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REVIEW ARTICLE

COMMUNITY HEALTH PRACTICE IN NIGERIA – PROSPECTS AND CHALLENGES

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ABSTRACT

Community health practice refers to provision of health care services, aimed at early diagnosis of disease, recognition of environmental and occupational hazards to good health and prevention of disease in the community. The Community is seen as the hub of Community Health Practice. It is the essential laboratory for practice of teaching, training and research in the subject of community medicine/health. The idea of the community as the centre of health services delivery was advocated as far back in 1960s. From the concept of Basic Health Services, Primary Health care emerged. In this regard, the principle of health services in relation to availability, accessibility, acceptability and appropriateness became important considerations in WHO health policy from the late 1960s and into the 1970s. The goal of Primary Health Care (PHC) was to provide accessible health for all by the year 2000 and beyond. Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade if the basic essence of the Universal Health Coverage – making health care accessible, available and affordable to rural poor is ignored to whatever extent. This work seeks to examine some cross cutting issues in community health practice in Nigeria and to outline triggers for community oriented health manpower in Nigerian health system and some prospects in the midst of obvious challenges. Essentially, community health practice using the policy and principles of Primary Health Care in Nigeria, especially in rural communities have come a long way and still require more to be done to achieve the goal for health for all now and beyond

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INTRODUCTION

Health they say is Wealth and wealth is created and /or measured by factors of productivity (useful healthy engagement). Community health practice; in the present context means provision of health care services, through early diagnosis of disease, recognition of environmental and occupational hazards to good health and prevention of disease in the community. Effective service delivery in the community entails several factors and /or components that must be harnessed adequately in a synergistic manner to achieve the aims and aspiration of health care as encapsulated in its variable terms of Promotive, Preventive, Curative and Rehabilitative health care services. The Community is seen as the hub of Community Health Practice, anything short of that is not considered as Community Health Practice. It is the essential laboratory for practice of teaching, training and research in the subject of community medicine/health (**Sunder Lal *et al*., 2010**). The definition of community has been varied because of its diversity and complexity, such that no common or universally acceptable definition is attempted. Community is seen as a group of people living within a common geographical boundary that may not necessarily be of the same origin as in language, culture and practices, but are often of the spirit of joint ownership of issues of common interest and advancement. The idea of the community as the centre of health services delivery was advocated as far back in 1960s. From the concept of Basic Health Services, Primary Health care emerged. In this regard, the principle of health services in relation to availability, accessibility, acceptability and appropriateness became important considerations in WHO health policy from the late 1960s and into the 1970s (**Watt, 1982**).

The goal of Primary Health Care (PHC) was to provide accessible health for all by the year 2000 and beyond. Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade if the basic essence of the Universal Health Coverage – making health care accessible, available and affordable to rural poor is ignored to whatever extent. The health services, based on PHC, include among other things: education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition, maternal and child health

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care, including family planning, immunization against the major infectious diseases, prevention and control of locally endemic and epidemic diseases and provision of essential drugs and supplies.

This presentation seeks to examine some cross cutting issues in community health practice in Nigeria and to outline some prospects in the midst of obvious challenges. To bring up these issues clearly and more understandably, we shall look at; meaning of community health, why community health in Nigeria, triggers for community oriented health manpower in Nigerian health system, community health indicators, some community health indicator improvement in Nigeria, prospects and challenges.

What is community health

According to **Alakija, (2000)**, Community Health is defined in the following perspective:

1. Part of medicine which is concerned with the health of the whole population and the prevention of diseases from which the population suffers.
2. It identifies the root causes of diseases and health problems not only from the individual but also from family, the community and the environment.
3. The community resources are utilized principally in solving their problems. The resources from government and private sector can also be used.
4. It aims at giving the highest level of health for all people in the community and such level includes that of physical, mental, moral, social and spiritual health.

In the reasoning of **Abanobi, (1999)**, Community Health consists of principles and practices aimed at achieving prevention of premature death, disabilities and diseases through organized Community efforts with a view to assuring the promotion of optimal health of members of a Community in the context of their environment. Optimal health is said to mean a balance of physical, emotional, social, spiritual and intellectual health. Community Health could also be seen as the application of simple but scientifically sound and culturally acceptable methods and skills in the prevention, promotion, rehabilitation and or treatment of health conditions in the population or community in reference.

Why community health practice in Nigeria

In Nigeria, the period from 1975-1980 (Third Development Plan) brought in a turning point in the health care system through the birth of the Basic Health Services Scheme (BHSS)- a system of providing health care at the Community level by trained personnel, most of whom are the Community Health Practitioners. The Basic Health Services Scheme (BHSS) was necessitated by the fact that the previous system of health care was hospital based and comprised of curative care. The scheme was therefore, based on the establishment of health centres at the community level to work with the community members. It is a care that covers among others;

a. The whole field of human biology including sociological and attitudinal problems such as the HIV/AIDS pandemic which is more of socio-behavioural origin.
b. Health services utilization etc.

The concept of Primary Health Care and its fusion with Community Health Practice cannot be made clearly understandable without bringing to fore the historical perspective of Primary Health Care. The concept of Primary Health Care started when the World Health Assembly at a meeting of health professionals from all over the world at Alma-Ata in U.S.S.R in September, 1978, wherein they propounded a new concept of health care delivery- Primary Health Care. The outcome of the conference was the Alma-Ata declaration, "Health for all the world by the year 2000" through the implementation of Primary Health Care as a cooperative international effort. The declaration emphasized the need to re-allocate resources to achieve this aim and emphasized the interrelation of health with economic and social development. It also outlined the gross inequality in health status of the people of the developing and developed countries and the contribution which an international effort can offer towards rectifying this imbalance in achieving world peace.

The conference defined *Primary Health Care as 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 at a cost 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 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 continuing health care process.

The concept of Primary Health Care is therefore explained in the following perspective:

1. It integrates preventive, promotive and curative services using the type of technology the community will accept at the level it can afford with an efficient and effective system of supervision and referral.
2. It involves in addition all health sections, all health related sectors. Any aspect of National and Community development in particular, the agriculture, animal husbandry, food and industry, Education, Housing, Public utility and work, Communications and other sectors and demand the coordinated efforts of all these sectors.
3. It also involves a close partnership between the community and government in the development of resources and health care.

The obvious challenges at primary level in establishing a health care system that will touch the lives of every citizen and tackle the conditions that cause the highest mortality and morbidity make it imperative, the bringing in of the concept of Community Health Practice. This is because the system must be organized for the grass root and woven into the fabrics of

the community through the process of Community mobilization and Participation.

Triggers for community oriented health manpower in Nigerian health system

We shall look at the cross cutting issue between the state of exiting health manpower and the created community oriented manpower as a matter of necessity.

State of Exiting Health Manpower

According to **Ransome-Kuti *et al*. (1999)**, even before 1978, Nigeria has exceeded the World Health Organization (WHO) standard for the African region of one doctor per 10,000 people. But the doctors were maldistributed, with concentration in the urban areas and southern states. There are communities that have never seen a doctor, while others have a ratio of one doctor to 200,000 populations. Attempts to persuade doctors to serve in the disadvantaged areas of the country have so far failed principally because of a medical education that does not equip doctors with the skills to work with a community. Second reason was lack of amenities such as water, electricity, and schools in rural areas. Again, there is still lingering beliefs that in some states doctors face discrimination in appointments and postings to comfortable stations.

The same source equally stated that Nurses were five (5) times more than doctors but they were also maldistributed. However, many rural health centres throughout the country were manned by nurses who provide health care to the best of their ability. Furthermore, in the early seventies, studies indicated that nurses, like doctors, were ill-equipped to deliver primary health services, and a major adjustment in the curriculum was required. Even, when this was done, the change never removed the overwhelming bias towards hospital-based or individual health care services, but it did increase considerably the content on primary health care nursing.

Advent of Community Health Practitioners

In view of the foregoing antecedence, in 1978, a new breed of Primary Health Care workers was introduced to man the Primary Health Care services. These were the family of Community Health Practitioners, comprising:

Community Health Officers,
Community Health Supervisors which training was stopped in 1990,
Community Health Assistants (now Community Health Extension Workers (CHEWs), and
Community Health Aides (now Junior Community Health Extension Workers (JCHEWs).

The Health Reform Foundation, (2007), described this family of Community Health Practitioners as "core" polyvalent workers and these have remained the core Primary Health Care Workers in Nigerian Primary Health Care system. The nomenclature of the Community Health Assistants and Aides were changed in 1987, because these personnel, the most important members of the Primary Health Care, are intended to be based in the community (50% and 80% of the time respectively), particularly, in the villages where they will motivate the community members to action in the provision of health services. In this regards, they are seen as architects of Community participation- a prerequisite for transforming a community from its traditional past to the age of science. Furthermore, **Ransome-kuti *et al*. (1999)**, while giving reason for changing the nomenclature stated thus; "while diagnosing and treating common conditions with simple measures, identifying pregnant women and ensuring that they deliver safely, or identifying malnourished children and providing health education in the community, the Community Health Extension Workers mobilizes the community for preventive action as in the building of latrines, wells and roads. This is no mean task and to call them 'aides' is therefore misleading and belittles their important role".

As Community Health Extension Workers, their role is to spread Community Health Care into and within the Community in a most responsible manner. They are not aides to anybody but skilled health workers in their own right with important functions to perform within the community health team and basic Primary Health Care team. They are agents of change and the link between the community and the clinics.

Community health indicators/parameters

"Community Health" parameters are different from health parameters of an individual. Community health can be measured through indicators of economics (Gross National Product, Gross National Income and Per Capita Income), life expectancy, under five mortality, infant mortality, literacy level, composite index like human development index, and maternal mortality rate (**Hindustan, 2005; UNICEF, 1998; UNDP, 2004**). The other indicators of community health are environmental indicators, demographic, health services, health care utilization and health policy indicators (**Sunder Lal *et al*., 2010**). A community is seen to be healthy if it enjoys sound health where disease and death rate are considerably low, it is not threatened with bad environments and its economy is sound and the health practices are sound and based on scientific evidences. It is also, seen to be healthy if it records high literacy level and having a balanced demographic sex ratio and the people live long, quality of life is good and human development index is high. A village is equally seen to be healthy when it has; safe source of improved water supply, safe method of waste water disposal, paved streets, disposal of garbage, refuse and animal excreta by manure pits, people use sanitary latrines, female literacy is high, girls enrolment is universal, deliveries are conducted by trained persons, birth rate and death rate are within acceptable limits, immunization coverage is high and housing condition is good (**Sunder Lal *et al*., 2010**).

Some community health indicator improvement in nigeria

- Attainment of 80% coverage in routine immunization in most vaccine preventable diseases except TT2 (54%) in 2013 to achieve herd immunity of the community (**NPHCDA, 2013**).
- Nigeria can boast of eradicating Guinea Worm, a poverty-related and crippling parasitic disease, transmitted exclusively by drinking contaminated water and since the

year 2008, few years behind the year 2005 target set by WHO, there has not been any tangible case of Guinea Worm attack in any part of the country, so declared by the members of the National Steering Committee on Certification and WHO.

- Home-Based Care Strategy piloted in three (3) local government areas (Ahoada West, Etche and Oyigbo LGAs) in Rivers State, in 2012 aimed at reducing maternal, newborn and child morbidity and mortality by 20% by 2015 in line with the UN Millennium Development Goals 4 and 5, has been shown to achieve an average of 26% improvement in utilization of maternal and newborn health services, an average of 27% overall reduction in maternal malnutrition status, an average of 14% overall improvement in U5years malnutrition status among others in 2013 on comparing with baseline indicators. Etc, Etc.

Challenges of community health practice

1. Though Primary Health Centres were established in both rural and urban areas in Nigeria with the intention of equity and easy access, regrettably, the rural populations in Nigeria are seriously underserved when compared with their urban counterparts.
2. While most PHC facilities are in various state of disrepair, with equipment and infrastructure being either absent or obsolete, the referral system is almost non-existent.
3. Poor political will in funding community health programme, leading to donor driven health programme in Nigeria.
4. Insufficient number of community oriented health team in the public service as well as their uneven distribution.
5. Poor logistic system in reaching out to difficult-to-reach communities/settlements.
6. Lack of understanding of Primary Health Care among health professionals and decision-makers resulting in poor quality services.
7. Health workers poor attitude to work (frequent absence from work).

Conclusion

Community health practice using the policy and principles of Primary Health Care in Nigeria and especially in rural communities have come a long way and still require more to be done to achieve the goal for health for all now and beyond.

Recommendation

1. Advocacy to policy makers to gain support and political will in providing adequate of resources in carrying out community health services.
2. Government should do well to engage community oriented health professionals in effectively carrying out community health services to improve the population health status.
3. More awareness creation on active community participation towards ownership of health programme/services to ensure sustainability and reduction in harmful cultural practices that affect their health negatively.
4. Training and retraining of health professionals on concept of Primary Health Care and Community Health Practice.

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