The Primary Health Care Services In Nigeria: Constraints To Optimal Performance

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ABSTRACT

Background: *This paper examined the management of the Primary Health Care Services in Nigeria using both Primary and Secondary data.*

Methods: *The Primary data were generated from social survey, interviews and participant observation while secondary data were sourced from health institutions. Data gathered were analysed using quantitative and descriptive methods.*

Results: *The findings of the study showed a low level of interaction and coordination among tiers of government which resulted in poor performance of PHC at the grassroot. The Primary Health Care Programme was grossly underfunded which manifested in the low performance of the PHC delivery facilities. The research identified some institutional impediments such as conflicts between Local and State Governments resulting in a strained relationship, poor collaboration and weak linkage. Community participation which is a sine qua non in the attainment of the objectives of the programme was very low. Finally, the participation of international organisations like UNICEF and USAID in PHC Programme was responsible for most of the achievement made so far.*

Conclusion: *The research recommended among others that the three tiers of government must relate to one another to ensure that a harmonious relationship exists at all times through official interactions on all issues that affect the three levels of government especially the policy formulation, implementation, and evaluation, and evaluation of the Primary Health care programme.*

KEY WORDS*: PHC; Policy; Intergovernmental Relations; Organistation and Funding.*

Paper accepted for publication 20th January 2005

INTRODUCTION

Local Government And Primary Health Care Services In Nigeria

Nigeria is a federation consisting of three tiers of administration namely, the Federal, the State and the Local Governments. The 1976 Local Government Reform and Section 7 of the 1999 Federal Republic of Nigerian Constitution[1] recognised the Local Government Administration, as the third tier of government. Accordingly, the constitution apportions legislative functions to the three tiers of government; thus the exclusive list, the concurrent list and residual list. The issue of health falls within exclusive and the concurrent legislative competence of the Federal and the State Governments respectively. All other matters that are outside the exclusive and concurrent lists are within the competence of the Local Government Councils.

Specifically, the Fourth Schedule of 1999 Constitution assigns to Local Government Councils certain functions which are essential elements of the Primary Health Care. They are:-

(i) Environmental Sanitation.
(ii) Provision and Maintenance of Health Services as well as,
(iii) The provision and maintenance of primary education.

Furthermore, Local Government Councils are expected to design and implement strategies to discharge the responsibilities assigned to them under the constitution and to meet the health needs of the community.

The strategies designed for Local Government to implement the primary health care, and the organisational structures put in place that could assist the Local Government to achieve the PHC goal are described.

A typical Local Government Council is politically headed by an elected Chairman and a handful of Councillors. There is also a Secretary to the Local Government who administratively

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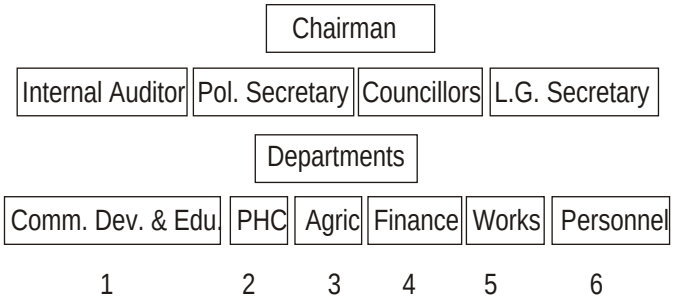
coordinates the activities of the six main Departments:-

Personnel Management
Works
Finance
Agriculture
Primary Health Care
Community Development and Education

The structure also makes provision for an office of Internal Auditor.

Fig. 1.Organogram of a Local Government in Nigeria



Source: Ife Central Local Government Office, Ile-Ife, Osun State.

National Health Policy

In line with the 1988 National Health Policy[2], the Local Government is expected to perform the following in order to enhance the effective implementation of the Primary Health Care:-

(i) to determine how best to provide the essential elements of the Primary Health Care;
(ii) to identify for each priority programme the activities to be carried out by the individuals and families;
(iii) to identify the support action required for each component of the programe;
(iv) to provide relevant health information to the people on such matters as personnel, hygiene, environmental sanitation, prevention and control of communicable diseases as well as such matters where a change in life style of the people can have significant impact on their health status;
(v) design and operate mechanism for involving the communities in the critical decisions about the health services;
(vi) mobilize resources to support the health programme;
(vii) ensure that the essential infrastructures for the primary health care programes are available and well maintained; and
(viii) to collect relevant data about health resources, health status of the community and health behaviour.

The Alma Ata declaration of 1978 equally assigned the following responsibilities to the Local Government Administration.

1. Education concerning prevailing health problems and method of preventing them.
2. Promotion of food supply and proper nutrition.
3. Adequate supply of safe water and basic sanitation.
4. Maternal and child health care and family planning.
5. Immunisation against the major infectious diseases.
6. Prevention and control of locally endemic diseases.
7. Appropriate treatment of common diseases; and
8. Provisions of essential drugs.

The Performance of PHC

The question yet to be answered is why has much not been achieved over a decade of the operation of Primary Health Care in our Local Government Council Areas in Nigeria? The answer is facile. Although Primary Health care made some tangible impact in the first five years of the National Health Policy but had since suffered a setback. In the words of Akinkugbe[3] the PHC impressive momentum has not been adequately sustained by kind of determined political will and adequate funding.

In a related development, field investigation conducted by Omoleke [4] in 1999, in few randomly selected Local Government Council Areas in the South Western Nigeria Health Zone confirmed substantially the ineffectiveness of PHC implementation, as indicated by the high incidence of diseases like Guinea Worm, typhoid fever, cholera and diarrhoea in the rural areas. There had also been sporadic outbreak of cholera, measles and typhoid fever in major cities and rural

settlements like Akinyele Local Government of Oyo State, Odeda Local Government of Ogun State and Irepodun Local Government Areas of Osun State. Evidently, his findings lend credence to Jinadu[5] when he asserted that various health status indicators like:-

(i) infant mortality rate;
(ii) child death rate; and
(iii) maternal mortality rate have not shown any significant reduction adding that immunization coverage has dropped to 11 percent, while majority of pregnant women have no access to safe delivery.

He argues further that sixty percent of our children are suffering from chronic malnutrition which will undoubtedly affect their physical development and future intellectual functioning. The author's participant observation in the 1999 Immunisation coverage in Oyo State of Nigeria also confirmed the low performance of one of the components of Primary health Care. Table I shows a very low percentage coverage of various vaccines. In particular BCG recorded the least coverage of the population which stood at 11 percent while TTV recorded 13 percent [6] for reasons we have identified above.

Table I.Immunization Coverage in Oyo State - January - December, 1999

Vaccine	Population Covered	% Coverage
BCG	37,826	11
DPT I	105,410	30
DPT II	91,389	26
DPT III	90,218	25
OPV 0	121,210	34
OPV I	145,323	41
OPV II	129,201	36
OPV III	116,767	33
Measles	126,472	36
TT I	99,467	45
TT II	83,318	38
TT III	61,591	28
TT IV	33,312	15
TT V	29,038	13

Source: Oyo State Ministry of Health, Ibadan.
Note: Oyo State Population 4,426,909 (1991 Census).
Annual Target (BCG & Measles) (8% of the total population)
Annual Target (Tetanus, TT) 5% - Pregnant Women.

Table II. Selected Health Indicators for Nigeria (Under 5).

Infant Mortality Rate	114,1000 live birth
Under 5 Mortality Rate	191,1000 live births
Percentage of Infants who had received any vaccination	11%
Percentage of women with access to delivery by trained midwives	10.0%

Selected Health Indicators For Nigeria In 1994

It has also been observed that 50.4 percent of Nigerian children (under 5) are stunted. As we are entering into a new Millennium, Nigerians cannot afford to retain the general poor state of health of the population as indicated in Tables I, II and III.

Table III. Selected Health Indicators for Nigeria.

Crude Death Rate	16 per 1,000 population
Crude Birth Rate	50 per 1,000 population
Childhood Mortality Rate	144 per 1,000 children aged 1-4 years
Infant Mortality Rate	85 per 1,000 live births
Life Expectancy at Birth	50 years

Source: Nigerian Fertility Survey, 1981-82 World Demography Record.

The Funding of PHC

The issue that agitates our mind is the relatively poor performance of our health institutions in spite of the fine tuned health policy put in place by the Federal Government (National Health Policy). In examining this vital issue, we may want to look at the responsibilities allocated to the local government councils vis-à-vis budgetary allocation of the councils.

Initially, an average of 5% of the Federal Government's Health Budget was allocated to PHC while considerable amount of resources were expended on the programme by international organizations such as WHO,

UNICEF, USAID etc. As years rolled by, resources allocated for the programme dwindled thus indicating declining political commitment to the programe. For instance, in 1987-89 about 5% of the total budget of the Federal Ministry of Health was allocated to the PHC Programme.

Table IV. Federal Budgetary Allocation to PHC 1987-1989 (in Million Naira)

Years	*Total MOH Budget for Health*	*Allocation for PHC*	*PHC Allocation as % of Total FMOH Budget*
1987	230.45	14.30	6.05
1988	443.11	18.50	4.18
1989	452.50	19.90	4.39

The financial commitment of the government had not helped the PHC in the 90s as nearly all the Local Governments visited in the South West of Nigeria complained of zero allocation from the Federation Accounts for six consecutive months. Consequently, there was no special allocation to the PHC at the Local Government Level. At the Local Government Level, the imprest to the PHC Department is a function of financial buoyancy of the Local Governments. This condition disallowed optimal performance.

Non- Continuity Of Leadership

Coupled with the problem of fund allocation was the lack of continuity of the Local Government Authority Leadership. The frequent change of leadership affected the PHC performance. For instance in the late 1989, the Local Government Councils were being governed by the Sole Administrators who were later replaced by the democratically elected officials. After a short spell, they were dismissed by the Military fiat. The Sole Administrators were appointed again in 1997 who later handed over to the democratically elected officials early in 1999. This situation did not help the continuity of programes of PHC. In as much as the Nigerian PHC approach was committed to genuine local participation in the planning, management and implementation of health services, each successive change in local leadership (five since 1986) required renewed effort in education and orientation to promote genuine local leadership of the PHC system. Added to this was the frequent transfer of secretaries of Local Government which also adversely affected the operation of the PHC.

Shortage Of Trained Personnel

Furthermore, lack of capability at local government Health Department seemed to have contributed to the level of performance of PHC. In 1986[7], when the National PHC programmes began, many Local Government C ouncils did not have highly trained health workers to assume leadership of PHC activities. In such a situation, the State Ministries of Health had to post Community Health Officers to head the PHC. Such personnel did not owe their primary allegiance to the Local Government Authority. This problem still exists today. Field investigation in the South Western States revealed that the PHC Departments were facing acute shortage of personnel as embargo was placed on fresh appointment. For instance only morning shifts were being run in most of the PHC clinics and Health Centres visited in Odeda (Ogun State) and Akinyele Olosun Community in Akinyele Local Government of Oyo State respectively.

Industrial And Political Conflicts

The performance of Local Government PHC Department had also been hampered by perennial industrial conflicts especially over non-payment of N3,000 Federal Government approved minimum wage. Generally, the absence of motivation of the PHC Staff demoralizes the professional workers and consequently spells doom on PHC implementation.

Of greater adversity is the institutional conflict arising from the political ideology of the parties that won elections in these Local Government Areas. For instance in Ona Ara, Shaki and Ido Local Government, Council Areas the Peoples Democratic Party won the election in those areas while All People Party won in Iresadu. Other Local Governments such as Oyo, Egbeda, Akinyele Councils were won by Alliance for Democracy. The Alliance for

Democracy embarked on Free Health Programe while the Peoples Democratic Party operated a fee paying health system. It is observed that unless such institutional and ideological conflicts are eliminated, the PHC programme may lack uniformity in its implementation and consequently suffer a set back.

Furthermore, industrial disharmony might have contributed to the low performance of the PHC in the Local Government Areas. For example there existed some institutional conflict in the area of trade union. The Nigeria Union of Local Government employees, to which majority of the staff of the PHC do not belong could force the PHC staff to participate in the industrial strike which ordinarily was not supported by the professional health workers[8].

Inter- Governmental Relations And Coordination

Apart from the industrial conflict, it appears the leadership of the Local Government Council was more interested in capital projects not related to health, rather than injecting more funds into the implementation of the Primary Health Care. There appeared to be a weak inter-governmental relations between Primary Health Care and secondary Care as well as the institutions charged with responsibility of integrating them. More often than not, the State Governments hijack the Local Government Councils' allocation coming from the Federal Government. Unfortunately, the strained relationship between the State and Local Governments resulted in the late release of the fund. It is very disappointing too that the Federal Ministry of Health could not take the bull by the horn by releasing the grant of Five hundred thousand Naira (N500,000) to PHC Department at Local Governments, rather the State's desire prevailed. The result of Chi-square test carried out showed the 'p' value to be 0.3835, meaning that the interaction of PHC officials at Local Government Councils with other tiers of governments is not significant. This affects the performance of the programme[4].

Poor communication along the three tiers of government had also resulted in poor coordination of PHC activities at the Local Government Level. Proper coordination between different units and the regular meeting of the State and Zonal PHC Committee could have helped the PHC at Local Government Levels but this was seldom held. Finally, furthermore, the poor performance of the Local Government PHC had also resulted from the foreign exchange problem. It was just in 1989 that the Federal Ministry of Health was able to make a bulk purchase of the essential drugs promised since 1986 to be released to PHC at the Local Government Areas.

Poor Infrastructure

Finally, the poor state of and inadequate infrastructure in our health institutions such as water, electricity, road network, telephone, vehicles and hospital equipment and drugs constitute another serious bane on the effective implementation of PHC.

RECOMMENDATIONS

Based on the above shortcomings, we wish to offer the following suggestions to enhance the effective role of the Local Government Authorities in the implementation of the PHC, the centre piece of the National Health Policy.

1. There is urgent need for a special Federal Allocation of fund tagged “PHC FUND” directly disbursed to the Local Government Councils Account. The financial system has been highly centralized. This has not helped PHC programme implementation at Local Government Councils Level. The institution is charged with great responsibility without corresponding financial assistance and disbursement.
2. The Local Government Councils should be mandated to contribute at least 2% of their internally generated revenue as imprest to the PHC Departments in order to enhance their capability to carry out health delivery services effectively.
3. Special concession should be granted to the Local Government Authorities to recruit the needed professional manpower for the PHC Department as few Local Government

Councils in the Federation can boast of adequate staffing of the PHC Department.

4. For a result oriented PHC, the Local Government Councils must adequately motivate their staff in kind and cash.
5. The Local Government bosses need to cultivate the habit of health first and all other things are secondary when budget proposals are being made.
6. The Chairmen of the Local Govemment Councils must interact more intimately with the secondary PHC Chief Executive as well as the Zonal Coordinator of the National Health Care Development Agency to discuss issues affecting the PHC services.
7. Effort should be directed to intensify rural electrification and the provision of portable water as these are essential health related facilities for the PHC. Many Local Government Councils in Nigeria lack these facilities. Whereas, there are some drugs (vaccines) which must be kept under certain level of temperature.
8. The establishment of PHC drugs compounding firms is long overdue. This will reduce pharmaceutical hostage of the PHC Department and minimize absolute reliance on external source of drugs and vaccines.
9. There is need for more political will and commitment to PHC on the part of the Chairmen and Councillors of the Local Government Areas.
10. The State Governments irrespective of political differences must be mandated to contribute two percent of their revenue to assist the Local Governments in the training and retraining of the Local Government PHC staff, and
11. It is sad that out of eight (8) types of vaccines required for PHC, only one has been available in Local Governments for long. More embarrassingly, the long disappearance of potent BCG vaccine in government drugs depot calls for concern[4].

CONCLUSION

This paper has examined the role of the Local Government Councils in Nigeria regarding the implementation of PHC. It was observed that there had been a downward trend in the performance of the responsibilities of the Local Government Councils on PHC. Therefore an attempt was made to analyse some constraints militating against the optimal performance of the Local Government Councils. These constraints rest on underfunding of PHC, poor logistics, weak coordination of activities, and inadequate political will and commitment to PHC.

Some useful solutions were offered to enhance a better performance of the Local Government Councils in the implementation of the Primary Health Care Services in Nigeria. Among the solutions proffered are:-

(i) adequate funding of Primary Health Care it was recommended that a result-oriented PHC must be adequately funded. The 5% allocation to PHC needs to be stepped up. The present revenue sharing formula which allocates 20%[9] of the Federation Accounts to the Local Government Councils needs to be reviewed upward;
(ii) training and retraining of professional manpower to meet the needs of the Department of Primary Health Care;
(iii) need for a stronger political will and commitment of the Local Government;
(iv) establishment of drugs compounding small scale firms;
(v) provision of essential social facilities like good roads, portable water, electricity, telephone facilities; and
(vi) community participation needs to be encouraged.

The author wishes to conclude with the advice of Emerson who asserted:

> *What makes a nation's pillar high, not gold, but only men can make a people great and strong. Men who for truth and honour sake stand fast and suffer long; they build a nation's pillars deep and lift them to the sky[10].*

Nigerians' health standard can be raised comparable to those of the advanced countries if the right men are in charge of affairs.

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