Course Code PHS 203

Course Title Introduction to Public Health

What you will learn in this Course

This course consists of modules which are broken into units and a course guide. The course guide tells you briefly what the course is about, what course materials you will be using and how you can work on your own with these materials. There will be regular tutorial sessions.

Course Aims

The aim of this course is to provide you with an understanding of basics of public health. It aims to help you care for people with needs concerning health conditions.

Course Objectives

Each unit has specific objectives to guide you into the purpose of the study. You should read the objectives before you begin the study and ask yourself whether the objectives have been met after you are through with such unit.

Course Team Leader Prof. Mba Okoronkwo (OON)

Contributors Dr. Gloria O. Anetor

Dr. Shehu Ibrahim

Mr. Samuel O. Azubike

Introduction

Introduction to Public Health is a two-credit course available to all students offering Bachelor of Science (B.Sc.) in Public Health. Public health is increasingly being recognised as an important part of general health especially in developing countries.

The course highlights issues of health in broad perspectives; ranging from various periods of recorded history, that is, from the antiquity to present times. The development and growth of public health from its inception are addressed. The various actors in the course of its development and the various roles played by each of them are highlighted. Also, the course traces the development of modern public health in Nigeria, that is, the development of health services and the basic health services to the development of the national primary health care system are highlighted.

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UNIT 1 GENERAL INTRODUCTION TO PUBLIC HEALTH

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Introduction

The focus of public health intervention is to improve health and quality of life through the prevention and treatment of disease and other physical and mental health conditions, through surveillance of cases and health indicators, and through the promotion of healthy behaviours. Promotion of hand washing and breastfeeding, delivery of vaccinations, and distribution of condoms to control the spread of sexually transmitted diseases are examples of common public health measures.

Its programmes range from Immunization, health promotion, and childcare to food labelling and food fortification to the assurance of well managed, accessible health care service. The planning, management, and monitoring functions of a health system are indispensable in a world of limited

resources and high expectations. This requires a well developed health information system to provide them feedback and control data needed for good management. It includes responsibilities and coordination at all levels of government and by nongovernmental organizations (NGO'S) and participation of a well-informed media and strong professional and consumer organization. No less important are clear designations of responsibilities of the individual for his/her own health, and of the provider of care for human, high quality professional care

Modern public health practice requires multidisciplinary teams of public health workers and professionals including physicians specializing in public health/community medicine/infectious diseases, psychologists epidemiologists, biostatisticians, medical assistants or Assistant Medical Officers, public health nurses, medical microbiologists, environmental health officers / public health inspectors, pharmacists, dental hygienists, dieticians and nutritionists, veterinarians, public health engineers, public health lawyers, sociologists, community development workers, communications experts, bioethicists, and others.

2.0 Objectives

At the end of this chapter, the students are expected to:

Discuss the history of public health

3.0 Main Content

3.1 General Historical Background of Public Health

The history of public health goes back to almost as long as history of civilization. Possible traditions during civilization may be, taboos against waste disposal within communal areas or near drinking water sources; rites associated with burial of the dead; and communal assistance during birth.

In the Ancient Societies (before 500 BC) the history is that of archaeological findings from the Indus valley (North India) around 2000 BC with the evidence of bathrooms and drains in homes and sewer below street level. There was evidence of drainage systems in the

middle kingdom of ancient Egypt in the time 2700 -2000 BC. There were written records concerning public health, codes of Hammurabi of Babylon, 3900 years ago.

The Book of Leviticus (1500 BC) had guidelines for personal cleanliness, sanitation of campsites, disinfection of wells, isolation of lepers, disposal of refuses and hygiene of maternity.

In The Classical Cultures (500 BC - 500 AD) public health was practiced as Olympics for physical fitness, community sanitation and water wells in the era, golden age of ancient Greek; and aqueducts to transport water, sewer system, regulation on street cleaning and

Infirmaries for slaves by Romans.

In the Middle Ages (500 - 1500 AD), health problems were considered as having spiritual cause and solutions. They were supernatural powers for pagans and punishments for sins for Christians. Leprosy, plague (Black Death) during the 14th century and syphilis were some of the deadliest epidemics which resulted from failure to consider physical and biological causes.

The era of renaissance and exploration (1500 – 1700 AD) was the rebirth of thinking about nature of the world and humankind. There was a growing belief that diseases were caused by environment, not by spirits and critical thinking about disease causation e.g. "malaria" - bad air.

In the eighteenth century, there were problems of industrialization, urban slums leading to unsanitary conditions and unsafe work places. Edward Jenner (1796) demonstrated vaccination against smallpox.

In the nineteenth century there were still problems of industrialization but agricultural development led to improvements in nutrition and there was real progress towards understanding the causes of communicable diseases towards the last quarter of the century. The Luis Pasture's germ theory (1862) and Koch's Postulate (1876) were remarkable progresses.

Twentieth century has been the period of health resources development (1900-1960), social engineering (1960 - 1973), health promotion (Primary Health Care), Alma Ata Declaration (1978) and market period (1985 and beyond)

The challenge in the twenty first century are reducing the burden of excess morbidity and mortality among the poor; counter reacting the threats of economic crisis, unhealthy environment and lifestyle; developing more effective health system and investing in expanding knowledge base.

3.2 HISTORICAL MARKERS in the development of Public Health (selected)

1700 BC The Code of Hammurabi – Rules governing medical practice

1500 BC Mosaic Law – Personal, food and camp hygiene, segregating lepers, overriding duty of saving of life (Pikuah Nefesh) as religious imperatives.

400 BC Greece – Personal hygiene, fitness, nutrition, sanitation, municipal doctors, occupational health; Hippocrates – clinical and epidemic observation and environmental health.

500 BC- AD 500 Rome – aqueducts, baths, sanitation, municipal planning, and sanitation services, public baths, municipal doctors, military and occupational health.

500 – 1000 Europe – destruction of Roman society and the rise of Christianity; sickness as punishment for sin, mortification of the flesh, prayer, fasting and faith as therapy; poor nutrition and hygiene pandemics; ant science; care of the sick as religious duty.

1348-1350 Black Death – origins in Asia, spread by armies of Genghis Khan, world pandemic kills 60 million in fourteenth century, 1/3 to 1/2 of the population of Europe.

1300 Pandemics – bubonic plague, smallpox, leprosy, diphtheria, typhoid, measles, influenza, tuberculosis, anthrax, trachoma, scabies and others until eighteenth century.

1673 Antony van Leeuwenhoek – microscope, observes sperm and bacteria.

1796 Edward Jenner – first vaccination against smallpox.

1830 Sanitary and social reform, growth of science.

1854 John Snow – waterborne cholera in London: the Broad Street Pump.

1854 Florence Nightingale, modern nursing and hospital reform – Crimean War

1858 Louis Pasteur proves no spontaneous generation of life.

1859 Charles Darwin publishes *On the Origin of Species*.

1862 Louis Pasteur publishes findings on microbial causes of disease.

1876 Robert Koch discovers anthrax bacillus.

1879 Neisser discovers gonococcus organism.

1882 Robert Koch discovers the tuberculosis organism, tubercle bacillus.

1880 Typhoid bacillus discovered (Laveran); leprosy organism (Hansen); malaria organism (Laveran).

1883 Robert Koch discovers bacillus of cholera.

1883 Louis Pasteur vaccinates against anthrax.

1884 Diphtheria, staphylococcus, streptococcus, tetanus organisms identified

1890 Anti-tetanus serum (ATS)

1892 Gas gangrene organism discovered by Welch and Nuttal

1894 Plague organism discovered (Yersin, Kitasato); botulism organism (Van Ermengem).

1923 Health Organization of League of Nations

1926 Pertussis vaccine developed

1928 Alexander Fleming discovers penicillin

1929-1936 The Great Depression – wide spread economic collapse, unemployment, poverty, and social distress in industrialized countries.

1946 World Health Organization founded.

1977 WHO adopts Health for all by the year 2000

1978 Alma-Ata Conference on Primary Health Care

1979 WHO declares eradication of smallpox achieved

1981 First recognition of cases of acquired immune deficiency syndrome (AIDS).

1989 International Convention on the Rights of the Child.

1990 W.F. Anderson performs first successful gene therapy.

1992 United Nations Conference on Environment and Development, Rio de Janiero

1992 International Conference on Nutrition.

1993 World Conference on Human Rights, Vienna, Austria.

1994 International Conference on Population and Development, Cairo, Egypt.

1998 WHO Health for All in the Twenty-first Century adopted.

Conclusion

The need to study the history of public health cannot be overemphasized. It reveals the steady progress in the field of public health and the contributions of different individuals are recognised.

Summary

In this unit, you have learnt the historical perspective of public health and the various contributions of individuals and organizations to the field of public health.

Tutor Marked Assignment (TMA)

1. Discuss the problems of public health in the 18^{th} and 19^{th} centuries and how they were solved.

References/ Further Reading

1. Mitike, G (2003). *Health Education for Health Science Students.* Lecture Note Series. Addis Ababa University-Department of Community Health.
2. Ranken, G. P., Amonoo – Laptaskan, R., Ebrahim, G. J and Lovel H. H (1996). *District Health Care Challenges For Planning, Organization, And Evaluation for Developing Countries*. Macmillan 2^{nd} Edition U.K.
3. Theodore, H.T., Elena A.V. (2000). *The New Public Health: An introduction for the 21st century.* Academic press, USA

Unit 2 CONCEPTS OF HEALTH AND PUBLIC HEALTH

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 Concept of Health

3.2 Different perspectives on health

3.3 Concept of Public Health

3.4 Key terms in the definition

3.4.1 Health promotion

3.4.2 The Elements of Health promotion

3.4. 3 Levels of Prevention

4.0 Conclusion

5.0 Summary

6.0 Tutor Marked Assignment

7.0 References/ Further Reading

1.0 Introduction

The word health is widely used in public communication, and yet its meaning looks simple. However, closer looks show various and diverse meanings.

The new public health is comprehensive in scope. It relates to or encompasses all community and individual activities directed towards reducing factors that contribute to the burden of disease and foster those that relate directly to improved health.

2.0 Objectives

At the end of this unit, you should be able to:

Define health

Define public health

Discuss key terms in public health

1.0 **Main Content**

1.1 Concept of Health

1. People say they are healthy when they are doing their activities with no apparent symptoms of disease in them.
2. Health can also be a measure of the state of the physical bodily Organs, and the ability of the body as a whole to function. It refers to freedom from medically defined diseases.
3. The most universal definition by the World Health Organization (WHO) in1948, Health was described as "A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity".

3.2 Different Perspectives on Health

Health is viewed as a right, as consumption good, and as an investment. Some view health as a right similar to justice or political freedom. The WHO constitution sates that ". . . the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". Others view health as an important individual objective of material aspect i.e. as consumption good. The third

view considers health as an investment, indicates health as an important prerequisite for development because of its consequence on the overall production through its effect on the productive ability of the productive force. These different views indicate differences in the emphases given to health by governments.

The WHO definition envisages three specific dimensions (physical, mental, and social), some other dimensions like spiritual, emotional may also be included.

Physical health- is concerned with anatomical integrity and physiological functioning of the body. It means the ability to perform routine tasks without any physical restriction.e.g. Physical fitness is needed to walk from place to place.

Mental Health- is the ability to learn and think clearly and coherently e.g., a person who is not mentally fit (retarded) could not learn something new at a pace in which an ordinary normal person learns.

Social health- is the ability to make and maintain acceptable interaction with other people. e.g. to celebrate during festivals; to mourn when a close family member dies; to create and maintain friendship and intimacy, etc.

Emotional health - is the ability of expressing emotions in the appropriate way, for example to fear, to be happy, and to be angry. The response of the body should be congruent with that of the stimuli. Emotional health is related to mental health and includes feelings. It also means maintaining one's own integrity in the presence of stressful situation such as tension, depression and anxiety.

Spiritual Health - Some people relate health with religion; for others it has to do with

personal values, beliefs, principles and ways of achieving mental satisfaction, in which all are related to their spiritual wellbeing.

3.3 Public health

Public health is defined as the science and art of preventing diseases, prolonging life, promoting health and efficiencies through organized community effort. It is concerned with the health of the whole population and the prevention of disease from which it suffers. It is also one of the efforts organized by society to protect, promote, and restore the peoples' health. It is the combination of sciences, skills and beliefs that is directed to the maintenance and improvement of the health of all the people through collective social actions.

Public health involves both direct and indirect approaches. Direct measures in public health include immunization of children, modern birth control, hypertension, and diabetes case findings. Indirect methods used in public health protect the individual by community-wide means, such as raising standards of environmental safety, assurance of a safe water supply, sewage disposal and improved nutrition. In public health practice, both direct and indirect approaches are relevant.

3.4 Key Terms in the definition

3.4.1 Health Promotion

Health promotion is a guiding concept involving activities intended to enhance individual community health and well-being. It seeks to increase involvement and control of the individual and the community in their own health. It acts to improve health and social welfare, and to reduce specific determinants of diseases and risk factors that adversely affect the health, well-being, and productive capacities of an individual or society,

setting targets based on the size of the problem, but also the feasibility of successful interventions, in a cost-effective way.

Health promotion is a key element in public health and is applicable in the community, clinics or hospitals, and in all other service settings. Raising awareness and informing people about health and lifestyle factors that might put them at risk requires teaching.

3.4.2 The Elements of Health promotion comprises of:-

1. Addressing the population as a whole in health related issues, in everyday life as well as people at risk for specific diseases:
2. Directing action to risk factors or causes of illness or death;
3. Undertaking activities approach to seek out and remedy risk factors in the community that adversely affect health;
4. Promoting factors that contribute to a better condition of health of the population;
5. Initiating actions against health hazards, including communication, education, legislation, fiscal measures, organizational change, community development, and spontaneous local activities;
6. Involving public participation in defining problems deciding on action;
7. Advocating relevant environmental, health, and social policy;
8. Encouraging health professionals' participation in health education and health policy.

3.4.3 Prevention

Prevention refers to the goals of medicine that are to promote, to preserve, and to restore health when it is impaired, and to minimize suffering and distress.

There are three levels of prevention:

Primary Prevention refers to those activities that are undertaken to prevent the disease and injury from occurring. It works with both the individual and the community. It may be directed at the host, to increase resistance to the agent (such as immunization or cessation of smoking), or may be directed at environmental activities to reduce conditions favourable to the vector for a biological agent, such as mosquito vectors of malaria.

Secondary Prevention is the early diagnosis and management to prevent complications from a disease. It includes steps to isolate cases and treat or immunize contacts to prevent further epidemic outbreaks.

Tertiary Prevention involves activities directed at the host but also at the environment in order to promote rehabilitation, restoration, and maintenance of maximum function after the disease and its complications have stabilized. Providing a wheelchair, special toilet facilities, doors, ramps, and transportation services for paraplegics are often the most vital factors for Rehabilitation.

Rehabilitation

Rehabilitation is the process of restoring a person's social identity by repossession of his/her normal roles and functions in society. It involves the restoration and maintenance of a patient's physical, psychological, social, emotional, and vocational abilities. Interventions

are directed towards the consequences of disease and injury. The provision of high quality rehabilitation services in a community should include the following:

1. Conducting a full assessment of people with disabilities and suitable support systems;

2. Establishing a clear care plan;

3. Providing measures and services to deliver the care plan.

4.0 Conclusion

There are various and diverse ways to define health; that is health is multidimensional. Public health is also one of the efforts organized by society to protect, promote, and restore the peoples' health. It is the combination of sciences, skills and beliefs that is directed to the maintenance and improvement of the health of all the people through collective social actions.

5.0 Summary

In this unit, you have learnt the different concepts and perspectives of health and public health. You have also learnt the key terms in the definition of public health that is: elements of health promotion and the levels of prevention.

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe the different concepts and perspectives of Health.
2. How do you perceive health?

7.0 References and Further Reading

1. Kishore, J.A. (2002). *Dictionary of Public Health.* New Delhi, India

2. Last, J. M. (1995). *A Dictionary of Epidemiology*. 3rd Edition. New York Oxford University Pres.

3. Michael H.M & et al. (2001). *International Public Health: Diseases, Programs, Systems, and Policies.* Maryland, USA.

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UNIT 3 DETERMINANTS OF HEALTH

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3.1 Determinants of health or ill health

3.2 Relations of culture and health

3.3 Factors affecting the health of community

4.0 Conclusion

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7.0 References/ Further Reading

1.0 Introduction

Health or ill health is the result of a combination of different factors. There are different perspectives in expressing the determinants of health of an individual or a community.

2.0 Objectives

At the end of this unit, you should be able to:

- Discuss the determinants of health
- Describe the relationship between culture and health
- Discuss the factors affecting the health of a community

3.0 Main Contents

3.1 Determinants of health

According to the “Health field” concept, there are four major determinants of health or ill health.

A. Human Biology:

Every human being is made of genes. In addition, there are factors, which are genetically transmitted from parents to offspring. As a result, there is a chance of transferring defective trait.

a. Genetic Counselling: This a service that provides information and advice about genetic conditions. These are conditions caused by changes (known as mutations) in certain genes and are usually passed down through a family. Genetic counselling is conducted by healthcare professionals who have been specially trained in the science of human genetics (a genetic counsellor or a clinical geneticist).

These specialists work as members of a healthcare team, providing information and support to families who have members with birth defects or genetic disorders and to families who may be at risk of a variety of inherited conditions. For instance during marriage, parents could be made aware of their genetic component in order to overcome some risks that could arise. Genetic counselling isn't a form of psychological counselling or psychotherapy and shouldn't be confused with counselling therapy used to treat mental health conditions, such as depression and anxiety.

b. Genetic Engineering: This is the process of manually adding new DNA to an organism. The goal is to add one or more new traits that are not already found in that organism. Genetic

engineering, also called transformation. It works by physically removing a gene from one organism and inserting it into another, giving it the ability to express the trait encoded by that gene. It is like taking a single recipe out of a cookbook and placing it into another cookbook. It may have a role in the treatment of cases like Breast cancer.

B. Environment:

Involves all that which is external to the individual human host. Those are factors outside the human body. Environmental factors that could influence health include:

a. Life support, food, water, air etc

b. Physical factors, climate, Rain fall

c. Biological factors: microorganisms, toxins, biological waste,

d. Psycho-social and economic e.g. Crowding, income level, access to health care

e. Chemical factors: industrial wastes, agricultural wastes, air pollution, etc

C. Life style (Behaviour):

It is an action that has a specific frequency, duration, and purpose, whether conscious or unconscious. It is associated with practice. It is what we do and how we act. Recently life style by itself received an increased amount of attention as a major determinant of health.

Life style of individuals affects their health directly or indirectly. For example: cigarette smoking, unsafe sexual practice and eating contaminated food

D. Health care organization

Health care organizations in terms of their resource in human power, equipment, money and so on determine the health of people. It is concerned with:

a. Availability of health service; People living in areas where there is no access to health service are affected by health problems and have lower health status than those with accessible health services.

b. Scarcity of Health Services leads to inefficient health service and resulting in poor quality of health status of people;

c. Acceptability of the service by the community;

d. Accessibility: in terms of physical distance, finance etc; and

e. Quality of care that mainly focuses on the comprehensiveness, continuity and integration.

3.2 Relationship between Culture and Health

Culture is that complex whole which includes knowledge, belief, art, morale, law, customs and other capabilities and habits acquired by man as a member of society. Culture refers to the sum total of the life- ways of a group of people who share values, beliefs and practices that are passed on from generation to generation and which change through time. Culture is one of the determinants of health among the environmental factors.An individual's culture influences his or her attitude toward various health issues, including perceptions of what is and is not a health problem, methods of disease prevention, treatment of illness, and use of health providers. In every culture, the care of the sick person is clearly dictated not only as to what care he/she is given, but also who will do it and how he/she should proceed. We learn from our own cultural and ethnic backgrounds how to be healthy, how to recognize illness, and how to be ill. Meaning

attached to the notions of health and illnesses are related to basic, culture-bound values by which we define a given experience and perceptions. People around the world have beliefs and behaviours related to health and illness that stem from cultural forces and individual experience and perceptions.

3.3 Factors affecting health of a community

These are:

1. **Physical Determinants** -The physical factors affecting the health of a community include: the geography (e.g. high land versus low land), the environment (e.g. manmade or natural catastrophes) and the industrial development (e.g. pollution, occupational hazards).
2. **Socio – cultural determinants** – The socio- cultural factors affecting the health of a community include the beliefs, traditions, and social customs in the community. It also involves the economy, politics and religion in the community.
3. **Community organization -** Community organization include the community size, arrangement and distribution of resources (“relations of productions”).
4. **Behavioural determinants-** The behavioural determinants affecting health include individual behaviour and life style affecting the health of an individual and the community. e.g. smoking, alcoholism and promiscuity.

4.0 Conclusion

Health or ill health is the result of a combination of different factors. Culture is a major determinant of health. Culture is peculiar to human beings. It separates man and the society from that of animals and insects, whose behaviour is always only instinctual and therefore does not change. Man's culture or learned behaviour makes it possible to change continuously.

5.0 Summary

In this unit, you have studied the determinants of health which are mainly: human biology, environment, life style and health care organization. You have also studied the relation of culture to heath and factors that affect the health of a community.

6.0 TUTOR MARKED ASSIGNMENT

1. Discuss the determinants of health
2. How does culture affect health of a certain community?

7.0 References and Further Reading

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Unit 4 MAJOR DISCIPLINES IN PUBLIC HEALTH

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3.2 Core activities in Public Health

3.3 Community Health, Clinical Medicine and Public Health

4.0 Conclusion

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6.0 Tutor Marked Assignment

7.0 References/ Further Reading

1.0 Introduction

In public health, the focus is on health promotion and disease/injury prevention, in contrast to the medical model of care, which focuses more heavily on diagnosing and treating illnesses and conditions after they occur. Public health professionals analyze and develop programmes that protect the health of individuals, families and communities

A career in public health opens the door to diverse opportunities in a variety of sectors such as federal, private and non governmental organizations. Public health experts play a key role in emergency preparedness and response. This may be why public health has become such a growing field in recent years.

2.0 Objectives

At the end of this unit, you should be able to

1. Discuss the key disciplines in public health
2. List the core activities in public health
3. Explain the relationship between community health, clinical medicine and public health

3.0 Main Content

3.1 Major Public Health Disciplines

The following are some of the major public health disciplines;

- **Community health**, a field of public health, is a discipline which concerns itself with the study and improvement of the health characteristics of biological communities. While the term community can be broadly defined, community health tends to focus on geographical areas rather than people with shared characteristics. The health characteristics of a community are often examined using geographic information system (GIS) software and public health datasets.

  Community health may be studied within three broad categories:

  - Primary healthcare which refers to interventions that focus on the individual or family such as hand-washing, immunization, circumcision

- Secondary healthcare refers to those activities which focus on the environment such as draining puddles of water near the house, clearing bushes and spraying insecticides to control vectors like mosquitoes and other arthropods.

- Tertiary healthcare on the other hand refers to those interventions that take place in a hospital setting such as intravenous rehydration or surgery.

The success of community health programmes relies upon the transfer of information from health professionals to the general public using one-to-one or one to many communication (mass communication)

● **Nutrition**: is the science of food, the nutrients and other substances therein, their action, interaction and balance in relation to health and disease. Nutrition professionals in public health are either Public Health Dieticians or Public Health Nutritionists. All public health nutrition professionals are registered dieticians (RD) who apply a nutrition lens to all aspects of health promotion and health protection. These specialized, regulated professionals are involved in a variety of essential activities, including:

· Assessing the nutrition-related needs of the community

· Participating in policy development

· Developing and managing nutrition programs

· Collaborating with and providing nutrition consultation to public health staff and community partners

· Advocating for accessibility to healthy, affordable, safe foods and for other nutrition-related issues

· Conducting research and evaluation to further nutrition knowledge and practice

· Building community capacity

●**Reproductive Health**: is a state of complete physical, mental and social being not only the absence of disease or infirmity, in all matters relating to reproductive system and to its functions and processes.

●**Environmental Health** The basic approach to environmental control is first to identify specific biologic, chemical, social and physical factors that represent hazards to health or well-being and to modify the environment in a manner that protects people from harmful exposures. The principal components of environmental health are wate,r sanitation, waste disposal, etc

● **Health Promotion and Health Education** Health promotion is defined as the process of enabling people to increase control over and improve their health. This process is based on the understanding that social conditions and personal actions both determine health. Hence, health promotion activities move beyond disease prevention and health education to address social change, institutional change and community change in addition to changes in personal behaviours. Health education is defined as a combination of learning experiences designed to facilitate voluntary actions conducive to health. It is an essential part of health promotion.

●**Epidemiology** is the study of frequency, distribution, and determinants of diseases and other related states or events in specified populations. The application of this study to the promotion of health and to the prevention and control of health problems is evident. Epidemiologists monitor the occurrence of disease and other health-related characteristics in human populations. They work with other public health professionals and the community to apply epidemiological findings to the control of disease and in planning, priority setting, policy development, evaluation of interventions and assessment of community concerns.

● **Health Economics** is concerned with the alternative uses of resources in the health services sector and with the efficient utilization of economic resources such as manpower, material and financial resources.

● **Biostatistics** is the application of statistics to biological problems; application of statistics especially to medical problems, but its real meaning is broader. Biostatistics is one of the fundamental specializations in the science and practice of public health, relating statistical information to concrete health issues -- especially those affecting human populations. The information provided by biostatisticians is central to the design of interventions and the development of public health policy and priorities.

● **Health Service Management** is getting people to work harmoniously together and to make efficient use of resources in order to achieve objectives.

● **Ecology**: is the study of relationship between living organisms and their environment. It is the science, which deals with the inter-relationships between the various organisms living in an area

and their relationship with the physical environment. Human ecology means the study of human groups as influenced by environmental factors, including social and behavioural factors.

● **Research** is a conscious action to acquire deeper knowledge or new facts about scientific or technical subjects. It is a systematic investigation towards increasing knowledge. It aims at the discovery and interpretation of facts, revision of accepted theories, or laws in the light of new facts or practical application of such new theories or laws.

● **Demography** is the study of population, especially with reference to size and density, fertility, mortality, growth, age distribution, migration, and the interaction of all those with social and economic conditions.

3.2 Core activities in public health

1. Preventing epidemics
2. Protecting the environment, work place, food and water;
3. Promoting healthy behaviour;
4. Monitoring the health status of the population;
5. Mobilizing community action;
6. Responding to disasters;
7. Assuring the quality, accessibility, and accountability of medical care;
8. Reaching to develop new insights and innovative solutions and
9. Leading the development of sound health policy and planning

3.3 Community Health, Clinical Medicine and Public Health

Community Health and Public Health

Community health refers to the health status of a defined group of people and the actions and conditions both private and public (governmental) to promote, protect and preserve their health. Whereas Public health refers to the health status of a defined group of people and the governmental actions and conditions to promote, protect and preserve their health.

Clinical Medicine and Public Health

Clinical medicine is concerned with diagnosing and treating diseases in individual patients. It has evolved from primarily a medical and nursing service to involve a highly complex team of professionals.

The overall objective of both public health and clinical medicine is better health for individual and for society. Both of them are vital and interdependent to improve individual and public health. Ready access to high quality health care services is a right of the population and a requirement of good public health. This requires the availability of high quality providers of clinical and preventive care.

Public health as previously discussed in unit 2 involves both direct and indirect approaches. Direct measures in public health include immunization of children, modern birth control, hypertension, and diabetes case findings. Indirect methods used in public health protect the individual by community –wide means, such as raising standards of environmental safety,

assurance of a safe water supply, sewage disposal, and improved nutrition. In public health practice, both the direct and indirect approaches are relevant.

4.0 Conclusion

Public Health is an organized community effort aimed at the prevention of disease and promotion of health. It links many disciplines. Many core areas form specialization in Public Heath.

5.0 Summary

In this unit, we have discussed the core disciplines in public health with their relevance, the activities in public health and the relationship between community health, clinical medicine and public health.

6.0 TUTOR MARKED ASSIGNMENT

1. Define public health and discuss the similarities and difference with clinical medicine.
2. Enumerate the core disciplines in public health
3. Discuss the role of public health in the health care delivery system.

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UNIT 5 ETHICAL ISSUES AND CHALLENGES IN PUBLIC HEALTH

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 Challenges and Ethical issues in Public Health

3.2 Public Health Values

4.0 Conclusion

5.0 Summary

6.0 Computer Marked Assignment

7.0 References/ Further Reading

1.0 Introduction

Public health is concerned with preventing disease, prolonging life, and promoting health. Public health is usually viewed as a broad social movement, a way of asserting social justice, value and priority to human life. Public health professionals operate in an ethically complex environment. There are tensions between achieving benefits for whole populations and protecting individuals' rights, also epidemiological data collection can conflict with the right to privacy. Health promotion interventions may be paternalistic or intrusive. Resources for public health also compete with other legitimate demands.

3.0 Main Content

3.1 Challenges and Ethical issues in public health

The following are identified challenges and ethical concerns in public health

1) Determining appropriate use of public health authority vis-a-vis economic impacts (2) Making decisions related to resource allocation, (3) Negotiating political interference in public health practice, (4) Ensuring standards of quality of care, and (5) Decision-making vis-a-vis questioning the role or scope of public health. (6) Measure and values (7) Surveillance versus cure.

Brief description of the listed items:

Determining appropriate use of public health authority vis-a vis economic impact:

Public health practitioners have substantial authority to limit individuals' freedom and privacy or to affect the economic viability of businesses in a community. Public health regulations affect the industries (e.g. tobacco), those paying for the public health benefits may not necessarily be the beneficiaries (e.g. regulatory actions for worker safety raising costs to consumers), people may not be willing to pay costs for benefits that would accrue in the long future (e.g. measures to limit global warming) and it is easier to calculate current costs incurred for public health than the benefits that would come later.

Other examples come to mind when determining the appropriate use of public health vis-a-vis economic impact. Studies have shown that several health officers and environmental health workers discussed the complex determinations they must make to decide, for example, when to close a contaminated beach that is an important source of tourism revenue in an area. Nurses and medical directors expressed a similar need to weigh public health gains vis-à-vis restrictions on

autonomy when considering partner notification or mandating treatment for infectious diseases. Many more examples can be listed in literature.

Making decisions related to resource allocation

The need to allocate limited public health resources, including program funds, personnel effort, and scarce products, requires practitioners at all levels to make difficult choices among competing programmes and population groups. There may be difficulty apportioning scarce products, such as annual influenza vaccine, despite extant federal guidelines. Many practitioners encounter challenges maintaining adequate staffing levels in clinics or determining how best to spend their own time among competing programmes. Some factors are considered to be inappropriate allocations, such as spending enormous resources in one area in the face of unmet needs in another. There is also the challenge of struggling to determine whether it was best to expend resources today or save resources for future public health needs. For example if many local health departments offered health plans for the uninsured in their communities, it becomes the task of the commissioners, health officers, and others to decide what proportion of the uninsured in their communities should be eligible for the care provided.

Negotiating political interference in public health practice.

Negotiating tensions that emerge from political oversight of public health practice proves to be ethically challenging for many practitioners. Individualistic societies resist the notion of public health's concern for the collective.

Such tensions create pressure to bend the rules or sacrifice best practices. Some practitioners, for example, struggle with political pressure to allow noncompliance with environmental health

regulations by a local politician or prominent constituent. Others have political pressure to perform duties in ways that were inconsistent with scientific evidence or to maintain programmes because they addressed the "issues of the day" rather than the issues of greatest health need in their communities. In this view, politics conserves the broad vision of public health and prefers it to limit into a technical enterprise focusing on controlling communicable diseases and a safety net providing medical care to the indigent. There should be a limit to political pressures for the purpose of improving community health.

Ensuring standards of quality of care.

Practitioners experience a strong commitment in ensuring and maintaining quality care across different populations. There is professional obligation to do what is perceived to be "right," even in the face of resource limitations or program constraints. Previous studies revealed that Practitioners, particularly those providing direct patient care, described the ethical tensions they experienced when compelled to provide lower-quality care to certain populations because of programme rules or limited resources. For example, practitioners in family planning clinics can provide birth control medications only from sample stockpiles and are prohibited from prescribing other medications that may be better suited for their patients. Also, there is a dilemma in cost benefit analysis – the difficulty of valuing life, and values to be assigned for the rich versus the poor.

Decision-making vis-a-vis questioning the role or scope of public health

Practitioners may share a macro level concerns about what the public health system should do and what functions or services it should provide. To some practitioners, the central duty of public health is to provide protection against infectious disease and other health threats for all members of a community; to others, public health properly includes providing safety net services to the most vulnerable. Practitioners sometimes perceive a disconnect between their view of the appropriate mission, role, or scope of public health and the types of services that were being provided in their communities. The public health practitioner may be involved in deciding which is more needed to attend to between paternalism and libertarianism. Paternalism involves restriction on individual behaviour for protecting their health (e.g. enforcing seat belts) libertarianism claims that the only purpose for which power can be rightfully exercised over any member of a civilized community against the person's will is when his act harms others (e.g. regulating drunkenness) and may even make others lose their lives especially when they drive. The development and application of formal frameworks may be one method of encouraging thorough and rigorous ethical analysis and decision-making. Such tools may help to unmask normative assumptions and may be an important addition to economic or other methods of analysis for decision-making.

Measure and values

Some public health measures are not acceptable on religious and moral grounds, (E.g. sex education and distribution of contraceptives and/or condoms to adolescences). Also, health authorities deciding on values and choices of those they serve (e.g. whether someone should not take the responsibility on behaviour causing ill health such as smokers, alcoholics, promiscuous

people),decision on whether to emphasize HIV/AIDS prevention versus anti- retroviral (ARV) therapy in poor countries.

Surveillance versus cure

This involves hoe to deal with sick subjects identified in routine survey/data collection and the extent of providing access of benefits to research subjects.

3.2 Public Health Values

Many academics and practitioners perceive a philosophy of social justice to be foundational in public health. Practitioners in the field of public health have attributed the values underlying their decisions and actions to commitment to the concept of fairness; an important element in any construct of social justice. The term *fairness* takes on a wide variety of meanings which include equal treatment across population groups, provision of services to those in greatest need, and expectations that individuals pay their fair share for services according to their abilities. Several practitioners have emphasized the importance of having evidence to support programming decisions and of using public dollars efficiently. Others emphasized the importance of respecting individuals' autonomy or including community values in programme decisions. These values are not necessarily inconsistent with social justice and utilitarianism, but they nonetheless portray a complex and heterogeneous set of values articulated by practitioners.

To be able to practice public health effectively, work through and resolve problems, practitioners may depend almost exclusively on their own experiences and judgment and informal consultation with others. All professionals in positions of responsibility must make independent judgments during the course of their daily work; however, it is important to consider whether practitioners'

individual moral compasses can suffice when they are responsible for community-level health. Clearly, professional experience—working through ethical challenges in numerous situations over time—builds an arsenal of knowledge and insights on which to base future decisions. Yet public health goals may call for practitioners to look beyond the realm of their own experiences and moral foundations to ensure that public health outcomes are a just outcome for all involved; that is, that the benefits and burdens of outcomes are equitably distributed in the population.

4.0 CONCLUSION

Utilitarianism alone is unlikely to provide an adequate account of public health ethics, other considerations are necessary. Identifying the sources of ethical tension among public health practitioners may create new opportunities to reduce or manage those tensions. There is the need in building links between ethical analysis and the practical work of public health

5.0 SUMMARY

You have been able to examine the ethical issues and challenges in public health; also we have been able to discuss public health values. We also have learnt that to work through and resolve problems, practitioners mostly rely almost exclusively on their own experiences and judgment and informal consultation with others. All professionals in positions of responsibility must make independent judgments during the course of their daily work.

6.0 TUTOR MARKED ASSIGNMENT

Discuss the ethical issues and challenges in public health.

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MODULE 2

HISTORY OF PUBLIC HEALTH IN NIGERIA

UNIT 1 PUBLIC HEALTH PRACTICE IN PRECOLONIAL NIGERIA

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1.0 Introduction

2.0 Objectives

3.0 Main contents:

3.1 Definition of Public Health

3.2 Context of Public health practice in pre-colonial/traditional Nigerian Society

3.3 Categories of Traditional Practitioners in pre-colonial Nigerian Society

4.0 Conclusion

5.0 Summary

6.0 Tutor Marked Assignments

7.0 References/Further reading

1.0 Introduction

The concept of Public health has existed before the scientific coining and definition of the term. The issue of disease and health is as old as man. The African local communities has several indigenous and traditional ways of responding to disease conditions .Preventive and curative practices were in place in various Nigerian communities before the coming of the colonial masters. While some of these are still being practiced today owing to their effectiveness, some have been redefined or upgraded in the context of modern public health practice.

2.0 Objectives

- To define public health
- To discuss Context of Public health practice in pre-colonial/traditional Nigerian Society
- To highlight Categories of Practitioners/Practices in Traditional society

3.0 Main contents

3.1 Definition of Public Health

Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases. Overall, public health is concerned with protecting the health of entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world.

However Winslow (1920) gave what could be described as comprehensive and robust definition of Public health as "the science and art of preventing disease, prolonging life, and

promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health" (p.183).

It is therefore obvious that public health does not only include actions taken to prevent development of diseases, but timely diagnosis , treatment and rehabilitative measures taken to prevent progression of diseases, reversal of communicability and limit disability. It is against this backdrop that public health could embrace aspects of curative and rehabilitative medicine.

History of public health in Nigeria therefore should embrace historical efforts aimed at evolving or developing preventive and curative services for the purpose of improving and sustaining Health.

3.2 Context of Public health practice in pre-colonial/traditional Nigerian Society

Health even before the coming of the colonial masters has been known as the most precious of all things and the foundation of all happiness. Traditional medicine has developed in various communities in Nigeria in response to the health needs of the people. Many communities have, therefore, since creation, developed various traditional systems using locally-available resources for the alleviation of their health problems. Besides, many rural communities have great faith in traditional medicine, particularly the inexplicable aspects as they believe that it is the wisdom of their fore-fathers which also recognizes their socio-cultural and religious background. The

development of traditional medicine in Nigeria has led to various categories of healers, the various healing methods, strategies and medicines or remedies now known.

Although this traditional system of health evolved separately in different micro-cultures, there is a great deal of philosophical and conceptual similarities. The origin of diseases in Africa was simplistic. It is either an enemy had cast a spell on somebody or one is being punished by divine powers for his sins. In the same sense disease preventive practices could be associated with regular rituals and sacrifices made to ancestral beings, family and community deities and are believed to help in warding off calamities including illness and sicknesses dominantly thought to be associated with evil spirit activities

3.3 Categories of Practitioners/Practices in Traditional society

Various categories of the practitioners include:

Herbalists

Herbalists use mainly herbs, that is, medicinal plants or parts of such plants to cure diseases.

Traditional Birth Attendants (TBAs)

These TBAs occupy a prominent position in Nigeria even till today as between 60-85 per cent of births delivered in the country and especially in the rural communities are by the TBAs. They assist the mothers at childbirth based on skills initially acquired to past participation in child delivery.

Traditional Surgeons

These function in the cutting of tribal marks, male and female circumcision (Clitori dectomy).These functions they carry out with special knives and scissors; blood-letting

operations etc. The wounds that result from these operations is usually treated with local procedures such as snail body fluid or pastes prepared from plants. They also remove whitlows

Traditional Bone setters

Traditional bone setting is recognized to have attained a level of success comparable to that in orthodox medicine in Nigeria. The skill tends to run in families or lineage as practioners tend to hand the practice over to their children or trusted relations who continue with the practice after their death.

Practitioners of Therapeutic Occultism (Spiritual healers)

These include diviners or fortune tellers, who may be seers, "alfas" and priests, and use supernatural or mysterious forces, incantations, may prescribe rituals associated with the community's religious worship and adopt all sorts of inexplicable things to treat various diseases. In some cases it may involve consultation with ancestral spirits, community deities and water spirits.

More so Preventive practices such as Isolation cannot be said to be foreign to Nigerian indigenous communities as Individuals known to be suffering from dangerous and contagious diseases such as leprosy were known to be isolated in secluded environment where they are kept incommunicado with other members of the community. Certain norms guide the maintenance of adequate sanitation in the communities. For instance, women and children, particularly the girls, sweep the homes/surroundings and empty refuse bins. There are also cultural festivals that emphasize cleanliness in various communities and many such festivals still persist till today.

4.0 Conclusion

Public Health which could be seen as "the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community and Governmental efforts, cannot be said to be an entirely new concept that was introduced by the colonial masters, but various aspects of it has been in practice before the onset of colonialization.

5.0 Summary

Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases. Many communities have, therefore, since creation, developed various traditional systems using locally-available resources for the alleviation of their health problems. Traditional medicine has developed in various communities in Nigeria in response to the health needs of the people. Herbalists, traditional birth attendants, traditional surgeons, bone setters, spiritual healers, and preventive practices such as isolation, environmental sanitation has been in existence before the coming of the Europeans.

6.0 Tutor marked assignment

Highlight six public health related practices existing in Nigeria before the colonization period.

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UNIT 2 HEALTH CARE SERVICES IN COLONIAL NIGERIA

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main contents:

3.1 Emergence of modern medical services in Nigeria

3.2 Early Organization/Administration of Health Care in Nigeria

3.3 Preventive Health Care services in colonial era

4.0 Conclusion

5.0 Summary

6.0 Tutor Marked Assignments

7.0 References/Further

1.0 Introduction

The challenges posed by a hostile environment infested with mosquito and other potent disease causing organisms provided incentives and need for medical care aimed at protecting early European explorers. However with the establishment of the colonial government in several coastal trading centers, formal medical services were established for the colonial military, expatriates and a few indigenous people living close to their quarters for the purpose of rendering

services to them. Later on the quest for evangelism by missionaries led to the establishment of health care services for general Nigerian populace.

2.0 Objectives

- To discuss the emergence of modern medical services in Nigeria
- To describe the early organization and administration of health care services
- To highlight the evolution of preventive health care service during the colonial period.

3.0 MAIN CONTENTS

3.1 Emergence of Modern Medical Services

The beginning of orthodox medical practice in Nigeria could be traced to 1854, when Dr Baikie introduced quinine, which greatly decreased mortality and morbidity related to Malaria among the western expeditioners. Earlier on, this disease posed a serious threat to the explorations of Mungo Park and Richard Lander. However this early form of health care introduced by the colonial master was tailored towards their own interest not that of indigenous populace. It was the church missionaries that first established health care services for the people. Throughout the ensuing colonial period, the religious missions played a major role in the supply of modern health care facilities in Nigeria .Prominent among these were the Roman Catholic mission, the Church Missionary Society (Anglican) and the American Baptist Mission, as well as the Sudan United Mission, which concentrated on middle belt areas, and the Sudan Interior Mission, which worked in the Islamic north. The first health care facility in the country was a dispensary opened in 1880 by the Church Missionary Society in Obosi, followed by others in Onitsha and Ibadan in 1886. However, the first hospital in Nigeria was the Sacred Heart Hospital in Abeokuta, built by the Roman Catholic Mission in 1885. The missions also played an important role in medical training

and education, providing training for nurses and paramedical personnel and sponsoring basic education as well as advanced medical training, often in Europe,

The British colonial government began providing formal medical services with the construction of several clinics and hospitals in Lagos, Calabar, and other coastal trading centers in the 1870s. Services were later extended to African employees of European concerns. Government hospitals and clinics expanded to other areas of the country as European activity increased there.

The establishment of the military headquarters in Lokoja in 1900 led to establishment of medical services there, the same applied to calabar, where incidentally, the first government hospital for civilians, the St. Margaret's Hospital, was built in Calabar in 1891.Other military health facilities were later established in other parts of the country following military activities associated with the first world war(1914-1918).The detrimental effects of the two world wars affected medical manpower as many were redeployed to serve in Europe. However after the war, medical facilities were expanded substantially, and a number of government-sponsored schools for the training of Nigerian medical assistants were established. The colonial government tried to extend modern health and education facilities to much of the Nigerian population partly in response to nationalist agitation. The announcement of ten-year development plan in 1946 gave birth to University College Ibadan in 1948.A number of schools of pharmacy and nursing were also established.

3.2 Early Organization and Administration of Health Care

The first centralization of control of health services in West Africa emerged with health services in Gambia, Sierra Leone, Ghana (then Gold Coast) and Nigeria being merged and controlled by

central office in London. However as health care management became more complex especially with the expansion of medical services with industrialization; the central administration of health care services became regionalized, with medical services being controlled by regional governments between 1952-1954.Meanwhile the 1946 health plan established by the Ministry of Health to coordinate health services throughout the country, including those provided by the government, by private companies, and by the missions, also budgeted funds for hospitals and clinics, most of which were concentrated in the main cities. Consequent to the regionalization of health care services, each of the three regions (eastern, western and northern) set up their own Ministries of Health, in addition to the Federal Ministry of Health. Although the federal government was responsible for most of the health budget of the States, the state governments were free to allocate the health care budget as they deemed fit.

3.3 Emergence of Preventive Health Care Services in the colonial times.

Preventive health care services (services aimed at preventing the occurrence of disease), did not necessary evolve at a different time as the role of environmental determinants in disease causation was quite appreciated by the colonial masters. Environmental sanitation, town planning etc were seen as measures of protecting public health. However the motives and methods of public health measures in the colonies differed significantly from those of Europe. The primary goal in those colonies according to Stock(2009), was to protect the health of colonial officials and troops from alleged threat to health from the natives' communities

.Hence at the initial times what was achieved by public works in Europe was achieved by racial segregation in the colonies. There was a free zone (Cordon Sanitaire) built between the colonial and indigenous settlements. European townships were to be separated from the African

settlements by cordon sanitaire of at least 350 and later 410 yards. No building was allowed within this zone. The cordon sanitaire according to report was necessary to prevent fever carrying mosquitoes originating in the indigenous communities and to minimize the risk of fires. It was also necessary to protect Europeans from drumming and similar disturbances emanating from African quarters according to Lugard (1970).

This was the situation in Northern Nigeria, where the British officials, non official expatriates and Nigerian residents within the townships lived in separate clusters.

Early medical reports as reported by Stock (2009), contained references to sanitary measures and their rigid enforcements in the townships. Mosquito control through the drainage or filling of potential breeding sites, clearing of grasses and prohibition of African children and cattle keepers passing through European areas feature prominently in sanitation programs. *Regulations* for organization of European townships were contained in several ordinances of colonial period. In order to strengthen environmental sanitation, the colonial; masters appointed British sanitary inspectors and their Nigerian aides who served as assistants. Their basic function was sanitary inspection. The roles of these inspectors were made more relevant during the bubonic plague epidemic of 1924. Environmental sanitation till date has continued to be one of the cornerstones of preventive health services in Nigeria. Several programs have been launched at both federal and state levels. However some of these programs lacked consistency and sustainability.

History of public health or preventive health in Nigeria cannot be concluded without mentioning the roles played by Dr Ladipo Oluwole. Dr Oluwole was born to an Anglican Bishop, Isaac Oluwole in 1892.He returned to Nigeria in 1918, after graduating with MB.CHB from the University of Glasgow, In 1925,Dr Isaac Ladipo Oluwole was appointed first African Assistant

Medical Officer of Health in Lagos He founded the first School of Hygiene in Nigeria, at Yaba, Lagos, providing training to Sanitary Inspectors from all parts of Nigeria. He re-organized sanitary inspection procedures in the port of Lagos to control the spread of bubonic plague. The plague, which broke out in unsanitary shanty towns in Lagos, caused many deaths between 1924 and 1930.

More so, Dr Oluwole opened the Massey Street Dispensary, reclaimed swampy islands to aid in malaria control and built a new abattoir to improve food hygiene. Oluwole started the first school health services in Lagos in 1925.He introduced regular sanitary inspections and vaccinations of children. He started a Healthy Baby Week and opened the first old people's home before being appointed Medical Officer of Health in 1936.He was awarded the Order of the British Empire in 1940. He died in 1953 being recognized as the father of public health in Nigeria.

4.0 **Conclusion**

The emergence of modern health care services in Nigeria could be traced to the colonial era. This was in attempt to contend the threats posed by malaria. The pattern of health care during this period showed marked urban-rural disparity whereby the priority of health service was to serve a few privileged individuals in Government quarters. This foundation has continued to trail health care services in Nigeria till today, despite the deployment of various policy documents to correct the imbalance.

5.0 Summary

The introduction of orthodox medical practice in Nigeria could be traced to 1854, when Dr Baikie introduced quinine, which greatly decreased mortality and morbidity, related to Malaria among the western expeditioners. Early form of health care introduced by the colonial masters was tailored towards the interest of the colonial masters. It was however the church missionaries that first established health care services for the general population of Nigerians. Preventive health care services (services aimed at preventing the occurrence of disease), did not necessary evolve at a different time as practices such as environmental sanitation, town planning, food hygiene etc were quite appreciated by the colonial masters. History of public health in Nigeria cannot be done without recognizing the role played by Dr Isaac Ladipo Oluwole who is recognized as the father of public health in Nigeria.

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UNIT 3: HEALTH CARE SERVICES IN THE POSTCOLONIAL PERIOD

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main contents:

3.1 Health Care in the immediate postcolonial Period

3.2 Health care services in the third and fourth Development plan

4.0 Conclusion

5.0 Summary

6.0 Tutor Marked Assignments

7.0 References/Further

1.0 Introduction

Following independence, Nigeria inherited the same health system developed by the colonial masters and the weakness of that system especially its being more clinically oriented, more curative at the detriment of preventive services were altogether inherited. Most of the projects and services were located at the urban areas, while the rural areas were grossly neglected. It was the desire to correct these anomalies and improve performance that led to the articulation of various developmental plans that followed.

2.0 Objectives:

- To discuss the situations and developments in health care services in the immediate post colonial Nigeria
- To discuss health care plans and services as contained in the third and fourth development plan.

3.0 MAIN CONTENT

3.1 Health care in immediate postcolonial period

The state of Nigerian health sector by 1960 shows that it was more clinically oriented, providing dominantly curative components of health care. Preventive health care was grossly neglected. The situation was worsened by the fact that these services were concentrated in the urban, serving roughly about 10-15% of Nigerian population. The first ten-year colonial National development plan ended in 1956.Following independence a first National Development plan(1962-1968) was put in place .It contained ground work for the promotion of industrial development, building of hospitals in major cities, dispensaries and maternity homes in few rural towns and villages. This plan seems to have been patterned after that of the colonial masters whose priority was to provide health care in few towns and cities occupied by expatriates .The obvious deficiencies of this plan necessitated the Second National Development Plan (1970-1974), The health component of this plan was aimed at correcting some of the deficiencies in health care delivery. The objectives of this phase even though well defined and good were not matched well with articulated projects and closely defined policies.

Environmental Sanitation though recognized by the Nigerian Constitution and was still effective in the post independence period for example routine house to house inspection was still effective

in the maintenance of Environmental Sanitation. However, political interference with the statutory role of Sanitary Inspectors led to the collapse of the house to house inspection programme and contributed to the poor sanitary conditions in the country.

Meanwhile another remarkable dimension in the evolution of preventive care occurred in 1966 during the outbreak of small pox in Nigeria .WHO strategy and recommendation was 100% vaccination of the susceptible communities. The resurgence of the disease was seen in West Africa and India despite 90% and 80% vaccination respectively. Unfortunately Nigeria recorded a delay in Vaccine supplies during this period. This led to evolution of surveillance and containment measures. Program staff made efforts to locate new cases and isolate infected villages which could then be vaccinated with the limited supplies. A reporting network using the available radio facilities was established to locate new cases. Containment teams moved swiftly to isolate infected persons and to vaccinate susceptible villages. Hence it was demonstrated that an alternative strategy of surveillance and containment measures such as isolation, vaccination of high risk groups could break the transmission chain of smallpox, even when less than half the population was eventually vaccinated.

3.2 Health Care in the Third and Fourth Development Plan

The Head of State,Lt Col Yakubu Gowon, in 1975, announced the Basic Health Service Scheme (BHSS) as part of the Third National Development Plan (1975-80). The objectives of the scheme were to increase the proportion of the population receiving health care from 25 to 60 percent, correct the imbalances in the location, distribution of health institutions and provide the infrastructures for all preventive health programmes such as control of communicable diseases, family health, environmental health, nutrition and others, and establish a health care system best

adapted to the local conditions and to the level of health technology (Sorungbe, 1989). There was a concerted effort for the first time to meet the World Health Organization's (WHO's) standard of 1 doctor -10,000 population ratio. Hence establishment of medical institutions and development of health manpower was given an important place. The plan however was affected by maldistribution of health personnel and facilities between rural and urban centers and the budgetary allocation to health at all levels of government.

Subsequently, there was the fourth National Development plan(1981-1985).The major policy objectives and programmes of this plan were (i)Establishment of 3-tier comprehensive health system (primary, Secondary and tertiary);

(ii) Concurrent health care responsibility from 3 levels of Government;

(iii) Establishment of Basic Health Services Scheme (BHSS) and of primary health care for all;

(iv) Establishment of Local Government Areas (LGAs) as basic Implementation unit;

(v) Establishment of BHSS for a population of 50,000;

(vi) Establishment of 4 categories of community health workers;

(vii) Utilization of village voluntary traditional practitioners and leaders;

(viii) Discouragement of expensive construction;

(ix) Decentralization of decision-making; and

(x) More balanced expenditure between hospitals and BHSS.

The problem with this scheme was its total neglect. The Federal Government in particular focused much more attention on the establishment of teaching and specialist Hospitals. This was reflected in the budgetary allocations for Health capital projects and programme as contained in the plan. Moreover the downward turn in Nigeria's economy began during this period, leading to major cuts in budgetary allocations.

4.0 Conclusion

The lack of equity that marked health care delivery in the colonial times continued in the postcolonial health care delivery experience. The government came up with fairly articulated plans with emphasis on Basic Health Services scheme (BHSS).However these programmes were poorly implemented, poorly financed and unable to correct imbalance in health service delivery.

5.0 Summary

The state of Nigerian health sector by 1960 shows that it was more clinically oriented, providing dominantly curative components of health care. Preventive health care was grossly neglected. The obvious deficiencies in the existing health plan necessitated the Second National Development Plan (1970-1974), The health components of this plan which were aimed at correcting some of the deficiencies in health care delivery were well defined but not matched well with articulated projects and closely defined policies. The third and fourth development plans had broader objectives with BHSS as their cornerstone; however they were affected by maldistribution of health personnel and facilities between rural and urban centers, as well as poor budgetary allocation.

6.0 Tutor marked assignments

Highlight key deficiencies of Nigerian Health care delivery in the postcolonial periods?

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UNIT 4: PRIMARY HEALTH CARE AND SUBSEQUENT HEALTH DEVELOPMENTS

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main contents:

3.1 Health Care Services in the immediate postcolonial Period

3.2 Health care services in the third and fourth Development plan

4.0 Conclusion

5.0 Summary

6.0 Tutor Marked Assignments

7.0 References/Further

1.0 Introduction

Primary Health Care (PHC), according to the Alma-Ata declaration, was aimed at addressing the main health problems in the community, providing promotive, curative, and rehabilitative

services. PHC is a shift towards the front-line of day-to-day activities carried out within the community. It was expected to correct the limitations of previous Governmental health strategies by bringing health care to the door post of community members. It was generally adopted as the cornerstone and guideline for implementation of subsequent reforms and policy instruments aimed at achieving health for all Nigerians.

2.0 Objectives

- To briefly discuss Primary Health Care as a cornerstone for national health care plan and delivery
- To highlight the important aspects of Health Systems Reform and National health bill
- To briefly introduce the National Strategic Health Development Plan (or NSHDP)

3.0 MAIN CONTENT

3.1 Primary Health Care/Fifth Development Plan

Following prevailing weaknesses and deficiencies in Health care delivery and policies, In August 1987, the federal government launched its Primary Health Care plan (PHC), which President Ibrahim Babangida announced as the cornerstone of health policy with the following objectives:

- accelerated health care personnel development
- improved collection and monitoring of health data;
- ensured availability of essential drugs in all areas of the country;
- implementation of an Expanded Programme on Immunization (EPI);
- improved nutrition throughout the country;

- promotion of health awareness;
- development of a national family health program;
- Widespread promotion of oral rehydration therapy for treatment of diarrheal disease in infants and children.

It would be recalled that Primary health care was adopted as a corner stone for achieving health for all following Alma ata declaration in 1978.

Implementation of PHC programs was intended to take place mainly through collaboration between the Ministry of Health and participating local government councils, which received direct grants from the federal government. The adoption of Primary Health care as the cornerstone of achieving health objectives of the fifth development plan of late 80s and early 90s led to the development of National Health policies in 1988 and 1998 .This policy document has Primary health care (PHC) as its cornerstone. It also accorded Priority to underserved and high risk groups. It Emphasized on effective management through better planning, budgeting and control; Increased funding and cost recovery including insurance; Reduction in capital development; Improvement of efficiency and utilization through better support drugs; Increased inter and non-governmental cooperation and community support; It gave more roles to the local Government in management of health services with focus on primary health care elements. It also encouraged Intermediate level manpower planning; and Inspection of private services. The National health philosophy was founded on the underlying principle of social justice and equity while The national health care delivery system is built on the basis of the three tier responsibilities, which are of the Federal, State and Local governments.

Despite these, the following problems continues to persist: inadequate coverage, proportionally high investment in curative to the detriment of preventive services, Inadequate skill to properly manage and coordinate health formulation, planning, monitoring implementation and evaluation Poor maintenance and servicing of health equipments and facilities, Poor management of health statistics.

3.2 Health System Reform /National Health Bill

Following the lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, mal-distribution of health work force and poor coordination amongst key players, the Health Systems Reform (HSR) was implemented between 2004-2007. The HSR was one of the social sector reforms undertaken by the Obasanjo administration, with the National Economic Empowerment Development Strategy (NEEDS) providing the overall national development framework.

The NEEDS health policy strategy includes:

- Strengthening local government capacity in public health management
- Refurbishing of primary health care facilities and making them operational
- Redefinition of the role and responsibilities of federal ministry of health and other federal public health services to Nigerians.
- Establishment of National Blood transfusion system
- Creation of the enabling environment for local manufacturing of about 70% of Nigerian needs for essential drugs/supplies Antiretroviral drugs and reagents

- Provision of minimum package of health services to all Nigerians as an integral part of the poverty reduction strategy.

The Health system reform specifically has a mission statement meant "to undertake a government-led comprehensive health sector aimed at strengthening the national health system to enable it deliver effective, efficient, qualitative and affordable health services and thereby improve the health status of Nigerians as health sector's contribution to breaking the vicious circle of ill-health, poverty and under-development". It has the following strategic thrusts:

- Improve the performance of the stewardship role of government
- Strengthen the national health system and improve its management
- Improve availability of health resources and their management
- Improve the access (including physical and financial) to quality health services
- Reduce the disease burden attributable to priority health problems
- Promote effective public-private partnership in health
- Increase consumers' awareness of their health rights and health obligations.

Though the reform has made some achievements in some of its priority focus, it is yet to be implemented in several sectors. However it is an ongoing process that requires time to fully take effects. One important development that has emerged in the course of ongoing reform was the development of the National Health bill. The Bill has seven parts:

- Responsibility for health and eligibility for health services and establishment of national health system
- Health establishments and technologies
- Rights and obligations of users and healthcare personnel
- National health research and information system

- Human resources for health
- Control of use of blood, blood products, tissue and gametes in humans
- Regulations and miscellaneous provisions

Generally The Bill if signed by President Jonathan will clearly define the various roles and functions to be played by the three tiers of government on health related issues. Once enacted, the bill is expected to help Nigeria achieve universal health service, guarantee improvement in the health sector, regulate healthcare practice, and promote professionalism among healthcare givers. The bill is also expected to set standards in health care services rendered across Nigeria and also help eliminate medical quacks in the system. It seeks among others, the enablement to provide one per cent of Nigeria's consolidated revenue fund for the development of primary health care. The various states across Nigeria through this fund are expected to improve on primary health care services in their states. The bill also covers provision of health care insurance for Nigerians especially the less privileged. It will provide guidelines in the development, promotion and formulation of national health policy, among others. Currently the bill even though signed by the senate on 19th February, 2014 is yet to be signed by the president due to perceived controversies and disagreements among interest groups especially healthcare professionals.

3.3 The National Strategic Health Development Plan (or NSHDP) (2010-2015)

The National Strategic Health Development Plan (or NSHDP) – reflects shared aspiration to strengthen the national health system and to vastly improve the health status of Nigerians. The Plan is the overarching reference health development document for all actors towards delivery on a shared Results Framework, to which each and everyone will be held accountable for achieving the goals and targets as contained in the Results Framework.

It has the following eight strategic priority areas:

• Leadership and Governance for Health;

• Health Service Delivery;

• Human Resources for Health;

• Financing for Health;

• National Health Management Information System;

• Partnerships for Health;

• Community Participation and Ownership; and

• Research for Health.

The plan is to serve as a guide towards meeting the aspirations of the health component of the National Vision 20:2020 to achieve better health in Nigeria.

4.0 Conclusion

The determination of the Nigerian government to improve the national health care services was reflected in the official launching of Primary Health care as a corner stone for achieving health for all Nigerians in consistence with Alma Ata declaration of 1978.Since this launching, several other reforms, policies and health plans have been developed for the purpose realizing health for all. Though some achievements have been made, Nigeria still seems to be far from her health objectives.

5.0 Summary

Following prevailing weaknesses and deficiencies in Health care delivery and policies, In August 1987, the federal government launched its Primary Health Care plan (PHC), which President Ibrahim Babangida announced as the cornerstone of health policy. The adoption of Primary Health care as the cornerstone of achieving health objectives of the fifth development plan of late 80s and early 90s led to the development of National Health policies 1988 and 1998.Subsequently a Health System Reform was put in place, based on which the National Health Bill was developed which is yet to be officially signed. Meanwhile in an effort to achieve her objective, another strategic plan - The National Strategic Health Development Plan has been put in place between 2010-2015 to serve as a guide towards meeting the aspirations of the health component of the National Vision 20:2020 to achieve better health in Nigeria.

6.0 Tutor Marked Assignment

- State any four objectives of Primary Health Care?
- Outline five strategic thrust of the National Health Bill?

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UNIT 5: STRUCTURE OF HEALTH SERVICE DELIVERY IN NIGERIA.

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main contents:

3.1 Federal Level of Health care service delivery

3.2 State level of Healthcare service delivery

3.3 Local Government Level of health care service delivery

4.0 Conclusion

5.0 Summary

6.0 Tutor Marked Assignments

7.0 References/Further

1.0 Introduction

The National Health System is decentralized into three tiers structures with responsibilities at federal, state and local government levels. Currently the three levels are involved to some extent in all the major health system functions, stewardship, financing and service provision. The fluid arrangements allow one level of the system to provide services at any of the other two levels despite holding a primary responsibility. However it is expected that the National Health Bill when signed into law would streamline and more properly delineate duties. These three tiers offer tertiary, secondary and primary care services respectively.

2.0 Objective

- To highlight the functions and parastatals of Federal level of Health Care Delivery
- To highlight the functions of State level of Health Care Delivery
- To highlight the functions Local Government level of Health Care Delivery

3.0 MAIN CONTENTS

3.1 Federal Level of Health care service delivery

At the federal level is the Federal Ministry of Health which is responsible for developing and implementing policies and programmes, along with other necessary actions that will improve and maintain a national health system capable of delivering an effective, efficient, affordable and quality service, and to foster an improved quality of life for all of Nigeria. It relates on behalf of the Nation with international bodies, provides guideline for National Health management information system as well as sees to the provision of tertiary care through specialist/teaching hospitals. These hospitals handle complex health problems/cases either as referrals from general hospitals or on direct admission to its own. It has such features as accident and emergency unit, diagnostic unit, wards units, treatment unit and outpatient consultation unit. Teaching hospitals also conduct researches and provide outcomes to the government as a way of influencing health policies.

Agencies under the Federal Ministry of Health include:

- National Primary Health Care Development Agency(NPHCDA)
- National Agency for Food, Drug Administration and Control (NAFDAC)
- National Health Insurance Scheme (NHIS)
- National Primary Health Care Development Agency (NPHCDA)
- National Institute for Pharmaceutical Research and Development(NIPRD)
- National Institute for Medical Research (NIMR)
- National Agency for the Control of AIDS(NACA)

3.2 State level of Healthcare service delivery

The State ministries are responsible for secondary care (through the general hospitals) , for regulation and technical support for local Government level. Secondary health centers are involved with not only Prevention but also with all treatments and management of minimal complex cases. However, the more complicated cases are referred to the tertiary or specialist hospital. General hospitals have provisions for accident and emergency unit and diagnosis unit etc. They should have a minimum of three doctors who are to provide medical, surgical, pediatric and obstetric care .It should be supported by beds and bedding for minimum of 30 patients. There should also be ancillary facilities for proper diagnosis and treatment of common ailments.

3.3 Local Government Level of Health Care Delivery

The local Government level has the responsibility of primary health care services which are organized through the wards. They are involved in record keeping, case reporting and patients

referral to higher tiers. Primary healthcare centre refer complicated cases to secondary general hospitals. Primary health centre are also to undertake such functions such as health education, diagnosis and treatment of common ailments, through the use of appropriate technology, infrastructure and essential drug list. It is the chosen frame work in the National policy for achieving health for all Nigerians. Primary health centers are known within the system in the context of health centre, maternity home/clinic and dispensaries. In addition each local Government should have at least one comprehensive health centre that offer Primary Health Care services and a limited number of secondary clinical services

Moreover it must be noted that there exist a variety of collaboration with non governmental and private agencies, especially religious bodies, which provide health care including both curative /preventive services alongside the government bodies in an integral feature of the national health system.

4.0 Conclusions

The National Health System is decentralized into three tiers structures with responsibilities at federal, state and local government levels. However the fluid arrangement allows one level of the system to provide services at any of the other two levels despite holding a primary responsibility.

5.1 Summary

There are three levels of health care service deliveries in Nigeria; Federal, State and local Government levels. At the federal level is the Federal Ministry of Health which is responsible for developing and implementing policies and programmes, along with other necessary actions that

will improve and maintain a national health system capable of delivering an effective, efficient, affordable and quality service, and to foster an improved quality of life for all of Nigeria. The State ministries are responsible for secondary care (through general hospitals) and for regulation and technical support for local Government level. The local Government level has the responsibility of primary health care services which are organized through the wards.

6.0 Tutor marked assignments

1. State two functions of the federal ministry of Health

2. Explain the relationship between state and local government levels of health care delivery

7.0 References/further reading

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MODULE 3

Unit 1 Primary Health Care Concepts and Principles

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 Primary Health Care concept

3.2 Definition and element of Primary Health Care

3.2.1 Definition

3.2.2 Element of primary health care

3.2.3 Principles of primary health care

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignments (TMA)

7.0. References & Further reading

2.1 Introduction

In this unit you will learn about the concept of primary health care, which is considered to be an essential care, which is acceptable, accessible and affordable to an individual, community and the country as a whole. You will also learn about Alma Ata Declaration and the components of primary health care. The principles of primary health care are also explained.

2.0 Objectives

At the end of this unit, you should be able to:

- Describe the concept of Primary health Care (PHC) and the related principles.

- Define Primary Health Care,
- List the elements of primary health care
- Explain the principles of primary health care.

3.0. Main Contents

3.1 Primary health concept

You have heard and learnt about primary health care and all of you are providing this care in the areas of your practice i.e. hospital, clinic or community setting. Before we start the discussion on this concept, you should try to decide which kind of care in the situation described below.

If you think for a while, you will be able to realize that the female Community Health Extension Worker is providing primary health care.

Primary health care is now a widely disseminated concept, but most of us are still not clear as to its current meaning. We shall, therefore, try to explain how the concept of PHC has evolved.

You know when a new progamme or technology in any area is implemented, it becomes imperative to evaluate its effectiveness. It is the same with health care approaches. Primary health care has evolved from e-examination and evaluation of existing health care approaches and assimilation of new experiences. The implementation of new knowledge and technology in terms of vertical programme, for eradication of disease did not achieve expected results' and it was realized that there was a need for establishment of permanent health services in rural areas to deal with the day-to-day work in the control and prevention of diseases and promotion of health.

It was realized that the world's priority health problems required development of new approaches for their solution. Hence the approach in health services was shifted from curative to a preventive approach; from urban to rural populations; from privileged to the underprivileged; from unipurpose to multipurpose workers and from vertical mass campaigns to a system of integrated health services forming a component of overall social and economic development.

Based on this, a shift in emphasis on health services to Basic Health Services Approach was conceptualized in 1970. This concept focused on increasing accessibility and availability of health services to the rural populations of developing countries. It was conceived as first level care or first contact care. Now the concept of Basic Health Services paved the way for Primary Health Care; the ideas contained in Basic Health Services were further expanded to cover accessibility, availability, acceptability, affordability and appropriateness of health services.

In May 1977, the Thirtieth World Health Assembly adopted a resolution in which it was decided that the main social target of Governments and of the *World* Health Organization in coming decades should be "Health for All" by the year 2000 AD. The basis of "Health for All" strategy is the Primary Health Care. In 1978, an international conference on primary health care was held at Alma Ata in the then USSR jointly by WHO and UNICEF. This led to the concept of Primary Health Care. This concept of PHC was recommended by various health committees including Nigeria.

This clearly indicates that PHC concept has its roots in the initial stages of our national health care approach. Ultimately, after reviewing the health situation from time to time, World Health Assembly, in its meeting in May 1977 decided that in coming decades the slogan for all the

countries should be to achieve the goal of 'Health For All (HFA) by 2000 AD'. It was only after that the Primary Health Care (PHC) was considered to be the strategy to achieve this goal. Later on, in 1978 an International Conference on PHC was organized at Alma Ata in USSR, addition to defining Primary Health Care (PHC).

3.2 Definition and elements of primary health care

3.2.1 Definition

Primary Health Care is defined in Alma-Ata Declaration (19768). The Alma Ata Declaration states:

Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every state of their development in the spirit of self-reliance and self-determination.

If you look at the definition, you will find that it involves accessibility, which means, continuing and organized supply of care which is geographically, financially, culturally within easy reach of the whole community.

Acceptability implies that care has to be appropriate and adequate in quality and quantity to satisfy the health needs of people and has to be provided by methods acceptable to them within their socio-cultural norms;

Affordable implies that whatever the methods of payment used, the services should be affordable by community and country;

Appropriate technology which means using appropriate methods, techniques and locally available supplies and equipment which together with the people using them can contribute significantly to solving a health problem.

Primary health care is based on socially accepted methods which the country can afford. Thus self-reliance and self-determination are emphasized.

Thus we can say primary health care is a practical approach to make essential health care universally accessible to individuals, families and community in an acceptable and affordable way and with their full participation.

The significance of PHC is to have contract with members of the community for providing continuing health care in the light of national health system. PHC focuses on promotive, preventive, curative, rehabilitative and emergency care to meet the main health problems in the community, giving special attention to the vulnerable groups such as mother and child.

3.2.2 Element of Primary Health Care

We hope our discussion on concept and definition of PHC may have benefited you. Now you will be interested to know what does this Primary Health Care include or what type and what level of care is involved., The eight essential elements or components of Primary Health Care as outlined in the Alma-Ata Declaration are:

- ✓ Education concerning prevailing health problems and the methods of preventing and

controlling them;

- ✓ Promotion of food supply and proper nutrition;
- ✓ An adequate supply of safe water and basic sanitation;
- ✓ Maternal and child health care including family planning; Immunization against major infectious diseases;
- ✓ Prevention and control of locally endemic disease;
- ✓ Appropriate treatment of common diseases and injuries.
- ✓ Provision of essential drugs.
- ✓ Dental & Mental Health are now added

3.2. 3 Principles of primary health care

The description and meaning of the five basic principles which provide the framework of the primary health care approach can be summarized as follows:

i. Equitable distribution of resources
ii. Manpower development
iii. Community involvement or participation
iv. Appropriate technology
v. Intersectoral coordination

i. Equitable distribution of resources

As you know, the attainment of a high level of health is the fundamental right of an individual or you can also say that all human beings have an equal right to health. You will be interested to know

how people can ensure this right. The answer is that all the people of the world/country should be provided with equal opportunities to develop health to the fullest and maintain it. So we can say that equitable distribution means that health services must be shared equally by all people irrespective of their ability to pay; and all the people -rich or poor, rural or urban -must have access to health services.

If we look at health statistics, you will find that the health situation as indicated by health status indicators, e.g. infant mortality rate (IMR), maternal mortality rate (MMR), birth rate (BR), death rate **(**DR**),** etc. is lower in urban areas than in rural areas. Why this difference? It is because health services are mainly concentrated in cities and towns, thus resulting in inequality of care for rural people. These statistics reflect how health-related resources are distributed with the countries - including access to health services, education and income-earning opportunities. This is called social injustice.

The inability to receive health care services by majority of rural people and those living in urban slums is inaccessibility.

The aim of PHC is to bridge this gap by shifting this concentrated health care system from cities or urban areas (where three quarters of health budget is spent) to the rural areas (where three quarters of the people live) and bring the services as near as possible to them.

The other feature of health equity in society is health status of women and the disparity in health between genders which indicates that women suffer more from health problems than men. This is a critical indication of health inequality. What can you, as a health care provider do? You can only provide care to an individual, diseased or healthy, irrespective of any disparity; but in general, these facts call for explicit policies and strategies to reduce inequalities in health.

ii. Manpower development

The manpower development in the context of health includes both professional and auxiliary health personnel, members of community and supporting staff.

Primary health care, aims at mobilizing the human potential of the entire community by making use' of all available resources. This can only be achieved if the individuals and families accept greater responsibility for their health.

The requirement of health manpower will vary according to the varying needs of groups of the population and desired outputs.

Primary health care focuses on:

- Education and training of health workers to perform functions relevant to countries health problems
- Reorientation of health personnel.
- Planning health manpower according to the needs of health system, in terms of the right kind of manpower, the right number, at the right time and in the right place.

At the first level of contact between individual and health care system, primary health care is provided by community health workers acting as a team. These workers have to be trained and retrained so that they can play a progressive role in providing primary health care.

The second categories of health personnel are traditional medical practitioners and birth attendants. They are often part of the local communities, culture and traditions and exert influence on local health practices. Therefore these indigenous practitioners need to be trained

accordingly for improving the health of the community.

Lastly we can say that family members are often main providers of health care, mainly women play an important role in promoting health, thus they can contribute significantly to primary health care, especially in ensuring the application of preventive measures. Women's organization can be taught and encouraged to discuss on question as nutrition, child care, sanitation and family planning. School teachers and adolescent girls can be trained on human sexuality and home nursing. Similarly young people can be educated on health matters. They can be effective in carrying these messages to their homes thus promoting primary health care.

iii. Community participation

We now come to the most essential and sensitive principle of PHC, i.e. community participation. Community participation is the process by which individuals, families and communities assume the responsibility in promoting their own health and welfare. By their own health decisions, they develop the capacity to contribute to their own and the community's development. Realizing the fact that a community can become the agent of its own development, a continuous effort should be made towards the involvement of the local community in planning, implementation and maintenance of health services.

The term community involvement in health describes a process in which partnership is established between government and local communities in planning and implementation of health activities. It aims at building local self-reliance and gaining social control over primary health care infrastructure and technology. For example, one such approach which is followed in

our country (Nigeria) is training of village health workers and aides. They are selected by the local community and are trained locally in the delivery of primary health care and are involved in planning the care for the community. This concept is an essential feature of PHC. The individuals in the community know their own situation better and are motivated to solve their common problems. Thus it can be stated that involvement of community in health matters will require attainment of capacity by individuals to appraise a situation, weigh the various possibilities and estimate what can be their own contribution. Your contribution in community participation, as a member of the health system, is to motivate the community to learn and solve their own health problems, explain, advise and provide clear information about favourable and adverse consequences of the health interventions proposed as well as their relative cost.

Having understood the idea of community participation, you will be interested to know about the areas in which individuals, families and communities can participate. Involvements of these are:

- Involvement of the community in assessment of the situation,
- Definition of the problem and setting of priorities.
- Planning of the primary health care activities and subsequently cooperating fully when these activities are carried out.

All these mean acceptance of a high degree of responsibility by the individuals for their own health care, for example, by adopting a healthy life style, by applying principles of good nutrition and hygiene and by making use of immunization services.

iv. Appropriate technology

Appropriate technology means the technology that is scientifically or technically sound, adaptable to local needs, culturally acceptable (i.e. acceptable to those who apply it and for whom it is used) and financially feasible.

This implies that technology should be in keeping with the local culture. It must be capable of being adapted and further developed, if necessary.

In addition, it should be easily understood and applicable by the community.

The Health for all target requires first and foremost scientifically sound health technology that people can understand and accept and which the non expert can apply. It also implies use of cheaper, scientifically valid, acceptable and available equipment, procedures and techniques rather than those costlier and non affordable and non accessible to the community. For example, oral rehydration fluid, locally prepared weaning food and stand pipes rather than house to house connection, cooperative food stores.

It is socially, economically and professionally acceptable to take the technology closer to the people, consumer, wherever possible. For example, making rehydration salts for babies available to mothers in every home is likely to be more useful than expecting the mothers to take the baby to the special center.

We cannot afford to continue the use of sophisticated technology which is appropriate for meeting the local health needs of people. For example, we know that expensive hospitals which are inappropriate to local needs are being built. These absorb a major part of the national budget, thereby affecting the improvement of general health services.

The concept of appropriate technology can further be explained by taking the example of ORT (oral rehydration therapy). The ORT packets, for diarrhoea, prescribed by WHO cannot be made available to each home; so the community is taught how to prepare sugar and salt solution to combat dehydration in a child with diarrhoea. With these concepts in mind, we shall discuss the principles of intersectoral coordination.

v. Intersectoral coordination

We now come to the principle which focuses on the concept that health of an individual, family and community is affected by other sectors in addition to health sector. Let us now try to learn more about this principle.

It is now realized that health cannot be attained and/or primary health care PHC) cannot be provided by the health sector alone. PHC requires the support of other sectors; these sectors serve as entry points for the developments and implementation of PHC. In our country the sectors responsible for economic development, antipoverty measures, food production, water purification, sanitation, housing, environmental protection and education all contribute to health. Development of PHC will rest on proper coordination at all levels between the health and all sectors concerned.

Declaration of Alma-Ata states that:

Primary Health Care involves in addition to the health sector all related services and aspects of national and community development; in particular, agriculture, animal husbandry, food, industry, education. Housing, public works, communication and other sectors," WHO (1978, HFA Series No.1).

We shall now explore the importance of these related sectors in providing PHC. We shall first discuss the importance of agriculture sector, water supply, sanitation and housing, then, we will talk about public works, communication and education sector and mass media. So let us begin with agriculture sector first.

Agriculture sector ensures the production of food for family consumption. Also nutritional status can be improved through programmes in agriculture, e,g. 'grow more food' and 'kitchen garden projects'. Similarly you know that water supply is very important for household use. A regular supply of clean water helps to decrease mortality and morbidity, in particular among infants and children. You are aware that many diseases like cholera, typhoid, diarrhoea, viral hepatitis are waterborne. Safe disposal of wastes and excreta also has a significant influence on health.

Housing has a positive' aspect on health, provided it is properly adapted to local climatic and environmental conditions. Housing needs to be proof against insects and rodents that carry diseases.

We have so far discussed the effect of agriculture sector, water supply and sanitation and housing on primary health care, now we shall discuss public works, communication, education sector and mass media. Certain aspects of public works and communication are of strategic importance to primary health care. Feeder roads not only connect people to the market but make it easier for them to reach other villages, bringing in new ideas and also the supplies needed for health. TV and radio communication serve as important vehicles for learning regarding health and health practices. Mass media can play a supportive educational role by providing valid information on health and ways of attaining it, and depicting the benefits to be derived from improved health

practices. It could help to create awareness regarding various health programmes, i.e. family planning, immunization, growth monitoring, diarrhoeal disease and ORS etc. in the people isolated. We all know that various messages are carried on TV or radio, regarding FP, ORS, nutrition, diarrhoeal diseases etc.

Now we come to educational sector which has a vital role to play in development and operation of PHC. Community education helps people to understand their health problems, possible solutions to them and the cost of different alternatives. Instructional material/literature can be developed and distributed through the educational system. Associations of parents and teachers can assume certain responsibilities for primary health care activities within schools or the community: such as sanitation programmes, food for health campaigns or Courses on nutrition and first aid, adult literacy programmes, kitchen garden projects, Courses on human sexuality and home nursing.

4.0 CONCLUSION

In this unit we discussed the concepts and definition of Primary Health Care. Primary Health Care is a practical approach to making essential health care universally accessible to individuals, families arid community in an accept- able and affordable way and with their full participation. You also learnt that the elements of primary health care are education concerning preventing health problems, promotion of good supply and proper nutrition, adequate supply of safe water and basic sanitation, maternal and child health, immunization, treatment of common diseases and injuries, and provision of drugs and vaccine.

Principles of Primary Health Care have also been explained in detail. These are:

.equitable distribution, which means that health services must be shared equally by all people -rich or poor, rural or urban; manpower development; community participation; or the process by which individuals, families and communities assume the responsibilities in promoting their own health and welfare and take their own health decisions; appropriate technology which means that technology that is scientifically or technically sound adaptable to local needs, cultural acceptable and financially feasible; and the principle of intersectoral coordination which focuses on the concept that the health of an individual, family and community is affected by other sectors in addition to the health sector.

5.0. SUMMARY.

In this unit we learnt about:

Definition of PHC ; Primary Health Care concept; Element of primary health care; Principles of primary health care and the principle of intersectoral coordination.

6.0. TUTOR-MARKED ASSIGNMENT

- Define Primary Health Care.
- List the principles of primary health care:
- Explain the rationale behind intersectoral coordination

7.0. REFERENCES/ FURTHER READING

1. Adeyemo, DO. Local Government and Health Care Delivery in Nigeria: A Case Study.J.Hum.Eco1.2005, 18(2):149-160.
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UNIT 2 HEALTH FOR ALL

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1.0 INTRODUCTION

In Unit 1 we learn about Primary Health Care (PHC); its concept, and principles. You have seen that primary health care is the essential care which should be easily available, acceptable, accessible and affordable to an individual and community as a whole. In this unit, you we learn the concept of "Health for all"

2.0 OBJECTIVES

At the end of this unit, you should be able to :

- ✓ Define Health For All.
- ✓ Describe global strategy for attaining Health For All.
- ✓ Explain the national strategy adopted to achieve the goal of Health For All.
- ✓ List the targets and achievement in Health For All.

3.0. MAIN CONTENTS

3.1 Concept of Health For All

As you know, there is a vast contrast in the health status of people in developed and developing countries despite of many scientific and technological advances in health care. You are also aware that most people in developed countries and elites of the developing countries including Nigeria enjoy good health, nutrition, sanitation, safe drinking water, education, income etc.

In Nigeria 80% of the population lives in rural area and urban slums in contrast to 10-20% who live in urban areas. It is only this small fraction of urban people who enjoy ready access to health services and facilities whereas the rest of the 80-85% are living in rural and urban slum areas do not have access to health services and/or facilities.

The disparities in health and socio-economic conditions between rich and poor, within countries and between countries, and the concern of members of WHO regarding status of health and deterioration of existing health status lead to new thinking in provision of health

care in order to narrow this gap and finally eliminate it. It was also realized that the underprivileged population constituting 80% of the total population have an equal claim to their rights and privileges of health services such as: health care, protection from vaccine prevented communicable diseases (VPD) of childhood e.g. Diphtheria, Tetanus, T.B., Whooping cough, Polio etc., maternal and child health care, and treatment/control of non-communicable diseases.

So there was felt a need among health planners/administrators for evolving a health care approach that would answer the problems and needs of under- privileged. Ultimately the 30th World Health Assembly resolved in May 1977 that the main social target of Governments and WHO in the coming decades should be the attainment of health for all by year 2000 AD.

In 1972-73 WHO study on the development of health services concluded that there was a widespread dissatisfaction among people with their health care systems which were failing to cope with primary health care problems in countries at all stages of development.

In developed countries, health care system despite the cost and impressive infrastructure and highly specialized technologies, the emerging health problems of people are not being solved. The principal reason for this discrepancy is that new health problems require completely new approaches, which emphasize individual self-reliance and commitment to good health.

Similarly most of the developing countries including Nigeria face major problems with control of infectious disease, provision of safe water and basic sanitation services, the provision of care during pregnancy and delivery and elevating the standard of living to a 'minimum acceptable level'. In the rural areas and rapidly expanding urban areas, millions of people still remain without

access to essential health care and life saving measures.

All the above concepts led to a continuing discussion of how health care system should evolve and how WHO could best support countries struggling to improve their health systems. Expressing the ideas that were dominating the International discussion during 1960s and early 1970s, the World Health Assembly (WHA) decided in a ground breaking resolution in 1977 that "main social targets of governments and WHO in the coming decades should be the attainment of all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" with the adoption of this resolution the HFA movement was born and the slogan was created.

3.2. Definition and meaning for “Health for All” (HFA)

HFA has been defined as "the attainment of a level of health that will enable every individual to lead a socially and economically productive life". From this definition you will realize that the goal of HFA implies realization of goal by all people of the highest possible level of health which includes, physical, mental and social wellbeing; secondly it also implies that as a minimum, all people in all countries should at least have such a level of health that they are capable of being economically productive, removal of unemployment and poverty) and participating actively in the social life' of the community in which they live i.e., have education, housing, water supply and sanitation.

“Health For All” means that health care/services are to be made accessible/within the reach of every individual in a given community. It implies the removal of obstacles to health, that is, elimination of ignorance, malnutrition, disease, contaminated water supply, unhygienic housing etc.

"Health For All" is a holistic concept. It calls for efforts in education, agriculture, industry, housing or communication first, as much as in public health and medicine. It symbolizes the determination of countries of the world to provide an acceptable level of healthful living to all people.

It is an expression of the feeling for social justice from all those who suffer inequity in health care services. It is intended to draw attention to the importance of health, to a serious search for new ways of solving the problems of health and to help mobilize all available resources for health.

To have a correct perception of the meaning of "Health For All" you should be convinced that HFA does not mean that as of the year 2000, we shall all be free of diseases and disability.

Health For All means that health is to be brought within the reach of every one in a given country including the remotest part of a country and the poorest members of the society. By health, is meant not just the availability of health services but a personal well-being and a state of health that enables a person to lead a socially and economically productive life.

"Health for all", means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it. Health begins at home, in school and in the work places. .People will use better approaches for preventing diseases and alleviating unavoidable illness and disability. There will be an even distribution among the population of whatever health resources are available.

That essential health care will be accessible to all individuals and families in an acceptable and affordable way and with their full involvement.

The achievement of the Health For All goal, calls for dramatic changes, and a social revolution in health development. It aims at bringing about the change in the mentality of people, restructuring of health system, and reorientation and training of health workers/professionals. So, to bring about these changes the practical shape to the slogan of HFA could be given only through development as a strategy.

3.3. Strategy for health for all

As you have seen in Unit 2, Alma-Ata conference called on all governments to formulate national policies, strategies and plans of action and set down the principles of Primary Health Care, which is the basis of "Health For All" strategy.

In 1981, global strategy of HFA was evolved by WHO through consultations with countries, regions and at the global level. That strategy defines the broad lines of action to be undertaken at policy and operational levels, nationally and internationally, both in the health sector and in other social and economic sectors.

This was followed by individual countries developing their own strategies for achieving HFA and synthesis of national strategies for developing regional strategies. Let us discuss the global and national strategies in the following subsections.

3.3.1 Global strategy

The global strategy for Health For All is based on the following fundamental principles.

- Health is a fundamental human right and a worldwide social goal.
- The existing gross inequality in the health strategies is of common concern to all countries and must be drastically reduced.

- People have the right and the duty to participate individually and collectively in the planning and implementation of their health care.
- Governments have a responsibility for the health of their people
- Countries must become self-reliant in health matters.
- Health is an integral part of the overall development of the countries.
- Energy generated by improved health should be channeled into sustaining development of a country.
- Better use must be made of the world's resources to promote health and development and this will help to promote world peace and prevent conflict among nations.

3.3.2 National strategy for health for all by 2000 AD

By the Alma-Ata declaration and Nigeria commitment to HFA by 2000 AD resulted in the formulation of National Health Policy.

- ✓ The Federal Government of Nigeria convened a national conference in February 1988 to discuss the national strategies and action plan to achieve Health For All.
- ✓ In July 1988 a working group on Health For All to evolve national strategies for implementation of health care programmes to move towards the goal for Health For All by 2000 AD and to suggest suitable indicators to monitor the progress achieved from time to time.
- ✓ The working group submitted its report in 1989 which was accepted by the Federal Government.
- ✓ Thus a National Health Policy was evolved by Government of Nigeria in 1989 which commits

the government and people of Nigeria to achieve the goal of Health For All by 2000 AD.

The health policy in Nigeria has the following key elements:

i. Creation of a greater awareness of health problems in the community and means to solve these by the communities,
ii. Supply of safe drinking water and basic sanitation using technologies that the people can afford,
iii. Reduction of existing imbalance in health services by concentrating more on the rural health infrastructure,
iv. Establishment of a dynamic health management information system to support health planning and health programme implementation.
v. Provision of legislative support to health protection and promotion, concerted actions to combat widespread malnutrition,
vi. Research into alternative methods of health care delivery and low-cost health technologies, and
vii. Greater coordination of different systems of medicine.

The health strategies include restructuring the health infrastructure developing health manpower and research development. WHO has established some global indicators as the basic point of reference to assess the progress towards Health For All. These indicators to achieve HFA are:

- Reduction of Infant Mortality Rate from the present level of 87 to below 60 by 2000 AD.
- To raise the life expectancy at birth from present level of 58 years to 64 by 2000 AD.
- To reduce the crude death rate from the present level of 10.4 to 9 by 2000 AD.

- To reduce the crude birth rate from present level of 27 to 21 by 2000 AD.
- To achieve a net reproduction rate of 1 by 2000 AD.
- To provide potable water to the entire rural population by 2000.

Nigeria took some steps to implement the strategies outlined in National Health Policy. Some of these are:

i. To establish one health centre for every 5,000 rural population (3,000 in tribal and hilly areas) with one male and female health worker.

ii. To establish one primary health center for every 30,000 rural population (20,000 in hilly and tribal areas).

iii. To establish Community Health Centres (CHC).

iv. To train Village Health Guides (NHG) selected by the community for every village or 1,000 rural population.

v. To train traditional birth attendants (TBA) in each village.

vi. Training of various categories of health personnel, e.g., multipurpose workers (MPW).

These schemes are expected to ensure the availability of adequate infrastructure and medical and paramedical manpower to take us nearer the goal of universal provision of primary health care as envisaged in the national health policy.

4.0 CONCLUSION.

You have learnt the concept and definition of health for all by the year 2000 AD. This implies "attainment of a level of health that will enable every individual to lead a socially and economically productive life." This concept has emerged out of the fact that existing health care approach was not able to solve the health problems mainly in developing countries including

Nigeria and there is gross inequality in health service distribution within a country and among countries. You have also learnt about the global strategy, which defines the broad lines of action to be undertaken at policy and operating levels, nationally and internationally. This focuses on 1**)** health a fundamental human right, 2) reduction of gross inequalities in health status, 3) participation of people in their own care, and 4) self-reliance of corn- munities in health matters.

We have focused our discussion on national strategy that resulted in the formulation of national health policy in 1983 with laid down specific targets and goals to be achieved by the year 2000 AD. This is to be considered in relation to various health indicators like, infant mortality rate, maternal mortality rate, immunization, safe water supply and demographic data like crude death rate, and birth rate and net reproductive rate.

5.0. SUMMARY.

- In this unit, we learnt the Concept of health for all by the year 2000;
- Definition and meaning of Health For All
- Strategy for health for all
- Global Strategy
- National strategy
- Strategies and actions proposed at international level
- Strategies and actions proposed at national level

6.0. TUTOR-MARKED ASSIGNMENT

1. Describe the concept of "Health for All" (HFA)?

2 . Write notes on the following:

- Global Strategy for health for all by the year 2000

- National strategy **for health for all by the year 2000**

3. Explain 4 key elements of health policy in Nigeria with respect to HFA by the year 2000.

7.0. REFERENCES /FURTHER READINGS

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UNIT 3. Organization of Health System Based on Primary Health Care

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3.5 Structural Organization of Health System Based on Primary Health Care Agency

3.5.1. Functions of the Primary Health Care Agency.

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3.6.3. Structure of the agency at Zonal level

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5.0. Summary.

6.0. Tutor-Marked Assignment

7.0. References /Further Reading.

1.0 Introduction

In this Unit, you will learn definition and essential characteristics of health systems. You will also learn organization of health system structure at Federal, State and Local Government levels. And at the end we shall introduce you to the organizational structure based on Primary Health Care, which mainly focuses on rural health services.

2.0 Objectives

At the end of this unit, you should be able to:

- ✓ Define the health system
- ✓ List the characteristics of health system.
- ✓ Describe the organizational structure of health system, at Federal, State and Local levels
- ✓ Explain the roles and organization of National Primary Health Care Development Agency.

3.0. Main Contents.

3.1 Meaning and characteristics of health system

Health system can be broadly defined as a coherent whole of many interrelated component parts, both sectoral and intersectoral, as well as community itself, which produces a combined effect on the health of the population. Health system should consist of coordinated parts extending to the home, the work place, the school and community.

If you try to understand the above definition you will be interested to learn what interrelated component parts are. The components of health system include **concepts** (e.g. health and disease), **ideas** (e.g. equity coverage, effectiveness, efficiency, impact), **objects** (e.g.

hospitals, health centers, health programmes) and **persons** (e.g. providers and consumers). Together these form a unified whole in which all the components interact to support one another. Of all these components discussed here we shall mainly highlight the **objects** and **persons** (health system infrastructure).

The health system aims at delivering the health services to the beneficiaries. It constitutes the management sector and involves organizational matters, and also in allocating resources, translating policies into services, evaluation and health education.

The aim of health system is health development, which includes continuous and progressive improvement of the health status of a population, i.e. community. Health system encompasses promotive, preventive, curative and rehabilitative aspects and also caters for the extremely disabled and incurable individuals.

We hope you have now understood the meaning of health system as discussed above. We shall now turn our attention towards the essential characteristics of the health system as given below:

These characteristics/principles are applicable to all health system based on primary health care.

The system should encompass the entire population on the basis of equality and responsibility. It should include components from the health sector and from other sectors, whose interrelated actions contribute to health (e.g. Education sector, public works, animal husbandry, and agricultural sector etc).Health is a subject of overall socio-economic milieu of the community.

3.2. Structural Organization of Health System at Federal Level

The official "organs" of the health system at the Federal level consists of both the Federal Ministry of Health and The National Council of Health.

3.2.1. The Federal Ministry of Health

The Federal Ministry of Health as headed by a Minister. It is a political appointment. Currently, the Federal Ministry of Health has 5 directorates/departments. These include:-

- Department of Personnel Management
- Department of Finance and Supplies
- Department of Planning, Research and Statistics
- Department of Hospital services and
- Department of Primary Health Care and Disease control.

The following are the responsibilities of the Federal Ministry of Health

i) Take the necessary action to have review national health policy and its adoption by the Federal Government.

ii) Devise a broad strategy for giving effect to the national health policy through the implementation by Federal, State and Local Government in accordance with the provisions of the constitution.

iii) Submit for the approval of the Federal Government a broad financial plan for giving effect to the Federal component of the health strategy.

iv) Formulate national health legislation as required for the consideration of the Federal Government;

v) Act as coordinating authority on all health work in the country on behalf of the Federal

Government, with a view to ensuring the implementation of this national health policy.

vi) Assess the country's health situation and trends, undertake the related epidemiological surveillance and report thereon to Government.

vii) Promote an informed public opinion on matters of health; Support State and through them Local Government in developing strategies and plans of action to give effect to this national health policy,

viii) Allocate Federal resources in order to foster selected activities to be under taken by State and Local Governments in implementing their health strategies;

ix) Issue guidelines and principles to help states prepare, manage, monitor and evaluate their strategies and related technical programmes, services and institutions.

x) Define standards with respect to the delivery of health care, and monitor and ensure compliance with them by all concerned; health technology, including equipment, supplies, drugs, biological pro- ducts and vaccines, in conformity with WHO's standards; the human environment; and the education, training, licensing and ethical practices of different categories of health workers

xi) Promote research that is relevant to the implementation of this national health policy and state health strategies, and to this end, to establish suitable mechanisms to ensure adequate co-ordination among the research institutions and scientists concerned;

xii) Promote co-operation among scientific and professional groups as well as non-governmental organizations in order to attain the goals of this policy;

xiii) Monitor and evaluate the implementation of this national policy on behalf of Government and report to it on the findings;

International health

The Federal Ministry of Health sets up an effective mechanism for the co-ordination of external cooperation in health and for monitoring the performance of the various activities. Within the overall foreign policy objectives, this national health policy is directed towards: -

- ✓ Ensuring, technical co-operation on health with other nations of the region and the world at large;
- ✓ Ensuring the sharing of relevant information on health for improvement of international health.
- ✓ Ensuring cooperation in international control of narcotic and psycho-tropic substances;
- ✓ Collaborating with United Nation agencies, Organization of African Unity. West African Health Community, and other International Agencies on bilateral and/or regional and global health care improvement strategies without sacrificing the initiatives of international community, and existing institutional and other infrastructural arrangements;
- ✓ Working closely with other developing countries, especially the neighbouring states within the region which have similar health problems, in the spirit of technical cooperation among developing countries, especially with regard to the exchange of technical and epidemiological information;
- ✓ Sharing of training and research facilities and the co-ordination of major intervention programmes for the control of communicable diseases.

3.2.2. The National Council of Health

The National Council of Health is composed of the following members:

- The Honourable Minister of Health (Chairman)

- The Honourable Commissioners for Health (States)

The following are the functions of the National Council of Health

The National Council on Health advises the government of the Federation with respect to:

- ✓ The development of national guidelines.
- ✓ The implementation and administration of the national health policy and
- ✓ Various technical matters on the organization, delivery, and distribution of health services.

The council is advised by the Technical committee.

Technical committee

The Technical Committee of the National Council on Health is composed of:

- The Federal and State Permanent Secretaries (M.O.H)
- The Directors of Federal Ministry of Health
- The Professional heads in the state Ministries of Health.
- A representative of Armed Forces Medical Services;
- Director of Health Services, Federal Capital Territory, Abuja.

Expert panels

a. The Technical committee usually set up as required, appropriate programme expert panels including the representatives of health related Ministries such as :

- ✓ Agriculture, Rural Development and Water Resources
- ✓ Education
- ✓ Science and Technology
- ✓ Labour
- ✓ Social Development, Youth and Sports

- ✓ Works and Housing
- ✓ National Planning
- ✓ Finance

b. Health related bodies

- ➢ National Institute of Medical Research ii. Medical Schools
- ➢ Schools of allied health professionals
- ➢ Non-governmental organizations
- ➢ Professional associations (Health) e.g. NMA, NANNM, PSN, among others

3.3. Structural Organization of Health System at State level

At present there are 36 States and the Federal Capital Territory, Abuja and has many types of health administration. In all the states, the management sector for health lies with the Ministry of Health while in some states, Health management Board also participates in the management.

3.3.1 State Ministry of Health Organization:

The state Ministry of Health is headed by an Honourable Commissioner, while in Health Management Board, there is governing Board with an Executive Secretary. The Commissioner is the Political head of the Ministry while the Permanent Secretary is the administrative head. There are Directors manning the directorates assisted by Deputy and Assistant directors.

Functions: The State Ministries of Health directs and co-ordinates authority on health work within the State via:

- Ensuring political commitment ii. Ensuring economic support

- Winning over professional groups
- Establishing a managerial process
- Public information and education
- Financial and material resources provision
- Intersectoral action
- Coordination within the health sector
- Organizing primary health care in communities
- Federal system
- Logistics system
- Health Manpower recruitment and retraining
- Priority health programmes.
- Health technology.

3.4 Structural Organization of Health System at Local level

There are 774 Local Government Areas in Nigeria with various health facilities operating under the hinges of primary health care (PHC).

The Local Government Headquarters coordinates the activities of the health facilities providing manpower, funds, logistics etc. The Local Government is headed by elected Chairmen with council members. Supervisory councilors are also appointed to oversee various aspect of Local Government activities including Health and Social Services. The health department is always headed by a Primary Health Care Coordinator.

Functions of the local government .Provision and maintenance of essential elements of primary health care: environmental sanitation; health education

i. Design and implement strategies to discharge the responsibilities assign to them under constitution and to meet the health needs of the local community under the general guidance, support and technical supervision of state health Ministries.

ii. Motivation of the community to elicit the support of formal and informal leaders.

iii. Local strategy for Health activities. Examine this illustration, which provides an overview of health care delivery system at the three levels of health care i.e. primary, secondary and tertiary levels. As you know a full range of primary health care (first level contact of individual, family and community health system) are being rendered through the agency of primary health centers.

iv. Secondary Health Care is being provided through the establishment of Cottage, General Hospitals where all basic specialty services are being made available.

v. Tertiary care is being provided at Teaching and Specialist Hospitals where super specialty services including sophisticated diagnosis, specialized therapeutic and rehabilitative services are available.

3.5 Structural Organization of Health System Based on Primary Health Care Agency

As a signatory to the Alma-Ata Declaration, the Federal Government of Nigeria is committed to achieve the goal of Health for All through primary health care approach. Keeping in view the goal of "Health for All" by 2000 AD and beyond, the National Health Policy laid down plans of actions for reorienting and shaping the existing rural health infrastructure within the frame work of various year plans. The establishment of primary health centers in our country in 1986 under the National Primary Health Care Development Agency has been a valuable national asset in

our efforts to increase the outreach of our health system based on primary health care.

3.5.1. Functions of the Primary Health Care Agency.

(a) Support to health policy

i. Review existing health policies, particularly as to their relevance to the development of PHC and to the integrated development of health services and health manpower, and propose changes when necessary.

ii. Prepare alternatives for decision makers at all levels based on scientific analysis, including proposals for health legislation;

iii. Conduct studies on health plans for PHC at various levels to see whether they are relevant to the national health policy, feasible and multi-sectoral

iv. Promote the monitoring of PHC implementation at various levels;

v. To stimulate the development of PHC technical on an equitable basis in all LGAs, for example technical support to implementation of selected PHC components as required. This assistance will be provided strategically to enhance orderly development, for example, to improve upon or introduce new skills required for the services or to integrate new components into them;

(b) Resources mobilization

i. To mobilize resources nationally and internationally in support of the programmes of the Agency.

ii. To conduct or commission studies on resource mobilization for health and issues of cost and financing, with particular reference to equity.

(c)Support to Monitoring and Evaluation

i. Monitor the development of the nation's PHC programme so that it keeps as much as possible within the guidelines set out for its development in the National Health Policy and PHC Guidelines and Training Manuals;

ii. Develop guidelines and design frame works for periodic evaluation of primary health care at various levels;

iii. Monitor the monitoring and evaluation process nationally, with particular respects to the development of capabilities of LGA level to analyze and make use of monitoring and evaluation data for management decision making.

(d) Technical support

i. Provide technical support to the preparation of a health manpower policy, including manpower projections to enable development of a PHC manpower plan;

ii. Provide advocacy and support for the orientation of medical undergraduate education, and the education of other health professionals, towards PHC.

(e) Organization of Health System

i. To identify orientation and continuing education needs of PHC manpower, including medical, organize programmes to meet these needs, using Schools of Health Technology as a resource;

ii. To support directly the strengthening of the Schools of Health Technology.

iii. Support to the village health system: In view of the importance of this level of the national health system in extending coverage, the Agency should:

iv. Pay special attention and provide maximum support to the training deployment, logistic support and supervision of village health workers and TBAs: the relationship between these workers and their communities and the mechanisms which link

these workers to the other levels of the health system;

v. Pay special attention to the involvement of women and grass-root women's organization in the village health system.

(f) Health system research (HSR)

i. Promote and support problem-oriented HSR as a tool for finding better ways for the provision of essential care as a component of health for all, in particular the introduction of HSR in the LGA health system and the support of the other levels of this efforts.

ii. To undertake or commission HSR operations research into the functioning of PHC programmes;

iii. To respond to request from government and other agencies in organizing special studies by mobilizing experts who will respond rapidly and in-depth to guide legislative and administrative action.

(g). Technical collaboration

i. To stimulate universities, NGOs and international agencies to work with LGAs in nurturing their capacity for problem solving;

ii. To develop LGA capacity to seek technical collaboration including from other LGAs in developing and implementing their PHC programmes;

iii. To promote collaboration with other sectors at all levels in the development and support of LGA primary health care system;

iv. To monitor the collaboration for PHC between the international agencies and government

at all levels;

v. Promote and organize both the sharing of experience of the Agency with the world community (publications, reports, etc) and the collection of all relevant information from other countries and international organizations and disseminate it to all interested parties;

vi. Promote maximum support to all its efforts by networking and creating formal and informal collaboration with relevant Nigerian and international institutions.

vii. Promotion of PHC: All activities carried out by the Agency will be promoting PHC. **Specifically, however, the Agency should**

a) carry out advocacy at the level of community leaders, mass media and NGOs, to promote PHC, making particular efforts to ensure that elected officials and party functionaries are continually oriented towards PHC and health for all;

b) re-orientate health professionals towards PHC by means of conferences, seminars, and other meetings;

c) support the documentation of PHC through commissioning of case studies, reviews, books, articles, newsletters and other media productions as appropriate;

d) establish Resource centers to serve as national and zonal depositories of information on PHC implementation;

e) Organize seminars, reviews and other meeting to promote PHC and share experiences in implementation, with a view to strengthening LGA health systems;

f) Provide annual reports which are widely disseminated on the status of PHC implementation nation-wide.

3.6. Organization of the Primary Health Care Development Agency.

To be able to perform its functions effectively, the Agency is an administratively autonomous Agency under the supervision of the Federal Ministry of Health. In addition, it has a Board of Directors. It has an Executive Director who heads the team responsible for guiding the development of the PHC system. He/she must therefore have' considerable experience in this area. There is also a Scientific Committee in the Agency in which various experts with relevant skills are represented. The composition and modalities for functioning of the scientific committee is prepared by the Executive Director and approved by the Board.

3.6.1. The Board.

The agency has a board to:

- Receive reports on the state of development of the national PHC programme.
- Approve the activities of the agency and its budget Have overall responsibilities for personnel matters;
- Assist with the mobilization of funds.

The board consists of the following members:

i. A chairman, who will be a highly respected primary health care practitioner;
ii. The secretary, who will be the executive director of the agency;
iii. Director of PHC at the federal level
iv. A representative of the conference of provosts of college of medicine;
v. A representative of the conference of principals of community health officer's

training institutions;

vi. A representative nominated by the National Association of Nigerian Nurses and Midwives;

vii. One State Ministry of Health representative from each PHC zone nominated by the National Council of Health in rotation to serve for a period of 3 years.

viii. One LGA representative from each PHC zone, nominated by the Conference of LGA Chairmen, in rotation to serve for a period of 3 years.

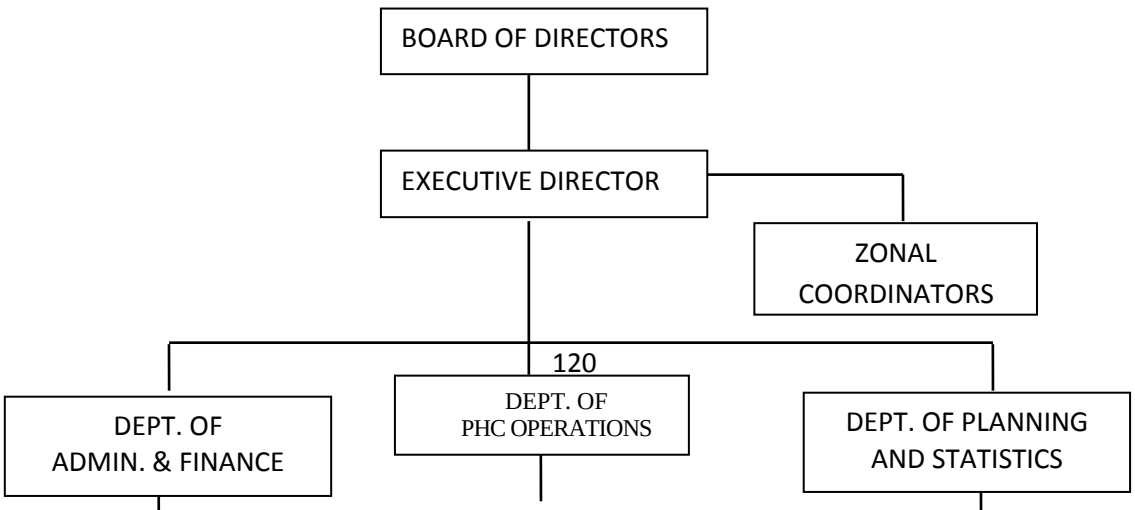
ix. A representative of the National Planning Commission;

x. A representative of NGOs working in PHC

xi. Representative of the National Commission for Women.

3.6.2. Structure of the agency at federal level. .

The Agency has a small core of professional staff at the Federal Level. The Staff are expected to follow the guiding principles of team work. Moreover, the Agency has the ability to draw on outside expertise to the maximum extent possible.



3.6.3. Structure of the agency at Zonal level

The offices should collaborate with the State Ministries of Health to strengthen LGA PHC systems. To be effective in providing LGAs with technical assistance, it is proposed that the zonal offices be organized along the same lines as the LGA PHC Departments are currently organized. The zonal offices, are therefore, proposed to be constituted as shown below.

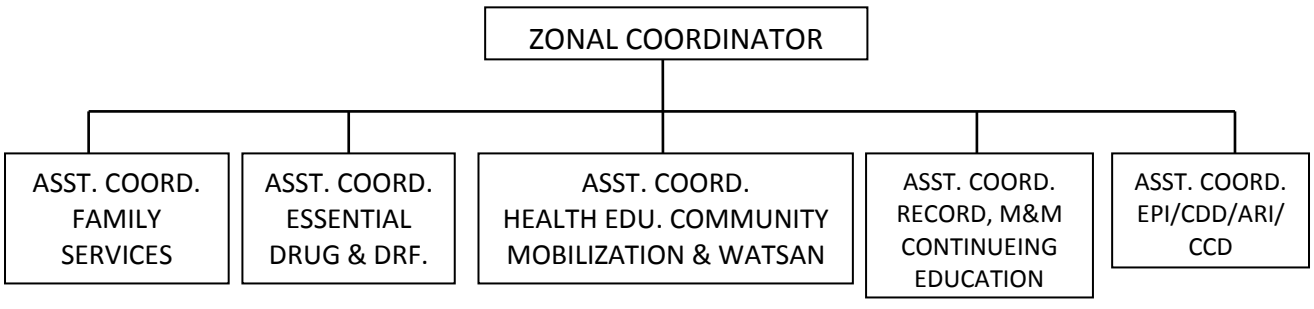


Fig. 2: Structure of the agency at zonal level

The assistant coordinators will oversee the functions allocated to them as follows:

Family health services*:* Maternal and child health services including family planning and nutrition/growth monitoring promotion; Essential drugs and drugs revolving fund, medical stores, essential drugs and drugs revolving fund promotion; Health education, community mobilization, water and sanitation.

Promotion of health education: Development of the managerial process through establishment of committee and training of committee members at all levels so as to achieve the followings:

- Promotion of water and sanitation projects;
- Records monitoring and evaluation,
- Collection, collation and analysis of monthly reports from all LGAs and States.
- Promotion of feedback to those levels;
- Writing periodic zonal report and widely disseminating the same;
- Establishment and maintenance of zonal resource centre;
- Serving as focal point support of PHC project formulation in LGAs in the zone
- Coordination of the integration of EPI and diarrhea diseases, ARI and communicable diseases control programmes (guinea worm, TB and leprosy, onchocerciasis, chistosomiasis and AIDS) in the PHC systems in the zone.

The above organizational structure entails strengthening the zonal offices considerably. The resources needed at this level include personal, office accommodation, transportation and increased financial allocation to ensure that field work will go in the LGAs unhindered.

4.0. CONCLUSION.

In this unit, you learnt about the organization of health system. Health system is defined as coherent whole of many interrelated components pans, both sectoral and intersectoral as well as community itself, which produces a combined effect on the health of the population. Health system is organized at three levels; federal, state and local level. At the federal level official organs are, Federal Ministry of Health and National Council of Health. The federal Ministry of Health is headed by a Minister assisted administratively by the Permanent Secretary and has five departments, namely planning, research and statistics, personal management; finance and supplies, hospital services and primary health care/disease control. These departments are headed by directors.

At the state level, the health sector comprises State Ministry of Health and Health Management Board in some states. The State Ministries of Health is headed by a Commissioner, assisted by Permanent Secretary and Directors. At the local level, the head of department is the Primary Health Coordinator with assistants overseeing other areas such as immunization, AIDS/HIV, measurement and evaluation, nutrition. Lastly, you learnt the structural organization of health system based on national primary health care agency which focuses on primary health care.

5.0 SUMMARY.

In this unit, you learnt Meaning and characteristics of health system based primary health care, structural organization of health system at Federal, State, and Local levels. You equally learnt Structural organization of Health system based on National Primary Health Care Agency including different roles of the Agency and its Organization.

6.0 TUTOR-MARKED ASSIGNMENT(TMAs)

I. Write briefly on the roles of the following:

- National Council on Health
- Primary Health Care Agency

2. List the eight (8) functions of the PHCDA.

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UNIT 4. COMMUNITY BASED HEALTH SERVICES

CONTENTS:

1.0. Introduction

2.0. Objectives

3.0. Main Content.

3.1 Definition of community based health service

3.2 Community Health Extension Workers

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3.4. Community involvement in health (CIH)

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3.5. Team Approach in Health Service

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3.5.3 Competence of health care team

3.6. Leader of the health Team

3.6.1. Attributes of a health team leader.

4.0. Conclusion

5.0. Summary

6.0. Tutor-Marked Assignments (TMAs)

7.0. References/ Further Reading

1.0. INTRODUCTION

Community based programs are public Health interventions that are designed, implemented and evaluated with the participation of the community representatives and with the guidance of professional experts. In Nigeria, after the acceptance of PHC in the national health policy,

different community based health programs has been initiated. Among these, the use of community health Extension workers and the new Health service extension package are discussed in this unit.

2.0. OBJECTIVES

At the end of this unit, you should be able to:

- ✓ Describe the responsibility of the community in the health care system.
- ✓ Describe the community involvement in the health delivery system
- ✓ Define the concept of the health care team.
- ✓ Describe the need for team based health care and role of the health service team leader.

3.0 MAIN CONTENT.

3.1 Definition of community based health service

Community Based Health Service is a package of services that includes provision of immunization, prevention, control and treatment of malaria, prevention of HIV/AIDS/STDs, tuberculosis, provision of oral contraceptives, deliveries, follow up of high risk pregnant mothers, first aid, sanitation services including excreta disposal, insect and rodent control, safe water supply, housing construction and overall environmental issues in the rural context. It is to improve access and equity to preventive essential health intervention through community based

health services with strong focus on sustained preventive health actions and increased health awareness.

3.2. Community Health Extension Workers

The concept of the community health Extension worker (CHEW) has found new expression in health programs in many parts of the world as part of the Primary Health Care initiative springing from Alma-Ata. It is an adoption of traditional village practice of midwives and healers to modern, organized public health services. CHEWs were first recruited to provide care in rural areas in developing countries without access to health care. They are selected from the community and training will be given by the Ministry of Health (health centers).

Community health Extension workers may provide services on categorical target diseases. These include malaria control, tuberculosis directly observed therapy (DOT, providing medication under supervision to assure compliance), support services and counseling for multiproblem families in an inner-city poverty area, STD follow-up, and promotion of immunization Health Service Extension Package (HSEP)

The main objective of HSEP is to improve access and equity to preventive essential health intervention through community based health services with strong focus on sustained preventive health actions and increased health awareness. The health extension service is being provided as a package focusing on preventive health measures targeting households particularly women/mothers at the rural level.

3.3. Community responsibility

Need, demand, custom and general development have led society to accept certain health services as a community responsibility on behalf of the total citizens. As the population increases and tends to concentrate in urban centers, some new health problems that have long been with communities become more complex and more difficult to manage. If community health problems of today are more complex, society has advanced technology in dealing with some of them. Most community health services directly or indirectly will be of value to all citizens but of greater value to lower income group than to higher economic groups. For instance, community immunization services will have a greater protective impact on lower income groups but will have some value, direct or indirect, for people on all income levels.

3.4. Community involvement in health (CIH)

The idea of community involvement in health (CIH) emerged as a result of concern to encourage local participation in all aspects of development, including health development. It means local participation in the design and delivery of health care services. In most areas of development, preference seems to be given to the term ‘community participation’ because of its deeper implications.

3.4.1. Community participation: There are a Varity of different interpretation of the concept of participation. It is important to reduce the different views of concept of participation by distinguishing two broad, but very different categories of interpretations as the two ends of a continuum: participation as a means and participation as an end.

Participation as a means: Health development is an important element in the development process in general and is therefore influenced in practice by different perceptions of what

constitutes development and what causes under development. Until recently, early 1970s, the development process was largely dominated by attempts on the part of development planners and workers to modernize and improve the technical performance of the physical assets of a particular country or area. But starting from the early 1970s, a fundamental reappraisal of the nature and content of the development process has been underway. The essential feature of this appraisal has been the concept of "participation". In this interpretation, participation is seen as the means of achieving a set of objectives or goals. Government and development agencies responsible for providing services and with the power to control resources see participation as a means of improving the efficiency of their service delivery systems. Sharing in the benefits of the delivery system is the more characteristic outcome of this form of participation. It is the form of participation more commonly found in rural development programmers and projects.

Participation as an end: Participation in rural development may on the other hand be regarded as an end in itself. In a rural development project, participation as a process is a dynamic un-quantifiable and essentially unpredictable element. It is an active form of participation, responding to local needs and changing circumstances. Generally, participation as an end in itself presupposes the building-up of influence or involvement from the bottom upwards. As a result, this form of participation has come to be associated with development activities along with the formal government sector, and is concerned with building up pressures from below in order to bring about change in existing institutional arrangements.

3.5. Team Approach in Health Service

3.5.1 Need for the Health service team.

In order to effectively respond to identified needs, health persons must be able to work within a team framework in which problem solving is approached in an integrated manner. A health team must be in a position to effectively communicate information to communities and individuals and develop mechanisms, which facilitate their involvement in all health activities. A health team must also establish communication links with other sectors and promote intersectoral collaboration. The need for a better-integrated health care team occurs because of:

- ✓ **Poor communication**: -Lack of integrated record keeping system result in an uneven and incomplete exchange of information among the professionals who provide health care services.
- ✓ **Duplications of services**: Lack of coordination and communication at times leads to duplication of services. For instance, if service provider does not have access to test results previously ordered, a request will be made for new test. Diagnostic tests and other services may be repeated by several service provides, resulting in excess cost and additional stress for the patient. Errors and inappropriate therapy from prescription of medication may occur when more than one health professional are prescribing drugs for a patient.
- ✓ **Lack of patient focus**: Patients are seeking continuity and coordination of care, competence, accessibility and timeliness, reasonable cost and some sense that someone in the "system" cares about them. When health care professionals do not work well together, patients feel that commitment to them as individuals in need of care is lost.

3.5.2 The health Team

The health team may be defined as a group of people who share a common health goal and common objectives, determined by community needs, to the achievement of which each member

of the team contributes, in accordance with his/her competence and skill and in coordination with the functions of others. All personnel working in the primary health care post, sub-center or center constitute the health team. The term does not refer only to the personnel concerned with the health care directly, such as medical officers, nurses, auxiliary nurses, midwives, sanitarians, and traditional or trained birth attendants, but also comprises of health care workers as well as other supporting personnel including, divers, clerks, storekeepers and other persons working in the health institution.

3.5.3 Competence of health care team

No one model is appropriate for the variety of settings in which team delivered health care operates. Membership of the team, and issues such as distribution of authority and communication mechanisms will vary widely depending on the purpose of the teams; whether the team is community based . . . delivering services to a home care population; or clinic based . . . providing services to individuals with severe chronic diseases; or hospital based . . . furnishing care to the most severely ill, in an intensive care unit. However, the absence of a single model does not mean that good teams share no common attributes.

The following are key **characteristics of a well functioning health care team Patient centered focus**:

a. **A good team must have as its first priority meeting the patient's need.** A team with a patient centered focus will consider and respect the patients values and preferences when making care decisions.
b. **Establishment of a common goal:** If the patient's needs are to be the focus, it is critical that all team members know what a successful outcome for each patient's care will be. At

times a successful outcome may not be self-evident. For example, health care professionals treating a critically ill patient may work at cross purposes if some feel the patient should be treated aggressively while other feel that the patient should only receive palliative care. Such confusion may be avoided only through an explicit process for goal definition. If choices are to be made between competing outcomes, the patient and/or the patient family must of course be involved.

c. **Confidence on other team members:** Confidence in other team members develops with time and most certainly requires an understanding of other member's roles. Each member must be able to trust the work of others. If professionals do not have trust in another's work, duplication of services may occur. For example, a specialist physician who is not confident in the care provided by the general practitioner may order extra or unnecessary test for the patient.

d. **Flexibility in Roles:** While understanding and respect for each person's specific role is important, flexibility in assignments is also important. It is undesirable for each team member to duplicate efforts made by others; but, if meeting the agreed upon objective calls for changes or flexibility in roles, team members must be prepared to act accordingly and with respect to professional standards of practice.

e. **Mechanisms for conflict Resolution:** Every health care team will experience instances of conflict. However, a successful health care team will identify a specific mechanism, clearly understood by all, for resolving conflict, through a team leader, outside leader, or other process.

f. **Development of effective communication**: Good health care team communication involves at least two components . . . a shared, efficient and effective reward keeping mechanisms, electronic or other, and a common vocabulary.

g. **Shared Responsibility for team Action**: Effective team functioning can occur only if each team member shares fully the responsibility for actions of the team as a group . . . and is willing to be held accountable to these actions. Understanding of such responsibility requires of course confidence in the abilities of the other team members, good communication and agreement up on a common goal.

h. **Evaluation and Feedback:** Team design must be dynamic open for evaluation and revision on a continuing basis. A model that worked previously may no longer be obtained, as there is change in the patient's needs, the health care delivery system or the expertise of team members. A specific mechanism must be developed for ongoing evaluation of a team's effectiveness and redesign activities where needed.

3.6. Leader of the health Team

The health team should have a leader, who should inspire confidence in the community, which needs and seeks medical care. The leader should be able to induce colleagues and team mates to work to the best of their capacity.

3.6.1. Attributes of a health team leader.

i. **Co-ordination and co-operation:** The team leader should be able to achieve preferred co-ordination and co-operation with all members of the team, so that the efficiency and output of the heath team is high and the work is interesting, satisfying and rewarding. The leader of the health team should realize that the health team consists of individuals who have

feeling, personal interests, stress, conflict, likes and dislikes, just as other people. Health team members appreciate encouragement praise and appreciation for their achievements, from their leader. The emotional needs of people are better satisfied, if they are given the responsibility and authority to carry out the jobs assigned to them.

ii. **Approachability:** The team leader should be easily approachable, so that the team members can reach him and seek his help and guidance for solutions to their personal, technical and official administrative problems. He should earn respect from his juniors and not command it by creating awe and by his blistering behavior.

iii. **Competence:** The leader should be competent in his own technical work, so that his teammates respect him for his knowledge and skills.

iv. **Disciplined and well organized:** The team leader should be disciplined and well organized in his thought and work. He should arrange to disburse the salaries of the staff regularly, procure supplies in time and exude an image of an efficient manager of affairs. This can easily be achieved by delegating responsibilities for simpler tasks to his subordinates.

v. **Delegation of authority:** The focus of a good team leader should be on setting the job done and not on who does the job. A manager should not overburden himself with routine activities, because he must have time to think, plan and co-ordinate the work of his teammates. Delegation of responsibility and authority by the team leader to the health team is equally important in the primary health care setting. The efficiency of the health care system improves since it saves time of the leader, particularly if the catchment area under him is large.

vi. **Supervision of the health team:** For accomplishing the desired result, activities of different members of the team need to be co-coordinated. Health team is like a chain; one weak link in the chain breaks the entire chain. A good leader identifies the weak links by constant supervision at regular intervals. The leader of the team should prescribe the proper norms of performance and define the time period during which the specific job should be completed. The workers should be made fully aware of what is expected of them. The supervision should then review their work by analyzing the tasks completed in the given time in relation to the expected quality of work and standard of performance.

vii. **Supervisory style:** Depending on the nature of the team, the team leader may be an autocrat or a democrat. Authoritative or autocratic and democratic or consultative style of supervision has a distinct place and role in taking management decisions. The autocratic style of supervision is more suitable, when the results proposed to be accomplished have to be consistent and uniform and need to be achieved quickly, such as health problems due to epidemics rages of war and natural disasters. It is good to apply democratic styles of supervision when the colleagues in the team are well educated, competent, reliable and experienced. In a consultative style of supervision, the workers shoulder greater responsibility and give their best to the organization.

viii. **Span of control of the supervisor:** For the best result, the span of direct control of the supervisor should be restricted to about six to ten persons. But a good manager may be able to extend his supervisory span indirectly by delegating some of his supervisory change to appropriate workers lower in the line of command.

ix. **Co-ordination between the team members:** the supervisor of the team should ensure that individuals in the health team cooperate with each other and coordinate their activities to

accomplish the desired tasks. Therefore, the first essential work by a supervisor to be communicated in unambiguous terms to the workers is what is to be done, by whom, where, how and when. If the number of people in the team to be coordinated is large, it is useful to convene a meeting of all concerned at a convenient, time acceptable to majority of them. In this meeting, the team leader should sort out difficulties and doubts of the workers and decision should be taken and announced to all members.

4.0. CONCLUSION

In this unit, we discussed extensively on concept of community based health services, rationale of community participation and involvement. We concluded with an overview of team approach in health service team including Leadership of the health Team.

5.0. SUMMARY

In this unit you learnt Definition of community based health service, description of Community Health Extension Workers, Community responsibility, Community involvement in health (CIH), Community participation, Team Approach in Health Service, The health Team and Attributes of a health team leader

6.0. TUTOR –MARKED ASSIGNMENTS (TMAs)

- Describe the responsibility of the community in the health care system.
- Describe the community involvement in the health delivery system.
- Define the concept of the health care team.
- Describe the need for team based health care and role of the health service team leader.

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