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COURSE CODE: NSS 311

COURSE TITLE: Primary Health Nursing

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Course Team Mr. K.S. Olubiyi (Developer/Adapter) – NOUN
Dr. Femi Peters (Editor) – NOUN
Professor O.C. Nwana (Prog. Leader) – NOUN
Mr. K.S. Olubiyi (Course Coordinator) – NOUN

NATIONAL OPEN UNIVERSITY OF NIGERIA

National Open University of Nigeria
Headquarters
14/16 Ahmadu Bello Way
Victoria Island
Lagos

Abuja Office
No. 5 Dar es Salaam Street
Off Aminu Kano Crescent
Wuse II, Abuja
Nigeria

e-mail: centralinfo@nou.edu.ng
URL: www.nou.edu.ng

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Course introduction

Nigeria comprises 80 per cent of rural population. There is a great imbalance in provision of medical care facilities and it has become a great challenge to provide health services to the very large population. Primary health care has been considered as the main instrument of action for providing Health For All.

Primary Health Nursing addresses the health needs of the community at all levels of care-primary, secondary and tertiary, in homes, school, health centers and hospitals etc.

The course on Primary Health Nursing is divided into four blocks. Block 1 deals with the concepts related to Health For All which focuses on how goal of health for all can be achieved and what .type of services are needed to achieve this goal. Block 2 focuses on Family Health Care, which focuses on the concepts and services provided to the family. Block 3 deals with Maternal and Child Health Care. Study of maternal and child health is extremely essential because these constitute the larger and vulnerable segment of population. Block 4 explains the various elements of primary health care and the role of a nurse in providing primary health care related to all these elements.

After studying the course on Primary Health Nursing, you should be able to:
.Explain the concepts of Health For All and Primary Health Care,
.Explain the concepts related to Family Health Care,
.Provide Maternal and Child Health Care, and
.Perform your role as a nurse in providing primary health care.

Block1 HealthForAll

In the country, the development of health services through primary health care approach is seen as a major thrust of Federal Governments policy which is supported by the International Conference held in Alma-Ata in 1978 which declared primary health care as the main instrument of action towards achieving Health For All by the year 2000 AD.

The Federal Government of Nigeria agreed upon the Primary Care approach for providing health care services. As health care providers, we all need to understand and/or refresh our knowledge and skills related to the concepts of primary health care, and Health For All etc. We must also be interested to learn and understand how the goal of health for all can be achieved? What type of health manpower and health system is required for providing the health services and how should we evaluate such services.

This block is divided into five units. Unit 1 deals with Health Concepts and pre-requisites, Unit 2 explains the Primary Health Care concept and principles, Unit 3 deals with Health For All, Unit 4 focuses on Organisation of Health Care System at various levels, and Unit 5 explains the Resources, Monitoring and Evaluation of Health Services.

As a distance learner you have to study these materials by self study. We have given self assessment questions at appropriate places. These are given to make self assessment. We have also given answers to check these questions at the end of each unit. While working on the self assessment questions you should not read through these answers. Instead you should make every effort to do them by yourself. We hope the information given in this block may help you in improving your knowledge and skill so as to provide effective health care to the people you serve.

Unit 1 Health Concept and Prerequisites

Structure

1.0 Objectives

In this unit you will learn the concept of health and prerequisites of health. After completing this unit, you should be able to:
.Explain the concept of health,
.Define health,
.List and explain the various dimensions of health
.Discuss determinants of health, and
.List and explain prerequisites of health.

1.1 Introduction

You would have already studied the concepts of health in your basic Nursing Programme. We shall now review and try to build on that in order to help you gain a deeper understanding of health. This will enable you to develop knowledge and skill in promoting the health of the people you serve.

Health is considered a fundamental human right and a worldwide social goal. In this unit, we shall try to concentrate on the concept and definition of health and the concept of positive health and well being. An individual is said to be healthy if he enjoys good health in four areas or dimensions i.e. physical, mental, social and spiritual well being. These dimensions will be explained in Section 1.3. Health is affected by various interlinked factors. We shall examine how these factors affect health in Section 1.4. At the end you will learn about the prerequisites of good health. We hope that this knowledge will help you to contribute effectively towards promotion of health.

1.2 Health concept

Every individual and, in fact, all communities have their own concept of health, which has some relationship with their culture. The oldest concept of health is "absence of disease". Even now, maintenance of health is neglected except in conditions of ill health. It is only during the past few decades that health became conceived as a fundamental human right and a worldwide social goal; that is, it is essential to the satisfaction of basic human needs and an improved quality of life. It is to be attained by all people. The perception of health varies among the members of a community including various professional groups (e.g. biomedical scientists, social scientist, specialists, health administrators, ecologists, etc.), which give varied views on the concept of health. You will learn about these changing concepts in the following subsection.

1.2.1 Changing concepts of health

Health has evolved as a concept from an individual concern to a worldwide social goal and encompasses the whole quality of life. A brief account of changing concepts of health is given below. Figure 1.1 will give you an overview of changing concepts of health. These are:

i. Biomedical concept
ii. Ecological concept
iii. Psychosocial concept
iv. Holistic concept

(i) Biomedical concept: This concept stresses the germ theory i.e. disease or ill health is caused due to disease causing organisms. The individual was considered to be healthy only if he was free from disease. The human body was viewed as a machine and disease was considered a consequence of the breakdown of the machine; and one of the doctor's tasks was to repair the machine. This concept was criticized on the basis that it had minimized the role of social, environmental, psychological and cultural

determinants of health. This model was found to be inadequate to solve some of the major health problems (e.g. malnutrition, chronic diseases, accidents, drug abuse, mental illness, environmental pollution, population explosion). In other words, we can say that this concept focused on the view that diseases can only be caused by the organism without taking other causative factors into consideration. For example, typhoid, cancer, malaria, hepatitis and accidents all lead to disease and/or ill health of a man; but you will agree that only typhoid, malaria and hepatitis are caused by organisms whereas cancer and accidents are not. So this concept needed to be changed.

(ii) Ecological concept: Dubos defined health as the relative absence of pain and discomfort and a continuous adaptation and adjustment to environment to ensure optimal function, which leads to longer life expectancy and a better quality of life. Ecology focuses on mutual relationship 'between man and his environment and visualizes health as a dynamic equilibrium between man and his environment. Maladjustment of a human being to his environment results in disease.

The ecological concept raises two issues, imperfect man and imperfect environment. For example, environmental pollution caused by deforestation and urbanization, resulting in water pollution, over- crowding and air pollution creates an imbalance between man and environment thus affecting his health.

(iii) Psychosocial concept: This concept. visualizes health not only as a biomedical phenomenon but that it is also influenced by various other factors, e.g. social, psychological, cultural, economic and political. These factors are essential in defining and measuring health. This is .both a biological and social phenomenon.

If we are physically tired, our capacity to respond to social interactions will be diminished. Some studies have shown that single people who live isolated, friendless lives, face a much greater chance of becoming ill or dying than people with close relatives and good friends.

iv) Holistic concept: This concept is a. synthesis of all the concepts mentioned above. It focuses on the impact of socioeconomic, political, environmental and biomedical influence on health. It sees the well being of a person as a whole in the context of his total environment.

The holistic approach to health insists that total good health and well being can be achieved only by understanding the whole person in a perspective that includes physical, mental, social and spiritual dimensions. All these four aspects are not separate but they are constantly interacting. In other words, we can say that it corresponds to the ancient view that health implies a sound mind in a sound body, in a sound family and in a sound environment.

We know from our daily experience that problems in one area of our lives affect other areas as well; emotional strain and conflicts can lower our resistance to illness.

SELF ASSESSMENT QUESTION 1

i) Traditionally health is viewed as absence of

ii) Changing concepts of health include:
   a)
   b)
   c)
   d)

iii) Tick *(✓)* the diseases caused by a micro organism
   a) Malaria ☐
   b) Typhoid ☐
   c) Cancer ☐
   d) Poisoning ☐
   e) Hepatitis ☐
   f) Accidents ☐

iv) Explain the 'holistic approach' to health.

1.2.2 Definitions of health

We understand the meaning of health but still we find it difficult to define. Different people have different perception of health. Some feel that when an individual is free from any sickness or disease he is healthy; others feel that an individual is said to be healthy if he is able to perform activities of daily living normally. Still others feel that an individual is healthy if he is well adjusted in social life and can function effectively even in stressful situations. What exactly is meant by health? You will be able to understand better if you go through the following definitions.

a. The conditions of being sound in body, mind or spirit and especially free from physical disease or pain (Webster).

b. Soundness of body or mind; that condition in which their functions are duly and efficiently discharged (Oxford English Dictionary).
c. A condition or quality of the human organism expressing its adequate functioning in given conditions -genetic and environmental.
d. A state of relative" equilibrium of body, form and function which result from its successful dynamic adjustment to forces tending to disturb it. It is not passive interplay between body substance and forces impinging upon it but an active response of body forces working towards readjustment." (Perkin)

The above mention definitions give varied views of health. We shall now try to look into the most widely accepted definition of health given by World Health Organisation (WHO), which states.

Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity.

If you look at the definition carefully, you will realize that three aspects or dimensions emerge from it. These are: (a) Physical (b) Mental and (c) Social Physical well-being means having the physical strength, endurance and energy to work towards your goals. Mental well being is ability to cope with the world in a way that brings you satisfaction; Social well being means development of relationships with others -both with people in your immediate surroundings and with the larger community through cultural, spiritual and political activities.

This also implies that goal of health now calls for not only the cure or alleviation of disease. It calls for even more than prevention of disease. Rather it looks beyond, to strive for maximum physical, mental and social efficiency for the individual, for his family, and for the community.

SELF ASSESSMENT QUESTION 2

i) Health is defined as a state of relative of body, form and functions by its dynamic adjustment to forces that disturbs it.
ii) Health is defined by the World Health Organization as:

1.2.3 Health as a relative concept

Health is a relative concept; this may be due to ecological conditions and the fact that standards of health vary among cultures, social classes and age groups.

This implies that health is not an ideal state and there are no international standards fixed for health. We cannot say that individuals of the same age, belonging to different countries and cultures will have the same health standards. There may be variations in weight and height of an individual belonging to different countries and socioeconomic groups but both will be healthy. We can further clarify this concept by the following example.

A newborn baby in Nigeria weighs 2.8 kg on the average compared to 3.5 kg in the developed countries and yet compares favourably in health.

1.2.4 Dynamics of health

The concept of health dynamics visualizes health as a dynamic phenomenon and as a process of continuous change, i.e. the health of an individual keeps on changing and is not static. It varies within a continuum that ranges from optimum well being to various levels of dysfunction including the state of total dysfunction, namely death. Health and sickness form a continuum ranging from total well being to death with many intermediate stages.

You can also say that health is a dynamic of life rather than a static entity. No longer is the individuals thought of as being "healthy" or "unhealthy", Individuals might function normally throughout a day with varying degrees of efficiency, depending upon the many factors which affect their state of well being which fluctuates on a health continuum rather than remaining static at one point (see Fig 1.2).

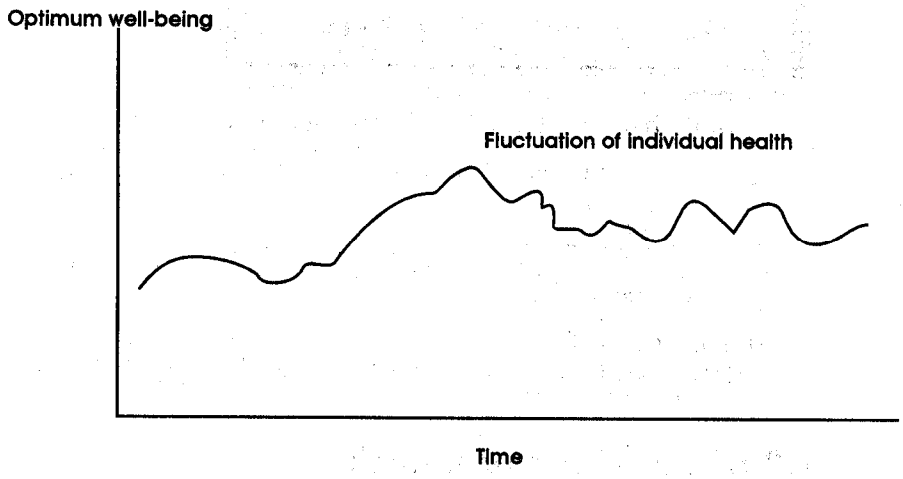
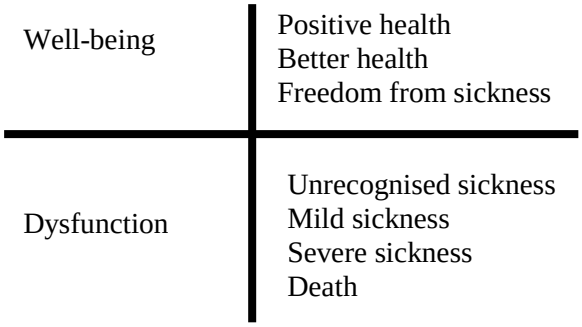


Fig 1.2: Health continuum

Health is not merely a continuum of physical well-being or of mental, spiritual or social well being but a combination of all four dynamically interrelated.

If you look at Fig 1.3, you will find that health and sickness lie along a continuum. The lowest point of the scale is death and the highest point corresponds to positive health. A person may be healthy today but may fall sick tomorrow. The transition from optimum health to ill health can also be rather gradual.



SELF-ASSESSMENT QUESTION 3

State true or false (use T for true and F for false)

a) Standards of health vary among cultures, social classes and age groups.
b) There are no fixed international standards of health.
c) Health is static.
ii) The health of an individual keeps on changing on a ...which ranges from optimum well being to various levels of dysfunction.

1.3 Dimensions of health

The definition given by WHO as mentioned above (in sub-section 1.2.2) covers three dimensions of health, i.e. physical, mental and social (Fig. 1.4). But as per the advances in knowledge you can think of more dimensions, which could be spiritual, emotional, vocational and political, etc. Of these we shall focus mainly on three dimensions and also the spiritual dimension.

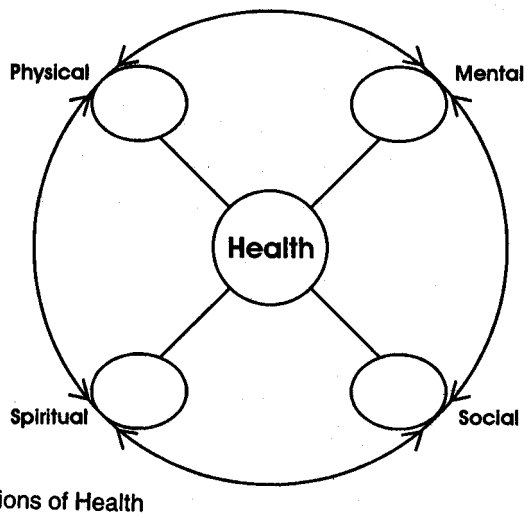


Fig. 1.4: Dimensions of Health

1.3.1 Physical dimension

It means normal functioning of a body or we can say that it is a state of health in which every cell of the body functions at optimum level and there is a balance in functioning within organs and the systems of body. Physical health includes a good complexion, clean and healthy skin, good body maintenance, good clothing, cleanliness, good appetite, happy disposition, sound sleep, regular activity of bowels and bladder. Other signs include normal pulse rate at rest, normal blood pressure and normal exercise.

We spoke about physical health 'and its components, now we shall talk about assessment of physical health which includes:

- self assessment of overall health
- general observation -clinical examination
- nutrition and dietary assessment
- biochemical and laboratory investigation.

You will know more about this under Block 2 in Family Health Care and in your courses in subsequent years.

If you are working in a community, the overall health status of the community can be assessed by knowing the mortality rate and life expectancy of the community.

1.3.2 Mental Dimension

As we said that health is more than mere absence of illness, similarly we can say that mental health is not merely the absence of mental disease or mental illness. Mental health and physical health are interdependent. A poor mental health adversely affects the physical health and vice versa.

Mental health is the ability of an individual to adjust to varied situations and to respond to varied experiences with a sense of purpose and with flexibility.

Mental illness is not simply the absence of mental illness but it is the ability to find happiness and fulfillment to adjust and change and to grow throughout one's life.
Mental health is happiness; the ability
.to get along with other people
.to cope up with the demands of the world without undue stress
.to be satisfied with the sense of achievement and personal fulfillment.

Mental health has been defined as:
.a state of balance between the individual and the surrounding world .a state of harmony between the individual and the surrounding world .state of harmony between oneself and others
.a coexistence between the realities of self, those of other people, and the environment.

Mental ill-health can lead to disturbances in physical and psychological functioning of the body and may lead to illness like hypertension, peptic ulcer and bronchial asthma.

We hope you have now understood the definition of mental health. We will now explain the characteristics or attributes of a mentally healthy person.

a. A mentally healthy person is free from internal conflicts; he/she is not at 'war' with himself/herself.
b. He/she is well adjusted, i.e. he/she is able to get along well with others. He/she accepts criticism and is not easily upset.
c. He/she searches for identity
d. He/she has a strong sense of self esteem
e. He/she knows himself/herself, his/her needs, problems and goals.
f. He/she knows his/her strengths and weaknesses
g. He/she has good self control-balances rationality and emotionality.
h. He/she faces problems and tries to solve them intelligently, i.e. problems of stress and anxiety.

1.3.3 Social dimension

We spoke about the physical and mental dimensions. Now we come to the third dimension of health, i.e. social health. This aspect visualizes the individual as a member of a family, community and the world and focuses on the well-being of a person socially and economically.

Social well being has been defined by J .E. Park as:
"The quality and quantity of an individual's interpersonal ties and extent of involvement with the community".
This means that social well being implies harmony and integration within the individual, between each individual and other members of society and between individuals and the world in which they live.

The social dimension includes practicing social skills, social functioning and the ability of a person to see himself as a member of larger society.
If you try to recall the discussion on the dimensions of health, you will realize that all the three are interrelated and interdependent. We cannot take them in isolation. If an individual is physically unhealthy, this will affect his mental health as well as social health and vice versa. If physical health is affected, there will be imbalance within the individual, which will affect his mental as well as social health.

1.3.4 Spiritual dimension

You will agree that another important dimension which could be examined is the spiritual dimension. This includes a study of principles of ethics, beliefs, purpose in life and commitment to some higher being. Spiritual well-being is not in isolation from mental well-being of a person. It is now believed that spiritual values influence our behaviour and mental well being e.g. if you do meditation, it helps to keep you free of mental worries and stresses of daily life and gives freshness and peace of mind.

To sum up the above discussion on dimension of health we can say that the individual functions as a whole or as an integrated unit with each dimension of health having an influence upon other dimensions. For instance physical illness has an effect on one's emotional well being, spiritual state and social relationships. The psychosomatic aspects of health also illustrate dynamic interrelation among these dimensions of health. For example, an individual beset with social and emotional problem has physical problems of high blood pressure or peptic ulcer.

All the concepts related to dimensions of health introduce us to the concept of positive health, which can be stated as follows:

If an individual is in a state of well-being biologically, psychologically, socially and spiritually he is said to have positive health.

The next question is: what are the factors that affect the health of an individual? The answer to this question is given in Section 1.4, i.e. determinants or factors affecting health.

SELF ASSESSMENT QUESTION 4

i) What are the main dimensions of health?
   a)
   b)
   c)
   d)

ii) Fill in the blanks:
   a) Physical well being means optimal. of body and there is a balance within the organs and systems of body.
   b) Mental health is the ability of an individual to ….situations.
   c) Social well being implies harmony and. within the individual, between individuals and other members of society.

1.4 Determinants of health

The health of an individual is affected by factors within the individual and within the society in which he or she lives. These factors may be health promoting or deleterious. These factors are given below (Fig. 1.5).

.Heredity
.Environment
.Life Style
.Socioeconomic conditions
.Health and family welfare services

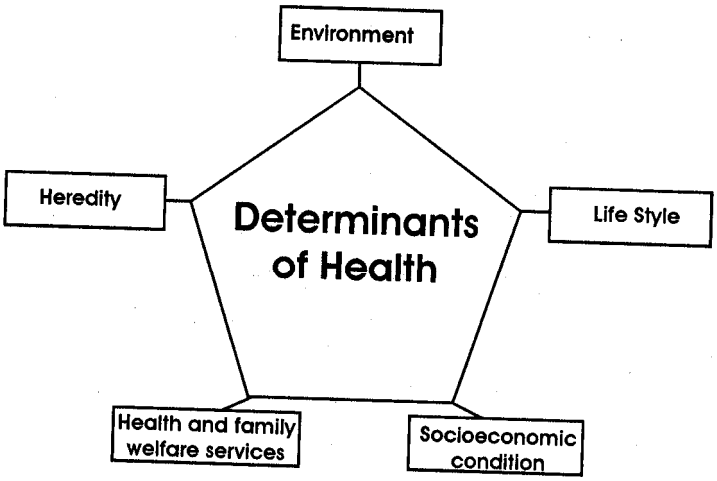


Fig. 1.5: Determinants of health

We shall now discuss these determinants in detail.

1.4.1 Heredity

An individual's physical and mental characteristics are inherited from his parents and these physical and mental traits of an individual are determined by genes during conception. The health of the mother, her nutritional status, the drugs she takes and the investigation she undergoes influence the health of the foetus. The genetic characteristics cannot be altered after conception and the genetic influence of the parents can lead to some genetic disorder in the child, which could be chromosomal anomalies like, hemophilia and Down's syndrome, errors of metabolism and mental retardation, etc. Thus the health status of an individual depends to some extent on his genetic constitution.

1.4.2 Environment

Environment refers to the surroundings in which an individual lives. The environment may be internal as well as external. The internal environment or microenvironment pertains to the tissues, organs and systems of the body and the harmonious relationship between them. The external environment or macro environment consists of all those things to which an individual is exposed after conception such as, air, water, food, housing, etc. Environment is divided into three components: physical, biological and psychosocial; each of these have a direct impact on the physical, mental and social well-being os human beings. Now we shall have a quick look at different types of environment.

i. *Physical environment*

Physical environment includes housing, water, light, noise, excreta disposal, etc., with which man is in constant interaction. A defective physical environment continues to be a major health problem in developing countries including Nigeria.

The environmental hazards could be water pollution, air pollution, noise pollution and urbanization, etc. We shall further try to explain this with the example given below.

Consider that if a person lives in an environment where there are no sanitary drains, no proper housing, no proper disposal of refuse and excreta and no water supply. There will be fly breeding. You can now imagine the hazards that man will be exposed to in this physical environment which will affect his health. These hazards would be diarrhea, cholera, typhoid etc. On the contrary, if he lives in a safer environment, with proper sanitary conditions, he is less exposed to hazards of health.

ii. Biological environment

Biological environment includes all living things which surround man, including man himself. The living things may be viruses, bacteria, insects, rodents, animals and plants some of which may act as disease producing agents, reservoirs of infection, intermediate host and vectors of diseases in their interaction with man.

iii. Psychosocial environment

Psychosocial environment refers to the people who live around the individual -may be at home, at school, at workplace, at neighbourhood and in professional organization. This implies that man is a member of a social group, member of a family, of a tribe, of a community and of a nation. If a person has healthy interactions with all these groups he feels healthy and happy. If he is frustrated in his interactions he feels mentally unhappy, which affects his health.

1.4.3 Life style

Life style refers to the way of living or the way the people live. It reflects social values, attitudes and activities of an individual. It refers to the way we behave, work, eat, rest sleep, and perform other activities of daily living. It consists of cultural and behavioural patterns and personal habits of an individual. Life style affects the health of an individual. A healthy life style helps to promote health and a poor life style has ill affects on health. For example in Nigeria due to persistence of a poor traditional life style especially in highly densely populated areas of our cities, there are risks of death and illness connected with lack of sanitation, poor nutrition, personal hygiene habits, customs and cultural patterns. Some life styles can promote health, e.g. adequate nutrition, enough sleep, sufficient physical activity, adequate education and employment.

Many of our health practices are those that we have learnt from our parents I or have adopted at an early age. These have become so intricately woven into the fabric of our current health behaviours that to become aware of them and their possible harmful effects requires a conscious effort to examine our lives from the perspective of health. We further have to make a concerted effort to change habits, which die hard, e.g. dangers of cigarette smoking are well known; every cigarette pack carries a warning that 'Smokers are liable to die young' .There are media campaigns to alert people to this danger; but despite this people continue to smoke.

Another factor is the quality of modem life styles, which are often the source of health problems. Due to a fast moving life, man is exposed to stress and strain, which are caused, by pollution, poor nutrition and psychological stress.

1.4.4 Socioeconomic conditions

The health of an individual is determined by his socioeconomic development, e.g. per capita G.N.P., education, nutrition, employment, housing and the political system of the country. We shall glance through these components to have an overview.

i. *Economic status:* This is an important factor in seeking health care as it determines the purchasing power, standards of living, life style and family size-which affects our health.

ii. *Education:* This is a major factor which influence health. Illiteracy leads to ignorance which can result in poverty, malnutrition, high infant and child mortality rates etc. Even if the health facilities are available the people, because of ignorance, with not be in a position to avail them. They also will not have healthy habits, thereby leading to ill-health.

iii. *Occupation:* This is a crucial factor which determines health. A person who is involved in some productive work or is employed will be healthy as compared to one who is unemployed, because unemployment means loss of income and inability to meet even basic needs. This can result in physical as well as mental damage.

iv. *Political system:* The health system is influenced by the political system of the country. Implementation of health technologies, choice of technology, resource allocation, manpower policy, and the degree of availability and accessibility of health services depends, to greater extent, on political will and political decisions. This affects the health of a community as a whole.

Poor health patterns can only be changed by changing the entire socio-political system in a given community. The health hazards of the people related to their working and living environments can only be removed by social, economic and political actions.

1.4.5 Health and family welfare services

The health services cover a wide range of individual and community services for prevention and treatment of disease and promotion of health. Health and Family Welfare Services aim at improving the health status of a population. This concept is clarified in the following example:

Immunizing the children can reduce the threat of incidence of communicable diseases like polio, diphtheria, and whooping cough.

Water-borne disease can be prevented by provision of safe and wholesome water supply to a community. Maternal and child health services will help to reduce the morbidity and mortality in women and children, If we analyze the above examples we can conclude that immunization, provision of safe water, and care of pregnant women are the health and family welfare services preventing communicable disease, water borne disease and infant and maternal mortality which is the ultimate goal of the health services.

SELF ASSESSMENT QUESTION 5

i) List the various determinants of health ,
ii) Recall any situation in your social environment which has made you feel happy. Give two reasons for your happiness (use the blank space for writing the answer)

1.5 Prerequisites of health

We hope you have now got a better idea about the determinants of health i.e. what factors affect the health of an individual and the community as a whole Having assimilated all these ideas, you are now in a better position to identify some of the prerequisites of health. These could be identified at three levels.

i. at the level of individual
ii. at the level of the environment
iii. at the level of the society

Let us elaborate each levels, as follows:

i. *At the level of individual:* In order to be healthy, an individual has to:

.follow hygienic practices which include cleaning and care of each body part, clothing, footwear, etc;
.take a well balanced diet;
.avoid unhealthy practices-overeating, under eating, smoking, drinking, using drugs, immoral behaviour;
.take good rest, sleep well, do active and passive exercises and select healthy recreational activities; and
.resort to preventive screening and take immunizations.

ii. At the level of the environment: The prerequisites for a healthy environment include:
.Sanitary housing
.Safe water supply .clean air
.standard light and sound

.Safe surroundings-proper measures to avoid accidents .proper disposal of excreta
.good placement of school, hospital, recreation facility, markets, parks, trees, slaughter houses, etc.
.removal of harmful vectors.

iii. At the level of the society: As you know, an individual cannot be healthy, if his social environment i.e. harmonious relationship and adjustment with his surroundings, is not good. So to enjoy positive health, an individual should seek;

.Good social relationship and working condition in the family .Healthy relationship and good working conditions in the workplace; .Good social relationship with the neighbourhood; and .Association with professional organizations.

1.6 Let us sum up

In this unit, we have discussed the following:

i) The concept of health which traditionally means the absence of disease.
ii) The definition of health by WHO which states "Health is a state of complete physical, mental, and social well being and not merely the absence of disease".
iii) Relative concept of health, i.e. we cannot set international standards of health and the health of an individual varies from culture to culture and country to country.
iv) We also explained dimensions of health, i.e. physical dimension which refers to the physical well being of an individual; mental dimension refers to the ability of an individual to adjust to varied situations and act purposefully and the social dimension which relates to the relationship of an individual with the society or the people with whom he lives. If an individual experience well being in all these dimensions, he is said to enjoy positive health.
v) You have also learnt about the determinants of health which include: heredity-the effect of genes on the physical and physiological characters of an individual; environment, i.e. physical, biological and psychosocial environments of the individual which influences health, and his life styles or ways of living (the standards of living, i.e. eating, behaving, rest, sleep, etc); socioeconomic conditions, i.e. level of income and education which affect the health of an individual and health services which cover individual and community, services for prevention and treatment of disease. At the end, we talked of prerequisites of good health which include healthy and hygienic practices, good environmental condition and social well being.

1.7 Glossary

Adaptation: Change or response to stress of any kind; may be normal, self protective, or development,
Agent: Causative factor invading a susceptible host through a favourable environment to produce disease.
Bacteria: Single celled organism that reproduces asexually
Culture: Standards for decisions on what is, what can be, how to feel, about it and how to do it.
Cultural values: The prevailing and persistent guides influencing, thinking and actions of people within a culture.
Gene: Basic unit of genetic information located on the chromosome.

1.8 Answers to self assessment questions (SAQs) SAQI

i) Disease
ii) a) Biomedical concept b) Ecological concept
c) Psychosocial concept d) Holistic concept
iii)a, b, c
iv)The holistic approach to health is achieved by understanding the whole person in a perspective that includes physical, mental, social and spiritual dimension.

SAQ2

i) Equilibrium
ii)Health is a state of complete physical, mental and social well being and not merely and absence of disease or infirmity.

SAQ3

i) a) True b) True c) False
ii) Continuum

SAQ4

i) a) Physical) b) Mental c) Social
d) Spiritual
ii) a) Functioning b) Adjust
c) Integration

SAQ5

i) a) Heredity
b) Environment c) Life style
d) Socioeconomic conditions
e) Health and family welfare services
ii)Write your own

1.9 Tutor-marked assignment

1. Briefly comment on the changing concepts of health.
(/ 2. Enumerate the prerequisites of health at the individual, environmental and societal levels.

UNIT 2 Primary Health Care Concept and Principles

Structure

2.0 Objectives

In this unit you will learn about the concept of Primary health Care (PHC) and the related principles. On completion of this unit, you should be able to: .Discuss and explain the concept of primary health care, .Define primary health care,
.List the elements of primary health care,
.Explain the principles of primary health care, and
.Explain and illustrate the role of a nurse in promoting primary health care.

2.1 Introduction

In Unit I you have learnt about the concept of health and prerequisites for good health. It was explained to you that health is a state of physical, mental and social well being of an individual. It is not merely the absence of disease or infirmity. You have also understood how health is affected by many factors, like heredity, environment, ways of living, socioeconomic status, health services etc. Now you may be interested to know how an individual or community can attain these three important dimensions or aspects of health: namely, physical, mental and social well being. The answer to this question is given in this unit i.e. by focusing on primary health care so that individual can attain a desirable level of health.

You know that during the last two decades the common slogan for health, in all countries, has been "Health For All"; and Nigeria is politically committed to achieve this goal. The Alma Ata Declaration

has stated that primary health care is the strategy to achieve this goal. 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 explained in Section 2.5. At the end we will discuss the role of the nurse in promoting primary health care.

2.2 Primary health care -the 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 the nurse is providing in each of the situations described below.

.A nurse assisting a surgeon in mistral valvotomy in a specialized institution;

.A nurse assisting a doctor while doing appendectomy in a district hospital; and

.A female health worker immunizing a child at a subcentre.

If you think for a while, you will be able to realize that the female health worker is providing primary health care but the other two nurses are engaged in secondary or tertiary care.

Primary health care is now a widely disseminated concept, but must 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 programme 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 (see Fig.2.1) 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.

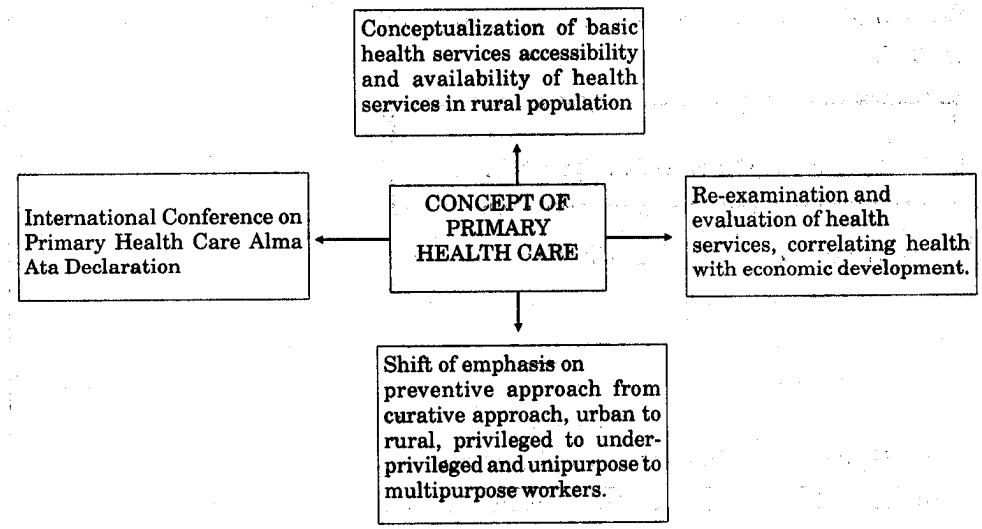


Fig. 2.1: Concept of primary health care

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 *j* World Health Organization in coming decades should be "Health For All" 11 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 in our country starting from 1946.

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, jointly by WHO and UNICEF, which made many declarations in

addition to defining Primary Health Care (PHC). We hope you may be interested to go through these recommendations which is given in Appendix I and then we shall turn our attention to the definition and elements of PHC.

With all the above concept in mind, let us now concentrate on the definition of PHC.

SELF ASSESSMENT EXERCISE 1

i) What is meant by basic health services? ,'.
ii) Basic Health Service concept came in
iii) A conference in Alma Ata was held in Sept. by

2.3 Definition and elements of primary health care

2.3.1 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 that 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 healthy 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.

So combining all these ideas of Primary Health Care, we can briefly say that PHC is based on socially accepted methods which the country can afford. Thus self-reliance and self-determination are emphasized.

SELF ASSESSMENT QUESTION 2

i) Define Primary health care
ii) The key words in primary health care are
iii) Tick *(✓)* the appropriate PHC activities, from the list given below:
a) D A nurse is assisting the doctor in mistral valvotomy
b) D A nurse is giving an intramuscular injection of antibiotic to an adult patient having pneumonia
c) D A Nurse is giving post-operative care to a patient who has undergone appendectomy.
d) D A female health worker is immunizing a child at a subcentre.
e) D A nurse is giving Inj. T.T. in the hospital emergency room to a child who met with a road accident.

2.3.2 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; and .Provision of essential drugs.

We shall only list these elements here. These are described in detail in Block 4 of this .course (NSS 311, Block 4, Units 1-6).

Hope you have got the idea of the comp9nents of primary health care. In order to achieve the target of Health For All (HFA), every health professional should be committed and concerned with the above care context so that he makes it a part of his daily health care practice.

SELF ASSESSMENT QUESTION 3

i) Which of the above mentioned components do you think nurses have a major role to play?
ii) Select one component and give two reasons
. To conclude, primary health care has evolved partly in the light of experience, positive and negative, gained in basic health services in a number of countries. With this understanding and definition of primary health care and its elements we introduce you to the principles of primary health care which are given below.

2.4 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

These principles are indicated in Fig. 2.3. Let us now briefly discuss each of these principles.

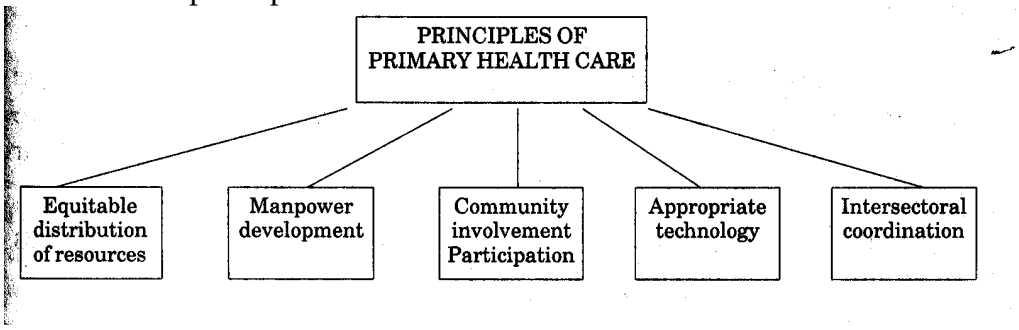


Fig. 2.3: Principles of PHC

2.4.1 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.

2.4.2 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 playa 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.

2.4.3 **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. Involvement of these are:

.involvement of the community in assessment of the situation, and
.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.

2.4.4 **Appropriate technology**

Appropriate technology means the technology that is scientifically or technically sound, adaptable to local needs, culturally acceptable (i.e. acceptable 0 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 an apply. It also implies use of cheaper, scientifically valid, acceptable and available equipments, procedures and techniques rather than those costlier and non affordable and non accessible to the community. For e.g. oral dehydration 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 dehydration 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 s 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.

2.4.5 **Intersectoral coordination**

We now come to the principle which focuses on the concept that health of m 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)f 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 about 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 who are

isolated. We all know that various messages are carried on TV or radio, regarding FP, ORS, nutrition, diarrhoeal diseases etc.

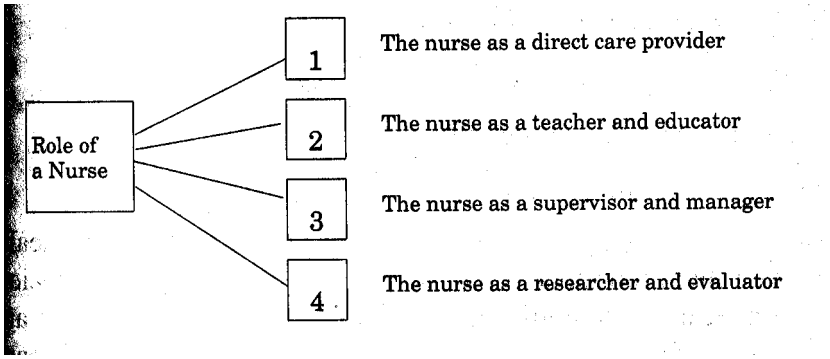
Now we come to educational sector which has a vital role to play in development and operation of PHC. Community education helps people to understand their health problems, possible solutions to them and the cost of different alternatives. Instructional material/literature can be developed and distributed 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.

SELF ASSESSMENT QUESTION 4

i) List the principles of primary health care:
ii) Fill in the blanks with appropriate words.
   a) Equitable distribution means that health services must be by all people.
   b) In community participation individuals, family and assume. in promoting their own health and welfare.
   c) Appropriate technology means technology that is sound. to local needs and feasible.
iii) List the areas where community can be involved
iv) The health related sectors are

2.5 Role of the nurse in promoting primary health care

Four main aspects of the Nursing Role in Primary Health care were identified WHO study group in their meeting in Geneva from 9-13 December, 1985 (W*HO Technical Report Series* No. 738). The roles identified are:



Let us now discuss each one of them *for* better understanding.

The nurse as a *direct care provider:* You as a nurse need *to* develop a variety f skills which you have *to* utilize in both clinical and community settings, in order to participate actively in providing care in relation *to* the components of PHC.

In the foregoing section you have already learnt about the essential eight components of primary health care. So, in order *to* provide and participate in such care, you have *to* develop a variety of clinical and community skills. It s by developing these skills that you shall be able to provide the proper nursing care *to* the patients, individuals, families and community. For example, if we take one of the components of PHC, i.e. control of communicable PHC, community center and hospital is *to* identify and give immunization *to* children and educating the parents regarding the control of these diseases. similarly, in providing MCH care, you as a health provider not only have *to* examine the mothers *to* identify risk factors, and give T. T., but also teach them about mother craft, immunization, nutrition, *rest* and sleep, exercise etc.

The nurse as a teacher and educator: Your central concern as a nurse is promotion of health, prevention of disease and disability. This calls *for* your 'ole as an educator when you have *to* educate the individuals and family about l healthy life style and the community on the primary prevention of ill-health IS well as protective and supportive health measures.

Your role as a teacher involves the training of other health care personnel, professional colleagues and auxiliary personnel. This brings us *to* the role of nurse as supervisor and manager.

The nurse as supervisor and manager: If you are engaged in providing Primary Health Care, you have to exercise some kind of leadership. Your duties in this regard include supervising other personnel in providing care, planning health service for the community in conjunction with other members of the health team and organizing and administering community health ices. While performing these functions you are involved in:

- assessing the health needs of the community,
- listening to the community's view on these needs,
- communicating with the community, and
- advising them accordingly.

As a community organizer, your role is to involve people in their own health and explain the importance of cooperation of other sectors of

society concerned with health e.g. housing, sanitation, agriculture, industry and education sector. So from your role as a direct care provider and teacher and educator you, as a primary health care nurse, assume the role of a manager wider scale.

The nurse as a researcher and evaluator: Primary health care system has to dynamic, as it deals with living human beings. Hence a nurse has to be dynamic in her services by bringing about changes and innovations in the health care provided based on facts. For this she has to be prepared to take .ole of a researcher and evaluator.

This role involves monitoring, observing, analyzing the health conditions, health services and the health care provided. For example, when an individual falls sick, then you, as primary care provider, are in a better position to determine the individual patient's health needs and to understand problems involved in meeting these needs.. With your knowledge and s, you are able to recommend changes or innovations in primary health services. For you to play this role effectively you need to have updated records. You will study about records in Block 2, Unit 5 of this course.

SELF ASSESSMENT QUESTION 5

l) List the four main aspects of the nurse's role in primary health care.

2.6 Let us sum up

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.
At the end we discussed the role of the nurse in promoting primary health care. The four roles are identified as (1) Nurse as direct care provider; (2) Nurse as teacher and educator (3) Nurse as a supervisor and manager and (4) Nurse as a researcher and evaluator.

2.7 Answers to self assessment questions

SAQ1
i) It is first level care which focuses on increasing access and availability of health services to the rural population and which is affordable. ii) 1970
iii) September 1978; WHO and UNICEF.

SAQ2
i) Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and appropriate 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 stage of their development in the spirit of self reliance and self determination.
ii) Accessibility, availability, acceptability, affordability, appropriateness. ill) b,c,d,e,
SAQ3
i) Maternal and child health care including family welfare immunization against major infectious diseases.
Education concerning promotion of health and prevention of illness.
ii) Nutrition
Mothers and children form the largest group of the population (About 70%)
Mothers and children are at a high risk/more vulnerable groups.
SAQ4
i) -Equitable distribution
-Manpower development
-Community participation -Appropriate technology -Intersectoral approach
,.
ii) a) Shared equally by all people b) Community, responsibility
c) Scientifically, adaptable, financially ';
ill) Assessment of situation or a problem

Definition and setting of priorities . Planning the activities for providing primary health care
iv) Agriculture sector
Water supply and sanitation/public works
Housing !.. Communication and mass media ' Education sector
SAQ5
Direct care provider
Teacher and education
Supervisor and manager
Researcher and evaluator.

Tutor-marked assignment

Identify and explain the nurses' role in Primary Health Care.

U**nit** 3 **Health for All**

Structure

3.0 Objectives

In this unit we shall discuss about health for all (HFA). After studying this unit, you should be able to: .Define health for all.
.Discuss the meaning of 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, and
..Discuss the role of nursing services in support of Health For All

3.1 Introduction

In Unit 1 we have discussed the concepts and prerequisites of health and in Unit 2 we discussed about Primary Health Care (PHC); its concept, principles, elements and role of nurses in promoting the primary health care. You have seen that primary health care is the essential care which should be easily available, acceptable, accessible and affordable to an individual and com- munity as a whole. You have also become aware of Alma-Ata Declaration (see Appendix 1) which affirms that primary health care is considered as the basic strategy for achieving goal of Health For All by the year 2000 AD.

As you have learnt in Unit 2 that in May 1977 the thirtieth World Health Assembly adopted a resolution in which it was decided that main social target of Governments and of World Health Organization in the coming decades should be the attainment by all people of the world by the year 2000 AD of a level of health that will permit them to lead socially and economically productive life. This is popularly known as health for all by the year 2000 AD *(HFA/2000).* In this unit we shall discuss the

concept, definition and meaning of Health For All. Achievement of goal of health for all aims at restructuring of health system and reorientation and training at different categories of health workers/professionals. Fulfillment of these aims is only possible through development of an appropriate strategy. We shall discuss the global and national strategies for HFA, in Section 3.3 and focus on achievements and targets of HFA. At the end we shall discuss nursing in support of health for all at international level and national level. As you go through this unit you are required to refer the appendices given at the end of this unit for broader perspective wherever indicated in the text.

3.2 **Health** for All

We shall discuss about the concept and definitions of Health For All in the following subsections.

3.2.1 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 much scientific and techno- logical 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 are.a and urban slums in contrast to 10-20% who live in urban areas. It is only this smalJ 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. Similarly if we look at health status of Nigeria as reflected by the number of indicators of health, as shown in Table 1 (see page 42), the need for urgently improving our health status is obvious.

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 and control of non-communicable disease.

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 thirtieth 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.

Further, there are several other experiences and developments which led to the evolution of goal of 'Health For All' by the year 2000 which are as follows.

.In 1972-73 a 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.

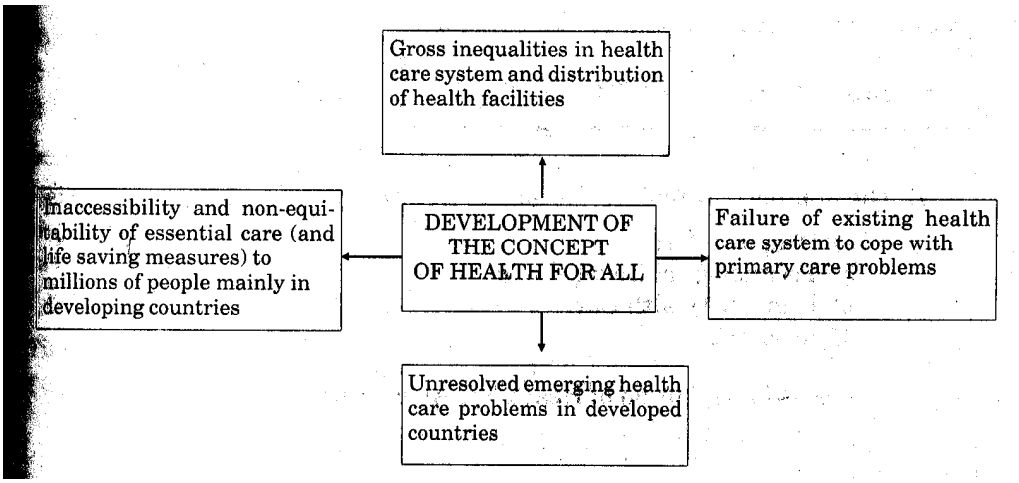


Fig. 3.1: Diagrammatic representation of the development of the concept of health for all (HFA)

.In developed countries, health care system despite their expensive 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 standard of living to a 'minimum acceptable level'.

.In the rural areas and rapidly expanding urban areas, million 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.

With this concept in mind we shall discuss next the definition and meaning of Health For All, after examining your memory .

SELF ASSESSMENT QUESTION 1

i) The approach to achieve the goal of Health For All by the year 2000 is
a) Hospital Care
b) Technological Development
c) Primary Health Care
d) Research

The basis for evolution of Heath For All concept include
a)
b)
c)
d)
e)

3.2.2 Definition and meaning for health for all (BFA)

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".

If you analyse 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 par-ticiatin actively in the social life' of the community in which they live, i.e., have education, housing, water supp y and sanitation.

Health for all means that health care/services are to be made aef accessible/within 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 HF A does not mean that as of the year 2000, we shall all be free of disease 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 place
.People will use better approaches for preventing disease and alleviating unavoidable illness and disability.

.There will be an even distribution among the population of whatever health resources are available.
.That the essential health care ~ill 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~ystem, 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. You will learn about these strategies for health for all in Section 3.3.

SELF ASSESSMENT QUESTION 2

i) Fill in the blanks:
Health For All concept focuses on health care services brought ; within the reach of every individual in a given. ii) Obstacles to the goal of health include:

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 HF A 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 sub-sections.

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 develop- ment 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

Alma-Ata declaration (as you have seen in Appendix 1) and Nigeria com- mitment to BFA 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 Govern- ment.
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. We shall briefly highlight the health strategies in health policy (for details of health policy refer Appendix 2)
The policy lays stress on the preventive, promotive, public health and rehabilitation aspects of health care and points to the need of establishing comprehensive primary health care services to reach the population in the remotest areas of the country.
The health policy in Nigeria has the following key elements:
.Creation of a greater awareness of health problems in the community and means to solve these by the communities,
.Supply of safe drinking water and basic sanitation using technologies that the people can afford,
.Reduction of existing imbalance in health services by concentrating more on the rural health infrastructure,
.Establishment of a dynamic health management information system to support health planning and health programme implementation.

.Provision of legislative support to health protection and promotion,
.Concerted actions to combat widespread malnutrition,
.Research into alternative methods of health care delivery and low-cost health technologies, and
.Greater coordination of different systems of medicine.

The health strategies include restructuring the health infrastructure develo ping health manpower and research development.

WHO has established 12 global indicators as the basic point of reference to assess the progress towards health for all. (These are discussed in Unit 5) The National Health Policy has laid down specific goals with respect to various health indicators to be achieved by differ~lJt,d.ftes 1990 to 2000 AD. (These are given in Table 1.) The IlJP51 important)naicators to achieve HFA are:

i. Reduction of Infant Mortality Rate from the present level of 87 to below 60 by 2000 AD.
ii. To raise the life expectancy at birth from present level of 58 years to 64 by 2000 AD.
iii. To reduce the crude death rate from the present level of 10.4 to 9 by 2000 AD.
iv. To reduce the crude birth rate from present level of 27 to 21 by 2000 AD.
v. To achieve a net reproduction rate of 1 by 2000 AD.
vi. To provide potable water to the entire rural population by 2000.

Table 1: National Health Policy Goals for Health and Family Welfare Programmes

You must be aware that during the sixth and seventh Five Year Plans, steps were already undertaken to implement the strategies outlined in National Health Policy.

Some of these are:

a. to establish one health subcentre for every 5,000 rural population (3,000 in tribal and hilly areas) with one male and female health worker.
b. To establish one primary health center for every 30,000 rural population (20,000 in hilly and tribal areas).
c. To establish Community Health Centres (CHC).
d. To train Village Health Guides (NHG) selected by the community for every village or 1,000 rural population.
e. To train traditional birth attendants (TBA) in each village.
f. 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.

SELF ASSESSMENT QUESTION

i) Mention the rates in numbers against each indicator given below a per the latest Health Statistics Report of your state.

i) Infant mortality rate. *s.* ii) Maternal mortality rate

~..'<" ill) Birth rate iv) Death rate

v) Literacy rate A ~~ vi) Population

The basis for evolution of Heath For All concept includes

a) b) c) ~ d) *'We)*

, ", ~ ;, ~, i

SELF ASSESSMENT QUESTlONL11

i) Fill in the blanks:

a) The basic strategy to achieve health for all is

b) Ministry of Health and Family Welfare (Nigeria) formulated National Health Policy to achieve goal of HFA in .

ii) The importan~ndicators to monitor progress towards health for all are:

With the above background we shall now focus our attention on nursing i: support of Health For All in the following section.

3.4 Nursing in support of health for all ~)f

We shall begin with the development of the role of nursing in support of health for all.

In 1979, WHO and International Council of Nurses (ICN) conducted a work- shop in Nairobi on the role of nursing in primary health care for leaders of Nurses Associations in which the commitment of the nursing profession to the goal of attaining health for all by 2000 was formally confirmed. Sub- sequently, National Nurses Association planned their own strategies in relation to their own National Health Policies. The National Association of Nigerian Nurses and Midwives also participated in this exercise.

In 1981, an informal meeting was convened in Geneva by WHO on 16-20 November to consider the role of nursing in contributing to the achievement of the goal of *HFA/2000* through Primary Health Care.
Strategies and actions proposed for change at international and national level are discussed in the following sub-sections.

3.4.1 Strategies and action proposed at international level

Five basic strategies have been proposed by the WHO-ICN meeting by Nurses, which are listed below. (See Fig. 3.1.)

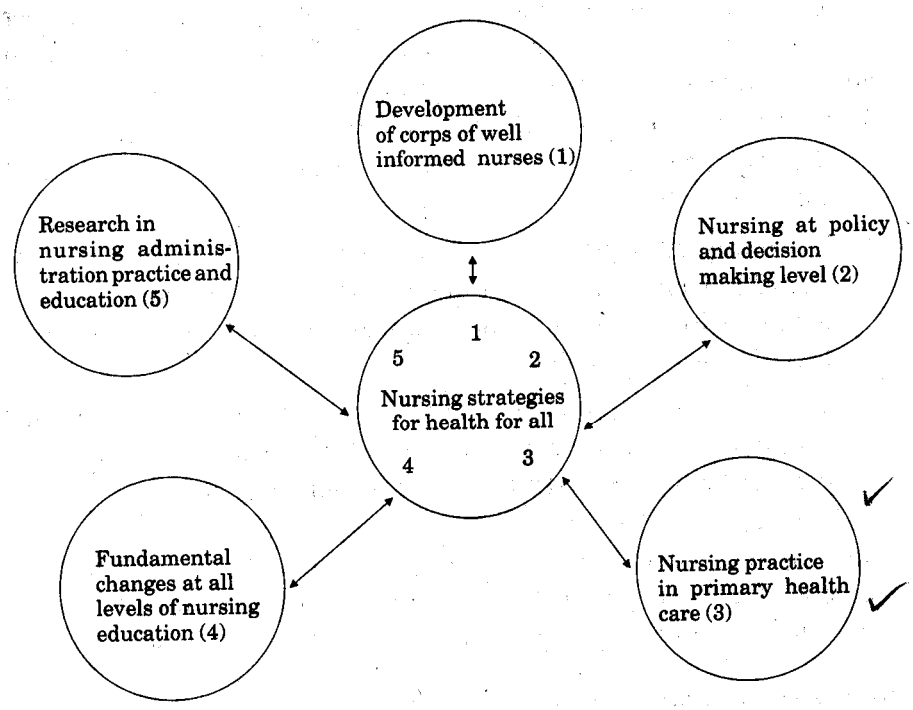


Fig. 3.1: Five strategies for change adapted by National Nurses Associations for their role in HFA through PHC

i. the development in each country of a corps of nurses that is well infonned about health care and ready to bring necessary changes in the nursing system.
ii. The inclusions of nursing personnel at all levels of policymaking and administration so that the profession can contribute to determining the action plan.
iii. The involvement of nurses, and the use of their skills, in initiating or extending primary health care.
iv. Fundamental changes at all levels of nursing education (basic, post-basic and continuing) to ensure that the priority needs of population are functionally integrated into the education and into nursing practice.
v. Research into nursing administration practice, and education, that will demonstrate nursing's contribution to primary health care.
We have listed the strategies for change. We shall now learn about the actions proposed for each strategy as given below.
i) Development of corps of well-informed Nurses
This will require
a. arranging and developing a series of international, national and . regional workshops or other meetings, that would bring together small groups of key nursing practising professionals for orientation and guidance in planning for primary health care in their own country . The purpose of these workshops would be:

.To help the nurses to understand the thrust of PHC nationally and internationally

.To interpret needs of these countries in their struggle for HFA/2000 and enable them to develop over all nursing plans of action at local. regional and national level, taking into account local needs and resources.

.To establish the regional support system and lines of communi- cation between and among countries for sharing plans, exchang- ing methodologies and report on the progress as the plan is further developed and put into effect

b. Develop texts, guides and communication aids, which will include review of current publications related to PHC and production of specific material to nursing in PHC.

ii) Nursing at policy and decision-making levels

.This will require planning and implementing training programmes and continuing educational programmes that will orient nurses and train therti in administration and management techniques, political and legislative processes, and help them to analyse existing legislation and enable them to develop action programmes to bring about necessary changes.

.Creation of administrative post in nursing at all levels of Government This can be accomplished through coordinated efforts of national nursing associations.

.Establishing a system for collection and compilation of information, on the supply and training of nurses as per the needs of community.

iii) Nursing practice and primary health care ~ ac...t- *of*

This calls for preparing and educating the nurses to assume responsibility forP10-~t1 c.a- 1

the provision of first level care in the community. This can be achieved by L r- 0 vt- t .conducting workshops, seminars and other continuing or in-service edu- ~

cation programmes,

.encouraging the Nurses to practice Primary Health Care.

.Providing facilities like housing, attractive remuneration and opportunity for continued learning to the public health nurses working at the periph- ery.

.Making efforts to close the existing gap between nursing education and nursing services.

iv) Fundamental changes at all levels of nursing education

This will require the administrative support from the national and local government in order to change the system of nursing education.

This change involves reorientation in basic nursing education, post-basic nursing education and organizing continuing education programmes.

Basic nursing education

This will include:

.Change of curriculum for current systems of nursing education and practice, and

.Formulating strategies for bringing about a change in basic nursing education from emphasis on care of sick individuals in hospitals to community based nursing education

Post-basic nursing education

This will involve:

.Preparation of nurses for leadership roles in administration for supervisory posts in organizations and agencies at all levels of health care planning and management, and for teaching post in primary health care.

.Preparation of nurse researchers who can conduct or direct investigations into Primary Health Care (PHC) issues as well as encourage systemic inquiry into questions related to community based nursing practice.

Continuing education

This involves organizing workshops, seminars and in-service programmes to enable nurses to acquire additional knowledge and skills related to PHC.

v. Research in nursing administration, practice and education for primary health care

This needs inclusion of research skills in all the nursing education programmes and continuing education programmes. Nurses at all levels should develop an enquiring and problem-solving attitude for working towards the goal of PHC. Priority should be given to research into

.the design and evaluation of programmes in which nurses provide primary health care, and

.study of problems that arise from the nursing in primary health care field. Government and intersectoral support should be sought for proposals that will enable nurse to initiate and/or collaborate with others in research methods and design for Primary Health Care (PHC).

Develop projects to demonstrate usefulness of research findings in nursing

practice.

You may have got a good idea of our discussion about nursing strategies and actions proposed in support of health for all. Before moving to the next subsection, have a look at a brief summary of what you have learnt in the above subsection from the following Table 2.

Table 2: Strategies and Action Proposed ' .

3.5 Let us sum up

You have studied 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 that 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 com- munities in health matters.

We have focused our discus~on 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. At the end of the discussion we have appraised you of the role of nurse in support of Health For All where we have discussed the strategies and actions proposed for achieving the goal.

These are

I. Development of corps of well-informed Nurses 2. Nurses at policy and decision making levels 3. Nursing practice and primary health care
4. Fundamental changes at all levels of nursing education
5. Research in nursing administration, practice and education for pri- mary health care.

Finally we have talked about the actions taken by National Nursing Associations and Organizations for achieving the goal of Health For All where we focused on recommendations and resolutions passed by the National Nursing Association. The main recommendation and resolution was to restructure and reorient the nursing education system as a whole towards PHC and HFA.

3.6 Answers to self assessment questions
SAQI
i) c = *P-r~""-t:\t\j* ~ l~ C4~
ii) a) cause of death and disease b) nutritional status
c) water supply and sanitation
d) litera~y and economic situation e) demographic tren4s
SAQ2 /
i) community
,

ii) poverty; malnutrition; ignorance, disease; contaminated water supply; poor housing ~.
~I) '~griculture, industry, education, housing and communi~ation
~ ~ A the attainment of a level of health that will enable every individual to /' (...,)lead a socially and economically productive life. J
.I
SAQ3 I
'.) t:\) Pr~mary Health Care
t; ...b) 1982
b) Infant mortality rate (IMR) L"!) .
.~ ii) k~e al mortality rate (MMR \ \ Crude death rate (CDR) Crude birth rate (CBR)
Net reproductive rate (NRR) Life expectancy.

3. 7 Tutor-marked **assignment**

1. (a) What is the concept of Health for All (HAF)?
(b) Explain the 5 strategies adapted by the Nationa} Nurses Associ ation for their role in HFA through Primary Health Care? ,

UNIT 4 Organization of Health System Based on Primary Health Care

Structure

4.0 Objectives

In this unit, you will learn about organization of Health system based on Primary Health Care (PHC). After studying this unit you should be able to:-

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

4.1 Introduction

In Unit 1 you revised and reviewed the concept of health, which is "a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity". (WHO 1946). Second unit dealt with concepts and principles of Primary Health Care. In Unit 3, you learnt that in 1977 thirtieth World Health Assembly decided the main targets of governments and WHO in the coming decades should be to achieve goal of health for all by the year 2000 *AD.*

In this Unit, we shall discuss the definition and essential characteristics of health system.

We shall also focus our attention on organization health system structure at Federal, State and Local levels. And at the end we shall introduce you to the i organizational structure based on Primary Health Care, which mainly focuses 1 on rural health services.

Let us begin with the definition and characteristics of health system.

4.2 Meaning and characteristics of health system

Health system can be broadly defined as a coherent whole of many interrelated component parts, both sectoral and inter-sectoral, 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 that what are interrelated component parts. 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 high- light 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 care of the extremely disabled and incurable.

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 agri- cultural sector etc). Health is a subject of overall socio-economic milieu of the community.

.Primary health care, consisting of at least the essential elements included in the declaration of Alma-Ata which should be delivered at the first point of contact between individuals and health system (See Unit 2, section 2, for reference of essential elements of PHC).

.At intermediate levels more complex problems should be dealt with and more skilled and specialized care as well as logistic support should be provided.

.Better trained staff, i.e. supervisory staff, should provide continuing education/training to primary health care workers, as well as guide the public of different communities and community health workers on practical problems arising in connection with all aspects of primary health care.

.The central level should co-ordinate all parts of the system and provide planning and management expertise. It should also provide highly specialized care, teaching for specialized staff. The staffing of such institutions (as central laboratories), and central logistic and financial support.
If you think deeply for a while and analyze, what do these above mentioned characteristics indicate? These clearly indicate that health system is not a separate entity. It includes components and actions not only from the health sector but also from other health related sectors such as agriculture, educa- tion, environment, animal husbandry communication, etc, at various levels (central, intermediate and local). We shall discuss these in the following sections.
.
SELF ASSESSMENT QUESTION
i) Fill in the blanks:

.,
a) a. Health system is defined as coherent whole of many. parts, both sectoral and. as well as community itself. v: b) Health system aims at. the health services.
l'
.c) Health system constitutes management sector and involves matters.
d) The aim of health system is health. [i List the characteristics of health system .

4.3 Structural organization of health system
You know that health system in Nigeria is organized at three levels (i.e.) Federal, State and Local levels.

Let us begin with organization at Federal level.

4.3.1 Organization at federal level

The official "organs" of the health system at the Federal level consists of: a) The Federal Ministry of Health
b) The National Council of Health 0;-
We shall talk of the organization and function of each one 6f them.
(a) 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/de- partment. These include:-
i. Department of Personnel Management ii. Department of Finance and Supplies
iii. Department of Planning, Research and Statistics iv. Department of Hospital services.

v. 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;
viii. Support State and through them Local Government in developing strategies and plans of action to give effect to this national health policy,
ix. Allocate Federal resources in order to foster selected activities to be under taken by State and Local Governments in implementing their health strategies;
x. Issue guidelines and principles to help states prepare, manage, moni- tor and evaluate their strategies and related technical programmes, services and institutions.
xi. 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
xii. 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;
xiii. Promote co-operation among scientific and professional groups as j well as non-governmental organizations in order to attain the goals of this policy;
xiv. 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 shall set 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 shall be directed towards:-
i. ensuring. technical co-operation on health with other nations of the region and the world at large;
ii. ensuring the sharing of relevant information on health for improvement of international health.
iii. Ensuring cooperation in international contrql of narcotic and psychotropic substances;
iv. 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 national, com- munity, and existing institutional and other infrastructural arrangements;
v. Working closely with other developing countries, especially the neighboring 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;
vi. Sharing of training and research facilities and the co-ordination of major intervention programmes for the control of communicable diseases.

(b) The National Council of Health
The National Council of Health is composed of the following members:
i. The Honourable Minister of Health (Chairman)
ii. The Honourable Commissioners for Health (States)
The following are the functions of the National Council of Health
The National Council on Health shall advise the government of the Federation with respect to:
i. The development of national guidelines.

ii. The implementation and administration of the national health policy; and
iii. Various technical matters on the organization, delivery, and distribution of health services.
The council shall be advised by the Technical committee.
Technical committee
The Technical Committee of the National Council on Health shall be com- posed of:
i. The Federal and State Permanent Secretaries (M.O.H) ii. The Directors of Federal Ministry of Health
iii. The Professional heads in the state Ministries of Health. iv. A representative of Armed Forces Medical Services;
v. Director of Health Services, Federal Capital Territory, Abuja.

Expert panels
a. The Technical committee. shall set up as required, appropriate programme expert panels including the representatives of health related Ministries:
i. Agriculture, Rural Development and Water Resources
ii. Education
iii. Science and Technology iv. Labour
v. Social Development, Youth and Sports vi. Works and Housing vii. National Planning viii. Finance
b. Health related bodies
i. National Institute of Medical Research ii. Medical Schools
iii. Schools of allied health professionals iv. Non governmental organizations
v. Professional associations (Health) e.g. NMA, NANNM, PSN, among others

SELF ASSESSMENT QUESTION 2
Fill in the blanks:
1) The official organizing health system at the national level consists of:
~ a) b) " ~\ 2) The five departments of the Federal Ministry of Health includes:
i
3) The National Council of Health is composed of. and with the sole responsibilities of So far we discussed the organization at the Federal level. Now we shall turn our attention to the organization at state level.

4.3.2 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 participate in the management.

i. 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 wi,th 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:
i. Ensuring political commitment ii. Ensuring economic support
iii. Winning over professional groups iv. Establishing a managerial process v. Public information and education
vi. Financial and material resources provision vii~ Intersectoral action
viii. Coordination within the health sector
ix. Organizing primary health care in communities x. Federal system
xi. Logistics system
xii. Health Manpower recruitment and retraining xiii. Priority health programmes. xiv. Health technology.

SELF ASSESSMENT QUESTION 3
Identify the organization structure of health in your state and present it diagrammatically

4.3.3 Local level
The are 774 Local Government Areas in Nigeria with various health facilities operating under the hinges of primary health care.
The Local Government Headquarters coordinates the activities of the health facilities providing manpower, funds, logistics Slid control.
W;'

The Local Government is headed by elected Chairmen during political era 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

.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.
.Motivation of the community to elicit the support of fonnal anq infonnal leaders
.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 (fust level contact of individual, family and community health system) are being rendered through the agency of primary health centers.

Secondary Health Care is being provided through the establishmynt of cottage, General Hospitals where all basic speciality services are being made available.

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

4.4 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 has laid down a plan of action 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.

Functions of the agency The functions of the Agency are:

.Support to health policy a. review existing health policies, particularly as to their relev- ance to the development of PHC and to the integrated devel- opment of health services and health manpower, and propose changes when necessary.
b. Prepare alternatives for decision makers at all levels based on scientific analysis, including proposals for health legislation;
c. 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;
d. Promote the monitoring of PHC.implementation of various

levels; e. To stimulate the development ofPHC technical on an equitable basis in all LGAs, for example technical support to implemen- tation of selected PHC components as required. This assistance will be provided strategically to enhance orderly develop- . ment, for example, to improve upon or introduce new skills required for the services or to integrate new components into
them;
.Resources mobilization
a. to mobilize resources nationally and internationally in support of the programmes of the Agen.cy.
b. To conduct or commission studies on resource mobilization for health and issues of cost and financing, with particular reference to equity.
.Support to Monitoring and Evaluation a. to 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;
b. develop guidelines and design frame works for periodic evaluation of primary health care at various levels;
c. 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 evalu- ation date for management decision making
.Technicalsupport
a. provide technical support to the preparation of a health man- power policy, including manpower projections to enable de- velopment of. a PHC manpower plan;
b. provide advocacy aI;ld support for the orientation of medical undergraduate education, and the education of other health professionals, towards PHC;

c. to identify orientation and continuing education needs oif PHC manpower, including medical, organize programmes to meet these needs, using Schools *of* Health Technology as a resource;
d. to support directly the strengthening *of* the Schools *of* Health Technology.
.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:
a. 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;
b. Pay special attention to the involvement *of* women and grass-root t- women's organization in the village health system.

.Health system research (HSR)
a. 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 OfHSR in the LGA health system and the support of* the other levels *of* this *efforts.*
b. to undertake or commission HSR operations research into the functionIng *of* PHC programmes;
c. 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.
.Technical collaboration
a. 10 stimulate universities, NGOs and international agencies to work with LGAs in nurturing their capacity for problem golving; b. To develop LGA capacity to seek technical collaboration including from other LGAs in developing and implementing their PHC programmes;
c. To promote collaboration with other sectors at all levels in the development and support *of* LGA primary health care system;
d. To monitor the collaboration for PHC between the international agencies and government at all levels;
e. Promote and organize both the sharing *of* experience *of* the Agency with the world community (publications, reports, visitors, etc) and the collection *of* all relevant information from other countries and international organizations and disseminate it to all interested parties;
f. Promote maximum support to alJ its *efforts* by networking and creating formal and informal collaboration with relevant Nigeria- nand international institutions.
! '},

.Promotion of PHC: All activities carried out by the Agency will be promotin.g PHC. Specifically, however, the Agency should.
a. carry out advocacy at the level of community leaders, mass media and NGGs, 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-oriented 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 annual reports which are widely disseminated on the status of PHC implementation nation- wide.

SELF ASSESSMENT QUESTION 3

i) List the eight (8) functions of the Agency

.Organization of the Agency .

To be able to perform its functions effectively, the Agency will be an administratively autonomous Agency under the supervision of the Federal Ministry of Health., In addition: it will have a Board of Directors;

It will have an Executive Director who will head .the team responsible for guiding the development of the PHC system. He/she must therefore have' considerable experience in this area;

There will also be a Scientific Committee in the Agency in which various experts with relevant skills will be represented. The composition and mo- dalities for functioning of the Scientific committee will be prepared by the Executive Director and approved by the Board.

The board .

a. The agency will have a board to:

Receive reports on the state of development of the national PAC programme.

Approve the activities of the agency and its budget Have overall responsibilities for personnel matters; Assist with the mobilization of funds.

b. The board will consist of the following:

A chairman, who will be a highly respected primary health care practitioner;

The secretary, who will be the executive director of the agency; The federal director of primary health care;

A representative of the conference of provosts of college of medicine; A representative of the conference of principals of community health officer's training institutions;

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

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

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

A representative of the National Planning Commission; A representative of NGOs working in PAC

Representative of the National Commission for Women. .Structure of the agency at federal level (see Fig. 4.1).
The Agency will have a small core of professional staff at the Federal Level. The Staff should follow the guiding principles of team work and polyvalence. Moreover, the Agency should have the ability to draw on outside expertise to the maximum extent possible. Further, it is understood that the structure of the Agency will be modified with experience.
.Zonal level (see Fig. 4.2)

The offices should collaborate with the State Ministries of Health to strengthen LGA PAC 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 PAC Departments are currently organized. The zonal offices, are therefore, proposed to be constituted as shown in Fig. 4.2

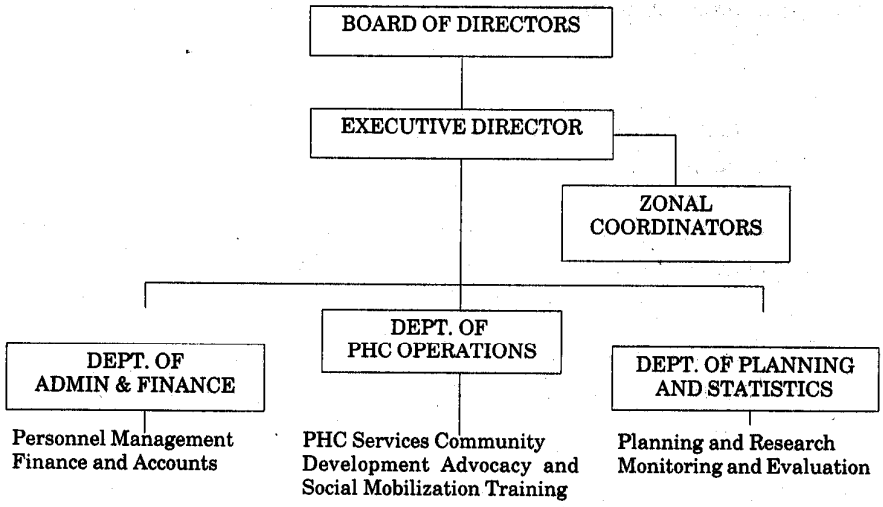


Fig. 4.1: Structure of the agency at federal level

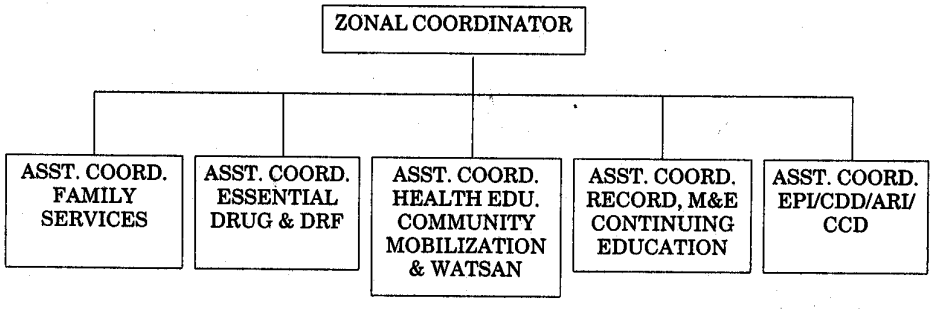


Fig. 4.2: Structure of the agency at zonal level

The assistant coordinators will over see 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.

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;
Development of capabilities at LGA level to analyze and make use of monitoring and evaluation data for management decision-making;
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.
.*EPI/CDD/ARl/CDD*
Coordination of the integration of EPI and diarrhea diseases, ARI and com- municable diseases control programmes (guinea worm, TB and leprosy, onchocerciasis, schistosomiasis 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.

4.5 Let us sum up
We have discussed about the organization of health system. Health system is defined as coherent whole of many interrelated components parts, 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 is headed by a minister assisted administratively by the permanent secretary and has five departments i.e. 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 of the State Ministry of Health and Health Management Board in some states. The State

Ministries of Health are headed by 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, meas- urement and evaluation, PHC, and nutrition. Lastly, we discussed about the structural organization of health system based on national primary health care agency, which focuses on primary health care.

4.6 Answers to self assessment questions

SAQI

i) a) interrelated
intersectoral
b) delivering ;,
c) organizational '
d) development
ii) Charateristics of health system . -serves all -equality
-prime responsibility -intersectoral action -essential elements -specialized

SAQ2

i) a) Federal Ministry of Health b) National Council of Health
ii) Department of Personnel Management
Department of Planning, Statistics & Research Department of Hospital Services
Department of Primary Health Care & Disease Control Department of Finance & Supplier
iii) The Minister of Health (Chairman) and the Commissioners of Health (State).
Responsibilities: Advises the federal government .Advisory the Federal Government
.Development of national guidelines on health
.Implementation and administration of the National Health policy
.Various technical matters on the organization; delivery, and
distribution of health services.
.

SAQ3

.Support to health policy .Resources mobilization
'. Support monitoring and evaluation
..Technical support , .Support to the village health system .Health system research .Technical collaboration
.Promotion of primary health care.

4.7 Tutor-marked assignment

1. Write briefly on the roles of the following: a) National Council on Health
b) Primary Health Care Agency

Unit 5 Health Care Resources and Monitoring and Evaluation of Health Services

Structure

5.0 Objectives

After completing this unit you should be able to:

.Describe the measures to develop human resources for health,

.Find and explain ways of ensuring community involvement to be adopted by the ministry of health,

.Describe the whole gamut of health manpower, including intema~

agencies engaged in delivery of national health care services,

.Explain the action required to develop monitoring and evaluation process as part of managerial process for national health development.

5.1 Introduction

In Unit 4 you have learnt the organization of health system based on primary health care and the action required to promote and support it, which are the main thrusts of the global strategy of Health For All. Inseparable parts of the strategy are the actions required to generate and mobilize all possible human and financial resources and development of suitable monitoring and evalu- ation process. Resources are needed to meet the many health needs of a community. No nation, however rich, has enough resources to meet all the needs or all aspects of health care of its citizens. Therefore an assessment of the available resources, their proper allocation and efficient utilization are important considerations for providing efficient health care services. This basic resources for providing health care are Man, Money and Material which you will learn in the following broad categories:

i. Human Resources ii. Money and Material Resources.

5.2 Human resources development

The strategy seeks to involve not only the health personnel but also many other personnel from various sectors as human resources. Primary health care has to mobilize human potential of the entire community. This is possible on the condition that individuals and families accept greater responsibility for their own health. People need to be involved in deciding on the health system required by them and the health technology acceptable to them, in delivering a part of national health programme. This is to be achieved through *self care andfamily care* and involvement injoint action for health. Health manpower constitutes a major part in human resources, so it is explained in further details

5.2.1 Strategy and definition

The term "health manpower" includes both professional (doctor & nurse) and auxiliary health personnel (ANM,'MPW, TBA, lab. techn.) who are needed to provide the health care. An auxiliary is defined by WHO as "technical worker in a certain field with less than full professional training". Health manpower requirements of a country are based on

i. *Health needs and demands of the populations:* The health needs in turn are based on the health situation and health problems and aspirations of the people.

ii. *Desired outputs:* preventive, promotive, curative or rehabilitative, control or eradication.

5.2.2 Sector wise distribution

The health care system is intended to deliver the health care services. It constitutes the management sector and involves organizational matters. It operates in the context of the socio economic and political framework

of the country. In Nigeria, it is represented by major sectors or agencies which differ from each other by the health technology applied and by the source of funds for operation. These are:

i. Public sector

a. Primary health centres

b. Hospitals/health centres Specialist hospitals Teaching hospitals

c. Health insurance scheme

ii. Private sector

a. Private hospitals, polytechnics, nursing homes, and dispensaries. b. General practitioners and clinics

iii. Indigenous system of medicine: -Homeopathy

-Unregistered practitioners (naturapathy) -Herbal medicine practitioners.

iv. Voluntary health agencies and non-governmental organizations. a. Nigerian Red Cross Society

b. Planned Parenthood Federation of Nigeria c. The Leprosy Mission Nigeria

d. *Professional bodies:* The Nigerian Medical Association, National Association of Nigerian Nurses and Midwives, Pharmaceutical Society of Nigeria, National Association of Physiotherapist, Health Records Registration Board, Medical & Health Workers Union.

e. *Missionary bodies:* Christian Health Association of Nigeria, Is- lamic Organization.

f. *International agencies:* WHO, UNICEF, UNDP, UNFPA, USAID, Sight Savers International, Society for Family Health (SFH).

5.2.3 Rural urban distribution

You have now learned about the sector wise distribution of health manpower which does not give the real picture of available manpower according to geographical area. When we analyze them between rural and urban area we

can observe the gross maldistribution of health manpower. Studies in Nigeria have shown that there is a concentration of doctors and nurses (up to 80 per

cent) in urban areas where only 20 per cent of population live. This maldis- tribution is chiefly attributed to absence of amenities in rural areas, lack of job satisfaction, professional isolation, lack of rural experience and inability to adjust to rural life by the professional doctors and nurses.

5.2.4 Planning and ratio in relation to population

Health manpower planning is an important aspect of community health planning. It is based on series of accepted ratios such as doctor population ratio, nurse-population ratio, bed-population ratio, etc. For your under- standing of the depth of the problem of the availability of health manpower in the state, a set of data sheets from various government publications is given for your read)} reference. See Appendix 4.

5.2.5 International action and the role of WHO

International action will include the following: i. Information will be collected and used internationally by the WHO regarding people and groups throughout the world who could provide indivi~ual or group support to countries on various aspects of their strategies;
ii. UNESCO, in its worldwide literacy programme will be requested to ~ use health information with a view to providing basic understanding of nutritional and health needs and of prevention and control of common health problems.
iii. WHO will engage in technical cooperation with its member states and promote such cooperation among them to ensure the m~imum mobilization and development of personnel for health;
iv. WHO will ensure the involvement of other UN organizations like UNDP, UNFPA, International non-governmental and voluntary organ-izations by identifying specific tasks in which they can engage;
v. WHO will promote dialogue between developing and developed coun- tries to prevent brain drain of health personnel.

SELF ASSESSMENT QUESTION 1

i) Outline the five major sectors where the health manpower are engaged. a) b)

5.3 Financial and material resources

Financial and material resources are as essential as human resources for the successful implementation of the strategy. It involves efficient use of existing resources and making provision for the additional resources.

Table 1: National Health Development Plans in Nigeria

1st National Health Development Plan (10 years)	1946 -1956
2nd National Health Development Plan (5 years)	1970 -1974
3rd National Health Development Plan (6 years)	1975 -1980
4th National Health Development Plan	1988 -Date

Source: National Health Policy (1989). Federal Ministry of Health

5.3.1 Financial resources and GNP

Money is an important resource for providing health services. Scarcity of money affects all parts of the health delivery system. In most developed countries, Government expenditure for health lies between 6 to 12 per cent of Gross National Product (GNP). In under-developed countries, it is less than I per cent of the GNP and it seldom exceeds 2 per cent of the GNP. To make matter worse, much of the spending is for services that reach only a small fraction of the population.

To achieve Health For All, WHO has set, as a goal, the expenditure of 5 per cent of each country's GNP on health care. At present, Nigeria is spending about 3 per cent of GNP on health and family welfare services. In Nigeria, 20% of the nation's budget is to be expended on health. The per capita health expenditure is not more than US$10 to 15. This is far less compared with Jamaica which expends US$100 and the United States of America with US$4,000. This accounts for the drop in the life-expectancy which is about 52 years. The greater part of the health expenditure goes to primary health care.

Infant mortality rate in Nigeria is about 80/ 1,000; Child mortality rate is about 28.8/1,000 on the average (urban and rural populations) and maternal mortality rate is about 4/1,000.

The federal government has also directed that 12% of the State's budget should go for health.

5.3.2 Priority in financial allocation

Since money and material are always scarce resources they must be put to the most effective use, with an eye for maximum output of results on minimum investment. Since deaths from preventable diseases such as malaria, whooping cough, measles, tuberculosis, tetanus, diphtheria, malnutrition frequently occur in developing countries, the case is strong for investing resources on preventing these diseases. Spending money on multiplying prestigious medical institutions and other high cost medical establishments which cater for a small percentage of the sick citizens, absorbs a large portion of the national health budget. Management techniques such as cost effectiveness and cost-benefit analysis are now being used for allocation of resources in the field of community health.

5.3.3 Review distribution and reallocation of health budget

i. Review of the allocation of health budget to primary health care at peripheral, intermediate and central levels in urban and rural areas and to specific underserved groups;
ii. Reallocation of the existing resources or any additional resources for providing primary health care to underserved population groups;
iii. Analysis of the needs, in terms of costs and material, for appropriate health technology and establishment of health infrastructure;
iv. Consideration of cost effectiveness of different technologies, of ,1 various health programmes, to find alternate ways of organizing the health system in relation to the cost.

5.3.4 Estimate the financial needs and secure additional funds

i. Estimation of the magnitude of total financial and material needs to implement the strategy;

ii. Consideration of alternative ways of financing the health system including the possible use of social security funds, e.g. ESI, CGHS;
iii. Identifying activities that might attract external grant or loans e.g. Leprosy control, child survival and Safe Motherhood, National Immunization Programme, AIDS control; .'"
.,iv. Encouraging governm~b~~ (in,developing countries) to request fo:) 1; .grants and loans from other sources sucli as external banks,bilateraJ " and multilateral agencies; e.g. World Bank; Rockfeller Foundation', ~i CARE, ODA of UK or Japan, Ford Foundation, UNDP, UNESCO; -L

v. In developed countries, to influence concerned agencies to provide grants and loans for the strategy; e.g. various religious organizations;
vi. Presentation of their government a master plan which outlines the use of all financial and material resources including direct and indirect financing e.g. local community resources in terms of available manpower, material and money, individual payments for service and the use of external loans and grants.

5.3.5 International action and the role of WHO

To mobilize financial resources, WHO's action will consist of the following

i. Ensure the exchange of information on alternative ways of financing health systems;
ii. Estimate the order of magnitude of financial needs for the strategy;
iii. Promotion and development of methodology for and support cost-benefit and cost-effectiveness studies on health systems and technology;
.iv. Strengthen developing countries' capacities, on request, to prepare proposals for funding from external sources for health;
v. Use its mechanisms to identify needs and facilitate mobilization of funds as well as transfers between countries;
vi. Establishment and coordination of activities of 'global health for all', Resources group representation countries, intergovernmental, bilateral and multilateral agencies and foundations, as well as non governmental organizations, working together to rationalize the transfer 1ofresources for 'Health For All' and to mobilize additional funds, if necessary.

SELF ASSESSMENT QUESTION 21

i) Enter T or F (T = True; F = False) against the following statements: National budget for health sector is:
a) mainly spent to build urban oriented prestigious curativ~ c institution

,
! b) directed to supply wholesome water and sewage system to ! the rural population.
c) 5% of GNP which is recommended by WHO to achieve health for alL

d) At present is only 3% of GNP. ; ii) State in 5 lines regarding the international action for mobilizing
financial and material resources :

5.4 Monitoring and evaluation

You have learnt all about health service resource in terms of Manpower, Money and Material distributed through out the country from center to peripheral level. All these resources are allocated for *specified programme* or *task with definite goal.*

In order to know the progress in implementation of any strategy, and to evaluate the effectiveness in improving the health status of the people it is essential to set up a process of *monitoring and evaluation.* Success of any programme depends on constant monitoring of its different activities by guidance of an inbuilt predetermined systems of monitoring and evaluation right at the stage of its inception. Monitoring process as well as evaluation are complementary to each other to observe and assess the progress of a planned programme.
We will now explain the process of monitoring and evaluation in the following sub section.

5.4.1 Definition and importance of monitoring

Monitoring, we define as the day-to-day follow-up of activities during their implementation stage, to ensure that they are proceeding as planned and are on schedule. It is a continuous process of observing, recording, and reporting on the activities of the organization or project. Monitoring, thus, consists of keeping track of the course of activities and identifying deviations and taking corrective action if deviations occur.

5.4.2 Monitoring vs surveillance

Definition of *monitoring* which you have learned is often taken as similar to that of surveillance. But in public health practice during the past 25 years they have taken on a rather specific, some what different meaning.
i. Monitoring: Monitoring is "the performance and analysis of routine measurements aimed at detecting changes in the environment or health status of population". Thus we have monitoring of an air pollution, water quality, growth and nutritional status of children etc. It also refers to the measurement of performance of an ongoing health service or a health professional, or of the extent to which patients comply with or adhere to advice from health professionals.

In management, monitoring refers to the continuous overseeing of activities to ensure that they are proceeding according to plan. It keeps track of performance of health staff, utilization of supplies and equipments, and the money spent in relation to the resources available

so that if anything goes wrong immediate corrective measures can be taken.

ii. Surveillance: Surveillance is defined in many ways. According to one interpretation, surveillance means to watch over with great attention and authority of the minute details in a situation. Surveillance is also defined as the continuous scrutiny of the factors that determine the occurrence and distribution of disease and other conditions of ill health. Surveillance pro- grammes can assume any character and dimension - thus we have epidemi- ological surveillance, demographic surveillance, nutritional surveillance etc:
The main objectives of surveillance are:
a. to provide information about new and changing trends in the health status of a population, e.g. morbidity, mortality, nutritional status or other indicators of environmental hazards.
b. to provide feedback which may be expected to modify the policy and the system itself and lead to redefinition of objectives, and
c. to provide timely warning of public health disasters so that interven- tions can be mobilized.

According to the above definitions, monitoring becomes one specific and essential part of the broader concept embraced by surveillance. Monitoring requires careful planning and the use of standardized procedures and methods of data collection, but can then be carried out over extended periods of time by technicians and automated instrumentation. Surveillance, in contrast, requires professional analysis and sophisticated judgement of data leading to recommendations for control activities.

5.4.3 Evaluation

It is worthy of note that both monitoring and surveillance processes are only to check the deviation of any programme or acti vity from its aim till it reaches to the goal in terms of its resources. These tools fail to assess the programme achievement at its different levels of implementation which is done by the process of evaluation.
The purpose of evaluation is to assess the achievement of the stated objectives of a programme, its adequacy, its efficiency and its acceptance by all parties involved. While monitoring is confined to day-to-day ongoing operations, evaluation is mostly concerned with the final outcome and with factors associated with it. Good planning will have a built-in evaluation to measure the performance and effectiveness and for feed-back to correct specific deficiencies.
Evaluation is the process by which results are compared with the intended objectives, or more simply the assessment of how well a programme is performing. Evaluation should always be considered during the planning and implementation stages of a programme or

activity. Evaluation may be crucial in identifying the health benefits derived (impact on morbidity, mortality, squelae, patient satisfaction). Evaluation can be useful in identifying performance difficulties. Evaluation studies may also be carried out to generate information for other purposes, e.g. to attract attention to a problem, extension of control activities, training and patient management, etc.

The *reasons* for evaluation are as follows: Health services. have become complex. There has been a growing concern about their functioning both in the developed and developing countries. Questions are raised bout the quality of medical care, utilization and coverage of health services, benefits to community health in terms of morbidity and mortality reduction and im- provement in the health status of the recipients of care. An evaluation study addresses itself to these issues.

5.4.4 Elements of evaluation process

Evaluation is perhaps the most difficult task in the whole area of health services. The components of the evaluation process are:

a. *Relevance:* Relevance or requisiteness relates to the appropriateness I of the Service, whether it is needed at all. If there is no need, the I service can hardly be of any value. Example, vaccination against smallpox is now irrelevant because the disease no longer exists in the world. .

b. *Adequacy:* It implies that sufficient attention has been paid to certain previously determined courses of action. For example, the staff allocated to a certain programme may be described as inadequate if sufficient attention was not paid to the quantum of work-loan and targets to be achieved.

c. *Accessibility:* It is the proportion of the given population that can be expected to use a specified, facility, service, etc. The barriers to accessibility may be physical (e.g. distance, travel, time): economic (e.g. travel cost, fee charged); or social and cultural (e.g. caste or language barrier).

d. *Acceptability:* The service provided may be accessible, but not acceptable to all, e.g. male sterilization, screening for cervical or rectal cancer, insertion of copper T if the professional worker is male/female as the case may be.

e. *Effectiveness:* It is the extent to which the underlying problem is prevented or alleviated. Thus it measures the degree of attainment of the predetermined objectives and targets of the programme, service or institution-expressed, if possible, in terms of health benefits, problem reduction or an improvement of an unsatisfactory health situation. The ultimate measures of the effectiveness will be the reduction in morbidity and mortality rates.

f. *Efficiency:* It is a measure of how well resources, money, men, material and time are utilized to achieve a given effectiveness. The following examples will illustrate: the number of immunizations provided in a year as compared with an accepted norm using cotton and gauze to clean the windows or chairs~ during personal work on project time, a medical officer who cannot speak the language of the client or a professional nurse who cannot insert a copper T or health personnel proceeding on long. leave with no replacement.

g. *Impact:* It is an expression of the overall effect of a programme service or institution, on health status and socioeconomic develop- ment. For example, as a result of malaria control in Nigeria, not only has the incidence of malaria dropped down, but all aspects oflife-ag- ricultural, industrial and social-showed an improvement. If the target of 100 per cent immunization has been reached, it must also lead to reduction in the incidence or elimination of vaccine preventable diseases. If the target of village water supply has been reached, it must also lead to a reduction in the incidence of diarrhoea diseases.

Planning and evaluation must be viewed as a continuous interactive process, leading to continual modification both of objectives and plans. Successful evaluatibn may also depend upon whether the means of evaluation were built into the design of the programme before it was implemented.

5.4.5 General steps of evaluation The basic steps involved are as follows: -Determine what is to be evaluated. -Establish standards and criteria.

-Plan the methodology to be applied. -Gather information. -Analyse the results. -Take action -Re-evaluate

Determine what is to be evaluated: Generally speaking; there are three types of evaluation:

a. Evaluation of "structure": This is evaluation of whether facilities, i equipment, manpower and organization meet a standard accepted by experts as good.

b. Evaluation of "process": The processes of medical care include the problems of recognition, diagnostic procedures, treatment and clini- cal management, care and prevention. The way in which the various activities of the programme is carried out is evaluated by comparing with a predetermined standard. An objective and systematic way of evaluating the physician (or nurse) performance is known as "Medical (or nursing) Audit"

c. Evaluation of "outcome": This is concerned with the end results, that is, whether persons using health services experience measurable benefits such as improved survival or reduce disability. The tradi- tional outcome

components are the "5 Os" of ill health, viz. Disease, death, disability, discomfort and dissatisfaction.

Establishment of standards and criteria: Standards and criteria must be established to determine how well the desired objectives have been attained. Natqrally such standards are a prerequisite for evaluation., Standards and criteria must be developed in accordance with the focus of evaluation-

i. Structural criteria: e.g. physical facilities and equipments

iii. Process criteria: e.g. every prenatal mother must receive 6 check-ups; every laboratory technician must examine 100 blood smears, etc;

iv. Outcome criteria: e.g. an alterations in patient health status (cured, dead, disabled): or a change in behaviour resulting from health care (satisfaction, dissatisfaction); or the educational process (e.g. cessa- tion of smoking, acceptance of a small family norm), etc.

Planning the methodology: A format in keeping with the purpose of evalu- ation must be prepared for gathering information desired. Standards and criteria must be included at the planning state.

Gathering infonnation: Evaluation requires collection of data or information. The type of information required may include political, cultural, economic, environmental and administrative factors influencing the health situation as well as mortality and morbidity statistics. It may also concern health and related socioeconomic policies, plans and programmes as well as the extent, scope and use of health systems, services and institutions. The amount of data required will depend on the purpose and use of the evaluation.

Analysis of results: The analysis and interpretation of data and feedback to all individuals concerned should take place within the shortest time feasible, once information has been gathered. In addition, opportunities should be provided for discussing the evaluation results with all concerned.

Taking action: For evaluation to be truly productive, emphasis should be placed on actions-actions designed to support, strengthen or otherw~se mod- ify the services involved. This may also call for shifting priorities, revising objectives, or development of new programmes or services to meet pre- viously unidentified needs.

Re-evaluation: Evaluation is an ongoing process aimed mainly at rendering health activities more relevant, more efficient and more effective.

5.4.6 Evaluation of health services

Randomized controlled trials have been extended to assess the effectiveness and efficiency of health services. Often, choices have to be made between alternative policies of health care delivery. The necessity of choice arises from the fact that resources are limited, and priorities must be set for the implementation of a large number of activities, which could contribute to the welfare of the society. An excellent example of

such an evaluation is the controlled trials in the chemotherapy of tuberculosis in Nigeria, which demonstrated that "domiciliary treatment" of pulmonary tuberculosis was as effective as the more costlier "hospital or sanatorium" treatment. The results of the study have gained international acceptance and ushered in a new era-the era of "domiciliary treatment" in the treatment of tuberculosis.

More recently, multiphasic screening which has achieved great popularity in some countries, was evaluated by a randomized vast outlay of resour~es required to mount a national programme of multiphasic screening in UK. Another example is that related to studies which have shown that many of the health care delivery tasks traditionally performed by physicians can be performed by nurses and other paramedical workers, thus saving physician's time f9r other essential tasks. These studies are also labeled as "health services research" studies.

SELF ASSESSMENr QUESTION 3

i i) Enter T or F (T = True; F = False) against the following statements: Monitoring of any programme is:

a) keeping track of course of activities ' 13) providing information about recent trends in disease pattern

c) identifying deviation and taking corrective action, if needed i d) day-to-day follow up activities during implementation

Ii ii) List all the seven steps involved in evaluation process in chronological order.

5.5 Indicators of health monitoring and evaluation

Now you have imbibed all about the process of monitoring and evaluation of Health Services implemented to uplift the health of the people. The level of health has to be measured in some units as kilogram for weight and meter for height. For this purpose we have different health indicators to measure the qualitative and quantitative variables in health.

A question that is often raised is, how healthy is a given community? (Indicators are required not only to measure the health status of a community, . but also to compare the health status of one country with that of another, for assessment of health care needs, for allocation of scarce resources and for monitoring and evaluation of health services, activities and programmes. Indicators help to measure the extent to which the objectives and targets of a programme are being attained.

As the name suggests, indicators are only an indication of a given situation or a reflection of that situation. In WHO's guidelines for health programme evaluation, indicators are defined as variables which help to measure change- s. Often they are used particularly when these changes

cannot be measured sequentially over time, they can indicate direction and speed of change and serve to compare different areas or groups of people at the same moment in time.

5.5.1 Characteristics of indicators .

Indicators have been given scientific respectability; ideal indicators:

a. should be valid, i.e. they should actually measure what they are supposed to measure;

b. should be reliable and objective, i.e. the answers should be the same if measured by different people in similar circumstances;

c. should be sensitive, i.e. they should be sensitive to changes in the situation concerned; and

d. should be specific. i.,e. they should reflect changes only in the situation concerned.

But in real life there are few indicators that comply with all these criteria. Measurement of health is far from simple.

5.5.2 Broad classification of indicators in health measure- ment

1/ As all of you have learnt that health is multidimensional in nature and each dimension is influenced by numerous factors, some known and many un- known. Therefore no single indicator can measure the health of people. It must be conceived in terms of a profile employing many indicators like:

r -Mortality indicators

t -Morbidity indicators

I.. -Disability (rate) indicators

-Nutritional status indicators

-Health care deli very indicators -Utilization (rate) indicators

-Indicators of social and mental health -Environmental indicators -SocioecQnomic indicators -Health policy indicators

.-Indicators of quality of life

-Other indicators for specific situations

We shall now study the same in detail for better understanding.

Mortality indicators

There are many measurements involved such as -

a. *Crude death rate:* This is considered a fair indicator of the com- parative health of the people. Crude death rate is defined as the number of deaths per 1000 population per year in a given community.

It indicates the rate at which people are dying. Strictly speaking, health should not be measured by the number of deaths that occur in a community. But in many countries, the crude death rate is the only available indicator of health. When used for international compari- son, the usefulness of the crude death rate is restricted because it is influenced by the age-sex composition of the population. Although not a perfect measure of health status, a decrease in death rate provides a good

tool for assessing the overall health improvement in a popu- lation. Reducing the number of deaths in the population is an obvious
I goal of medicine and health care, and success or failure to do so as a measure of a nation's commitment to better health. In 1991 the crude death rate (CDR) for Nigeria is 9.8 per thousand population.
b. *Expectation of life:* Life expectancy at birth is "the average number of years that will be lived by those born alive into a population if the current age-specific mortality rates persist". Life expectancy at birth is highly influenced by the infant mortality rate where that is high. Life expectancy at the age of 1 excludes the influence of infant mortality, and life expectancy at the age of 5 excludes the influence of child mortality. Life expectancy at birth is used most frequently. It is estimated for both sexes separately. It indicates an increase in the health status.

Life expectancy is a good indicator of socio-economic development in general. As an indicator of long-term survival, it can be considered as a positive health indicator. It has been adopted ;as a global health indicator. A minimum life expectancy at birth of 60 years is the goal of health for all by 2000 AD. For Nigeria life expectancy is 62.8 for urban and 53.7 in rural areas at present.
c. *Infant mortality rate:* Infact mortality rate (IMT) is the ratio of deaths under 1 year of age in a given year to the total number of live births in the same year, usually expressed as a rate per 1000 live births. It is one of the most universally accepted indicators of health status not .I only of infants, but also of whole populations and of the socioecon- omic conditions under which they live. In addition, the infant mor- tality rate is a sensitive indicator of the availability, utilization and effectiveness of health care, particularly perinatal care. The global strategy of health for all has suggested an infant mortality rate not more than 50 per 1000 live births by 2000 AD. In 1991 the IMR in Nigeria is 80 per thousand live births.
d. *Child mortality rate:* Another indicator related to the overall health status is the early childhood (1-4 years) mortality rate. It is defined as the number of deaths at ages 1-4 years in a given year, per 1000 children in that age group at the mid-point of the year concerned. It thus excludes infant mortality. Irt'Nigeria the CMR is 18.2 for urban and 39.4 in rural area at present.

Apart from its correlation with inadequate MCH services, it is also related to insufficient nutrition, low coverage by immunization and adverse environmental exposure and other exogenous agents.
Mortality indicators represent the traditional measures of health status. Even today they are probably the most often used indirect indicators of health. As infectious diseases have been brought under control, mortality rates have declined to very low levels in many countries. Consequently mortality indicators are losing the sensitivity as health indicators in

developed countries. However mortality indi- cators continue to be used as the starting point in health status evaluation.

Morbidity indicators

To describe health in terms of mortality rates only is misleading. This is because; mortality indicators do not reveal the burden of ill health in a community, as for example mental illness, rheumatoid arthritis. Therefore morbidity indicators are used to supplement mortality data to describe the developing countries than in the developed countries. The child mortality rate may be as much as 250 time higher. This indicates the magnitude of the gap and the room for improvement in the health status of developing and developed countries.

Maternal (puerperal) mortality rate: Maternal (puerperal) mortality accounts for the greatest proportion of deaths among women of reproductive age in most of the developing world, although its importance is not always evident from official statistics. There are enormous variations in maternal mortality according to country level of socioeconomic status. At present in Nigeria the MMR is 3-4. There are enormous variations in maternal mortality according to country level of socioeconomic status. At present in Nigeria the MMR is 3-4 per 10,000 deliveries against our national target of below 2 per 10,000 by 2000 AD.
Disease-specific mortality: Mortality rates can be computed for specific diseases. As countries begin to extricate themselves from the burden of communicable diseases, a number of other indicators such as deaths from cancer, cardiovascular diseases, accidents, diabetes etc. have emerged as measures of specific disease problems. Mortality statistics have also their own drawback. They tend to overlook a large number of conditions which are sub clinics, in apparent, that is, the hidden part of the iceberg of disease.

The following morbidity rates are used for assessing ill health in community

i. incidence and prevalence ii. notification rates
iii. Attendance rates at out-patient departments, health centers, etc. iv. Admission, readmission and discharge rates v. Duration of stay in hospital, and
vi. Spells of sickness or absence from work or school *Nutrition status indicators*
Nutrition status is a positive health indicator. Three nutritional status indica-
tors are considered important as indicators of health status. They are:
*J*anthropometrics measurements of preschool children, e.g. weight and height, mid-arm circumference;
b. height (and sometimes weight) of children at school entry; and

c. prevalence of low birth weight (less than 2.5 kg.)

Health care delivery indicators

The frequently used indicators of health care delivery are: a. Doctor population ratio b. Nurse population ratio c. Population bed ratio

d. Population per health center/subcentre

e. Population per traditional birth attendant (TBA)

These indicators reflect the equity of distribution of health resources in different parts of the country, and of the provision of health care.

Utilization rates

In order to obtain additional information on health status the extent of use of health services is often investigated. Utilization of services-or actual cover- age-is expressed as the proportion of people in need of a service who actually receive it in a given period, usually a year. It is argued that utilization rates give some indication of the care needed by a population and therefore, the health status of the population. In other words, a relationship exists between utilization of health care services and health needs and status. Health care utilization is also affected by factors such as availability and accessibility of health services and the attitude of an individual towards his health and the health care system. A few examples of utilization rates are given below:

a. proportion of infants who are "fully immunized" against the 6 pre-ventable disease through national programme of immunization (NPI)

b. proportion of pregnant women who receive antenatal care, or have their deliveries supervised by a trained birth attendant.

c. Percentage of the population using the various methods of family planning.

d. Bed-occupancy rate (i.e. average daily in-patient census/average number of beds).

e. Average number of patients using the health centre clinics.

The above list is neither exhaustive nor all~inclusive. The list can be expanded

depending upon the services provided. These indicators direct attention away from the biological aspects of disease in a population towards the discharge of social responsibility for the organization in delivery of health care services.

Indicators of social and mental health

As long as valid positive indicators of social and mental health are scarce, it is necessary to use indirect measures, viz, indicators of social and mental pathology. These include suicide, homicide, other acts of violence and other crime; road traffic accidents, juvenile delinquency, alcohol and drug abuse; smoking; consumption of tranquilizers; obesity, etc. To these may be added family violence, battered-baby and battered-wife syndromes and neglected and abandoned youth in the neighborhood. These social indicators provide a guide to social action for improving the health of the people.

Environmental indicators

Environmental indicators reflect the quality of physical and biological envi- ronment in which diseases occur and in which the people live. They include indicators relating to pollution of air and water, radiation, solid wastes, noise, exposure to toxic substances in food or drink. Among these, the most useful indicators are those measuring the proportion of population having access to safe water and sanitation facilities, as for example, percentage of households with safe water in the home or within 15 Minutes walking distance from a water standpoint or protected well, adequate sanitary facilities in the home or immediate vicinity.

Socioeconomic indicators
These indicators do not directly measure health. Nevertheless, they are of great importance in the interpretation of the indicators of health care.
These include:
a. rate of population increase b. per capita GNP
c. level of unemployment
d. dependency ratio ... e. literacy rates, especially female literacy rates f. family size
g. housing; the number of persons per room h. per capita "calorie" availability
Other indicator series a. Social indicators: Social indicators, as defined by the United Nations Statistical Office, have been divided into 12 categories: population, family formation, families and households, learning and educational services, earning activities, distribution of income, consumption, and accumulation, social security and welfare services, health services and nutrition, housing and its environment, public order and safety, time use, leisure and culture, social stratification and mobility.
b. *Basic needs indicators:* Basic needs indicators are used by ILO. Those mentioned in "Basic needs performance" include calorie consump- tion; access to water; life expectancy; deaths due to disease; illiteracy, doctors and nurses per population; rooms per person; GNP per capita.
c. *Health/or all indicators:* For monitoring progress towards the goal of health for all by 2000 AD, the WHO has listed the following four categories of indicators.
.Health policy indicators
-Social and economic indicators related to health -Indication for the provision of health care -Health status indicators.

5.5.3 Details of indicators selected for monitoring pro- gress towards health for all

a. Health policy indicators

-political commitment to health for all
-resource allocation -the degree of equity of distribution of health services
-community involvement
-organizational framework and managerial process
b. Social and economic indicators related to health: -rate of population increase -GNP or GDP
-income distribution -work conditions
-adult literacy rate -housing
-food availability
c. Indicators for the provision of health carte: -availability
-accessibility -utilization
-quality of care
d. Health status indicators
-low birth weight (percentage)
-nutritional status and psychosocial development of child -infant mortality rate
-child mortality rate (1-4 years) -life expectancy at birth

-maternal mortality rate li(J ii,
-disease specific mortality f) : , , ,.
-morbidity-incidence and prevalence I ' -disability prevalence ,t

SELF ASSESSMENT QUESTION

Situation: In the year 1992 an urban community' A' is inhabited by a group of people having birth rate of 40 per 1000 population have evidenced with 320 unfortunate children who could not see their 1st birthday.

i) Calculate the total number of live births in the community and calculate the infant mortality rate of the above community *'A'*.

ii) List five health care delivery indicators. '!

a) b) c) d) etional funds for this purpose. International transfer of resources from de- veloped to developing countries will be rationalized and, if necessary, these transfers will be increased.

Monitoring and evaluation are the essential parts of the strategy. To monitor progress during implementation and to evaluate its effect, a suitable moni- toring and evaluation process will be set up. Indicators at the national level such as health indicators for the provision of health care and health status indicators will be used. At the global level evaluation will be based on the number of countries in which certain indicators comply with predetermined norms. These are: endorsement of policy at the highest official level, availa- bility of primary health to the whole population, equitable distribution of resources, life expectancy at birth over 60 years, literacy rate over 70%, and infant mortality rate below 50 per 1000 live births. At the international level, WHO's

mechanisms will be used for reporting on progress and assessing the impact of the strategy.

5.7 Glossary

Health resources: all the means available for a health system's operation, including manpower, money, materials, building, equipment, supplies, skills, knowledge and technology and operational time.
Health status: the general term for the state of health of an individual, group or population measured against accepted standards at a point of time.
Evaluation: is the systematic assessment of the achievement of the stated objectives in terms of its relevance, adequacy, progress, effi- ciency, effectiveness and impact of a health programme. It gives a feedback to correct deficiencies.
Relevance: a programme is relevant if it answers the needs and social and health policies and priorities it has been designed to meet.
Adequacy: a programme is adequate if it is proportionate to requirements. Efficiency: a programme is efficient if the effort expended on it is as good as possible in relation to the resources devoted to it.
Effectiveness: it is effective if the results obtained conform with the objectives and targets for reducing the extent of the problem or improving an unsatisfactory situation.
Impact: it is the overall effect on health status and socioeconomic devel- opment.
Cost benefit: is the relationship between the cost of an activity and the benefits that accrue from it.
Cost effectiveness: is the relationship between cost and the extent to which a pro- gramme or other activity is contributing to the attainment of the objectives and targets for reducing the problem or improving an unsatisfactory situation.

5.8 Answers to self assessment questions

SAQI
i) a) Public sector
b) Private sector
c) Voluntary agencies
d) Indigenous medicine
e) International agencies.
ii) a) Engage in technical cooperation with its Member States to ensure the maximum mobilization and development of personnel for health
b) Organize the collation and international use of information regarding people and groups who can provide support to the strategy;
c) promote dialogues between developing and developed countries to prevent the brain-drain of health personnel.

SAQ2

i) a) True b) False c) False d) True

ii) WHO will ensure exchange of information on alternate ways of financing health systems. It will estimate the order of magnitude of financial needs for the strategy. Support developing countries on request in preparing proposals for external funding for health, and will work together with other multilateral and bilateral agencies, foundations and 'Health For All' Resources group to rationalize international transfer of resources.

SAQ3

i) a) True b) False c) False d) True

ii) a) Identification of problem

b) Establishment of standard and criteria c) Plan the methodology to be applied d) Gather information e) Analyse the results f) Take action g) Re-evaluate

SAQ4

i) Total Live Birth of Community A = Birth Rate x Population

$$= \frac{40}{1000} \times 100{,}000 = 4{,}000 ,$$

$$\text{IMR} = \frac{\text{Deaths of children below 1 year}}{\text{Total live birth in the same year}} \times 1{,}000$$

$$\text{IMR} = \frac{320}{4000} \times 1000$$

$$= \underline{80 \text{ per } 1{,}000}$$

ii)

a) Doctor population ratio

b) Nurse population ratio

c) Population bed ratio

d) Population per health center/subcentre

e) Population per traditional birth attendant.

5.9 Tutor-marked assignment

Enumerate the processes/components of evaluation of health services.

Appendix 1 Alma-Ata Declaration

You know that the attainment of health for all by the year 2000 was the central issue of the International Conference on Primary Health Care, health at Alma-Ata in September 1978. The Declaration of Alma-Ata is reproduced here in full.

Declaration of Alma-Ata

The International Conference on Primary Health Care meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most import worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promo- tion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V Government have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social
justice.

VI

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 stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.
3. includes at least: 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; mater- nal and child health care, including family planning, immunization against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular, agriculture, animal hus- bandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops, through appropriate education, the ability of com- munities to participate;
6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VII
All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

VIII
All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in anyone country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

IX
An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better us of the world's resources, a considerable part of which is now spent on. armaments and military conflicts. A genuine policy of inde- pendence, peace, ditente and disarmament could and should release additional re- sources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

Appendix 2

Health Policy
The Government of Nigeria adopted a National Health Policy in October, 1988. An abridged Para-wise description of the policy is given below:-

Para 1: *The National Health Policy Declaration of the Federal Republic of Nigeria.*
The Federal, state, and local government of Nigeria committed themselves and all the people to intensive action to attain the goal of health for all citizens by the year 2000 and beyond. This is a level of health that will permit them to lead socially and economically productive levels at the highest possible level.

Para 2:Evolution of Health Development and the health status of people in Nigeria. The Health services of Nigeria have evolved through a series of historical developments including a succession previous administration. The health services are judged to be, unsatisfactory and

inadequate in meeting the needs and demands of the public as reflected by the low state of health of the population.

Para 3: *Fundamental Principles underlying the National Health Policy.*
This national health policy to achieve health for all Nigerians is based on the national philosophy of social justice and equity. A health system based on primary health care is adopted as the means of achieving the goal. This philosophy is clearly enunciated in the 2nd National Development Plan, 1070-1974 which described the five National objectives to ;make Nigeria:-
a. a free and democratic society b. a just and egalitarian society
c. a united, strong and self reliant nation d. a great and dynamic economy
e. a land of bright and full opportunities for all citizens
These principles of social justice and equity and the ideals of freedom and opportunity have been affirmed in the constitution.
Para 4: *The Goal of the National Health policy.*
The goal of the national health policy shall be a level of health that will enable all Nigerians to achieve socially and economically productive lives. The national health systems shall be based on primary health care.
Para 5: *National Health Care System.*
The Federal, state and Local Government shall support in a coordinated manner a three-tier system of health care. Essential features of the system shall be its compre- hensive nature, multisectoral inputs community involvement and collaboration with non-government providers of health care.
Para 6: *National Health Strategy*
The implementation of this national Health policy, and progress towards the achieve- ments of the goals, require the elaboration of strategies at the local, state and national levels. The roles and responsibilities of the different arms of government shall be defined from time to time. A managerial process of health development shall be established.
Para 7: *National Health System Management. It is generally recognized that a more effective delivery of health care can be achieved in this country by a more efficient management of the health resources. Experiences have shown repeatedly that many well-conceived health schemes fail to meet expecta*tions because of failures in implementation. It is essential to establish permanent, systematic managerial processes for health development at all levels of care. These shall include appropriate control to ensure the continuity of the managerial process from design to application.
Para 8: *National Health Information System.*
The effective management of health services demands the establishment of a national health information system. Basic demographic data are essential for planning and monitoring of health services. Simple but

efficient information systems shall be estab- lished and supported to grow both in quality and quantity.

Para 9: *National Health Manpower Development.*
Ministries of health shall ensure that medical, nursing, public health and other schools of health sciences under their jurisdiction include in their education programmes the philosophy of "Health for All", the principles of primary health care, and the essentials of the managerial process for national health development, and to provide appropriate, practical training in these areas. In a similar manner, efforts shall be made to involve technical workers in other sectors having a bearing on health. The selection training and development of health manpower shall reflect the national objectives with particular emphasis of the primary health care approach. Appropriate policies shall be evolved to secure a more equitable distribution of health personnel throughout the country.
Para 10: National health technology. The most appropriate health technologies shall be selected for use at all levels of the health care systems. Particular care shall be taken to identify the most cost effective technologies and to maintain them at the highest level of efficiency. In order to reduce importation of supplies, indigenous manufacturing capabilities shall be fostered in the spirit of self-reliance.
Para 11: *National health research*
Priorities for health services and biomedical research shall be review3ed in collaboration with the Ministry of Education, Science and Technology. Mechanisms shall be devised to promote support and co-ordinate research activities in the high-priority areas and to strengthen the research capabilities of national institution to enable them to wider take these essential tasks
Para 12: *National health care financing*
The Federal and State Government shall review their allocation of resources to the health sector. Within available resources, high priority shall be accorded to primary health care with particular reference to wider-served areas and groups. Community resources shall be mobilized in the spirit of self-help and self-reliance.
Para 13 *Health education*
The recommended efforts, on various fronts, would bear only marginal results unless nationwide health education programmes, backed by appropriate communication strategies, are launched to provide health information in easily understandable form, to motivate the development of an attitude for healthy living. The public health education programmes should be supplemented by health, nutrition and population education programmes in all educations at various level.. Simultaneously efforts would be required to be made to promote universal education, specially adult and family education, without which the various efforts to organize preventive and promotive health

activities, family planning and improved maternal and child health cannot bear fruit.

Para 14: *Management information system*

Appropriate decision making and programme planning in the health and related fields is not possible without establishing an effective health information system.

Para 15: *Medical industry The country has built up sound technology and manufacturing capability in the field of drugs, vaccines bio-medical equipments etc. The available know how requires to be adequately exploited to increase the production of essential and life saving drugs and vaccines of proven quality to fully meet the national requirements, specially in regard to the national programmes to combat Malaria, TB, Leprosy, Blindness, Diarrhoeal disease etc. The production of the essential, life saving drugs under their generic names and the adoption of economical packaging practices would considerable reduce the unit cost of medicines, bringing them within the reach of the poorer sections of society, besides, significantly reducing the expenditure being incurred by the governmental organization on the purchase of drugs. In view of the low cost of indigenous and herbal medicines, organized efforts may be launched to establish herbal gardens, producing drugs of certified quality and making them easily available.*

The practitioners of the modern medical system rely heavily on diagnostic aids involving extensive use of costly, sophisticated bio-medica! equipment. Effective mechanisms should be established to identify essential equipments required for extensive use and to promote and enlarge their indigenous manufacture, for such devices being readily available, at reasonable prices, for use at the health care centers.

Para 16: *Health insurance*

It would be necessary to devise well considered health insurance schemes, on a State wise basis, for mobilizing additional resources for health promotion and ensuring that the community shares the cost of the services, in keeping with its paying capacity.

Para 17: *Medical legislation*

It is necessary to urgently review all existing legislation and work towards a unified, comprehensive legislation in the health field, enforceable allover the country.

Para 18 *Medical research*

Special attention should be paid to:

i. containment and eradication of the existing, widely prevalent diseases

ii. translation of available know-how into.simple, low cost, appropriate technologies iii. applied operational research for improving cost effective delivery of health services

iv. more effective treatment and preventive procedures for blindness, leprosy and TB
v. contraceptive research, and vi. nutrition research.

Para 19: *Inter sectoral cooperation*
It is necessary to secure inter sectoral coordination of the various efforts in the fields of health and family planning, medical education and research, drugs and pharmaceutical, agriculture and food, water supply and drainage, housing, education and social welfare and rural development.

Para 20: Monitoring and review of progress
It would be of crucial importance to monitor and periodically review the success of the efforts made and the results achieved in reference to the goals.

Comments about nation health policy
The Health policy is a valuable document and provides a clear framework for national health planning. However, it has been criticized on the following grounds.
i. The policy talks of poverty alleviation, (e.g. through the minimum needs pro- gramme), as a necessary precondition for Health For All. However, the policy does not speak even once about social justice (in health and in other fields such as land reforms and wages), which is an essential prerequisite for Health For All.
ii. No definite programme has been suggested for promoting community participa- tion in health.

Appendix 3
The Nursing Structure The existing nursing structure, organised after Independence, has remained somewhat stagnant. It has neither grown nor developed to keep the desired pace with the expansion of the health services in the country. Despite health survey committees, recommenda- tions in 1946 and 1954, scarce attention has been paid to improvement in the nursing profession suggested by these committees. This is so because of the surbodinate status of the profession and the implementation power of these resting with the non-nurse administrators. Though there has been some upgradation in nursing education, increase in nursing positions and creation of these- at the Health Directorates at the Federal and in the State Governments, these developments have not surfaced much in terms of availability of improved nursing care to the masses. Obviously, this is so because of the isolation of nurses from the planning process and the decision making machinery of the government.
What we see today is that the valuable contribution of the nursing profession is greatly undermined. Non-nurse health planners fail to

appreciate the significant contribution of the nursing profession to the protection and promotion of health of the people. They fail to recognise the underdeveloped and undeveloped leadership potentials of the nursing profession. Instead of giving this established health care profession its due place in the system, it has purposefully neglected and lowered the profession to such an extent that nurses at any level have no autonomy to function independently and pursue the profession in pace with the trends- in health care system.

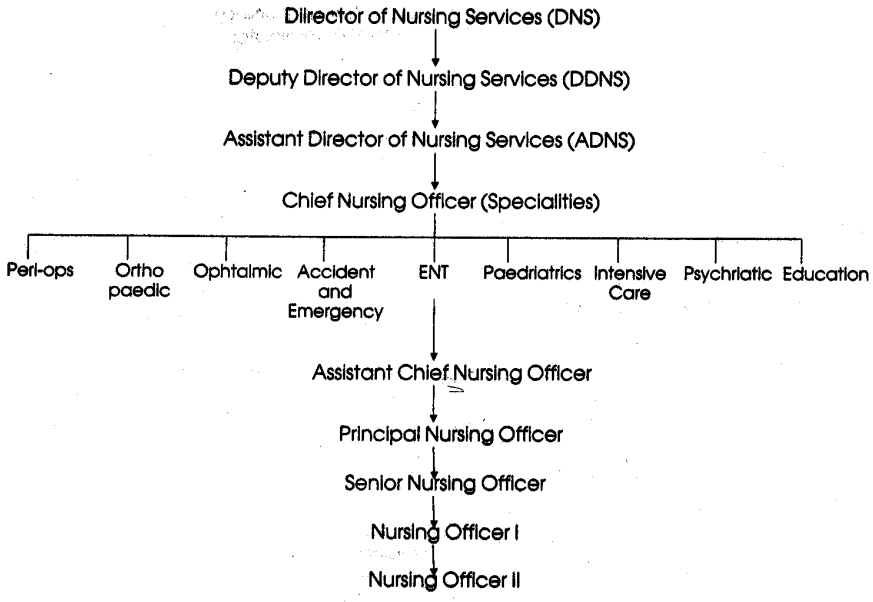
The growth and development of health services and health manpower over the period of nearly seven five year plans reveals the lopsided development in various categories of health professionals.

In view of the present position in Nursing, nurses at various levels are so placed in the organisational set-up that their involvement in policy formulates is not possible. Specially at the Federal, the highest positions in Nursing are merely advisory. There is hardly any coordination of Nursing Service, Education and community care. Even in the State Health Directorates, each position is attached with a medical person rather than with nurses. In such an isolated situation, the Nursing profession has remained fragmented and underdeveloped with the result that Nursing positions are often abolished than expanded and mostly filled on an *ad hoc* basis. Hardly any efforts are made to fill these positions and prepare Nursing leaders.

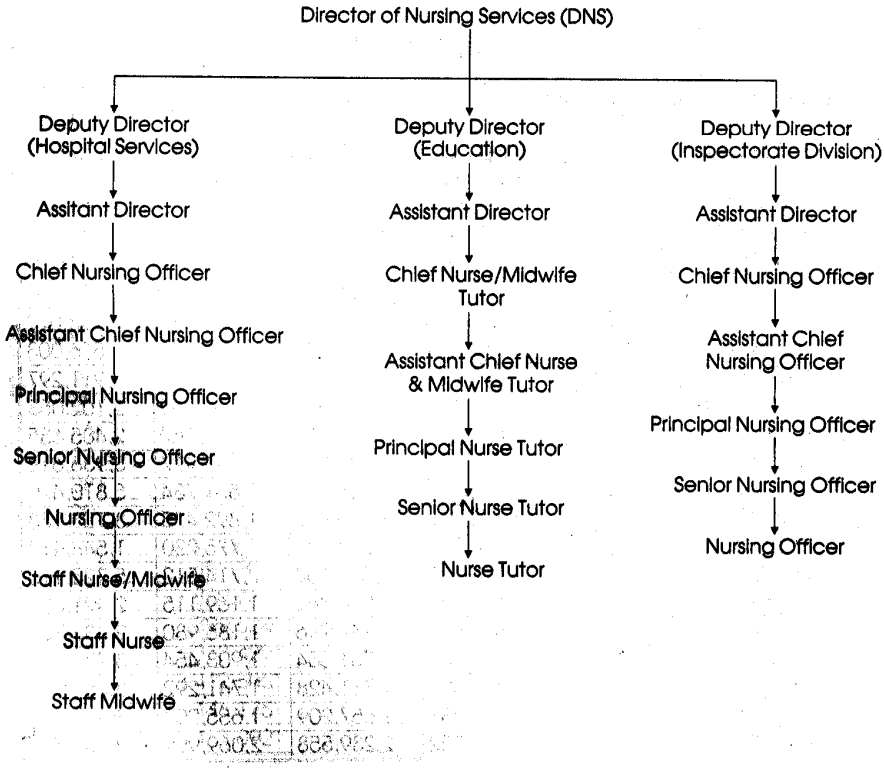
Nursing is a profession and a distinct service in its own right. It is equipped with necessary competence required to be responsible and accountable to the Nursing components in providing health care to the people as colleagues with other health professionals.

Therefore it is essential that Nursing components of the health care be directed by nurses themselves. We have nurses with professional background of Ph.D level available in the country to take up such leading positions. The Association recommends the following organisational structure for equipping nurses with the needed authority and support to function effectively:

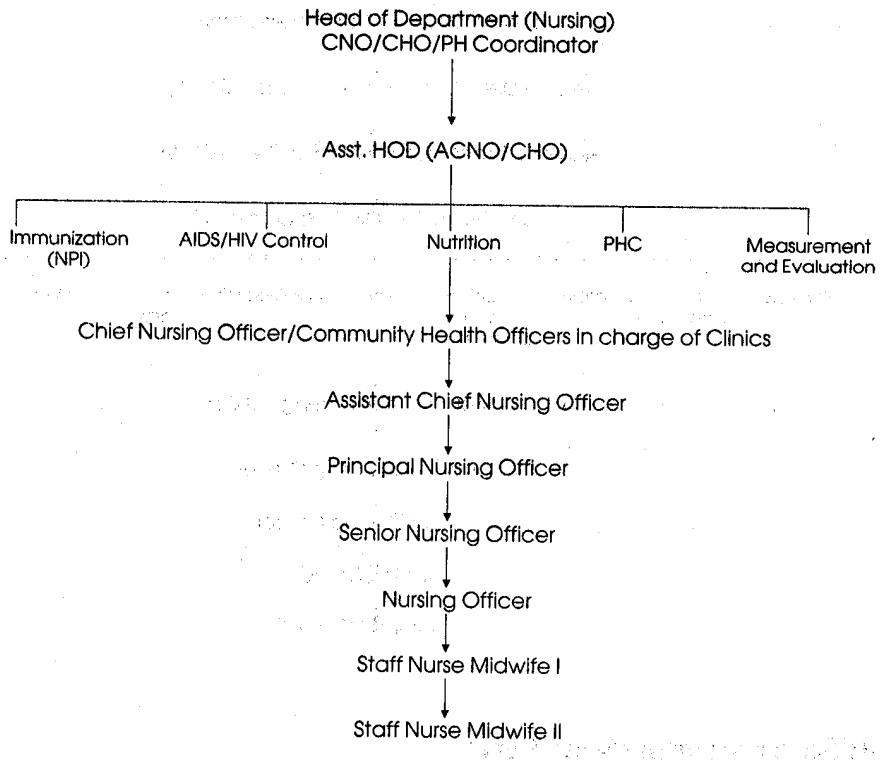
A: Organizational Structure of Nursing at the Federal Level



B: Structure at the State Level



C: Structure at the Local Level



Appendix 4

Population in States by Sex and Number of Households (Nigeria)

STATE NAME	NUMBER OF HOUSEHOLDS	MALES	FEMALES	BOTH SEXES
AKWA IBOM	473,445	1,167,829	1,241,784	2,409,613
ANAMBRA	586.921	1,374,671	1,421,804	2,796,475
BAUCHI	774,554	2,192,423	2,158,584	4,351,007
EDO	441,798	1,085,156	1,086,849	2,172,005
BENUE	498,554	1,368,965	1,384,112	2,753,077
BORNO	562,659	1,296,111	1,239,892	2,536,003
CROSS-RIVER	392,494	956,136	955,161	1,911,297
ADAMAWA	406,683	1,050,791	1,051,262	2,102,053
IMO	541,396	1,166,448	1,319,187	2,485,635
KADUNA	721,784	2,041,141	1,894,477	3,935,618
KANO	1,120,811	2,958,736	2,851,734	5,810,470
KATSINA	722,000	1,860,658	1,892,475	3,753,133
KWARA	326,804	773,182	775,230	1,548,412
LAGOS	1,293,379	3,010,604	2,714,512	5,725,116
NIGER	454,143	1,252,466	1,169,115	2,421,581
OGUN	578,835	1,147,746	1,185,980	2,333,726
ONDO	821,231	1,881,884	1,903,454	3,785,338
PYO	769,525	1,711,428	1,741,292	3,452,720
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RIVERS	815,322	2,239,558	2,069,999	4,309,557

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ABIA	510,971	1,125,999	1,212,488	2,338,487
DELTA	573,042	1,271,932	1,318,559	2,590,491
ENUGU	638,113	1,475,648	1,678,732	3,154,380
JIGAWA	570,492	1,455,780	1,419,745	2,875,525
KEBBI	380,996	1,035,723	1,032,767	2,068,490
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TARABA	273,951	759,872	752,291	1,512,163
YOBE	288,393	714,729	684,958	1,399,687
ABUJA (FCT)	86,254	205,299	166,375	371,674
COUNTRY TOTAL	**17,979,503**	**44,529,608**	**44,462,612**	**88,992,220**

Population Distribution by Single Years of Age and Sex

AGE	BOTH SEXES	in %	MALES	in %	FEMALES	in %
0	2,134,586	2.4	1,101,442	2.5	1,033,144	2.3
1	2,918,647	3.3	1,523,589	3.4	1,395,058	3.1
2	3,074,556	3.5	1,554,733	3.5	1,519,823	3.4
3	3,021,536	3.4	1,530,517	3.4	1,491,019	3.4
4	3,194,564	3.6	1,634,173	3.7	1,560,391	3.5
5	3,091,456	3.5	1,566,614	3.5	1,524,842	3.4
6	3,109,699	3.5	1,583,455	3.6	1,526,244	3.4
7	2,855,667	3.2	1,454,566	3.3	1,401,431	3.2
8	3,135,048	3.5	1,578,192	3.5	1,556,856	3.5
9	2,308,258	2.6	1,191,487	2.7	1,116,771	2.5
10	3,374,960	3.8	1,765,195	4.0	1,609,765	3.6
11	1,510,123	1.7	783,263	1.8	726,860	1.6
12	2,641,020	3.0	1,391,133	3.1	1,249,887	2.8
13	1,857,299	2.1	962,833	2.2	894,466	2.0
14	1,765,279	2.0	910,114	2.0	855,165	1.9
15	2,623,723	2.9	1,357,465	3.0	1,266,258	2.8
16	1,650,412	1.9	797,291	1.8	853,121	1.9
17	1,457,747	1.6	706,913	1.6	750,834	1.7
18	2,451,926	2.8	1,114,815	2.5	1,337,111	3.0
19	1,151,980	1.3	552,327	1.2	599,653	1.3
20	3,681,355	4.1	1,446,440	3.2	2,234,915	5.0
21	933,646	1.0	453,861	1.0	479,785	1.1
22	1,268,959	1.4	465,671	1.3	703,288	1.6
23	990,477	1.1	468,578	1.1	521,899	1.2
24	797,133	0.9	379,753	0.9	417,830	0.9
25	3,459,769	3.9	1,414,133	3.2	2,045,636	4.6
26	857,656	1.0	406,938	0.9	450,718	1.0
27	1,047,806	1.2	526,103	1.2	521,703	1.2
28	1,350,147	1.5	636,149	1.4	713,998	1.6
29	596,293	0.7	321,416	0.7	274,877	0.6
30	3,895,084	4.4	1,678,846	3.8	2,216,238	5.0
31	455,155	0.5	266,350	0.6	188,805	0.4
32	830,735	0.9	449,588	1.0	381,147	0.9
33	399,524	0.4	227,795	0.5	171,729	0.4
34	338,429	0.4	186,050	0.4	147,379	0.3
35	2,412,505	2.7	1,204,919	2.7	1,207,586	2.7
36	446,175	0.5	241,784	0.5	204,391	0.5
37	435,092	0.5	257,186	0.6	175,906	0.4

AGE	BOTH SEXES	In %	MALES	In %	FEMALES	In %
38	629,935	0.7	330,399	0.7	299,536	0.7
39	293,226	0.3	172,583	0.4	120,643	0.3
40	2,824,028	3.2	1,365,049	3.1	1;458,979	3.3
41	232,386	0.3	141,392	0.3	90,994	0.2
42	419,221	0.5	242,308	0.5	176,913	0.4
43	227,503	0.3	135,674	0.3	91,829	0.2
44	142,780	0.2	86,774	0.2	56,006	0.1
45	1,490,881	1.7	809,497	1.8	681,384	1.5
46	201,582	0.2	123,062	0.3	78,520	0.2
47	215,724	0.2	131,648	0.3	84,076	0.2
48	340,610	0.4	187,129	0.4	153,481	0.3
49	167,906	0.2	103,765	0.2	64,141	0.1
50	1,975,757	2.2	1,045,645	2.3	930,112	2.1
51	132,186	0.1	77,090	0.2	55,096	0.1
52	242,772	0.3	135,780	0.3	106,992	0.2
53	110,484	0.1	66,772	0.1	43,712	0.1
54	109,600	0.1	63,363	0.1	46,237	0.1
55	623,171	0.7	350,085	0.8	273,086	0.6
56	153,684	0.2	91,883	0.2	61,801	0.1
57	119,276	0.1	71,285	0.2	47,991	0.1
58	153,146	0.2	82,463	0.2	70,683	0.2
59	70,492	0.1	42,659	0.1	27,833	0.1
60	1,368,131	0.5	723,104	1.6	645,027	1.5
61	68,922	0.1	40,046	0.1	28,876	0.1
62	133,332	0.1	67,344	0.2	65,988	0.1
63	65,573	0.1	37,299	0.1	28,274	0.1
64	54,416	0.1	31,008	0.1	23,408	0.1
65	501,290	0.6	261,525	0.6	239,765	0.5
66	45,354	0.1	27,509	0.1	17,845	—
67	74,689	0.1	43,827	0.1	30,862	0.1
68	97,452	0.1	48,928	0.1	48,524	0.1
69	945,155	0.1	24,751	0.1	20,404	—
70	719,009	0.8	401,036	0.9	317,973	0.7
71	37,201	—	21,792	—	15,409	—
72	79,199	0.1	39,108	0.1	40,091	0.1
73	29,073	—	17,556	—	11,517	—
74	21,820	—	12,694	—	9,126	—
75	241,043	0.3	132,935	0.3	108,108	0.2
76	27,057	—	15,385	—	11,672	—
77	24,618	—	14,103	—	10,515	—
78	40,695	—	22,546	0.1	18,149	—
79	18,410	—	10,486	—	7,924	—
80	403,877	0.5	218,712	0.5	185,165	0.4
81	19,037	—	10,343	—	8,694	—
82	34,021	—	15,692	—	18,329	—
83	11,343	—	6,275	—	5,068	—
84	12,408	—	7,037	—	5,371	—
85+	42,989	0.5	230,585	0.5	194,404	0.4

Population in States by Sex and Sex Ratio

STATE NAME	MALES	FEMALES	SEX RATIO
AKWA IBOM	1,167,829	1,241,784	94.04
ANAMBRA	1,374,671	1,421,804	96.68
BAUCHI	2,192,423	2,158,584	101.57

STATE NAME	MALES	FEMALES	SEX RATIO
EDO	1,085,156	1,086,849	99.84
BENUE	1,368,965	1,384,112	98.91
BORNO	1,296,111	1,239,892	104.53
CROSS-RIVER	956,136	955,161	100.10
ADAMAWA	1,050,791	1,051,262	99.96
IMO	1,166,448	1,319,187	88.42
KADUNA	2,041,141	1,894,477	107.74
KANO	2,958,736	2,851,734	103.75
KATSINA	1,860,658	1,892,475	98.32
KWARA	773,182	775,230	99.74
LAGOS	3,010,604	2,714,512	110.91
NIGER	1,252,466	1,169,115	107.13
OGUN	1,147,746	1,185,980	96.78
ONDO	1,881,884	1,903,454	98.87
PYO	1,711,428	1,741,292	98.28
PLATEAU	1,657,209	1,655,203	100.12
RIVERS	2,239,558	2,069,999	108.19
SOKOTO	2,208,874	2,261,302	97.68
ABIA	1,125,999	1,212,488	92.87
DELTA	1,271,932	1,318,559	96.46
ENUGU	1,475,648	1,678,732	87.90
JIGAWA	1,455,780	1,419,745	102.54
KEBBI	1,035,723	1,032,767	100.29
KOGI	1,039,484	1,108,272	93.79
OSUN	1,043,126	1,115,017	93.55
TARABA	759,872	752,291	101.01
YOBE	714,729	684,958	104.35
ABUJA (FCT)	205,299	166,375	123.40
COUNTRY TOTAL	**44,529,608**	**44,462,612**	**100.15**

Population Distribution by Age in Five Year Groups and Sex

AGE GROUP	MALES	in %	FEMALES	in %	BOTH SEXES	in %
0-4	7,344,454	16.5	6,999,435	15.7	14,343,889	16.1
5-9	7,374,314	16.6	7,126,144	16.0	14,500,458	16.3
10-14	5,812,538	13.1	5,336,143	12.0	11,148,681	12.5
15-19	4,528,811	10.2	4,806,977	10.8	9,335,788	10.5
20-24	3,314,303	7.4	4,357,267	9.8	7,671,570	8.6
25-29	3,304,739	7.4	4,006,932	9.0	7,311,671	8.2
30-34	2,808,629	6.3	3,105,298	7.0	5,913,927	6.6
35-39	2,206,871	5.0	2,008,062	4.5	4,214,933	4.7
40-44	1,971,197	4.4	1,874,721	4.2	3,845,918	4.3
45-49	1,355,101	3.0	1,061,602	2.4	2,416,703	2.7
50-54	1,388,650	3.1	1,182,149	2.7	2,570,799	2.9
55-59	638,375	1.4	481,394	1.1	1,119,769	1.3
60-64	898,801	2.0	791,573	1.8	1,690,374	1.9
65-69	406,540	0.9	257,400	0.8	963,940	0.9
70-74	492,186	1.1	394,116	0.9	886,302	1.0
75-79	195,455	0.4	156,368	0.4	351,823	0.4
80-84	258,059	0.6	222,627	0.5	480,686	0.5
85+	230,585	0.5	194,404	0.4	424,989	0.5
TOTAL	**44,529,608**	**50.0**	**44,462,612**	**50.0**	**88,992,220**	**100.0**

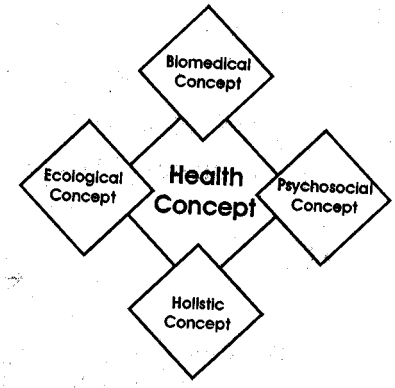
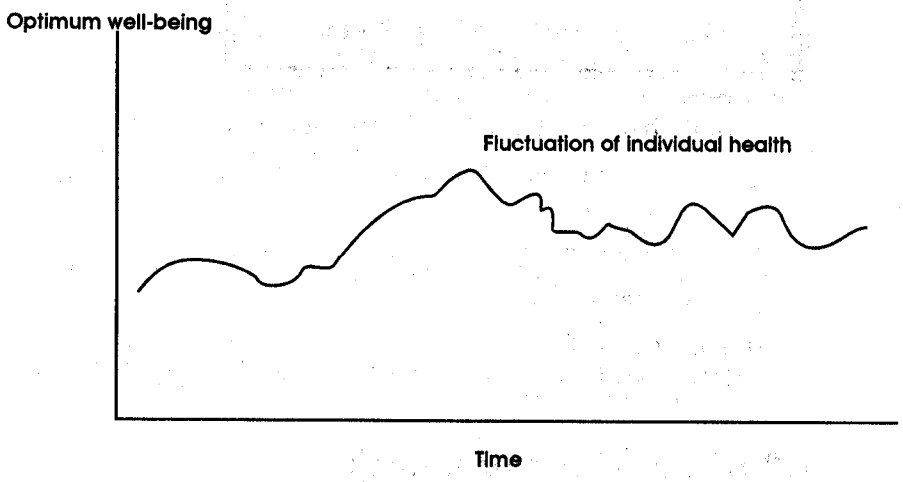


Fig. 1.1: Changing Concepts of Health



Well-being	Positive health
	Better health
	Freedom from sickness
Dysfunction	Unrecognised sickness
	Mild sickness
	Severe sickness
	Death

Fig. 1.3: The health and sickness scale

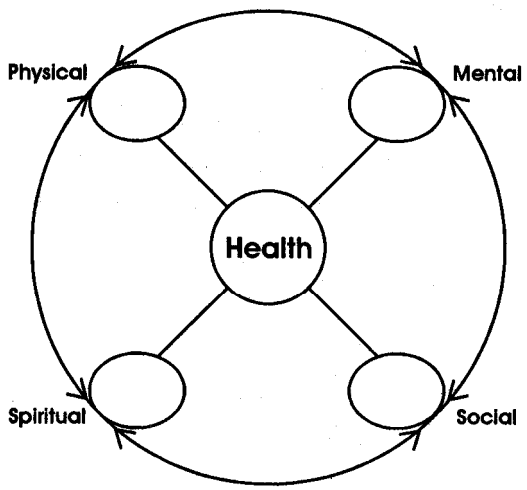


Fig. 1.4: Dimensions of Health

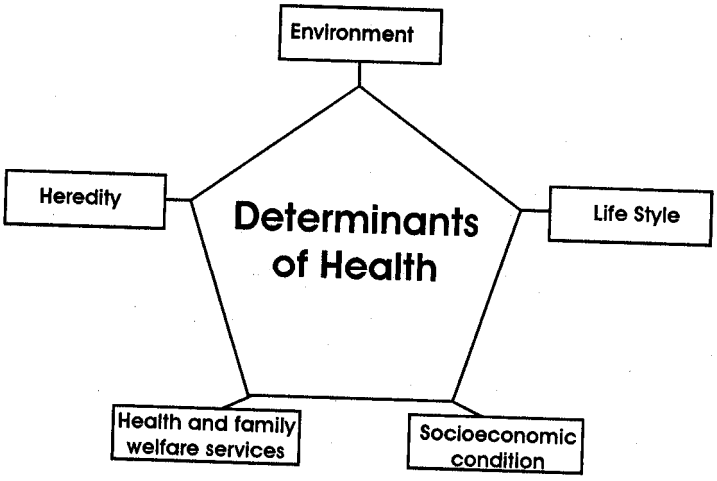
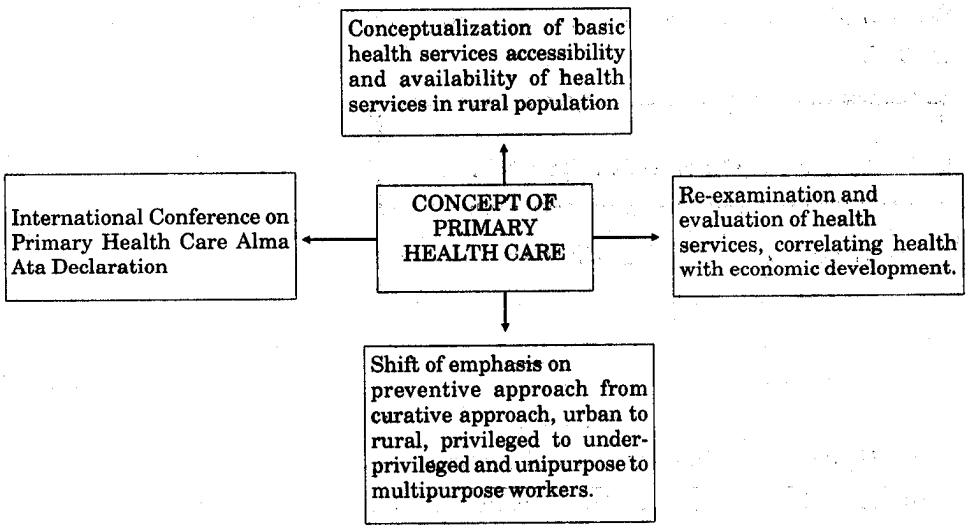


Fig. 1.5: Determinants of health



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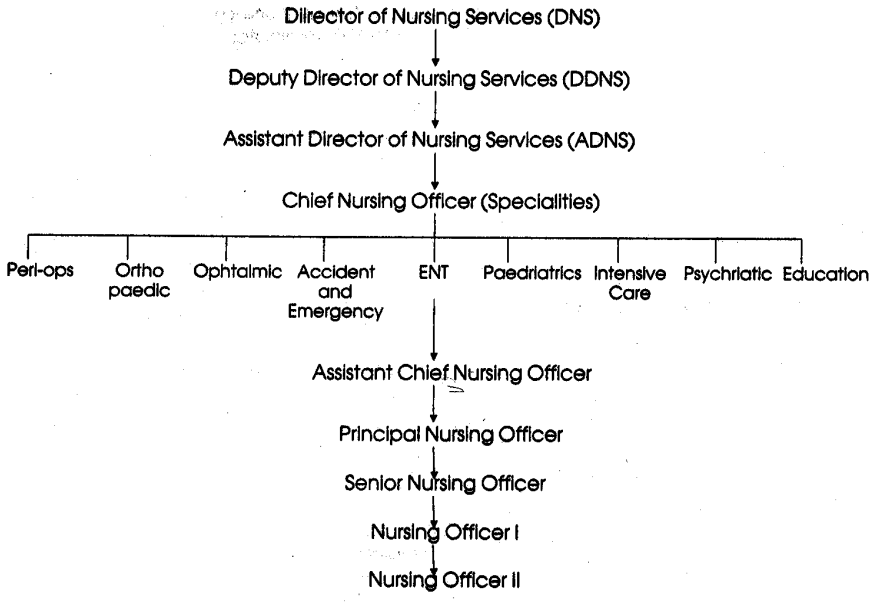

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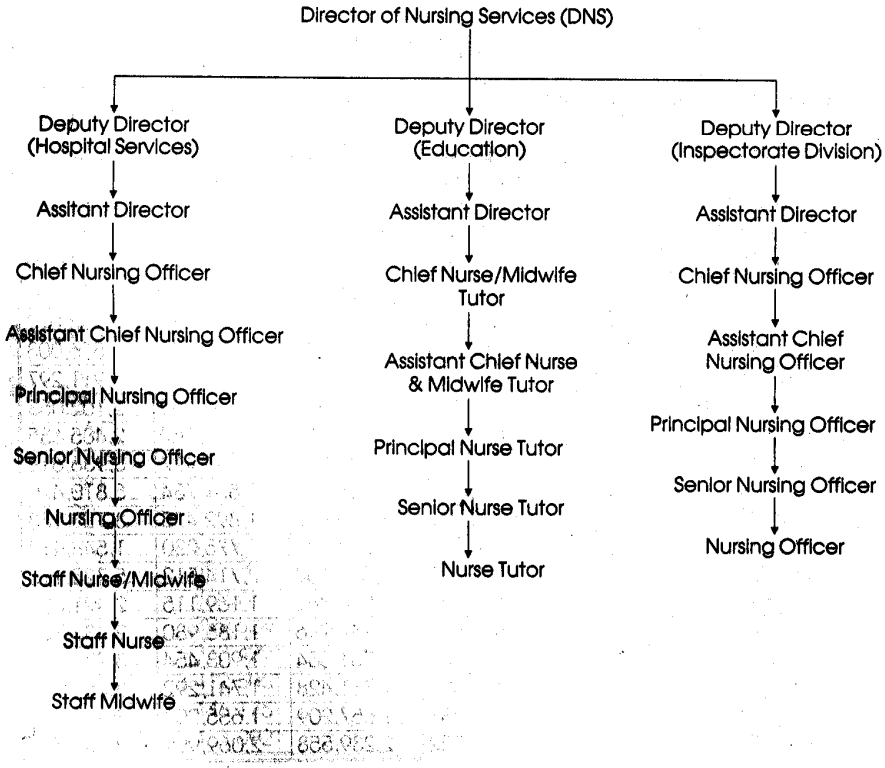
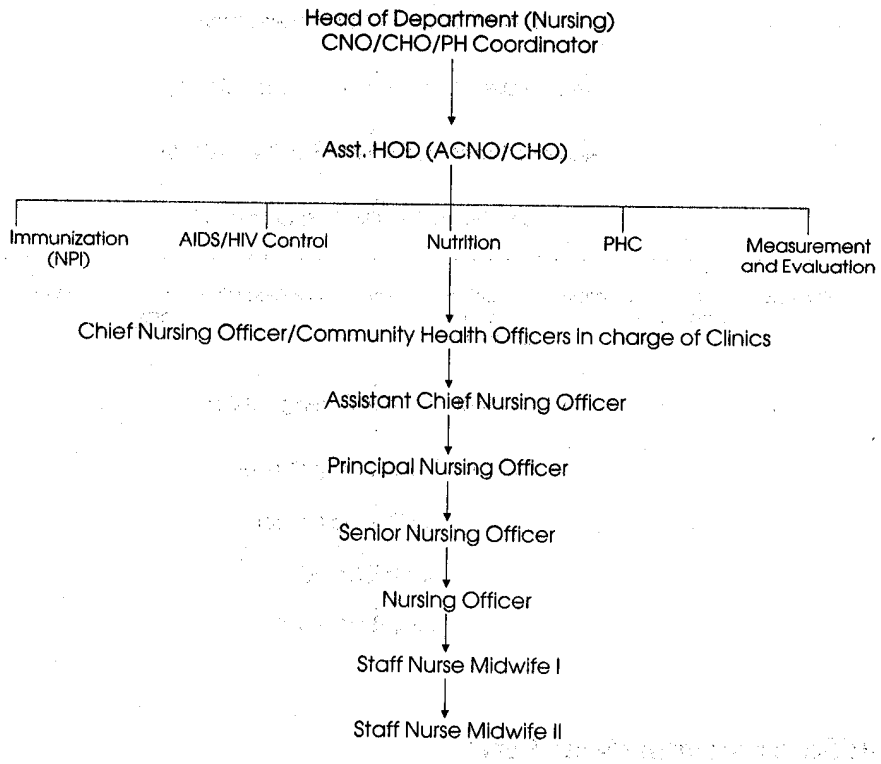


C: Structure at the Local Level



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COUNTRY TOTAL	**17,979,503**	**44,529,608**	**44,462,612**	**88,992,220**

Population Distribution by Single Years of Age and Sex

AGE	BOTH SEXES	in %	MALES	in %	FEMALES	in %
0	2,134,586	2.4	1,101,442	2.5	1,033,144	2.3
1	2,918,647	3.3	1,523,589	3.4	1,395,058	3.1
2	3,074,556	3.5	1,554,733	3.5	1,519,823	3.4
3	3,021,536	3.4	1,530,517	3.4	1,491,019	3.4
4	3,194,564	3.6	1,634,173	3.7	1,560,391	3.5
5	3,091,456	3.5	1,566,614	3.5	1,524,842	3.4
6	3,109,699	3.5	1,583,455	3.6	1,526,244	3.4
7	2,855,667	3.2	1,454,566	3.3	1,401,431	3.2
8	3,135,048	3.5	1,578,192	3.5	1,556,856	3.5
9	2,308,258	2.6	1,191,487	2.7	1,116,771	2.5
10	3,374,960	3.8	1,765,195	4.0	1,609,765	3.6
11	1,510,123	1.7	783,263	1.8	726,860	1.6
12	2,641,020	3.0	1,391,133	3.1	1,249,887	2.8
13	1,857,299	2.1	962,833	2.2	894,466	2.0
14	1,765,279	2.0	910,114	2.0	855,165	1.9
15	2,623,723	2.9	1,357,465	3.0	1,266,258	2.8
16	1,650,412	1.9	797,291	1.8	853,121	1.9
17	1,457,747	1.6	706,913	1.6	750,834	1.7
18	2,451,926	2.8	1,114,815	2.5	1,337,111	3.0
19	1,151,980	1.3	552,327	1.2	599,653	1.3
20	3,681,355	4.1	1,446,440	3.2	2,234,915	5.0
21	933,646	1.0	453,861	1.0	479,785	1.1
22	1,268,959	1.4	465,671	1.3	703,288	1.6
23	990,477	1.1	468,578	1.1	521,899	1.2
24	797,133	0.9	379,753	0.9	417,830	0.9
25	3,459,769	3.9	1,414,133	3.2	2,045,636	4.6
26	857,656	1.0	406,938	0.9	450,718	1.0
27	1,047,806	1.2	526,103	1.2	521,703	1.2
28	1,350,147	1.5	636,149	1.4	713,998	1.6
29	596,293	0.7	321,416	0.7	274,877	0.6
30	3,895,084	4.4	1,678,846	3.8	2,216,238	5.0
31	455,155	0.5	266,350	0.6	188,805	0.4
32	830,735	0.9	449,588	1.0	381,147	0.9
33	399,524	0.4	227,795	0.5	171,729	0.4
34	338,429	0.4	186,050	0.4	147,379	0.3
35	2,412,505	2.7	1,204,919	2.7	1,207,586	2.7
36	446,175	0.5	241,784	0.5	204,391	0.5
37	435,092	0.5	257,186	0.6	175,906	0.4

AGE	BOTH SEXES	In %	MALES	In %	FEMALES	In %
38	629,935	0.7	330,399	0.7	299,536	0.7
39	293,226	0.3	172,583	0.4	120,643	0.3
40	2,824,028	3.2	1,365,049	3.1	1;458,979	3.3
41	232,386	0.3	141,392	0.3	90,994	0.2
42	419,221	0.5	242,308	0.5	176,913	0.4
43	227,503	0.3	135,674	0.3	91,829	0.2
44	142,780	0.2	86,774	0.2	56,006	0.1
45	1,490,881	1.7	809,497	1.8	681,384	1.5
46	201,582	0.2	123,062	0.3	78,520	0.2
47	215,724	0.2	131,648	0.3	84,076	0.2
48	340,610	0.4	187,129	0.4	153,481	0.3
49	167,906	0.2	103,765	0.2	64,141	0.1
50	1,975,757	2.2	1,045,645	2.3	930,112	2.1
51	132,186	0.1	77,090	0.2	55,096	0.1
52	242,772	0.3	135,780	0.3	106,992	0.2
53	110,484	0.1	66,772	0.1	43,712	0.1
54	109,600	0.1	63,363	0.1	46,237	0.1
55	623,171	0.7	350,085	0.8	273,086	0.6
56	153,684	0.2	91,883	0.2	61,801	0.1
57	119,276	0.1	71,285	0.2	47,991	0.1
58	153,146	0.2	82,463	0.2	70,683	0.2
59	70,492	0.1	42,659	0.1	27,833	0.1
60	1,368,131	0.5	723,104	1.6	645,027	1.5
61	68,922	0.1	40,046	0.1	28,876	0.1
62	133,332	0.1	67,344	0.2	65,988	0.1
63	65,573	0.1	37,299	0.1	28,274	0.1
64	54,416	0.1	31,008	0.1	23,408	0.1
65	501,290	0.6	261,525	0.6	239,765	0.5
66	45,354	0.1	27,509	0.1	17,845	—
67	74,689	0.1	43,827	0.1	30,862	0.1
68	97,452	0.1	48,928	0.1	48,524	0.1
69	945,155	0.1	24,751	0.1	20,404	—
70	719,009	0.8	401,036	0.9	317,973	0.7
71	37,201	—	21,792	—	15,409	—
72	79,199	0.1	39,108	0.1	40,091	0.1
73	29,073	—	17,556	—	11,517	—
74	21,820	—	12,694	—	9,126	—
75	241,043	0.3	132,935	0.3	108,108	0.2
76	27,057	—	15,385	—	11,672	—
77	24,618	—	14,103	—	10,515	—
78	40,695	—	22,546	0.1	18,149	—
79	18,410	—	10,486	—	7,924	—
80	403,877	0.5	218,712	0.5	185,165	0.4
81	19,037	—	10,343	—	8,694	—
82	34,021	—	15,692	—	18,329	—
83	11,343	—	6,275	—	5,068	—
84	12,408	—	7,037	—	5,371	—
85+	42,989	0.5	230,585	0.5	194,404	0.4

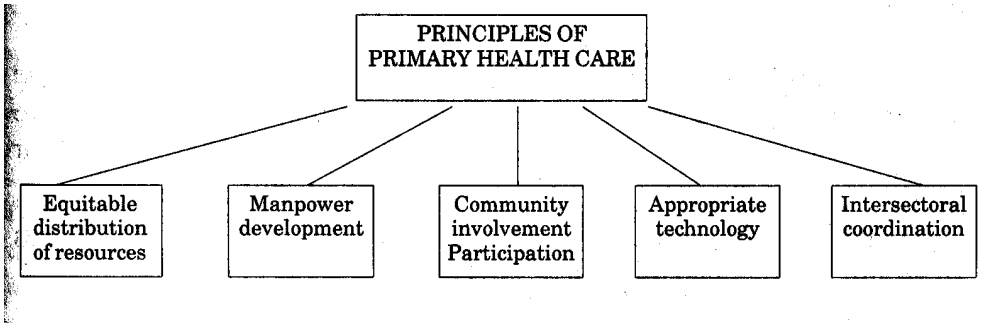
Population in States by Sex and Sex Ratio

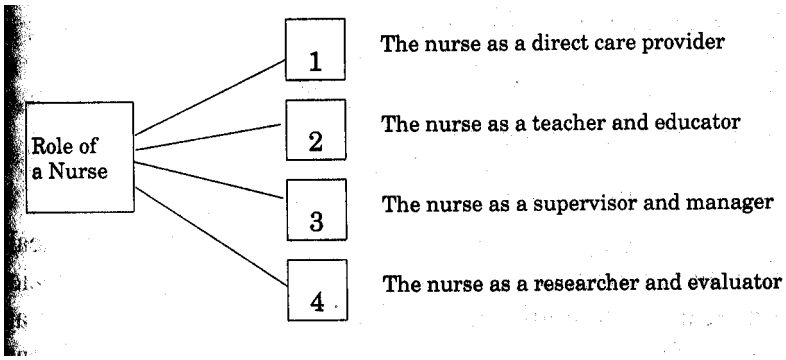
STATE NAME	MALES	FEMALES	SEX RATIO
AKWA IBOM	1,167,829	1,241,784	94.04
ANAMBRA	1,374,671	1,421,804	96.68
BAUCHI	2,192,423	2,158,584	101.57

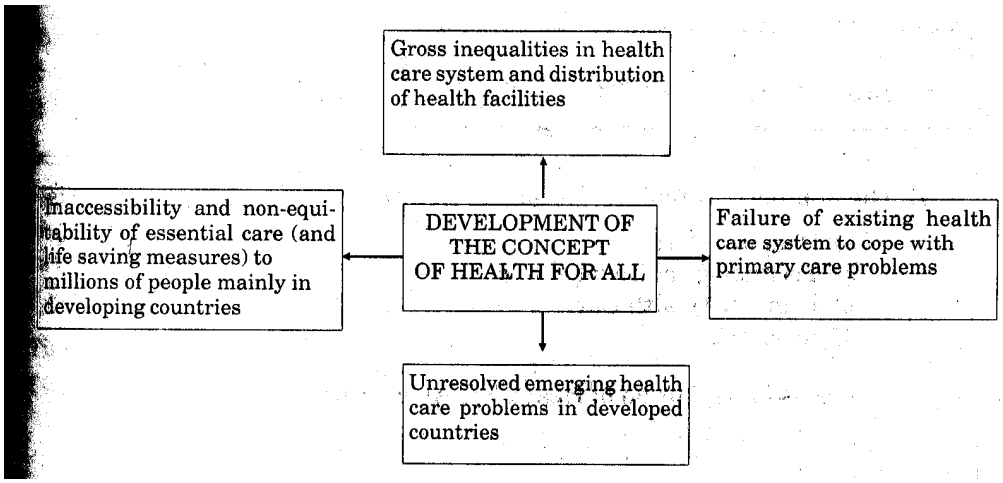
STATE NAME	MALES	FEMALES	SEX RATIO
EDO	1,085,156	1,086,849	99.84
BENUE	1,368,965	1,384,112	98.91
BORNO	1,296,111	1,239,892	104.53
CROSS-RIVER	956,136	955,161	100.10
ADAMAWA	1,050,791	1,051,262	99.96
IMO	1,166,448	1,319,187	88.42
KADUNA	2,041,141	1,894,477	107.74
KANO	2,958,736	2,851,734	103.75
KATSINA	1,860,658	1,892,475	98.32
KWARA	773,182	775,230	99.74
LAGOS	3,010,604	2,714,512	110.91
NIGER	1,252,466	1,169,115	107.13
OGUN	1,147,746	1,185,980	96.78
ONDO	1,881,884	1,903,454	98.87
PYO	1,711,428	1,741,292	98.28
PLATEAU	1,657,209	1,655,203	100.12
RIVERS	2,239,558	2,069,999	108.19
SOKOTO	2,208,874	2,261,302	97.68
ABIA	1,125,999	1,212,488	92.87
DELTA	1,271,932	1,318,559	96.46
ENUGU	1,475,648	1,678,732	87.90
JIGAWA	1,455,780	1,419,745	102.54
KEBBI	1,035,723	1,032,767	100.29
KOGI	1,039,484	1,108,272	93.79
OSUN	1,043,126	1,115,017	93.55
TARABA	759,872	752,291	101.01
YOBE	714,729	684,958	104.35
ABUJA (FCT)	205,299	166,375	123.40
COUNTRY TOTAL	**44,529,608**	**44,462,612**	**100.15**

Population Distribution by Age in Five Year Groups and Sex

AGE GROUP	MALES	in %	FEMALES	in %	BOTH SEXES	in %
0-4	7,344,454	16.5	6,999,435	15.7	14,343,889	16.1
5-9	7,374,314	16.6	7,126,144	16.0	14,500,458	16.3
10-14	5,812,538	13.1	5,336,143	12.0	11,148,681	12.5
15-19	4,528,811	10.2	4,806,977	10.8	9,335,788	10.5
20-24	3,314,303	7.4	4,357,267	9.8	7,671,570	8.6
25-29	3,304,739	7.4	4,006,932	9.0	7,311,671	8.2
30-34	2,808,629	6.3	3,105,298	7.0	5,913,927	6.6
35-39	2,206,871	5.0	2,008,062	4.5	4,214,933	4.7
40-44	1,971,197	4.4	1,874,721	4.2	3,845,918	4.3
45-49	1,355,101	3.0	1,061,602	2.4	2,416,703	2.7
50-54	1,388,650	3.1	1,182,149	2.7	2,570,799	2.9
55-59	638,375	1.4	481,394	1.1	1,119,769	1.3
60-64	898,801	2.0	791,573	1.8	1,690,374	1.9
65-69	406,540	0.9	257,400	0.8	963,940	0.9
70-74	492,186	1.1	394,116	0.9	886,302	1.0
75-79	195,455	0.4	156,368	0.4	351,823	0.4
80-84	258,059	0.6	222,627	0.5	480,686	0.5
85+	230,585	0.5	194,404	0.4	424,989	0.5
TOTAL	**44,529,608**	**50.0**	**44,462,612**	**50.0**	**88,992,220**	**100.0**


PRINCIPLES OF PRIMARY HEALTH CARE
Equitable distribution of resources
Manpower development
Community involvement Participation
Appropriate technology
Intersectoral coordination


Role of a Nurse
1
2
3
4
The nurse as a direct care provider
The nurse as a teacher and educator
The nurse as a supervisor and manager
The nurse as a researcher and evaluator


Gross inequalities in health care system and distribution of health facilities
Inaccessibility and non-equitability of essential care (and life saving measures) to millions of people mainly in developing countries
DEVELOPMENT OF THE CONCEPT OF HEALTH FOR ALL
Failure of existing health care system to cope with primary care problems
Unresolved emerging health care problems in developed countries

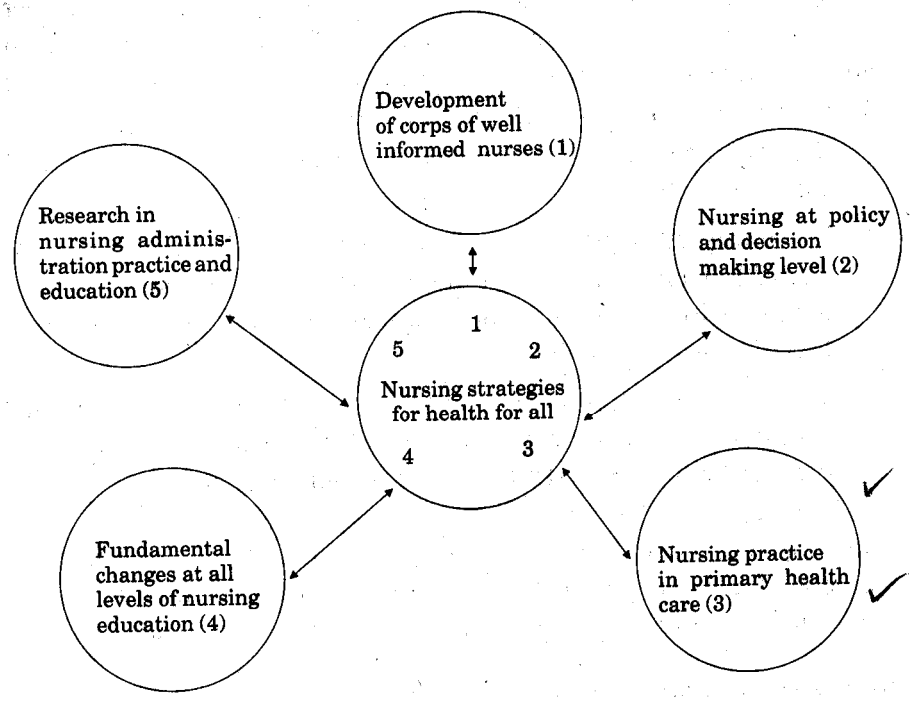


Fig. 3.1: Five strategies for change adapted by National Nurses Associations for their role in HFA through PHC

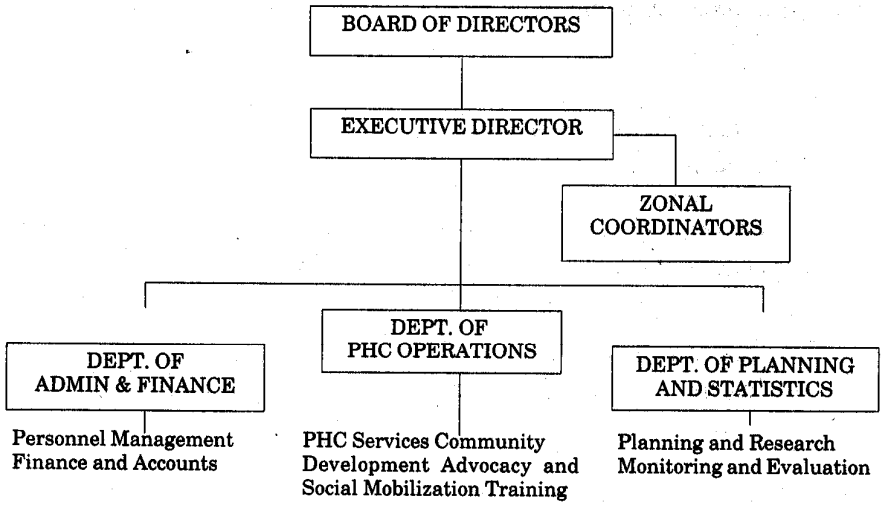


Fig. 4.1: Structure of the agency at federal level

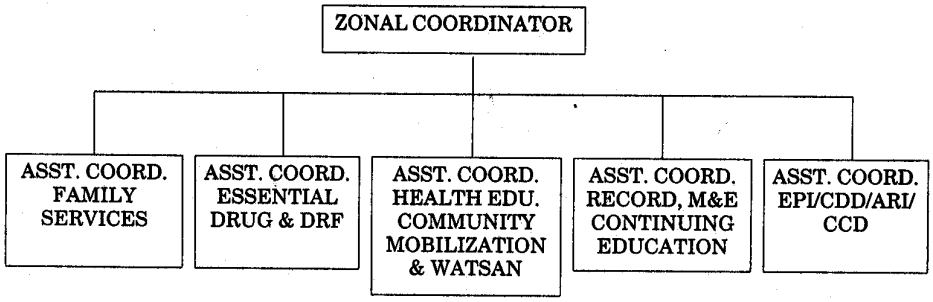


Fig. 4.2: Structure of the agency at zonal level