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Governance and Health System Reforms



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Governance and Primary Health Care Delivery in Nigeria

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Introduction

The National Health Policy in Nigeria (NHP), with the main objective of 'Health for All' by the year 2000, was launched in 1988. The provision of an effective system of primary health care delivery at the local government level was one of the main goals of this policy. The central focus of the National Health Policy was a 'community-based health system in which primary, secondary and tertiary health care is organised at local, state and federal levels, with each mutually supporting the other'. Before then (in 1986), fifty-two local government areas (LGAs) had been selected as pilot project sites, with the purpose of strengthening Primary Health Care (PHC) at the grassroots. Each of these LGAs was linked with a university teaching hospital or school of health technology for the purpose of training their health officials. State governments were directed by the then federal military government to devolve all PHC responsibilities to local governments over a three-year period terminating in June 1990. The state governments were however left with the responsibilities of supervising and coordinating PHC activities, as well as playing an advocacy role. The local communities were supposed to be carried along in the programme in order to ensure its success. To this end, district and village health committees were constituted to ensure the participation of local communities. The input of these committees was to be in the form of providing information, giving suggestions for improvement, complaints, control, etc. The PHC programme as conceived then revolved around nine core functions:

- Public health education
- Nutrition improvement
- Adequate safe water and basic sanitation
- Maternal and child health care, including family planning

- Immunisation
- Prevention and control of endemic and epidemic diseases
- Provision of essential drugs and supplies
- Elderly and handicapped care
- Accident and injury care

It is almost two decades now since the NHP was launched but the ultimate goal of 'Health for all' by the year 2000 seems to be as remote as ever. Effective delivery of primary health care at the local level is almost non-existent. A study conducted in the mid 1980s and which is still relevant today shows that the spatial density of hospitals in Nigeria ranges from 415 square kilometres per hospital in Lagos State (in the South West) to 9716 square kilometres per hospital in Borno State (in the North East). The corresponding implied accessibility of hospitals ranges from 9.67 kilometres walking radius in Lagos State to 55.55 kilometres in Borno State (Idachaba: 1985:5).

Before the introduction of the NHP, it was not possible to make an accurate assessment of the health status of Nigerians. There was no system of collecting basic health statistics on births, deaths, the occurrence of major diseases, and other health indicators on a country-wide basis. There were estimates from a few centres where such data were collected from sample surveys as well as from institutional records and special studies, such as the one referred to above (National Health Policy Guidelines 1988:4). Within the framework of the NHP, Primary Health Care is defined as:

[E]ssential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community and through their full participation and at a cost that the community can afford in the spirit of self reliance and self determination. It forms an integral part 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 with 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 (ibid:13).

Primary Health Care was envisaged to perform two functions under the NHP:

To provide general health services of preventive, curative, promotional and rehabilitative nature to the population as the entry point of the health care system. The provision of care at this level is largely the responsibility of local governments with the support of state ministries of health. Private medical practitioners shall also provide health care at this level. Noting that traditional medicine is widely used, and that there is no uniform system of traditional medicine in the country but wide variations, with each variant being strongly bound to local culture and beliefs, the local health authorities shall, where applicable, seek the collaboration of the traditional practitioners in promoting their health programmes such as nutrition, environmental sanitation, personal hygiene, family planning and immunisations. Traditional health

practitioners shall be trained to improve their skills and to ensure their cooperation in making use of the referral systems in dealing with high risk patients. Governments of the federation shall seek to gain a better understanding of traditional health practices, and support research activities to evaluate them. Practices and technologies of proven value shall be adapted into the health care system and those that are harmful shall be discouraged (ibid:13).

It was envisaged that local authorities would design and implement strategies to meet the health needs of the local population, and this should be done with the guidance, support and technical supervision of the state ministries of health. In addition, the local councils should be able to elicit the support of formal and informal leaders, traditional rulers, religious and cultural organisations as well as other influential persons and groups in support of community action for health. Local health authorities were given a free hand to adopt strategies to make the programme a success. In this regard, the NHP envisaged, among other strategies, that:

- Local authorities can determine how best to provide the essential elements of primary health care;
- Provide relevant health information to the people on such matters as personal hygiene, environmental sanitation, prevention and control of communicable diseases as well as such matters where a change of lifestyle of the people can have a significant impact on their health status;
- Design and operate mechanisms for involving the communities in the critical decisions about the health services; and
- Collect relevant data about the health resources, the health status of the community and their health behaviour, including the utilisation of health services. Such data shall form the basis of the information of the local health services.

However, Primary Health Care delivery has failed almost two decades after the introduction of the NHP. Both the United Nations Children's Fund (UNICEF) and the Federal Government of Nigeria unanimously agreed recently that weak Primary Health Care Centres have largely contributed to the high level of the disease burden in the country. According to the Master Plan of Operations for 2002-2007, jointly published by the two bodies, weak PHCs have exacerbated the problem of childhood morbidity, caused largely by malaria, measles, and, in recent years, HIV/AIDS. The Action Plan noted that coverage interventions known to reduce child and maternal mortality remain very low, and only about one per cent of children under five years were reported to sleep under insecticide-treated bed nets (*New Nigerian*, 21 March, 2005). It has been estimated that Nigeria now has the unenviable record of contributing approximately ten percent of the world's maternal death and eight percent of the world's child death, and this is a trend that has been on the increase over the years. Many such deaths could have been prevented with well known cost-effective interventions if they had been available to women and children who needed them.

The Birnin Gwari Case Study

We tried to find out through an empirical study in Birnin Gwari local government some of the main causes for the failure of primary health care delivery in the country, conscious, however, that the data gathered from this local government were by no means representative, nor a fair coverage, of the operations of most local governments in the northern part of the country. What we tried to do here is to investigate empirically (which, in the end, may either validate or falsify the reasons generally given for the failure of the programme) the reasons for the failure of PHC. The data collected were based on the following broad questions we had in mind:

- Is the local government well equipped with qualified personnel and materials to ensure the success of programme implementation?
- How much, in terms of financial resources, has been spent on the programme over the past five years?
- Are the people, as stakeholders, involved in the implementation of PHC as the blueprint for the programme suggests?

Based on these broad questions, the data collected from the local government were categorised into two:

Endogenous Data: related to the internal structure and facilities available to the health services of the local government. Data collected in this regard referred to the number of health clinics, and maternity centres in the local government area. The availability of trained nurses, midwives, etc. Also considered were the financial resources available to the LGAs over a seven year period, and the materials available to the LGAs - storage facilities, drugs, etc.

Exogenous Data: material collected here enabled us to examine demographic patterns in the local government; the causes of morbidity and mortality (by age and sex); the use of health services, including maternity and child health clinics, and the degree of involvement of the people in their own health care, including the use of traditional healers.

Located in the central part of Kaduna State (in North Central Nigeria), Birnin Gwari local government has a total population of 231,617. The local government is divided into three zones – the Central zone with a population of 84, 189; the Eastern zone with a population of 76,448; and the Western zone with a population of 70,980. (Source: Birnin Gwari Local Government Council).

An examination of the statistics made available to us shows that Birnin Gwari local government has a reasonable number of facilities to cater for the health needs of the local community. The central zone has eleven clinics; the Western zone has the same number, while the Eastern zone has seventeen. In terms of storage facilities, the following are available:

- 1 Refrigerator
- 3 Deep Freezers
- 8 Cold Boxes

- 160 Vaccine carriers
- 2 Ice pack freezers
- 480 Ice packs

To ensure a constant supply of electricity, the local government has one solar energy plant and four standby generators to serve the three zones. An examination of the staff strength of the health department reveals that it is adequately staffed, with 188 personnel. This is made up of fourteen Community Health Officers, fifty-six Senior Community Health Extension Workers, seven Junior Community Health Extension Workers, three Environmental Health Officers, two Environmental Health Technicians, ten nurses and midwives, three Dental Assistants, and ninety-three Health Attendants.

The PHC unit sends out District Health Superintendents to supervise field staff from the village level to the districts. They usually assess the performance of the field staff by observing the latter performing their basic functions. Once every three months, staff planning meetings are held. This is done with the aim of identifying problems in the field. For example, some of the problems employees encounter in the clinics and with the local community include a reticence to report cases of births and deaths in the local government area, and the lack of co-operation with officials of the health department during immunisation programmes. These problems may be due to religious or traditional beliefs. During such monthly meetings the PHC staff air their views and make suggestions as to how to overcome some of the problems encountered in the field. In addition, the PHC unit also sends out staff to the field to gather health statistics. This enables the department to assess its performance and it also helps to guide them on where to concentrate their efforts. Statistics gathered usually include mortality rates, accident rates, infectious diseases, expanded programme on immunisation (EPI) activities, and control of diarrhoeal diseases (CDD).

As enumerated in the blueprint of the NHP, district and village health committees have been constituted in all the wards of the local government area. There are also the Traditional Birth Attendants (TBAs) who are recruited to supplement the efforts of the village health workers (VHWs). The minimum qualification for the TBAs is usually a certificate in adult education. While the TBAs' main focus is on child birth, the VHWs are trained in preventive health care methods, first aid etc. According to the head of the health department of the local government, the District and Village Health Committees play significant roles in primary health care delivery in the local government. They do this through the mobilisation and sensitisation of the local communities about the need for total involvement in health care programmes; supporting and maintaining the drug revolving fund; providing voluntary work (for example, there are security guards for some of the clinics who are not on the payroll of the local government); and holding frequent meetings to discuss problems such as the use of medical facilities, staff punctuality, and guarding against malpractices committed by staff of the local government.

However, the health status of the residents of Birnin Gwari leads one to question the effectiveness of the district and village health committees in performing their duties. The inhabitants of Birnin Gwari local government are still afflicted by common diseases which normally should not pose a threat to them. Presently, the causes of morbidity and mortality in the local government area are:

- Measles (in children between the ages of 1–5 years, both male and female)
- Diarrhoea
- Malaria
- Deaths related to child births
- Tetanus A – caused by injuries sustained during farming
- Tetanus B (neo-natal) in new-born babies
- Cerebro-spinal meningitis
- Malnutrition in children and pregnant women
- Road traffic accidents

Source: Health Department, Birnin Gwari Local Government.

The prevalence of these common diseases and accidents points to one basic fact: that primary health care delivery has failed in the local government. This failure, we believe, is due to two main reasons. The first reason is attributable to the lack of close and effective contact by local health officials with the local communities, consequent upon the inefficiency of the district and village health committees. Visits by the health officials to the local communities total no more than three times a year, and this is only to collect data on diseases afflicting the local communities. The organic link which is supposed to exist between policy makers and the local communities, through the district and village health committees, is non-existent. Consequently instead of being stakeholders, local communities are mere 'beneficiaries' of PHC. They thus see in the implementation of the PHC programme a similarity with all other programmes embarked on by the local government, which often end in failure, despite the enormous resources allocated to such programmes. The resultant effect is that the officials of the health department of the local government do not know their target population sufficiently well. As Tom Gabriel (1991:2) succinctly puts it:

Development programmes, basic needs strategies, primary health care schemes etc., all share a common requirement: each has to make the most efficient use of financial and staff resources at a time when development funds are actually decreasing. Yet those responsible for planning, funding and implementing these essential activities often possess scant knowledge of how their target populations live. Insulated from food security, chronic ill health, illiteracy or powerlessness, their good intentions or occasional field visits to nearby settlements cannot adequately replace this lack of fundamental knowledge. They are usually extremely remote from the living conditions of their clients.

The second reason for the failure of the PHC programme can be traced to the lack of transparency and accountability in programme implementation. Over the past five years, from 2001 to date, the health department has witnessed its share of total budgetary spending increase significantly, as the Table below indicates.

Table 1: Figures on Local Government Finances

Year	Budget of Local Govt	Allocation to the Health Sector	Total Budget for the Health Sector %
2001	216,200,253.00	21,100,000.00	9.71%
2002	261,940,082.00	31,500,000.00	12%
2003	259,000,000.00	20,000,000.00	7.72%

For the year 2001, the health sector received 21,100,000 naira which was 9.71 percent of the total budget of the local government which stood at 216,200,253 naira. In 2002, the approved estimate for the health sector was 31,500,000, representing 12 percent of the estimates of capital expenditure of 261,940,082 for the local government. In 2003, the health sector received 20,000,000 out of a total estimate of 259,000,000 naira for the local government. This represents 7.72 percent of total spending for that year. In absolute terms, these figures represent a marked increase in budgetary allocation for health over the preceding years where for example, the health sector received in 1993, 740,000 naira, representing 4.99 percent of the total estimates of 1,950,000.

The ineffectiveness of local governments in Nigeria to provide basic services to local communities has been mainly attributed to the lack of sufficient financial resources. Financial inadequacy, we believe, is not a key constraint or obstacle to effective service delivery. This is because although local governments do not receive as much, both in terms of absolute revenues per capita and in terms of the total share of public expenditures vis-à-vis the state and federal governments, their functional responsibilities are correspondingly limited. Apart from this, the total share of fiscal revenue accruing to local authorities from federal allocations has more than quadrupled over the past four or five years. A cursory glance at the revenues which have accrued to local governments in Nigeria from the federation account, shows that their revenue base increased tremendously over a nine-year period, from 1997 to 2001 as Table 2 shows.

The increase in revenues over the past five years points to one basic fact: that poor service delivery in the local governments cannot be attributed to inadequate finances. One major problem, which contributes to the failure of local governments in meeting target goals, can be traced to the lack of transparency and accountability in governance. For example, the annual financial estimates for the health department in Birnin Gwari local government are hardly made public. They are treated as secret documents and financial reports on disbursements are hardly made available to the community, who as stakeholders have the right to know.

Table 2: Revenues Accruing to Local Governments 1993-2001

Year	Total Revenue (in billions of naira)
1993	18.31
1994	17.32
1995	22.25
1996	29.61
1997	53.06
1998	65.98
1999	116.12
2000	244.14
2001	248.63

Source: Federal Office of Statistics.

Reports of financial spending are treated as documents only for the consumption of the personnel. Even the junior nurses and community health workers have only a skeletal knowledge of how the department operates its annual budget. This problem is not peculiar to Birnin Gwari local government alone, but is widespread all over the country. According to Dr Shehu Mahdi, the executive director of the National Primary Health Care Development Agency, 'official analysis show that 60 percent of the total health spending (in the country) between 1999 and 2003 went into settling out of pocket expenses. This, in a situation where primary health care services are not available to the majority of the people and where the services are available, the quality is so bad that people prefer to go elsewhere for the services' (*The Guardian*, May 30, 2005).

Conclusion

There is no doubt that severe problems have bedevilled the Nigerian state in health care delivery. The provision of an effective system of health care delivery, as a right, and not a privilege, is but a dream in Nigeria. The failure of the Nigerian state to provide an effective, functional and sustainable health care system has led to a situation where access to health care is not possible for the majority of the populace. Coupled with this problem is the issue of brain drain, where medical practitioners, nurses, and midwives leave the country in search of better conditions of work, often to countries in the developed world. At the heart of the economic, political and social crises bedevilling Nigeria is the lack of transparency and accountability in governance, a situation which has led to the failure of many public policies. Often, reforms of the public sector, meant to address the failure of public policies, usually focus on structural issues, relegating the behavioural to the background. Reform of public institutions is a step in the right direction, but the ultimate goal of a reform being effective and functional may not be achieved without putting in place the mechanisms which will regulate the behaviour of the

individuals operating in the system. Rather than focusing on ‘strong local governments’ with adequate financial wherewithal, as a panacea for an ineffective service delivery, any reform, in order to be effective, should rather focus on the characteristics of the delivery system itself. To understand the failure of policy implementation, one must understand the motivations of the myriad of individuals who play major roles in the service delivery. The point made by William Dillinger (1993) cannot be clearer in this regard:

There is no single institutional arrangement that can be universally prescribed for the delivery of urban services. What is important are not the organizational labels, but rather the relationships - the rules that govern the transactions between local political leaders, administrators and the urban dwellers. A ‘good’ arrangement is likely to be a very complicated one and one that is not defined merely by the designation of municipal responsibilities and revenue sources. Urban service delivery appears to be a problem that cannot be addressed by taking the organizational context as a given and attempting to change the behavior of one organization – municipal government – within it. Instead, it appears to be a problem of the public sector as a whole, and one that must be addressed by looking at the variety of factors that influence the performance of the public sector and those factors’ implications for urban service delivery.

Primary Health Care Delivery has failed in Nigeria because there was no serious interaction between formal management structures and local residents. In the first place, this led to the absence of a local mechanism for ensuring public accountability and inducing greater transparency in governance. Secondly, because local communities were not seriously involved in policy making and implementation with regards to health care delivery, they did not see formal management structures in the local governments as particularly relevant to their existence. Thirdly, the local authorities, depending largely on subsidies from federally allocated revenues for their operation, saw no need to cultivate the local communities as their natural constituencies, and thus lacked the capacity to mobilise the local populace for the effective implementation of the project. This is true not only with regards to primary health care delivery, but with all other development programmes in the local governments. To enhance service delivery in the local governments therefore requires a new approach to policy making which will eliminate the prevailing dichotomy between the formal management structures and the informal sector. There is a need to put in place a unified management system injected with a strong dose of citizen participation. To achieve this, efforts must be made to ensure that:

- Local associations that have emerged to deal with particular problems in particular neighbourhoods are officially and legally recognised;
- These associations must be integrated into the normal processes of formal management;
- Efforts must be made to progressively build up the capacities of these neighbourhood associations to gradually align them with the existing modern urban management system.

These advances require the integration of traditional neighbourhood organisations into the governance of urban centres. It will be necessary, in this respect, to identify all the neighbourhood institutions in the local governments, to appreciate the nature of their leadership and their organisation, and seek to harness them for the overall administration of the locality. However, the leadership of these neighbourhood organisations must be entrusted to men and women of integrity, who have the trust and confidence of the community, and through whom information can flow from the local government council to residents of neighbourhoods and vice versa. This will have the effect of reducing the level of alienation in the local governments, because the people will know more about what is going on in the local government councils.

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