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Managing Primary Health Care in the South - South Geo Political Zone of Nigeria

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ABSTRACT

Management of Primary Health Care (PHC) is one of the main pillars of a health system through Human Resources. Furthermore, the quality of health services depends to a large extent on the people who manage the services. The paper reviews the role of stakeholders in the management of primary health service provisioning in general and in Primary Health Care in particular, it examines brief historical review of the gradual introduction of new cadres of health managers into the health system in response to perceived health needs, training and deployment of health during the colonial era, establishment of the advance schools for health workers, events at third national development plan and the unfortunate decline of community nursing and community midwifery, etc. It further analyzes factors and challenges of leadership which affect the performance of health managers. It also discussed case studies of proven innovative approaches and best practices in the management of human resources in sub – Saharan Africa and Nigeria. Data used in this paper is derived from secondary sources. An urgent need for a comprehensive database on the Human Resource for Health (HRH) situation in Primary Health Care should be developed. The current Human Resource situation indicates that the availability and distribution of HRH and PHC is far from being adequate. The need to mobilize communities to get them to take ownership of primary health care delivery and its maintenance is important. The morale and motivation of personnel have major implications for their performance. In the case of Human Resource for PHC in Nigeria, data is not easily available and when available tends to be incomplete and/or contradictory. The distribution and availability of HR and PHC is also a major concern in most parts of Nigeria. The poor distribution and inadequate number of the various health personnel

required for an effective PHC in Nigeria is compounded by the brain drain, poor motivation among health personnel and inappropriate policies among others.

Keyword: Primary Health Care, Community Nursing, Community Midwifery, Human Resources.

INTRODUCTION

The purpose of this paper is to review the human resource situation in the Primary Health Care (PHC) system in Nigeria. Human resources are now acknowledged as the most important resources of an organization so much so that the term, human capital, is being increasingly used to indicate this importance. In health care, the importance of human resources is accentuated by the fact that the quality, quantity, disposition and commitment of the available human resources are often crucial for the quality and effectiveness of health outcomes. This is especially the case in primary health care which has to be considered and has, in fact, been accepted as the most important level of achieving the health objectives, such as those provided in the Millennium Development Goals, of a society. In the primary health care system therefore, all aspects of managing human resource policies available, the quality of supervisory management, work attitude and orientations, the quality of human resource records and research, the various human resources management processes and systems (such as goal setting processes, the recruitment and selection procedures, training and development systems, the performance appraisal system, the reward and recognition system and the disciplinary system) play a crucial role in shaping health outcomes.

scussion takes a cursory look at the human resource management situation prior to the introduction of Basic Health Services Scheme (BHSS) in Nigeria before focusing on the current situation of managing human resources in the Primary Health Care system in Nigeria.

History Of Primary Health Care In Nigeria

The history of the health sector in Nigeria falls conveniently into three distinct but naturally overlapping periods. These are in chronological sequence:

1. The Pre – Colonial
2. The Colonial
3. The Post Colonial

This paper gives a broad overview of the structure, administrative patterns and trends of critical components of the health sector in the three periods identified above. Appropriate references are made, and attention drawn to relevant social, cultural, political and economic antecedents, that helped to shape the subsequent direction of policies and interaction between the indigenous traditional and the western orthodox health care dispensations.

The growth, in the post – colonial period, of a parallel orthodox private health care service with minimal formal functional interaction and relationship with the public service is discussed. A more detailed review of the current situation and the impact of various contemporary policies undertaken by the government on the health services delivery system are provided in other areas of this study.

The geopolitical entity known as Nigeria came into existence in 1914 with the amalgamation by the British Colonial Government of its 'Northern Protectorate' with the 'Southern Protectorate' which had earlier, in 1906, been joined with the Lagos Colony, the latter of which itself was annexed to Britain in 1861. However, the verifiable medical history of Nigeria dates back to the 15th century, in forms that are related to trading activities on the Atlantic Coast and across the Sahara. Schram (1996:326) observed and I quote:

ese traded with Benin Empire from 1472, and traces of Catholic influence and Portuguese soldiers abound in Benin bronzes. They are credited with being the first people to bring western medical care to their traders in outposts but not to the indigenous African population.

eral reasons, it is difficult to define precisely the beginning of the colonial era, and therefore the nature and corresponding succinct impact of 'colonization' in Nigeria. If 1861 is taken as the pivotal point, it would exclude the preceding six decades that witnessed the overthrow (in 1804) in the North of indigenous Hausa rule by the Fulanis, itself an enduring act of colonization, in the mode of similar events replicated throughout history. Although considerable changes in the socio – cultural fabric of the indigenous communities were likely to have taken place, the scantiness and in most cases, lack of ready access to any reliable documented information on the health system of the region, inevitably means that the facet of the history of the Nigerian health sector will not compromise a definitive feature in this review. This notwithstanding there is substantial residual evidence in the North, of the influence of ancient Arabic and Persian medicine 'transferred' across the trans-Saharan trade routes, as was the corresponding and more prevalent non-indigenous 'western' medicine across the Atlantic Ocean.

Schram (1971, 1996) draws attention to a variety of appellation for 'medical careers' in different parts of the country in the pre-colonial period. Some examples are, in the North, the "Wombai" or first aider, and the "Gozam", an all purpose barber surgeon in Nupeland. A medicine man that used magic was known as a "Cigbecizi". In Iboland, medicine men were generally referred to as "Dibias" while the general practitioner in Yoruba land was known as and popularly referred to as the "Adahunse".

purpose of this study, the pre-colonial era in Nigeria would be taken to be the period before the annexation of Lagos, as a colony by Great Britain. The administration of the amalgamated Northern and Southern Protectorates and the colony of Lagos lasted until 1951. Regional Civil Services were established in 1954 and internal self – government was granted to the

Southern regions (East and West Lagos) in 1956, and the Northern region in 1959. The end of the colonial era could therefore be taken to be 1st October 1960 when Nigeria emerged as an independent sovereign state. The 1950s could be justifiably considered as a period of transition from the colonial to the post – colonial era.

The Global Situation In Human Resources For Health

It is significant that the 2006 report of the World Health Organization was dedicated to a review of the human resources fore health resources for health situation at the global level. According to Lucas (2007), the Director – General of World Health Organization, the report focused on this challenge because

3, before I took up the position of Director-General I asked many leaders and decision makers in health what they saw as the most important issues in their countries.One common theme, whether in developed or developingcountries, was the crisis in human resources".

isis was represented by several factors: a chronic global shortage estimated at over 4 million of well trained health workers with countries in sub-Saharan Africa experiencing the most acute relative shortages, poor distribution of health personnel especially in underdeveloped countries, and inability of countries to 'educate and sustain the health workforce that would improve people's chances of survival and well-being' (Lucas, 2007). This is especially the case in Nigeria, which produces more trained health personnel than its health system can use effectively, yet trained health care staff continues to migrate from Africa to more developed countries. There are also disparities in the distribution of available Human Resources for Health (HRH) personnel among the different geo-political zone and at the different levels of care. In the Nigerian situation, the crisis of human resources appears to be most acute at the level of the primary health care. There is need for Africa's health authorities with support from international partners in line with national goals and priorities to design and implement creative programme of managed emigration.

Management Of Human Resources For Health Prior To Basic Human Service Scheme (Bhss)

Training as 'Local Health Visitor' began in Nigeria as early as 1949 when girls with Middle II schooling who were Grade II midwives were trained for the new Rural Health Centre in Western Nigeria. This then evolved into the idea of 'community nurse', an auxiliary health visitor, receiving six months' or a year's training in a health auxiliary training school, based on Grade II Midwifery background (Schram, 1971). By 1958, with the assistance of the WHO, training facilities were expanded and the Ibadan Health Auxiliary Training School which by now had replaced the old school trained all categories – public health inspectors, community nurses, family visitors,

leprosy inspectors, dispensary attendants, and health overseers, and organized refresher courses. Similar trainings were offered in the Medical Auxiliary Training School in Kaduna and School of Hygiene in Kano in Northern Nigeria, as well as the School of Hygiene in Aba and Oji River Rural Health Training School in the East.

Various categories of health workers existed in different parts of Nigeria before the Basic Health Service Scheme (BHSS). A survey of health manpower across the country around 1976 showed that there were about 40 groups of different health workers within the public health sector in different parts of the country working outside the hospital setting as shown in the table below. Many of the workers were trained for one specific health activity or programme as may be necessary and were therefore described as 'mono-valent workers'. With the introduction of the BHSS in 1977, the need arose for streamlining the recruitment, training and utilization of these health workers. Consequently, the Federal Government through Basic Health Service Implementation Agency (BHSSIA) of the Federal Ministry of Health decided to regroup them in 1977 (some after retraining) into four cadres of "core" polyvalent workers and these have remained the core primary health workers in Nigeria's PHC system. They are:

1. Community Health Officers
2. Community Health Supervisors
3. Community Health Assistants
4. Community Health Aides

The Community Health Supervisor Cadre was later phased out while the Assistant and Aide were renamed the Community Health Extension Workers (CHEWS).

Management Categories And Groups In Phc

Obviously, the starting point for reviewing human resources for PHC is the identification of the human categories and groups involved in PHC. As the WHO (2006a) discussion of health workers has shown, there is difficulty in defining and therefore listing the different categories of personnel involved in a health system. For example, if it is accepted that 'health workers are all people engaged in actions whose primary intent is to enhance health', would the activities of mothers and family members who look after their sick children and paid and unpaid caregivers in private homes be included among the health workforce?

h a different class of problem, Asuzu (2007) observed that, 'In Nigeria, the Nigerian auxiliary community health workers refuse to accept that they are auxiliary community health workers and resist any attempt even to upgrade the training of any of them who desires'. Should this category of health workers be counted among auxiliary community health workers or should they be designated community health workers given the fact that in Nigeria some categories of "auxiliary health workers were massively trained in ways different from the way they had been developed in countries where

their training and utilization worked such as in Kenya, the Fiji Islands and the Philippines (Asuzu, 2007)".

discussion, health workers are those who are employed (part time or full time; in self-employment or as paid employees) and trained (formally or informally) for the purpose of providing services in any of the areas of the health system. In a PHC system, health workers would include:

1. Community Health Officers (CHO)
2. Public Health Nurse/Midwifery
3. Environmental Health Officer
4. Health Information Officer
5. Laboratory Technician
6. Medical Records Officers
7. Pharmacists/Technicians
8. Community Health Extension Workers (CHEW)
9. Traditional Birth Attendants (TBA) and Voluntary Health Workers (VHWs)
10. Support Staff

Factors Affecting the Performance of Health Personnel in PHC

Many factors determine the performance of health personnel at the PHC level. These include:

1. The policy environment.
2. The number and geographical distribution of PHC facilities
3. The organizational structure of PHC
4. Availability and distribution of health personnel
5. The personnel mix
6. The composition of the health teams for PHC
7. The location of the health facilities where health personnel provide services.
8. The availability of training and development opportunities.
9. Relationships among members of the health teams
10. The distribution of costs among the PHC elements
11. Leadership, coordination and supervision
12. Political factors
13. Communal participation

The Hrm Policy Environment

At the level of any individual institution, good practice dictates that management of human resource practices are grounded in policies that tie the practices to the strategic goals of the institutions. The grounding of HR practices in policies is to ensure that the attraction, use and retention of the HR of the institution lead to best outcomes not only for the institution but also for people in the organization themselves. This consideration acquires greater importance at the level of an entire sector such as health not only

because of the greater complexities and uncertainties that characterize such a system but especially because of the increased impact that inappropriate HR practices can have on the effectiveness of the entire system and its constituent parts. The implication of this is any discussion of HRM in PHC must begin with a review of (i) the overall population health policy and (ii) the HRM policy environment.

Table 1: Health care facilities by type of ownership and level: south-south.

S/N	STATES	OWNERSHIP		PRIMARY	SECONDARY	TERTIARY
		PRIVATE	PUBLIC			
1	Edo	378	308	367	315	3
2	Delta	310	317	557	68	2
3	Bayelsa	6	153	143	15	1
4	Rivers	378	289	624	44	1
5	Akwa Ibom	149	390	345	191	1
6	Cross River	61	429	490	52	Nil
	TOTAL	1,282	1,886	2,526	685	8
	AVERAGE	214	314.33	421	114.167	1.6

Compiled from FMOH: Health Facilities Data Base in Nigeria: By State, LGA, Type and Ownership Year 2000

Requirements, Availability and Distribution of HRH for PHC

The availability and distribution of health personnel for PHC has major implications for the performance of not only the health personnel but the PHC system as a whole. For this reason, a key concern of HR policy in health is the availability and distribution of health personnel. For example, the Draft National Human Resources for Health Policy 2006 (NNRHP) provides for planning the current and future needs and requirements at all levels. The result of such planning will be the determination of the numbers, categories and quality of health personnel required in the right evaluations of the human resources situation at any levels of the health system must flow from analysis and comparisons of what is required with what is actually available. This professionals in PHC is largely determined by mix of personnel are available in the right quantity, quality and places.

Basis of the existing PHC structure, Ogundeji (2000) suggests that a minimum of 167 health workers in eight different categories supported by 80 TBAs/VHWs are needed at the Local Government level. Given the fact that there are 774 Local Government Authorities in Nigeria, this translates to some 129,258 health workers and 61,920 TBAs excluding the requirements for the Federal Capital Territory, Abuja. We consider the number provided by Ogundeji (2000) to be too small especially in the area of medical doctors.

The calculation is based upon a ten ward structure per Local Government. It also does not take into account the number of primary health facilities actually on the ground. Finally and perhaps most seriously, it does not take account of the minimum prescribed by WHO which provides for one doctor per 10,000 of the population. If the WHO standard is used, then Nigeria would need 14,000 doctors for its estimated 140 million people. This would translate to 18 doctors for each of the 774 LGAs in the country. Assuming a distribution of the doctors among the tertiary, secondary and primary levels

of the health system in the proportion of 40%, 35% and 25%, this would provide that at least four doctors are located in the PHC system at the LGA level. If the revision is made then the number of doctors and more than 142,184 professionally qualified health workers with another 68,112 TBAs. These figures do not provide however for other essential members of the health team such as pharmacist, laboratory scientists, and medical records officers. The question that arises from this set of statistics, no matter how tentative they may be, is how well is the PHC system staffed in relation to these requirements?

Unfortunately, it is impossible to indicate the actual number of health personnel in the PHC sector in Nigeria. Firstly, data on some categories of HR for PHC do not exist at all or where it exists is, sometimes, inaccurate. Secondly, the data for HRH is usually in aggregate form and does not provide specifically for PHC. Thirdly, different sources of HR health statistics often provide conflicting data. There is no easy solution to any of these problems. One of the solutions adopted here is to assume that some categories of health personnel are expected to function specifically at the PHC level; therefore national data on these categories are taken as being indicative of the HRH situation in PHC for these categories. A second solution is to use the different but often conflicting data sources together so that the gaps in one source of data can be filled by data from the other provided together.

Although WHO (2006) figures indicate that there were less than 200,000 health workers in Nigeria in 2004, the National Human Resources for Health Policy (NHRHP 2006) estimates that there were some 403,457 professional health personnel in Nigeria as at December 2006. Community health practitioners, nurses and midwives accounted for more than 50% of this number with doctors also showing a fairly strong presence in this number. The large number of community health practitioners can be taken to be indicative of their presence in the PHC system. These observations need to be strongly qualified however by the admission of government that the figures presented above: "are for some health professional categories registered by Nigeria's professional medical/health regulatory professionals who are not practicing in the country or may not be practicing health care at all".

National Human Resources For Health Policy (Nhrhp Data 2006)

The NHRHP (2006) data shows the numbers and distribution of some categories of health personnel for the majority of the States in Nigeria as at August, 2005 (table 2). Again, before proceeding to make use of the data it is necessary to take cognizance of the observations in the NHRHP document that:

In tables 1 and 2, the data is reorganized to indicate the relative distribution of the health human resource across South-South geopolitical zones. Earlier, it was shown that the North-West and North Central geo-political zones had the highest number of primary care facilities. When it

comes to the availability and distribution of HRH, we find that the situation is reserved. The North Central Zone is placed fifth in terms of average number of doctors per state in the zone (145) and first in terms of average number of CHOs/CHEWs (810) per state. The South-West is placed first in terms of the average number of doctors per stated in the zone (1,217) and second in terms of the average number of CHOs/CHEWs per state in the zone (630). The North-West geo-political zone is placed fourth in terms of average number of doctors per state in the zone (197) and sixth in terms of average number of CHOs/CHEWs (381) per state.

Table 2: Categories of health personnel in the health sector.

S/N	State	Population	Doctors	Dentists	Nurses	Midwives	Med. Lab. Scientist	Rehab. Therapy	Radiographers	Pharmacist	H. R	CHO/CHEWS
1	Akwa Ibom	3,730,227	321	NA	6,528	NA	122	3	9	142	32	224
2	Bayelsa	1,737,020		6		392	17		0			
3	C/River	2,551,896	407	2	1642	999	39	6	7	102	58	861
4	Delta	4,010,879	470	NA	1,950	NA	144	18	16	277	57	149
5	Edo	3,363,098	399	NA	1,431	NA	203	18	7	436	38	299
6	Rivers	4,936,709	404	NA	NA	NA	118	10	21	448	20	786
	TOTAL	20,329,709	2,001	8	11,551	1,391	643	55	60	1,405	205	2,319

NA - Not Available

Federal Republic of Nigeria: National Human Resources for Health Policy 2006:12 -13

The North-East zone is placed sixth in terms of the average number of doctors per state in the zone (107) and the third in terms of the average number of CHOs/CHEWs per state in the zone (517). The South-South geo-political zone (table 1 & 2) is placed third in terms of the average number of doctors per state in the zone (400) and fourth in terms of average number of CHOs/CHEWs (464) per state. The South-East zone (4c) is placed second in terms of the average number of doctors per state in the zone (625) and fifth in terms of average number of CHOs/CHEWs per state in the zone (426). Although the data recognizes that there are variations between the states in each of the geo-political zones and that population statistics may also alter the availability and distribution of HRH for PHC between the zones and the states in the zones, they are generally indicative of the situation.

The Human Resource Health (Hrh) From The Database At The Federal Ministry Of Health

The second set of data on HRH availability and distribution for PHC in Nigeria is for 2006 and was compiled from the HRH database at the Federal Ministry of Health. The data provides details of the health human resources at the level of each of the 774 Local Government Areas in the country. The data is aggregated from the HRH profile of each of the LGAs in the Federation as provided in the HRH database in FMOH. This data shows there

were at least 6,433 doctors providing care at the level of the Local Governments in 2007. While the data shows that there are at least nine doctors per Local Government, the numbers are not evenly distributed across the Local Governments. The data has been aggregated, for manageability, to represent the situation in each of the geo-political zones (FMOH, 2004, 2005).

Table 3: Human Resources Availability In The Health Care Industry

S/N	State	Population	Doctors	Dentists	Nurses	Midwives	Med. Lab. Scientist	Rehab. Therapy	Radiographers	Pharmacist	H.R	CHO/CHEWS
1	Akwa Ibom	3,730,227	321	NA	6528	NA	122	3	9	142	32	224
2	Bayelsa	1,737,020		6		392	17		0			
3	C/River	2,551,896	407	2	1642	999	39	6	7	102	58	861
4	Delta	4,010,879	470	NA	1950	NA	144	18	16	277	57	149
5	Edo	3,363,098	399	NA	1431	NA	203	18	7	436	38	299
6	Rivers	4,936,589	404	NA	NA	NA	118	10	21	448	20	786
	TOTAL	20,329,70	2,001	8	11,551	1,391	643	55	60	1,405	205	2,319
	AVERAGE	3,388,285	400.2	4	2,887.75	695.5	107,167	11	10	281	41	463.8

Table 4: HRH for PHC by geo political zones in nigeria compiled from lga data: south – south.

s/n	state	doctors	nurses/ midwives	cho	chw	auxiliary nurse	retired health workers	nursing students	others	total
1	edo	399	1,427	78	0	4	320	533	0	2,761
2	delta	480	1,949	101	520	0	0	0	0	3,050
3	bayelsa					na				
4	rivers	267	1,001	250	1,886	10	76	291	0	3,781
5	akwa ibom	321	2,311	251	1,267	63	226	489	0	4,928
6	crosss river	93	409	262	0	0	70	436	0	1,270
	total	1,550	7,097	942	3,673	77	692	1,749	0	15,740
	average	312	1,419	188.4	735	15.4	138.4	349.8		

Political Factors

The performance of health personnel for PHC is compounded by political factors. In an appropriate political environment, it will be possible for surpluses in any category of health personnel in one part of the country to be attracted to other parts where there are shortages. In addition, it will be possible for the indigenes of any State where there are no facilities to be trained in other States where such facilities exist. As the NHRHP 2006 correctly observes. 'Considering the large number of capital outlay required

in setting up and operationalzing training institutions, the short term solution should not be the replication of programmes in all States (NHRHP 2006:11)'. However, political considerations prevent States from collaborating in the development, attraction and retention of critically needed health professional. Thus, 'some States are noted for having rules and regulations that are not indigenes' (NHRHP 2006:15). Political factors also affect attitude to work, morale and performance of health professionals at the PHC level. A key respondent at FMOH narrated a case where a health worker in a primary care facility in one of the Northern States refused to show up for a scheduled meeting with officials of FMOH to review the performance of the PHC facility because 'he had gained his position through the traditional ruler in the area and did not feel accountable to anyone else'.

Leadership, Coordination And Supervision

The leadership, coordination and supervision of the work of health professional have implications for the performance of the health system at all levels. In Nigeria however, the management structure through which the linkages between the different levels of care are to be maintained has been acknowledged to have problems (FMOH 2004, Health Sector Reform Program). It is recognized that there is no effective coordination between the Ministries of Health in the States and the Federal Ministry of Health. Yet, it is through this relationship that primary health care goals are expected to be driven because under the new health policy the State Governments have responsibility for providing supervision to the Local Government Health Authorities through their States Primary Health Care Development Boards. Ineffective linkages among levels in the system have obvious implications for the quality of supervision of health service delivery at the Local Government level. The quality of supervision is a major human resource input in PHC as, indeed, in the overall public health system.

Findings

A major problem that still needs to be addressed is the existing dearth of statistics on vital elements of HRH for Primary Health Care (PHC). Although the FMOH has recognized this need, urgent action needs to be taken to deal with the problem.

1. Finally, there is need to recognize that a lot of the measures needed to address the existing HRH problems in PHC have a political character.
2. For example, there is need to ensure that existing legislation in some parts of the country that discriminates against non-indigenes in employment is reviewed.
3. Again as the Malian example has shown, the adoption of a national policy which will articulate HRH issues makes much greater impact if it is celebrated as a national event that involves various interest

groups and seeks to realize 'a national ambition'. It is expected that the Nigerian National Health Policy will receive this kind of reception.

CONCLUSION

Human resources constitute the most important element in the effectiveness of any health system. The situation in different parts of the Third World and especially in Nigeria shows that there are major problems in the HR for PHC in Nigeria, data is not easily available and where available tends to be incomplete and/or contradictory. The distribution and availability of HR for PHC is also a major concern in most parts of Nigeria. The poor distribution and inadequate number of various health personnel required for an effective PHC in Nigeria is compounded by the brain drain, poor motivation among health personnel and inappropriate policies among others. Although the Federal Government and the FMOH have recognized the problems, examples from a number of other Third World countries within and outside Africa indicate how some of them may be overcome. Among all the challenges however, the greatest and most important remains that of developing an appropriate HR database that can, in fact, indicate the degree and scale of the problems of HR for PHC in Nigeria.

RECOMMENDATIONS

Management of HR for PHC in Nigeria indicates several challenges.

1. First is the urgent need for a comprehensive database on the HRH situation in PHC. Although some effort is being made in this regard at FMOH, there is no doubt that the desired results are far from being attained.
2. Another challenge is the implementation of the elaborate provisions set out in NHRHP 2006. On the one hand, it is clear that the NHRHP 2006 is expected to benefit from the programme of health sector reforms that were initiated in 2004. However, not only is the level of success of these reforms still a matter that needs to be established it has also been established that public sector reforms that are driven by the logic of liberalization and deregulation do have serious negative consequences for HR for the public health system in general and for PHC in particular.
3. Thirdly and more fundamentally, it is also clear that the implementation of the policy provisions in the NHRHP 2006 document will depend upon the existence of accurate data on the HR situation in PHC as much as upon the actual situation of HR currently existing in PHC.

4. The current HR situation indicates that the availability and distribution of HRH for PHC is far from being adequate, with the existence of large disparities among Local Governments in the same geo-political zone and the different geo-political zones in the country. The challenge in this regard is how to achieve an equitable balance between the various parts of the country.
5. A fifth challenge is the need to mobilize communities to get them to take ownership of primary health care delivery and its maintenance. There is also no doubt that while motivational and morale problems exist at all level of the public health system they tend to be most acute at the PHC level where the additional problems of training and development and politics in the assignment of staff and duties also tend to be at their worst. These problems pose a special challenge for the effectiveness of PHC in Nigeria. The composition of health teams for PHC at the ward and village levels has major implications for the performance of health personnel.
6. The morale and motivation of personnel have major implications for their performance. The motivation and morale are affected by several factors that include levels of health personnel in general.
7. Opportunities for training and development have major implications for the performance of health personnel in general.
8. Working conditions will need to be improved upon especially in the rural areas.
9. There may also be need to provide a special package of incentives for health workers in rural areas. With difficult terrains such as motor vehicles, boats and other means of transportation.
10. Finally, the question of the appropriate mix of personnel suitable for addressing the health problems at the PHC levels of care remains a major HR challenge in Nigeria. It is clear that to address these and other HR problems for PHC, major measures are needed.

Dealing with the Challenges: Experience From Other Countries

There is no doubt that the Federal Government has recognized the HR challenges of the public health system in particular in Nigeria. The various policy and reform documents issued by government through the FMOH are clear indications that the challenges have indeed been recognized. Moreover, both Revised National Health Policy and the NHRHP 2006 provided for adequate policy measures that, when implemented, should deal with the identified problems. However, even then, it is necessary to look beyond the provisions in the health reform and policy documents to the experience of other Third World countries that appear to have done much better than Nigeria. This is various public sector programmes in Nigeria has usually been inspite of, rather than for lack of, enabling and robust policies.

In doing so, it is also clear that no HR programme in any Third World Country has all the needed features to provide an all-round system of 'best

practices'. Different countries have areas of 'best practices' that other countries could learn from. A good example in this regard is the system of categorizing and providing for the personnel mix for primary health care facilities. In Jamaica, this system (table 8) has five different levels of primary comprehensively with the health problems of the community as envisaged by the Alma Ata Declaration. The system also reduces pressure on the secondary and tertiary levels of care and ensures that most of the health needs of the community can be met at the level. It is believed that the adoption of this system in Nigeria will increase the effectiveness of PHC.

At a broader level, the example of Mali (Maiga et al, 2003) shows how the key elements of an effective HR for public health delivery in general and PHC in particular are established and sustained following programmes of reforms. The Malian case shows that:

1. The health reform process must have the wholehearted commitment of 'principal participants' – politicians, health professionals, communities and external partners. In the case of Mali, 'politicians maintained a favourable attitude (during the reform) process. In particular, they signified their support for a policy of decentralization and of responsibility and involvement of the community in the health sector. The Bamako Initiative and the government's declaration were both formally adopted by the government through the Council of Ministers. Health professionals at all levels through numerous working committees… Certain communities had amply demonstrated their commitment by constructing health centers and paying salaries for support staff … (WHO, UNICEF, USAID, The World Bank, Fonds d'Aide et de Cooperation Francaise and various local NGOs) supported the efforts of national health professionals (at different) stages…' (Maiga et al, 2003).
2. The announcement of the health policy document must constitute a major event; its contents must be informed by past experience and must reflect all the debates and participation that produced it. It must also become and function as an instrument 'for mobilizing and coordinating interventions in pursuit of a national ambition' (Maiga et al, 2003) that is shared by all those who produced it.

Hrm For Phc In Nigeria: Needed Measures

The Nigerian experience and the experience of other countries that have been reviewed indicate some of the measures that need to be undertaken to improve the performance of HR in PHC in Nigeria.

1. The starting point is filling the evident gaps in the current National HRH Policy. The most important of these gaps is the lack of specification of the complement and mix of health professionals that should be involved in PHC. This policy needs to indicate not only the categories of personnel that should be involved in PHC but also, taking into consideration the disease

burdens in different areas of the country, the minimum numbers of each category of health professional in a primary health care facility. On this basis, it will be possible to indicate the numbers of personnel required in each category and determine the extent to which existing HRH levels match requirements. It is expected that FMOH will address this issue in the shortest possible time. Another gap in the existing policy is the failure to provide for different types of health care centers has implications for the determination of the mix of health personnel required and the services to be provided by the health personnel in the health care center.

2. Following the needed policy review, there has to be a major effort to develop a robust and comprehensive data bank that provides information on various aspects of the HR situation in PHC. To accomplish this, FMOH will need to setup a dedicated team with clear terms of reference and timelines. This can be completed within a year and thereafter annual updates of the database can be undertaken. Indeed, it will be necessary to setup a system that enables changes in the HR situation to be captured and documented as soon as such changes occur. As at now, a large part of the HRH information available on issues such as the level of motivation, work attitudes and levels of collaboration within and between the members of the health teams in PHC is based upon the perceptions of officials in FMOH or PHCDA. Such perceptions need to be grounded in empirical research that generates information on actual conditions. A major part of the effort to create an HR database for PHC must include sponsored research into a number of the prevailing HR conditions in PHC.

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