WINNING ENTRY - PROFESSOR OLIKOYE RANSOME-KUTI MEMORIAL ESSAY COMPETITION

ALMA ATA 41 YEARS LATER: THE NIGERIAN STORY

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ABSTRACT

Since eons past, the primacy of health as a fundamental human right has been established. However, this oft-repeated assertion has not been reflected in the general health of people all over the world, occasioned by glaring inequities in health distribution, as well as the very low community participation and synergy. The world's attempt at solving this existential problem gave rise to the Alma Ata Declaration.

This essay looks at how the declaration of Alma Ata has rubbed off on primary health care in Nigeria. It looks at the efforts made to imbibe the declaration in the national health policies, and the effects of such salutary actions. Next, the essay sheds light on the problems that have stymied the progress of primary health care. Viable courses of action are proffered to help correct all that has put a clog in the wheel of primary health care as well as preventing future occurrences. It concludes by reiterating the fact that there is no substitute for health care, hence the need to pay much more than lip service to the principles of Alma Ata.

Keywords: Alma Ata Declaration, Primary Health Care, Impact, Nigeria.

INTRODUCTION

"A primary health care (PHC) approach is the most effective way to sustainably solve today's health and health system challenges. " » Alma Ata Declaration (1978)

Health, from time immemorial, has been an important, and as well problematic, issue for the world. This assertion, in a nutshell, is anchored on the age-long aphorism, "health is wealth". This is why attention has always been paid to finding detailed designs that will spur better health care delivery all over the world.

Drawing from the foregoing, the international community, in a conference co-sponsored by the Wormld Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at Alma Ata (presently called Almaty, in Kazakhstan) in September 1978, came up with the Alma Ata Declaration to serve as the linchpin for the goal of achieving Primary Health Care (PHC) all over the world [1].

BODY

The Alma Ata Declaration was a watershed moment in the history of health care. Emerging from the conference was the consensus that health was a human right based on the principles of equity and community participation. Alma Ata broadened the perception of health beyond doctors and hospitals to social determinants and social justice. The declaration also advocated, amongst a myriad of other recommendations, a new Economic Order that will help achieve the objectives of the declaration by providing the needed finances [1].

Primary Health Care is the first level of contact of individuals, families and communities with the national health system, bringing health as close as possible to where people live and work, and constitutes the first element of the continuing health care process [2]. Maurice King [3] views a PHC centre as a unit which provides a family with all health services, other than those which can only be provided in a hospital.

The health services, based on PHC, include among other things: education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition, maternal and child care, family planning, immunization against the major infectious diseases, prevention and control of locally endemic and epidemic diseases and provision of essential drugs and supplies [4].

The year 1985 heralded a new dawn in the efforts for entrenchment of PHC with the appointment of Professor Olikoye Ransome-Kuti as the Minister of Health. He adopted PHC in 52 Local Government Areas based on the declaration of Alma Ata, with a comprehensive National Health Policy set into motion in 1988 [5]. From 1986 to 1990, Professor Olikoye Ransome-Kuti expanded PHC to all Local Governments, achieved over 80% universal child immunization, and devolved responsibility for PHC to Local Government Authorities [5]. Professor Olikoye Ransome-Kuti, being a stickler to details, worked assiduously between 1985 and 1992 to implement PHC policy based on the Alma Ata Declaration for the benefit of the Nigerian population, placed emphasis on preventive medicine and health-care services

at the grassroots, ensured exclusive breast feeding practice, encouraged the use of oral rehydration therapy by nursing mothers, made compulsory the recording of maternal deaths, and encouraged continuous nationwide vaccination as well as pioneering an effective HIV/AIDS campaign. In 1992, the National Primary Health Care Development Agency (NPHCDA) was established to ensure that the PHC agenda was continued and sustained [3,5]. During his time, access to health care soared from 30% to a staggering 80%.

41 years on, a look at the current trend reveals that the goal of Alma Ata, which is achieving health for all by the year 2000, and to which Nigeria was a signatory to, has not been fully implemented in the country. According to WHO (6), although Nigeria constitutes less than 1% of the global population, she accounts for about 19% of the global maternal deaths, with a maternal mortality ratio of 814 per 100,000 live births while a 2017 report by the WHO saw the country given the unsavory tag of 187 out of 190 countries in the world health system report [7].

It is not also happenstance that the country has been stuck ankle deep in the double trouble of communicable and non-communicable diseases (NCDs). Statistics shows that the top ten causes of death in Nigeria in 2017 were lower respiratory infection, neonatal disorders, HIV/AIDS, malaria, diarrhea, tuberculosis, ischemia heart disease, stroke, cirrhosis, and meningitis (8). Communicable, maternal, perinatal, and nutritional conditions account for 63% of total deaths, while NCDs, such as cardiovascular disease, cancer, diabetes, chronic respiratory diseases and other NCDs account for 30% of total deaths in Nigeria (9). Obviously, a robust PHC system across the country would have at least reduced these numbers greatly, and ensured more presentable healthcare statistics.

Clearly, the collapse of PHC in Nigeria has been attributed to a medley of factors. Unstable leadership, time and again, has been viewed as an ill wind that has blown healthcare no good. The incessant military juntas and the rapid change of health ministers have done a lot of harm. At the Local Government level, the leadership has not been less erratic, evinced in the way councils have changes in chairmen as much as twice a year. In the words of Adeyemo [10], "This high leadership turnover has had negative influences on the implementation of PHC Services". Despite WHO recommendation that 5% of Gross National Product (GNP) be set aside for health and the Abuja Declaration of 2001 mandating African nations to provide a 15% of budgetary layout for the attainment of health, PHC in Nigeria has continued to suffer from inadequate funding. Most PHC Centres lack commonplace medical equipment and drugs, a clear contravention of Alma Ata and the Bamako Initiative, and this has effectively dented their functionality. The Structural Adjustment Programme (SAP) also left a bitter taste in the mouth of people as it reduced government expenditure on health.

Mention must also be made of community perception of poor quality of services at PHC facilities, rife across the nooks and crannies of the country, which has undermined the programme. People prefer to queue up at Teaching Hospitals for treatment than go to the PHC centres close to them, established solely as a means of providing efficient and affordable health care at the grassroots. Perception influences acceptance, they say, which in turn determines utilization and because perception truly has been poor, community participation, the hall mark of PHC, has also been at its nadir. This is even accentuated on the one hand by the problem of personnel management, occasioned by a dearth of health personnel in some areas, and where they are enough, inter-cadre conflicts that impinge on output, and on the other hand, an exodus of health professionals due to poor working conditions and unsuitable pay packages.

With PHC in Nigeria taking a downward spiral and with less than 20% of the 30,000 PHC facilities working (11), efforts have been made to rewrite the narrative. Such efforts include a Plan to End Preventable Newborn Deaths in Nigeria, initiatives such as the National Health Insurance Scheme (NHIS), the Free Maternal and Child Health (MCH) Programme, the Midwives Service Scheme (MSS), and PHC Under One Roof (PHCUOR). Others include the Subsidy Re-investment & Empowerment Programme, Maternal and Child Health (SURE-P MCH), and Saving One Million Lives (SOML) (12). These efforts, however, are yet to achieve the desired impact. One cannot, therefore, fault the position of industry players and citizens alike that concerted efforts must be made to revamp PHC in Nigeria.

IMPROVING PRIMARY HEALTH CARE IN NIGERIA

With an outlook towards making primary health care in Nigeria more effective, the following courses of action, I believe, will help us hit the bull's eye:

1. National Awareness Creation: Health education should be carried out at all levels by the Government for proper understanding of the meaning and usefulness of PHC as well as the need for community participation in the implementation. We need to strengthen the units at the PHC Centres mandated with creating awareness. The National Orientation Agency (NOA) must take up the gauntlet and ensure a higher percentage of the citizenry get to understand the bolts and nuts of the programme. This will serve as a fresh tonic in the push for greater effectiveness
2. Improving Community Participation: With the hard-rock conviction that the PHC facilities are not up to standards, community participation has been low. Govern-

ment must take action by putting necessary infrastructure and equipment in place if they people are to regain their trust. Also, the understaffed facilities must have enough medical officers placed at the units. This will help shore up people's trust in getting necessary and efficient treatment at all times.

3. Adequate Funding: The National Health Bill of 2014 needs to be adhered to, as does the Abuja Declaration of 2001. This will provide the financial outlay needed to restore PHC to its famed status in the days of yore. This also will reduce the overbearing dependence of PHC centres on the meager Local Government purse so that more funds will reach the centres.

4. Safeguard Against Brain Drain: No doubt, PHC cannot be sustained without our medical workforce. To put our money where our interest lies, government must begin to provide better working environment with good salaries as and when due.

5. Collaboration: Alma Ata declaration stressed the need for support from other sectors.. This, however, has not been paid proper attention. Teaching hospitals must begin to send medical officers on a regular basis in the form of posting to the PHC facilities to supplement the staff on ground. Additionally, the Ministry of Agriculture should provide regular supply of food commodities for medical officers and patients to make the process better.

6. Periodic Holistic Review: It is important that we undertake a regular review of the PHC situation which will afford us the opportunity to take stock and look back, find out our loopholes, and to also come up with more responsive methods of improving the programme in the country. Part of this involves a regular assessment of the state of facilities and supervision of the medical officers across the facilities so as to ensure that all hands are on the plough.

CONCLUSION

With over 30,000 PHC facilities and a staggering medical workforce of about 40,000 (11) Nigeria should be on a perpetual upward spiral. The onus is on us to ensure proper implementation of the Alma Ata Declaration, and just like Mr. Tochukwu Nwachukwu, a lecturer at the University of Nigeria, poignantly submitted, "Primary Health Care in Nigeria can never be the same again because even though the ebullient Prof. Olikoye Ransome-kuti no longer lives, his dream lives on".

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