited where they are least needed. There is therefore a need to find ways that the spirit of goodwill implied by the expected intersectorial collaboration is legally concretised. This will, at least, compel parties to an agreement to act.

Furthermore, given our field experience this far, we doubt if there has been a meaningful incorporation of Traditional Medical practitioners into the PHC activities. This stems basically from the larger debate of Traditional versus modern medical care. It should however be noted that the Alma–Ata Conference has noted the high social standing of Traditional Medical Practitioners and Birth Attendants in local community's culture and traditions. It has therefore proceeded to recommend that with the support of formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community.

While success stories can be said to have been recorded to some extent in the case of TBAs, similar story is far from being so in the case of main stream Traditional Medical Practitioners. The relation between the two (MCH and TMC) is still one of foes rather than that of allies. This to us is a major set–back in the grassroot involvement drive of PHC. We cannot ignore the fact that people do cling to their old/traditional ways of doing things. And to get them to change we might have to go through that which they already have and believe in. While one is not here saying that changes are not taking place in terms of Health attitudes and values of the people at the grass–root, we should agree at the same time that tradition still has a strong hold on the people.

Over 70% of the people are still known to patronise Traditional Medical Practitioners at least as first course. And a neglect of TMP is likely to mean the alienation of the people. This will no doubt slow down the rate of success in the 'Health for all by the year 2000' drive of PHC.

Finally and relatedly, we still see a continuation of the 'catch–up' syndrome (modernisation drive) in the implementation of the PHC despite the decentralised structural arrangement. For example, much as the VHW is selected from amongst the people and by the people; the training outside the community implies a need to "catch–up" with that which the community ought to be. This no doubt will affect the attitude of the people to the VHW as well as to his activities.

6. Some Suggestions

There is no doubt that the PHC programme is laudable and that its success is of paramount importance for a healthier nation. To consolidate its string of success (as evident from our discussions above) various efforts have to be made. Some of such efforts should be evident from our comments above. First among such efforts is that there is a greater need for co–ordination of efforts amongst the various sectors involved in the implementation of PHC. An accord that will be legally binding is seriously needed.

Lastly, as should be obvious, PHC relies so much on grass–root initiatives and participation. Consequently, grass–root self organisation becomes a sin–qua–non. It is on the basis of this that we posit: How strong or what are the level of NGOs at the community level in Nigeria? From our field experience, their present level of development is not that strong to carry the responsibility which the PHC policy package bestows on them. We shall need to mobilise and develop them where non–exist. The DFRRI attempted to do this sometimes in 1990 but like various government projects, the initiative did not meet with general success. We need the NGOs so that the people can begin to "dialogue" on the development of their community through their own initiatives and efforts–that is a development effort from bottom–to–the–top rather than from the top–to–bottom. For as it was rightly noted by the Alma–Ata declaration, PHC is part of a total development strategy.

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13

Strategies For Developing the Human Resources at CommunityLevel

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Introduction

In most countries, Local Governments are designed to serve as centres of local initiatives and agencies for the implementation of grassroots development of the government. At present in Nigeria, Local Governments form the third tier of government after the Federal and State governments and they are democratic institutions under elected officials. Being the closest tier of government to the mass of citizens, they have a very important role to play in the well being of such people. The Local Government reforms undertaken by the Obasanjo regime in 1976 underscore this role which local governments are expected to play.

The guidelines to the reforms gave as the main objectives of the reforms:

i. To make appropriate services and development activities responsive to local wishes and initiatives by developing or delegating them to local representative bodies.

ii. To facilitate the exercise of democratic self government close to the local levels.

iii. To mobilise human and material resources through the involvement of members of the public in their local development, and

iv. To provide a two-way channel of communication between local communities and government (both State and Federal).

These objectives are still as important today as they were in 1976 and lie at the heart of Nigeria's effort to develop the rural areas.

One of the most important features which the local governments have to perform, perhaps even more than both the Federal and State governments, is the area of primary health care. This is primarily because it is at the very grassroots level where the issue of primary health care is most important and it is here that the impact of a successful primary health care programme would be most appreciated. Thus primary health care officers at the local governments are very important agents for bringing about the much needed change at the grassroots in terms of people's attitude to health matters.

Most importantly, in the course of enhancing the well being of the mass of citizens, the primary health care system requires adequately trained and motivated manpower. In other words, the human resources of the local government in this important area of health care needs to be properly developed. Very few individuals will argue with the fact that people are the most important resource for national development or on a much lower level, for the efficiency of an organization. There can be no doubt that no matter the abundance of funds, the sophistication of technology etc., little can be achieved if the human factor if not properly harnessed towards corporate goals. F. Harbission, an American economist had as far back as 1964 argued for what he called Human Resources Development under the rationale that the investment in people is equally as important as investment in material things and that a country's rate of growth is dependent as much upon the development of human resources and the rate of human capital formation as upon the rate of physical capital formation.

It is for this reason that governments and employers expend so much effort and resources in developing their stock of human resources. The importance of human resources becomes even further heightened in such developing areas as Nigeria where a chronic shortage of capital and technology implies that a great deal of organizational effectiveness will depend mainly on what people rather than machines do. Thus as another American social scientist puts it, 'the quality and quantity of human resources can be effectively increased through education, training and personal development'.

Much of the activities involved in human resources development at the local government level (mainly education and training) depend very heavily on the various government for funding. Unfortunately, just as the State governments, the local governments depend almost entirely

on the federal government for their funding. This is particularly unfortunate because local initiatives, for instance, in the area of primary health care, would achieve very little if funding from the central government is not forthcoming. This is clearly an intolerable situation which needs to be remedied. In other words, other sources of funds must be sought in order to pursue the health programmes of each local government area apart from the regular subvention from the Federal government which on the long run might prove inadequate for all the programmes of the local government.

One alternative is to suggest that local governments intensify their internal fund generation activities. As desirable as this option is, it is a relatively limited one. This is partly as a consequence of the all pervading atmosphere of poverty in many of the local government areas, especially those in the rural areas which makes the collection of taxes and rates a very difficult task indeed. Similarly internal revenue generation also suffers from the unwillingness and uncooperative behaviour of a large proportion of the general populace. A great deal of taxes and rates evasion takes place in Nigeria which the local governments are ill-equipped to effectively check.

Clearly some other techniques of attracting funds must be sought to complement that which the Federal (and in rare cases the State) government can provide for primary health care activities. One technique which forms the basis of the present paper, is that of seeking funds from non-governmental sources. There is a large number of international agencies and non- governmental organizations (NGOs) operating both inside Nigeria and outside who could be approached by primary health care officers for funds to pursue some particular primary[1] health care programmes or for manpower training and development purposes. Such agencies include the WHO, UNICEF, UNDP, Carter's Global 2000, the World Bank etc.

However to take advantage of the funds which these agencies make available, the officer concerned must be able to present a properly articulated and written proposal for the consideration of the funding agency. Proposal writing is a fairly technical task whose pattern may

1 In fact sometimes the government itself usually in conjunction with international agencies might advertise for applications for funding for specific projects which primary health care officials might be interested in.

vary from situation to situation, but which however has certain laid down steps to be followed by the applicant. The rest of this paper examines these various steps drawing examples from a recently advertised project on Onchocerciasis i.e. river blindness, jointly organized by the Federal Ministry of Health & Human Services and UNDP/World Bank/WHO Special programme for Research and Training in Tropical Diseases.

Steps in Proposal Writing

The first step we want to consider is the introduction or what may be called a background. The introduction should consist of the following themes:

i. *Identification of the research problems:* In this section, the problem to be dealt with is introduced and the area within which the problem is situated is identified. By the 'problem' here, we mean the subject with which the writer is interested and in the example referred to above, the problem is that of the prevalence of river blindness in Nigeria and how to get the rural sufferers of the diseases to accept the use of the drug ivermectin. Next, authoritative sources, e.g. other scientists, are quoted to assess what is known about the particular issue and what is still unclear and needs further investigation.

ii. *Literature Review.* Here the writer looks around for relevant articles, books, government publications etc. on the subject and apart from citing them also comments on them. Often it is useful to group the articles into different categories related to particular variables or other conditions considered relevant, perhaps using sub-headings. Other types of background information should also be presented. The purpose of literature review is primarily to per-

mit a clear formulation of the problem to emerge and it also helps in the formulation of the hypothesis of the study.

iii. *Statement of the problem.* This section takes into account the above two sections. It gives a more accurate approach to the issue at hand and clarifies the purpose of the study. It should be very short and precise and should define the main variables.[2] This section should terminate logically in a statement, preferably itemised, of the objectives of the study. For example, we can have the following objectives:

1. to determine in the area of study, women's knowledge of and attitudes towards onchocerciasis.
2. to determine the traditional role of women in the disease's prevention, treatment and control.

iv. *Statement and rationale of the hypotheses.* Essentially problems are questions about relations among variables and hypotheses are tentative, concrete and testable answers to such problems. The role of hypotheses is not only to suggest explanations for certain facts or problems but also to guide in the investigation. Thus the wording of the hypotheses should be done in a clear and concise way. It should give logical arguments to show that each hypothesis is plausible, reasonable and sound. An example of an hypothesis from our river blindness proposal is thus that "the greater women's knowledge about the drug ivermectin, the greater would be their willingness to propagate its use both within their households and their communities".

v. *Operational definition of the variables.* The operational definition of the variables does not only give precise indications as to what are the fundamental characteristics of a concept. It also gives precise indications about how to observe or even measure the characteristics under study. Stated in another way, an operational definition is based on the observable characteristics of an object

2 A variable is defined as an empirical property that is capable of taking two or more values. If a property can change in value or in kind, it can be regarded as a variable, but if it cannot take more than one value, it is a constant, e.g. 'sex' of the participants of this conference can be regarded as a variable because it is either male or female. Variables can be *independent* or *independent*.

of phenomenon and indicates what to do or what to observe in order to identify these characteristics. Thus in this section, the writer should give the operational definitions of the main variables already identified.

vi. *Significance of the study.* The relevance of the problem is highlighted considering two major aspects: theoretical and practical implications. For primary health officials, the practical implications will tend to have more importance and the potential benefits of the study must be stated as clearly as possible.

The second main step after the introduction is the method to be utilized in the proposed study. The researcher himself will have to make a decision, based on the particular problem at hand, which research method is most appropriate. The following methods are available to the researcher: Observation, Surveys, Documentary research and Experiments.

Observation: Although a seemingly straightforward technique, observation must be pursued in a systematic way, following scientific rules if usable and quantifiable data are to be obtained. The method can be divided into two types: simple observation which is the recording of events as observed by an outsider. For example, the primary health care official involved in the study of river blindness simply going into the community and observing and recording how many people are afflicted etc. However, a major weakness of this method especially when human beings are involved, is that once they become aware that they are under observation, they might change their behaviour or cease the activity entirely.

The second type of observation is participant observation. In this case the investigation conceals the real purpose of his presence by becoming a participant. He joins the group or community as one of its members, sharing in all activities. Becoming an insider allows a deeper insight into the research problem. This method has been found to be particularly adequate for anthropological research and studies of minority groups such as jail inmates or drug addicts.

Surveys: These are perhaps the most used data collection methods by social scientists. In a survey, questionnaires are either sent or given directly in interviews, to a selected group of people — sometimes as many as several thousands. The survey involves a number of steps which however need not delay us here. In our river blindness proposal, we found this method as the most useful for our purposes.

Documentary research: This is the systematic use of printed or writ-

ten materials for investigation. It is a less frequently used method of data collection although there are very few pieces of field work or survey research which do not involve some scrutiny or documentary material. Some of the documents most frequently consulted in social research are government documents, church records, letters or judicial records. The documents used in research virtually always also include information and findings produced by previous writers on the subject in question.

Experiments: This can be defined as an attempt, within artificial conditions established upon others. Experiments are widely used in the natural sciences, but the scope of experimentation is limited in the social sciences. We can only bring small groups of individuals into a laboratory setting, and in such an experiment, people know that they are being studied and may behave differently from normal.

Whichever method the researcher decides to use, it should incorporate consideration of the following:

a. *Subjects* (respondents/participants). In this section all issues and information concerning the subjects of the research are examined, among which are the characteristics of the target population and of the sample,[3] the sampling procedure, is the technique by which the sample is chosen and the size of the sample.

b. *Method for data collection.* The type of activity that the participants will be asked to perform should be described as well as the instrument to be used. Thus the participants could be asked to complete a questionnaire schedule or participate in an experiment, whichever instrument chosen, its main characteristics should be given and a justification provided as to why it was felt that this is the most suitable data collection technique.

c. *Data analysis.* If required by the funding agency, a statement of how the data collected will be analysed should be discussed. Here

3 The entire set of objects and events or groups of people which is the object of the research and about which the researcher wants to determine some characteristics is called the population or the universe. Thus because it is impossible in many cases to study the entire population, it is usual to take a sample from that population. Therefore the sub-set of the whole population which is actually investigated and whose characteristics will be generalised to the entire population is called a sample.

the statistical tests to be applied to the data collected needs to be discussed.

In some instances, a work plan is required. This is a detailed explanation of the time required to undertake and complete the research project. Some funding agencies stipulate a particular time frame within which the project should be completed while others might provide just broad guidelines. However, an example of a work plan is as follows:

1. Two months – Pilot survey of the study area in order to demarcate the local government and identify the households to be involved.
2. Two months – Questionnaire design and standardization of the questionnaire and training of research assistants.
3. Two months – Questionnaire administration and additional informal interview by the principal investigators with selected groups in the study area.
4. Two months – Coding/Analysis of data.
5. Two months – Write up of the report and submission of report.

Finally, the proposal should in most cases contain a budget, stating in clear terms the amount of money being requested for and showing a breakdown of how the money is to be spent. Usually, the funding agencies set certain upper limits within which applicants are to confine themselves. In relatively rare cases, applicants are left to use their own judgement as to how much they require. The idea is not to ask for too much money than required as this could disqualify the applicant or conversely ask for too low an amount, which may in the end not be sufficient to carry out the project. A sample budget for our proposed study is as follows:

1. Research Materials and supplies
   a. Books, Journals, Government publications.
   b. Duplicating paper, photocopying and other stationeries.
   c. Printing of questionnaires
      — ₦2,000.00
2. Transport and Accommodation
   a. Transport for principal investigators and research assistants from Ibadan to Enugu State.
   b. Accommodation for principal investigators, research assistants and reviewers.

— ₦2,000.00

3. Data Collection and Analysis
   a. 5 research assistants employed for 3 months
   b. 15 interviewers employed for one month
   c. 5 coders to code the raw data obtained from the field.
   d. Computer expenses.
      — ₦3,500.00
4. Publication, including secretarial assistance and binding
   — ₦1,500.00
5. Miscellaneous expenses in the field: ₦500.00

   Grand Total — ₦9,500.00

The budget of course varies with the specific purposes for which the proposal is required.

Conclusion

It must be pointed out that the contents of the present paper represent only one strategy for seeking funds for health programmes and human resources development activities by primary health care officers. There of course exists other strategies, but it is felt that officer should master the various steps involved in the writing of proposals in order to be in a position to take advantage of the resources available to the various non-governmental organizations.

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14

Primary Health Care (PHC) and Independent Source of Funding in Nigeria.

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Introduction.

Primary health Care (PHC), as defined by the World Health Organization (WHO) during its Alma Ata declaration of 1978 is "a practical approach to making essential health care Universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation" (WHO,1978:). From this definition the objectives of PHC are: (1) accessibility to the whole population, (2) acceptability to the people, (3) identification of those medical needs of the population which can be prevented, modified, or tested, and (4) making use of manpower and resources to meet the medical need of the population "(Morrel et. al. in Marson et al. 1973). The last of these Objectives is the area of interest of this paper. To be able to make use of resources to meet the medical needs of the population needs an efficient management of the available scarce resources.

By efficiency it simply means "having power to work well and give good results without wasting time or effort ". Efficient management, therefore, refers to the way something is "organized" for "good results" without any "waste". Applying this to funding means management of "money intended to be used for a certain purpose in the case of the PHC". Since PHC is the first or nearest contact between the individual and the health Care services, fund must be used for optimum benefit of the people. This means that it should be used for the needs of the ordinary people.

It is imperative to realize that meaningful health Care delivery service cannot take place unless there is/are independent source(s) of funding. As a result the WHO emphasizes the need for community participation in primary health Care delivery a method aimed at a cost

the State can afford and based on the national objective of self reliance. The fact that the state is overburdened with many responsibilities, other than health is hindered to effectively cope with the funding of the health care system. Much has been said about funding of the health care system in Nigeria but the problem of disparity between curative and preventive care is yet unresolved. In order to alleviate this problem PHC programme was set up. This and the need to improve health care in the face of the dwindling or shrinking national health budgets has prompted the theme of this paper. Therefore, the paper is divided into five parts. They are: (1) The need for PHC, (2) The need for independent source of funding, (3) What is needed, (4) Approaches to effective management of funds, and (5) Conclusion.

The Need For PHC.

Problems facing health sector have been subsumed under three main headings according to a World Bank Report. They are: (1) allocation–insufficient spending on cost–effective health programmes; (2) Internal inefficiency–wasteful public programmes, and (3) inequality–inequitable distribution of benefits of health services (World Bank, 1987). It has been argued that it is the financing of expensive hospitals care that needs be changed, not the existence of the health car per se. One may agree with this taking into consideration the way and manner funds have always been allocated within the health sector in favour of hospital (curative care) at the expense of PHC in this country. For instance, Pearce (1986) indicated that:

> "The medical system which the Nigerian government inherited from the colonial administration had the hospital as its corner stone as opposed to preventive care and public health is associated with hospital work. The new government continued the same policies.....In 1962, expansion of public health laboratories and the national institutions for social and preventive medicine, over ₦4 million was earmarked for just three hospitals in Lagos and Ibadan".

In order to promote preventive health care, however, the PHC was based on the same strategy used for the Basic Health service scheme (BHSS) in the 1970s. The provision of structures was embarked upon in addition to the evolution of a new career path for preventive health worker (Mojekwe, 1978; Orubuloye and Oyeneye, 1982, and Jinadu,

1988). According to Odebiyi (1988) some achievements were made in the provision of these infrastuctures. In fact, the success of BHSS was feasible only in the provision of structures, and according to Adesina (1989) it was this development pattern that the PHC de- emphasizes for manpower development.

The responsibilities of PHC are shared among the three tiers of government with full participation of the community. The Federal Government formulates the policy and provides resources for direct implementation, which are carried out by the state and local governments. Now the PHC Agency has been established to sustain PHC efforts in the country after the transition programme (PHC Development Agency in Nigeria, 1992). In fact, the prime function of this agency is provision and management of PHC funds. Hence, the need to generate funds from other sources than the government.

The Need For Independent Source of Funding.

The World Health Organization's Global strategy of Health for all by the year 2000, published in 1981, estimates that "the cost of achieving PHC for all people in developing countries is approximately $30 billion annually (or about $10 per capita) for twenty years (1980–2000). The amount now being spent on health services by public sector sources combined in the same countries is about $40 billion ($13.3 per capita) annually" (World Bank, 1987). Given these needs and approximate over-all spending, could PHC fund be efficiently managed in Nigeria to achieve maximum efficiency in PHC delivery?

In order to enhance efficient management, there should, first, be sufficient fund. One problem with PHC in Nigeria, as enumerated earlier in this paper, is insufficient allocation of fund. To compliment the example cited earlier the situation has become more critical at the sub–regional level. For instance, in Oyo State, the total estimated capital expenditure in the health sector as a whole between 1981 and 1985 was just 7.9% of the state's total budget while for the same period, it was about 3.42% in Ondo State (Aguda, 1988). Aguda (Op. cit), however, maintained that this may arise from very small government financial allocations to the health sector which was below 2% of the total annual government budgets. And Worst still, because of the relatively low Gross National product (GNP) compared with those of developed countries such as the United States of America, Canada, Britain, Japan and Sweden.

Despite all these the government has taken steps to fulfil its obligation as a signatory to the Alma Ata declaration. At the inception of the PHC programme the Federal Government made available the sum of ₦500,000 to the first 113 model Local Government Areas (LGAs) as seed grants. This made little or no impact because there was no equitable distribution of the resources. In the process of providing funds for PHC all the LGAs in the country were directed to make budgetary allocation for population activities. This amount was expected to compliment the matching grants to be provided by the World Bank through the Department of Population Activities (DPA) of the Federal Ministry of Health and Social Services. But it should be noted that most LGAs could not provide the required budgetary allocation.

On the other hand efforts have been directed at re-orienting the PHC programme in Nigeria. With the introduction of Drug Revolving Fund (DRF) Scheme the source of finance was being expanded. This was as a result of the programme known as "The Bamako Initiative". The main objective of this programme is to strengthen local financing and management of PHC activities at the community level.

In pursuance of this objective, the Federal Government obtained a World Bank loan of $70 million. Of this amount Ondo State, for instance, received ₦38.340 million out of which ₦7 million was earmarked for essential drugs alone (Jegede, 1992).

However, right from the time of independence through first and second republics, more funds have been pumped into health care system. New hospitals were built in cities while dispensaries were built in towns and rural areas. Expansion of Medical Schools in the University of Ibadan and Lagos were done while new ones were built in University of Nigeria, Nsukka, Ahmadu Bello University, Zaria, University of Benin and the Obafemi Awolowo University, Ile-Ife. These development fostered the training of Medical personnel and consequently increased the development of the health care system. Inspite of these developments in infrastructures, the facilities available were not still adequate. Most of the hospitals were established in the urban centres while the rural areas were neglected. The number of Medical doctors available are numerically and locationally inadequate in addition to the cost of the services rendered (Okediji, 1973; Pearce, 1984; and Ityavyar, 1987). This was attributed to the problem of inadequate source of funding.

The table below shows the gross inadequacy of health personnel and infrastructures due to inability of the state to provide adequate fund.

About 2,000 community Health Workers (Extension Workers and Officers) who are specifically trained for PHC programme were unemployed as a result of financial problem. There is mal-distribution of these cadre to the disadvantage of the rural and urban poor (Owumi and Jegede, 1991)

Table 1
Population per Health Resources in Nigeria since 1960

	1960	1965	1970	1975	1980	1986	% Change since 1960
Population per Nigerian Doctor	146,330	79,840	47,620	24,570	13,680	7,750	94.7
Population per Doctor	47,330	29,260	24,530	10,540	10,540	6,200	86.9
Population per Nigerian Dentist	3,190,860	2,635,000	1,462,280	685,260	417,400	128,100	96.0
Population per Dentist	1,042,240	805,140	692,660	444,600	297,300	99,000	90.5
Population per Veterinary Surgeon	963,580	597,700	480,310	190,060	98,070	75,970	92.1
Population per Pharmacist	94,220	87,570	75,630	50,400	36,150	24,300	74.2
Nurse (R.N./SRN)	8,600	6,100	5,040	4,170	3,110	1,950	77.3
Midwife (R.M./SCM)	25,000	14,660	9,190	5,710	3,960	2,340	90.6
Public Health Superintendent	1,702,300	292,780	122,100	94,670	51,350	22,600	98.7
Medical Laboratory Technologist	1,702,300	682,000	582,320	180,850	63,710	34,400	98.0
Radiographer	1,702,300	1,486,400	940,000	444,600	260,710	198,280	88.4
Dental Technologist	6,383,700	289,500	1,731,000	933,660	353,100	311,760	95.1
Dental Therapist		4,140,700	1,778,400	1,098,400	532,570	338,370	
Population per Hospital Bed	2,520,	2,310	2,210	1,380	1,120	1,100	54.4
						AVERAGE	87.6

Source: Adapted from Federal Republic of Nigeria Health Profile — 1986, Federal Ministry of Health, Lagos, pp. 13 & 15. in Aguda (1984).

Although the health care system has made some progress since independence, yet it has not emerged from financial problem. It is now obvious that majority of the population can only benefit from a service that is "primary in nature" because the culture of the people has long promoted and supported the traditional health care system. Besides, proximity and cost are vital utilization determinants, an ethos which traditional medicine possess and propagated by Primary Health Care (Owumi and Jegede, Op. Cit.). Hence, any programme attempting to improve the health care of the poor people and encourage them to participate or patronise the modern health care must aim at wooing them and making health *cost affordable and accessible* through independent funding and efficient management.

What is Needed.

Figure 1 below shows an integrated source of independent funding of PHC which should be implemented by both government, private sector, the non-governmental organizations, the community and the private individuals. It is a social responsibility that has to be fulfilled to the citizenry. To ensure effective source of funding for PHC all the parties involved must either provide or make adequate provision for basic human needs. These include education, primary health care, nutrition, safe drinking water, housing, environmental sanitation, occupational safety, good communication system (information, roads, transportation, etc.) electricity etc.

FIGURE I

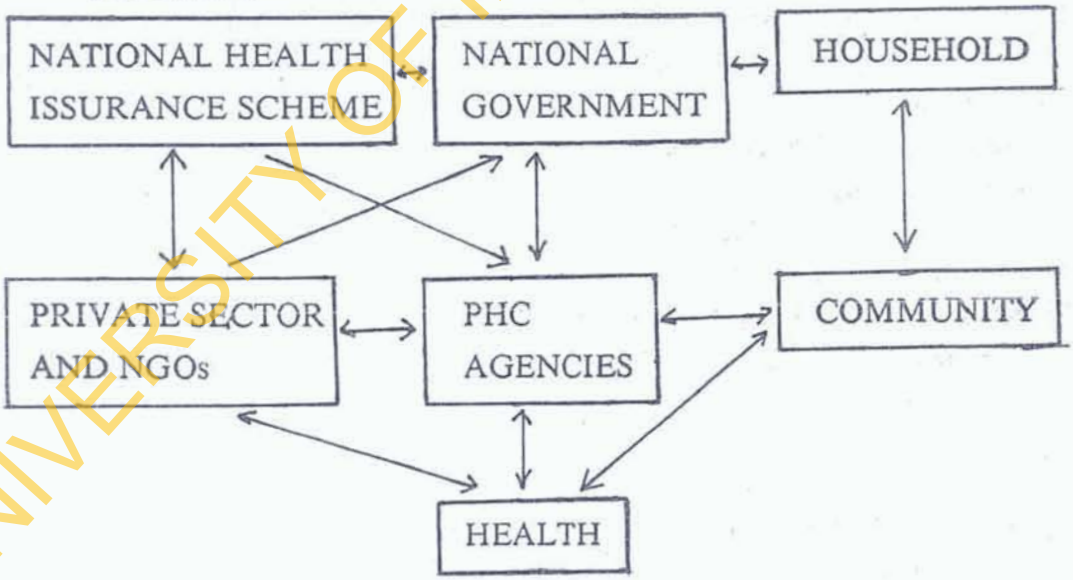

Figure 1: An Integrated Source Of Independent Funding Of The Primary Health Care (PHC) Delivery.

The socio-economic infrastructure mentioned above, according to Aregbeyen (1991), have direct positive effect on health where they are provided simultaneously in an integrated manner. Besides, they lead to improved standard of living which also lead to gradual reduction in poverty, illiteracy and ignorance. These, therefore, will reduce the cost of PHC and they remain as indirect source of funding for PHC programmes.

The figure proposes a more direct approach in which the individuals in the household, the community and the private sector will pull resources together. The role of health insurance scheme is very vital in sustaining the PHC. Although, all these sources of financing will be determined by the level of the National policy on income which will determine the income of the individuals and also what accrues to households and the community. The financial capability of the private sector and the ability to finance Health Insurance Scheme (HIS) also have direct effect on the success of PHC. They will all lead to improved health care delivery. Improved health care delivery will also lead to healthy community, healthy households and a healthy and productive labour force.

While the above measures are capable of ensuring adequate sources of financing, it is certain that the PHC Agency should be saddled with the responsibility of coordinating the efforts in order to mobilize those concerned and this has to be monitored by the Government through the Federal Ministry of Health.

Towards Effective Management of PHC Funds

Following the objectives of the PHC as stated earlier in this paper, effective management of fund should be the responsibility of all. The success of the PHC programme is good financial management at all levels. It has been argued that one major impediment in the way of good financial management is lack of skill. Another predicament of good financial management is that people usually do not have faith in public accountability (Bamako Initiative, 1991).

The strategies of financial control at all levels should include the following: keeping of open financial records and books of account, community participation, and full record keeping. To achieve these objectives the following steps must be taken. At the community level every participating community should establish an accounting system. The account should be operated regularly. To forestall shortage of

drugs the DRF scheme should be maintained and accounted for. The voluntary health workers (VHW) who are the closest to the people should be allowed to maintain some imprest account for the day to day running of the health care programme in their LGA and this must be properly accounted for. The following organizational structure should be used in running community PHC Finance Management Committee (FMC). There should be a finance committee to be headed by the Committee's Chairman and must include at least six other members. The Treasurer should supervise directly the VHW/TBAs and make periodic check on their accounts as well as collect, on daily basis, all proceeds from sales and charges. The chairman should, on the other hand, supervise the Treasurer who himself will be under the supervision of the District Coordinator. The PHC coordinator should collect all financial reports on weekly basis and make a monthly and yearly summary. The summary should be transmitted to the State and the Federal Governments for record purpose. At the facility level, all monies received should be with receipt and this must be submitted on daily basis by the cashier. A supervising officer should be appointed who would audit, on daily basis, income and expenditure of the facility. For effective management, all drugs issued per day must be calculated against sales so as to know the difference and check fraud. All transactions must be properly recorded and submitted to the PHC Coordinator on monthly basis.

The LGA should perform a supervising role. The LGA should make periodic checks on the VHW/TBAs and Health facilities. There should be a monitoring and Evaluation (M & E) unit in the PHC Coordinator's office for financial monitoring in the LGA. All irregularities should be promptly reported to the PHC Coordinator immediate and appropriate actions must be taken. Apart from this, the PHC Coordinator should submit all the PHC accounts to the LGA auditor, on monthly basis, for auditing. To avoid financial mis-management all the signatories to the LGA account should also be signatories to the PHC account and the PHC Coordinator inclusive.

Below is the proposed Financial Management Model (FMM).

Figure II: A Typical Model of Financial Management Organogram For Effective Management of PHC Funds At The LGA Level

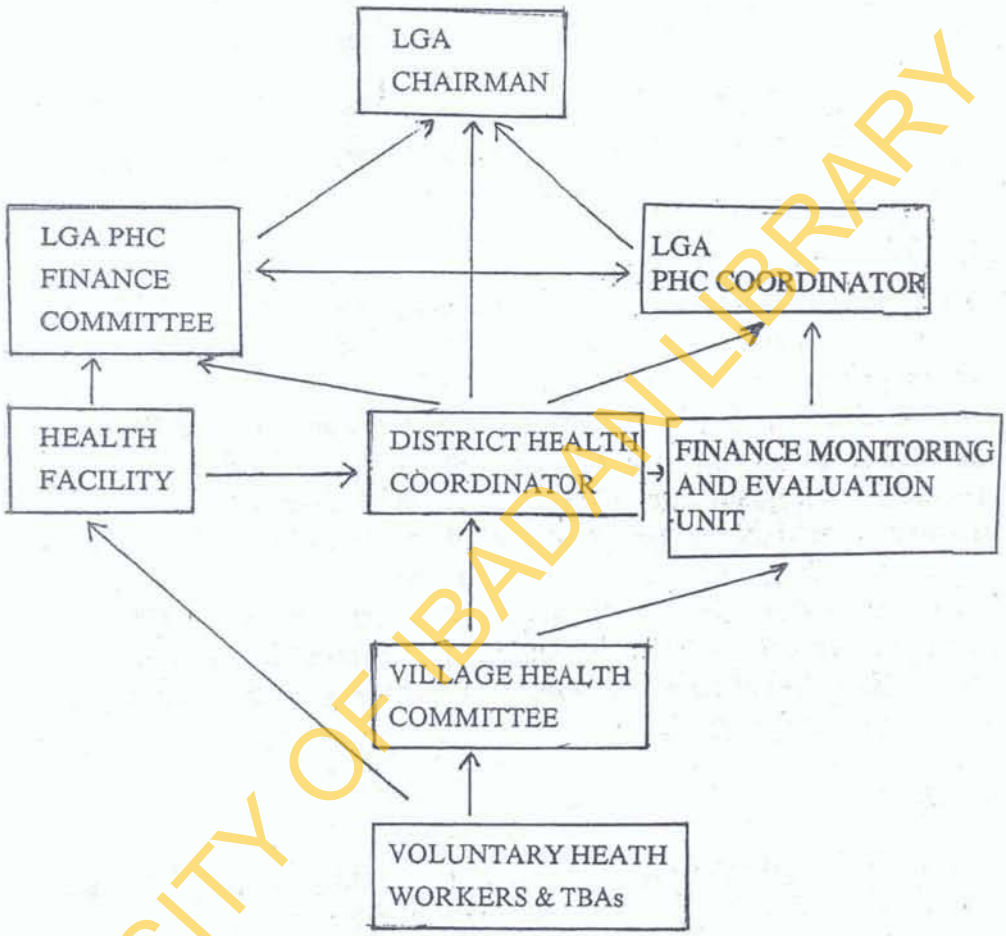

Figure II above shows the pattern of relationships that should exist between the various groups of people involved so as to enhance effective financial management at the grassroot level. All the people in-

volved in the PHC should be accountable to the chairman of the LGA. Using this model it will enhance proper coordination, distribution and utilization of resources as well as effective management of resources for the optimum benefit of the people.

Finally, there is need to train workers in the area of finance. They should be introduced to basic training in book keeping through regular seminars, workshops and conferences. Also, they should be provided with necessary facilities to enhance adequate performance.

Conclusion

In this paper I have shown that there is need for independent funding of PHC due to inability of the state alone to shoulder the burden. The paper has also discussed the efforts made so far in order to sustain the PHC programme and the impact on the population. It also explored possible ways of improving the financial source.

In order to make health accessible to all at affordable cost it has been suggested that there is need to avoid wasteful spending of PHC funds and encourage accountability. Available funds should be properly utilized. In as much as charges should be moderate, expenditure should be, mostly, on essential areas. Prevalent diseases in various communities should be identified so that their drugs could be purchased for storage. Drugs should not be purchased indiscriminately. Only essential drugs and materials should be of priority in this case. Also, all parties involved in the PHC should be accountable for their roles. Accountability should be emphasized and encouraged to enhance proper functioning of the PHC.

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INDEX

ABOUT THE BOOK

The text is devoted to the analysis of the implementation of the Primary Health Care/ Activities of the executors of the programme, as well as the policy makers and suggest possible strategies for making it more goal oriented.

It also attempts to rekindle, awaken and inform the Nigerian public of the primacy of Primary Health Care in our health quest.

Cadalad Nigeria Limited
ISBN 978-32524-1-0

Printed by Baptist Press (Nig.) Limited, Ibadan.