ASSIST IN PREPARATION OF HEALTH PORTION OF FIVE-YEAR DEVELOPMENT PLAN FOR THE FEDERAL MINISTRY OF HEALTH NIGERIA

VOLUME I

A Report Prepared By PRITECH Consultants:
DR. STELLA GOINGS
DR. NICHOLAS CUNNINGHAM

During The Period:
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THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF HYGIENE AND PUBLIC HEALTH

Department of International Health

August 20, 1986

Ms. Daniele Grant
PRITECH
1655 N. Ft. Myer Drive
Arlington, Va. 22209

Dear Ms. Grant:

This trip report is a synopsis of my activities in Nigeria between July 29, 1986 and August 13, 1986, as a PRITECH consultant for the Ogun State Health Planning Exercise. I met very briefly with Larry Eicher, USAID Nigeria, on the morning of July 30th and proceeded directly to Abeokuta in Ogun State. There I met Dr. Bazak (WHO) and Mr. Richard Olanyan (Nigerian MOH) and the staff of the Ogun State MOH. We began the planning exercise in accordance with the terms of reference prepared and agreed upon by the World Health Organization, Johns Hopkins University, and the Federal Ministry of Health, Lagos, Nigeria on July 2, 1986 (Attachment A). On August 5th, we were joined by Dr. Cunningham whose assistance was most valuable. His extensive background in Nigeria, expertise in health planning, hard work and good humor were fundamental to the success of this activity.

This activity was the first in a planned series of state level health planning activities and was intended to serve as a model for presentation at a National Workshop for State Health Planners. The ultimate objectives included; the development of state level health planning expertise; the preparation of a five-year health plan by each state; and the eventual consolidation of these efforts as a part of Nigeria's five year development planning process.

The Ogun State Planning Exercise was envisioned as involving the coordinated support of the Nigerian Federal Ministry of Health, Directorate of National Health Planning; the Johns Hopkins University (through the USAID sponsored PRITECH project); the World Health Organization; and the World Bank (representatives concurrently involved in a pre-identification mission in Ogun State). To some extent, unforseen problems with scheduling obviated this potentially beneficial interaction. Representatives of the World Bank had concluded their pre-identification mission and departed prior to the initiation of planning activities. Participants in the actual planning activity and contributing external consultants are listed below:

Ogun State Ministry of Health

Dr. O. O. Adelowa - Chief Health Officer, Ministry of Health
Dr. S. A. Onadeko - Chief Medical Officer, Ministry of Health
Mr. S. O. Sabayo - State Chief Pharmacist, Ministry of Health

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Mr. O. O. Ogun - Acting Chief Planning Officer, Ministry of Health

Federal Ministry of Health

Richard O. Olaniyan - Planning Officer, Director of Health Planning

Charles O. Do/Regos - Senior Statistician, Director of Health Planning

USAID (PRITECH)

Dr. Stella Goings - Johns Hopkins University

Dr. Nicholas Cunningham - Columbia University

World Health Organization

Dr. Bazak

Secretarial support for this activity was provided by Steven Ku Obasi of the Federal Secretariat, Directorate of National Health Planning, Lagos, Nigeria. We are indebted to the numerous individuals in Ogun State representing the State Ministry of Health (MOH), the State Ministry of Local Governments and Community Development (MLGCD), and the private sector who contributed to the health planning activities. A list of those participants is included in Appendix C.

As a part of this exercise, site visits were made to the Abeokuta State Hospital, the Abeokuta Family Community Health Clinic, the University Teaching Hospital at Shagamu, Sacred Heart Hospital in Abeokuta, and St. Joseph's Hospital in Ifo/Ota (Dr. Cunningham). At the conclusion of the consultancy, summary meetings were held with the administrative staff of the Ogun State Ministry of Health; Dr. Sulaiman, Director, the National Health Planning Directorate, Federal Ministry of Health, Lagos, Nigeria; Keys Macmanus, and Larry Eicher, USAID Mission, Lagos, Nigeria.

Major Accomplishments of the Ogun State Health Planning Exercise

1. Orientation of the State Ministry of Health to a Health Planning Approach.

   Historically, projects within the state ministry of health have been developed as individual schemes which are presented to the federal level with a one to two page written description of the perceived need for the activity and a budget request. Individual schemes have not previously been consolidated into a comprehensive statewide plan and accordingly the basic concept of health planning as an integrated activity involving all of the state health activities, the private sector, and non-government organizations was a fresh concept which was advanced with some explanation and instruction.

   Progress toward this re-orientation was one of the principal accomplishments of this consultancy.

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2. *The Production of a Draft Health Plan and the Enhancement of Skills in Health Planning by Ogun State MOH Staff.*

Health planning at the state level was initiated in Ogun State, in accordance with the policies and guidelines set for the National Health Policy for Nigeria (Attachment B), and is part of an ongoing effort to decentralize aspects of the planning process. Representatives of the Federal Ministry of Health and external consultants functioned as facilitators and coworkers with the Ogun State Ministry of Health staff in this activity. It should be emphasized that wherever possible, materials prepared within the State Ministry of Health have been incorporated into the health plan document with minimal modifications.

This exercise involved the introduction of health planning (concepts and processes) to officials in the State Ministry of Health. Various approaches to the collection, consolidation, analysis, and interpretation of pertinent data at the state level, were presented and these were enthusiastically received by the Nigerian workers. The exercise was productive of "a draft state health plan" (attachment C).

Three points should be noted:

1) the health plan produced in Ogun was generated in the face of numerous significant obstacles which will be discussed in this report,

2) the current health plan document (Attachment C) is acknowledged to be an early draft. Section VII contains a brief discussion of the steps which remain to be accomplished prior to the completion of the planning activity, and

3) this health plan represents a significant achievement for the Ogun State Ministry of Health. It is viewed by those within the ministry with pride and is the first time that there has been a consolidated, systematic approach to health planning at the state level in Nigeria.

3. *Preparation of the draft materials for the Federal Workshop for State Health Planners.*

Assistance in the preparation for a planned Federal Workshop was provided simultaneously with work towards the development of the Ogun State Health Plan. Efforts consisted of time spent with Mr. Olaniyun developing recommendations for the

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curriculum and some teaching materials to be used in the state workshop. It is anticipated that support for the development of this workshop will continue over the next month. Both Drs. Goings and Cunningham have indicated their willingness to support these preparations via the mail, and if feasible, to provide on-site support during the workshop.

4. Critical evaluation of constraints to help planning.

While an recognized as an intregal part of the health planning process, the accomplishment of a systematic review and analysis of administrative, managerial as well as financial constraints should be regarded a major accomplishment during the Ogun State exercise.

5. Reinforcing of the Federal Health Policy Guidelines.

The Ogun State planning exercise was conducted in compliance with the Federal Health Policy guidelines (appendix B). This document places an overriding priority on strengthening of primary health care systems during the fifth five year plan. It acceptance represents a philosophical reorientation from "curative medicine" to "promotive & preventive health" within the State Health Ministry. While individuals MOH staff members clearly recognized the importance of primary health care and were quick to vocalize those insights, their efforts toward translating that commitment to primary health care into a prioritization of specific program areas and objectives, should be recognized as a major attainment.

Constraints to Health Planning

1. Administration

It was clear that administrative obstacles to the health planning activity will also be significant obstacles to the implementation and monitoring of primary health care programs in Nigeria. Characteristics of the current administrative structure are presented in Appendix C. The result of numerous, partial reorganizations and attempts at realignment the resulting system is at once fragmented, duplicative, and functionally inefficient. The administrative authority for health activities, primary and curative, is shared by the State Ministry of Health (MOH) and the State Health Board (SHB). MOH is responsible for primary health care activities and receives approximately 10% of the State health budget while the SHB is responsible for curative care medicine and receives approximately 90% of the State health budget. Numerous other administrative entities including, the Ogun State Water Commission, the Federal Ministry of Local Governments Community Development (MLGCD), and the State Ministry of Education, all providing health services with no

clear administrative links to the Ministry of Health.

Recent attempts to realign the SHB and bring it under the jurisdiction of the MOH, seem to have been minimally successful, but have not resulted in any budgetary reapportionment scheme or in a clear administrative chain of command between the two divisions. The result is that the MOH, the SHB, and the MLGCD are all carrying out primary health care activities within specific areas and often in close proximity to one another with little to no coordination. There is no focal or coordinated mechanism for assessing the needs in this system or for monitoring its functioning or its outputs.

Officials in Ogun State are aware of this difficulty and are attempting to resolve this multifactorial and exceedingly complex issue.

2. Inadequate data base.

A major recognized constraint to the process of health planning in Ogun (and presumably in the rest of Nigeria) is the absence of a consolidated data base. There are no birth or death registries and data generated within the health sector is of inferior quality. Admission and discharged data from clinics is collected sporadically and with poor reporting compliance (approximately 10% of hospitals reporting). There are also problems with reporting accuracy which are non-trivial.

In the area of population, all population estimates are projected forward from 1963. There are major political sensitivities impeding acceptance of the results of the interim census done in 1973 or the results from the world fertility survey. Estimates or projections of the population reducing the numbers downward are unacceptable as states receive their Federal budget allocations on a per capita basis.

As can be imagined, the problems in the administration of the health sector are also problems affecting the collection of data regarding the health status of the people. When reports are received at one of the various administrative levels, they may or may not be collated depending on the procedures in the receiving office. Reports are certainly not analyzed or distributed in any systematic fashion. Similarly, there are major difficulties with the collection of data on the administration, maintenance, and management of health facilities and health care personnel.

It should be noted that at many levels, there is the tradition of collecting and preserving data in terms of "what

has been authorized and/or approved" rather than in terms of "what is actually there". Often these authorized and/or approved figures bare little to no resemblance to the real situation.

For example, when we began to address the issue of health manpower, we requested information on staffing strength and distribution and were very quickly provided with a tally of "approved staffing patterns, total staff, and health manpower distribution". These carefully maintained sheets suggested that there were in excess of 7,000 health workers on the Government payroll in Ogun. In actuality, these figures were very misleading. After a week and a half laboriously reviewing records in each of the various administrative divisions, actual counts of physician and nursing personnel were obtained. These showed that actual personnel were much fewer than the authorized figures for these two cadres. They suggested that the total numbers of personnel working in the government health sector may be projected at fewer than 3,000.

In addition, data which would be useful in establishing the cost of a program is neither routinely collected nor maintained at the State Ministry level.

3. *Limitations of Technical Capability of State Staff*

Ogun State boasts and impressive rooster of highly intelligent, skilled staff. Despite a limited familiarity with basic population and health status indicators, methods of data collection analysis and interpretation, they have worked to establish a health system which is acknowledged to be one of the best in Nigeria. Efforts were made throughout the consultation to enhance the technical capability of the Ogun State Staff. Nevertheless, it seems apparent that the requirement for external consultancy in Ogun and in the other states, may have been significantly underestimated and that there is a need for continued efforts towards development.

4. *Absence of Community Private Sector Involvement*

Ogun State has historically taken little initiative in generating community involvement or conducting active outreach activities. Indeed, there was no existing strategy for community involvement as a part of the planning or delivery of primary health care programs. The failure to recognize the need to involve the community and/or the private sector represented a major obstacle to the accomplishment of comprehensive planning.

The Significance of Current and Plans for the Future

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It cannot be overemphasized that the work conducted in Ogun State represents the beginning of health planning at the state level in Nigeria. The Ogun health planning team developed a significant esprit decor and are anxious to continue planning activities and to integrate them into the daily activities of the ministry. It seems clear to this consultant that consistent fortification from the Federal level will be required and it is my recommendation that ample external technical support should be provided until the completion of the planning activity.

The ground work has been laid for the national workshop for state health planners. Dr. Sulaiman has suggested that this activity be divided into two separate workshops. First to address the federal guidelines, the national reorientations toward primary health care and to stress the essentials of data collection, consolidation, analysis, interpretation, and basic costing in health planning. A second workshop will subsequently be convened at which time the issues of feasibility, cost benefit analysis, prioritization of health programs, etc. will be presented.

I have indicated to Dr. Sulaiman that Johns Hopkins wishes to remain responsive to Nigeria's requirements for technical support, but have stressed to him that our staff also have major global commitments and that our ability to contribute meaningfully in Nigeria will, to some extent, depend on his prompt clarification of schedules and consultancy requirements. While modification of the Nigerian timetable for health planning (Appendix B) would be helpful, it seems apparent that the current timetable for the development of the fifth national five-year development plan is not subject to discussion or negotiation. With this in mind, I have urged Dr. Sulaiman to transmit to us a projected schedule as soon as possible.

Sincerely yours,

Stella A. J Goings, MD, MPH
Asst. Professor
International Health

SG:lp

cc/Dr. Cunningham
Dr. Baker
Dr. Tayback

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APPENDIX A

Draft *

TERMS OF REFERENCE FOR SUPPORT TO STATE-LEVEL HEALTH PLANNING AND RELATED MANAGEMENT DEVELOPMENT IN NIGERIA

JULY TO NOVEMBER, 1986

I. Introduction

These Terms of Reference are written in an effort to describe the externally-provided technical support requested by the Nigerian Federal Ministry of Health for the purpose of strengthening health planning and management at the state level. During the second half of 1986, the Federal and State Ministries of Health will be engaged in the preparation of the health portion of the Fifth Five-year Development Plan. This plan is to begin implementation in March, 1987.

While it is the responsibility of the Federal Ministry of Health, Directorate of Planning and Research to prepare the national health development plan, the Minister of Health wishes the plan to incorporate the health development intentions of each of the twenty states, and as well, he wishes each State Ministry of Health to have a clear plan describing the health development objectives, technical and managerial strategies, programmes, resource requirements, sources and mechanisms for financing for the next five years. This heavy State involvement in the plan preparation is the initiation of a strategy to strengthen management at all levels of the health service system; federal, state and local government. Particular emphasis is being placed on improving policy and programme implementation. Thus, the purpose of these activities extends beyond the production of State Health Plan documents. A continuing process of management improvement is to be put in motion during this planning period which will expand into all health development activities and include a practical system for monitoring and evaluation.

It therefore is a condition for the success of these collaborative activities, that all participating foreign staff function as facilitators

* Drafted by WHO team on 2 July '86

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and co-workers, rather than teachers, experts, or health planners. The national and state-level staff must actually produce the required analytical and planning products, in order that such products be national in character, and "belong" to the States. Similarily, the national workshop faculty must produce and deliver the workshop programmes in order to be prepared to conduct such learning methods in the future. The foreign staff must function in the background, suggesting methods and techniques, and perhaps demonstrating their use, but not actually performing the tasks, and producing the products. All issues and decisions of technical and administrative nature must be decided by Nigerian staff, while being supported by the foreign consultants in understanding the options available and their likely consequences.

The support to the State-level Five Year Planning is to be provided to five specific activities:

1. Preparation of the Ogun State Five Year Health Development Plan (14 July to 10 August) — Scraped 7-22 Aug
2. Preparation of the National Workshop for State Health Planners (about 10 to 20 August) — 1 week Sept.
3. Conduct of the National Workshop for State Health Planners (about 1 to 12 September)
4. State Health Planning Efforts (about 15 September to 24 October) — 1 Mo State contr. 200 L 15. Berna
5. Preparation and conduct of a National Workshop for State Health Plan Review and Finalization (about 27 October to 7 November)

While support to the above activities is to be provided predominently by staff of the John Hopkins University School of Public Health (JHU), staff support will also be provided by country, Regional Office and Headquarter staff or consultants of the World Health Organization. (World Bank staff will also participate in the first two weeks of the Ogun State Health planning effort as part of a project identification mission.) It is desireable that all participating agencies attempt to the extent possible, to provide the same staff for supporting all activities, in order to maximize continuety and

understanding of the Nigerian situation.

II. Activities and Support Tasks

A. Ogun State Planning Effort (14.7 - 10.8)

1. To support Ogun State, local government, and Federal MoH planners and national consultants in preparing a draft five year health pla for the state. (The entire planning process and product is to be completed in this 4-week period, although Ogun State may develop the plan further in ensuing weeks.)

2. To assist national staff in applying the National Health Policy and the national health planning guidelines in the plan preparation, and in the use of available and necessary data.

3. To advise on the most appropriate planning steps for efficiently producing a State plan in the time available.

4. To progressively describe the planning process used in a manner which facilitates the preparation of the National Workshop for State Health Planners.

B. Preparation for the National Workshop for State Health Planners (10 - 20 August)

1. To review the planning steps used in Ogun State and assist staff of the Federal MoH Directorate of Health Planning in preparing a description of the planning process to be recommended to all States, including the data to be analyzed, and the format and content of plan documentation.

2. To help the national workshop faculty prepare the workshop programme, session guides and background materials. (The workshop should pro provide minimal lecturing, and maximize learning through group work. The participants may be divided into four zonal working groups.)

3.

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3. To assist national faculty in assuming responsibility for, preparing and conducting workshop sessions as assigned. Foreign consultants should minimize their role in presenting and leading workshop sessions.

4. To design a workshop evaluation method based on measuring the achievement of individual workshop session objectives.

C. Conduct of the National Workshop for State Health Planners (1 - 12.9)

1. To assist the national faculty in the overall management and daily administration of this 10-day workshop for 60 - 70 State and Zone officers. The objective of this workshop is to enable State planners to undertake an efficient analytical and planning process, and produce draft five-year plans by the end of October, 1986, which address the National Health Policy and its objectives, and which follow the planning guidelines provided from the Federal Ministry of Health.

2. To act as background facilitators to the workshop, particularly, within working groups, but to minimize their direct teaching functions, so as to insure that national capabilities to conduct such learning methods are generated.

3. To assist in the description of the workshop and its evaluation results.

D. State Health Plan Preparation (15.9 - 24.10)

1. To provide technical support to actual state level planning, particularly in states which have less well-formed planning teams. (The amount and duration of this support remains to be confirmed.)

E. Preparation and Conduct of a Workshop to Review and Finalize State Health Plans (27.10 - 7.11)

1. To help prepare a five-day workshop which is intended to:

- enable a joint review of draft State Health Plans
- facilitate the consolidation of major State proposals into the National Health Plan and Programmes
- discuss recommended implementation strategies

2. To act as background facilitators in the conduct of this workshop.
3. To support the description and evaluation of the workshop.

III. Consultant Staffing Requirements

It is anticipated that for the above activities two JHU and one WHO HQ staff members will be required.

Period 1 14 July to 20 August (5½ weeks) for Ogun State planning and preparation for the National Workshop

Period 2 1 to 17 September (2½ weeks) for supporting the conduct of the national workshop and its write-up.

Period 3 2 to 3 weeks from mid-September to end October to support State-level planning (to be confirmed)

Period 4 27 October to 12 November (2½ weeks) to support the plan review workshop.

Period 1 and 2, and periods 3 and 4 may in fact be linked to reduce travel costs, if the assigned consultants can remain on assignment for the combined periods. Thus, the total consultant requirement is:

JHU 6.5 man-months

WHO 3 man-months

All consultants provided should have extensive experience in actual national health planning and in the design and conduct of workshops for preparing planning teams. They should be fully familiar with public health technology in developing countries and with practical methods for data analysis, programme design and implementation planning. Financial analysis and manpower planning skills will also be needed. The most important skill required will be the ability to work at a low profile within national and state planning teams and workshop faculty.

HEALTH PLANNING TIME-FRAME AND PRODUCTS

1. WHO Preparatory Mission - 23.6-22.7

   (Sapirie 22.6-8.7, Janclos 26.6.12.7, Abel-Smith 8.7-22.7)

   Products:
   1. Outline of long-term health plan
   2. Frame-work for the Fifth Five-year Health Plan (including the guidelines for the State plans)
   3. Cost projections for the long-term plan and estimates for the 5-year period
   4. Financing options
   5. A strategy for strengthening the managerial process including guidelines for the State Health planning process
   6. A plan of work for the planning process and its follow-up managerial strengthening activities.

2. First State Planning Effort (Ogun State 14.7-10.8)

   (In conjunction with the World Bank Health Sector Reconnaisar Mission, 14-28 July)

   Participants: Ogun State Health Planners and decision-makers
   FMOH Planning Directorate Staff
   IBRD - Radel, Dean, Pratt
   JHU - Berman, ( )
   WHO - ( )

   Products:
   1. Draft State Health Plan responding to Federal Guidelines
   2. Description of the general planning process

   (Concurrently to this planning effort, the World Bank would identify with Government official possible project components)

3. Preparation of National Workshop for State Health Planning (10-20 August)

   Participants: FMOH Planning Directorate and national consultants

JHU - Berman, ( )

WHO - ( ) ( )

Products_ 1. Programme, modules, session guidelines and supporting materials for a 10-day workshop for training planning coordinators and support staff (3) from 19 states and 4 zones.

2. Preparation of national, international facilitators for supporting the workshop.

4. National Workshop for State Health Planners (1-12.9)

Participants: State and Zone Office Planners (69)

FMOH Planning Directorate and national consul

JHU - 2 staff

WHO 1-2 staff

Products: 1. State and Zone Officers prepared for undertaki two-month health planning efforts

2. State and Zone Officers understanding of National Health Policy and planning guidelines

(It is likely that the workshop participants would be organized into 4 zonal groups)

5. State Health Planning Efforts (6 weeks, 15.9-24.10)

Participants: State health planning teams supported by Zonal and Federal level staff and national consultants

Product: 1. Draft State 5-year Health Development and Implementation Plan. (LGA PHC projects are to be included)

6. National Workshop for State Health Plan Review and finaliza (27.10-7.11)

Participants: State and Zonal Planning Teams

Federal Minister of Health

FMOH Planning Directorate

JHU - 2 staff

WHO - 1-2 staff

ibid

Products: 1. Review, finanization of State Health Plans

2. Consolidation of State portion of National Health Plan

3. Implementation Strategy Guidelines

7. Finalization of National Health Plan (8.11-25.11)

Participants: FMOH Planning Directorate and other staff as assigned

8. Set Up State Implementation Strategies (10.11-26.12)

Participants: State and Zone health administrations
FMOH Planning Directorate
FMOH PHC COordinating Unit

Products: 1. 4 Zonal workshops to formulate state implmentation strategies in conjunction with LGA PHC projects.

2. State implementation schedules and monitoring systems

9. National Health Plan Implementation Monitoring Seminar (5 days in June, 1987)

Participants: State and Zonal Planning Teams
Federal Minister of Health
FMOH Planning Directorate
FMOH PHC Coordinating Unit
IBRD, JHU, WHO consultants

Products: 1. State Implementation Status Reports

2. Identification of common implementation difficulties

3. Strategies for implementation improvement

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Tom Hall —
Manuel L. Mapp.
VISP Planning

Preparatory process for the Preparation of the Fifth FYDP for Health

3.7.2.22

A discussion on the above subject took place in the office of the Federal Minister of Health at 1.30 p.m. 27th June, 1986, with the following:

Final filing.

Prof. Olikoye Ransome-Kuti	-	Hon. Federal Minister of Health
Dr. A. B. Sulaiman	-	Director, National Health Planning
Mr. Coker	-	Assistant Director, FOS
Mr. R. O. Olaniyan	-	Planning Officer Directorate of Health Planning
Dr. Michel Jancloes	-	WHO, Geneva
Dr. S. A. Sapirie,	-	WHO, Geneva
Prof. William Reinke	-	John Hopkins University School of Public Health
Mr. Edward Brown		World Bank, Washington, D.C.
Ms McManus	-	USAID, Lagos

The discussion was convened to clarify the process and timing of the preparation of the Fifth Five-Year Health Plan in Nigeria and the nature of John Hopkins University collaboration. During this discussion the Minister reiterated his expectations of the 5-year planning process, its products and time frame, as follows:

- that a comprehensive (Federal and State level) health development plan for Nigeria be completed by October - late November, 1986.
- that this plan be formulated in support of a long-term health policy and strategy which is to be derived from the existing National Health Policy.
- that the five-year national health development plan is to include the collection or consolidation of State health plans, which therefore must be developed within this same time frame.

- that the long-term Health For All policy and strategy framework and the related guidelines for state planning be necessary pre-requisites which he expects the on-going WHO mission to help produce.
- that State plans be to reflect the state health situations while serving to guide the implementation of the National Health Policy and strategy in each state.
- that the Federal portion of the health plan would specify the Federal services and support to the states.
- he therefore hopes that the technical assistance in the form of a number of JHU consultant missions can provide support to the State health planning process during this period.

Professor Reinke outlined a possible approach for providing such support utilizing a concentrated two-week workshop for State health decision-makers and planners. The workshop could cover data preparation, use of Federal guidelines, the steps of the planning process, and the specific planning products required. Some of the planning tasks would actually be performed during the workshop, but the draft plan including aspects of priority determination, cost estimation, financing, and implementation would have to be finalized during the weeks following the workshop. He noted that JHU staff are likely to be more available in the near-term, July to September period.

After some discussion it was further agreed that:

1. the State-level planning process to be taught in the workshop should be based on at least one actual state planning experience.

   An opportunity for such experience exists in Ogun State (either ~~14-~~15-18 July, or ~~28 July to 10 August~~) at which time a World Bank reconnaissance mission will be working with State officials to identify project possibilities. It was agreed that JHU and possibly, WHO staff use this opportunity to assist Federal and State

staff to actually develop the five year state plan at this time. The process, which will extend beyond the two weeks of the World Bank mission for another two weeks, would subsequently be described as a basis for the national preparatory workshop on State health planning

2. A follow-up workshop should be scheduled in late october - early November during which the draft State Health plans would be reviewed and the basis for their consolidation within the national plan agreed upon.

3. That the FMOH Planning Directorate staff supplemented by national consultants from outside the Ministry would be the secretariat and facilitators for conducting the workshop and providing support to the states. International staff would support the national team in this process.

4. That management development at the State level would require follow-up activities focussed on the implementation of the plans and problem-solving. Federal staff and collaborating agencies should be prepared to support such follow-up.

A preliminary draft schedule of these activities and products is attached to this note. IBRD, USAID, JHU, and WHO are asked to take the immediate steps necessary to confirm the availability of appropriate staff support at the times indicated. Dr. Sulaiman will be the national coordinator for the planning-related activities and should be informed of the support being made available.

attachment: Planning Time Frame and Products

APPENDIX B

DRAFT

NATIONAL HEALTH POLICY

PART I - HEALTH POLICY

CHAPTER 1

HEALTH POLICY DECLARATION OF THE FEDERAL REPUBLIC OF NIGERIA

1.1 The Federal, State and Local Governments of Nigeria hereby commit themselves and all the people of Nigeria to intensive action to attain the goal of health for all Nigerians by the year 2000, that is a level of health that will permit them to lead socially and economically productive life at the highest possible level.

1.2 The Governments are convinced that the promotion, the protection, the maintenance and the restoration of the health of the Nigerian people not only contribute to a better quality of their lives but are also essential for the sustained economic and social development of the country as a whole.

1.3 The people of Nigeria have the right to participate individually and collectively in the planning and implementation of their health care. However, this is not only their right, it is their solemn duty.

1.4 Primary health care is the key to attain the goal of health for all the people of Nigeria. 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 involvement and at cost that the community and State can afford to maintain at every stage of their development in the spirit of self-reliance. It shall form an integral part both of the State's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

1.5 The Federal and State governments shall formulate strategies and plans of action, including action to be taken by Local governments, to launch and sustain primary health care in accordance with the national health policy.

1.6 All governments shall cooperate among themselves in a spirit of partnership and service to ensure primary health care for all Nigerians, since the attainment of health by people in any one State directly concerns and benefits every other State in the Federation.

1.7. The Federal Government shall provide policy guidance and strategic support to States in their efforts at establishing health systems that are based on primary health care and are accessible to all their people, coordinate State efforts in order to ensure a coherent, nation-wide health system, provide incentives in selected fields to the best of its economic ability to promote this endeavour, and in collaboration with the State Governments, undertake the overall responsibility for monitoring and evaluation of the implementation of the strategy.

1.8 The Governments shall exercise political will to mobilize the resources and to use all available resources rationally.

CHAPTER 2

EVOLUTION OF HEALTH DEVELOPMENT AND HEALTH STATUS OF PEOPLE IN NIGERIA

The health services of Nigeria have evolved through a series of historical developments including a succession of policies and plans which had been in introduced by previous administrations. The health s services in the current state are judged to be unsatisfactory and in adequate in meeting the needs and demands of the public as also reflected by the poor level of health of the population.

2.1 Background

This document has been prepared against the historical background of the growth and development of the health services, the previous attempts to formulate national policies on health and the present state of the health services.. The policy prosed and the strategies emerging from it have been based on an appreciation of the current status of the health of the people of Nigeria with a careful analysis of the major factors which affect the health of the population as well as the nature of interventions which can produce improvement most rapidly and economically.

2.2 Historical Background

The Government medical services in Nigeria originated from the British Army Medical Services. With the integration of the Army with the Colonial Government during the Colonial era, the Governemtn offered to treat the local civil servants and their relatives, and eventually, the local population living close by the Government stations.

This developed into the Colonial Medical Service which was duty bound to provide free medical treatment to the Army and the Colonial Service Officers. Medical treatment which the Government initially provided its officials, was made available to the local population only as an incidental service. Various religious bodies and private agencies established hospitals, dispensaries and maternity cetnres in different parts of the country.

2.2.1 The first attempt at planning ahead for the development of health services in Nigeria took place in 1946, as part of the exercise which produced the overall Ten-Year Plan for Development and Welfare (1946-56) covering all aspects of governmental activities in the country. Since Nigeria was still a colonial territory, the proponents of this plan were mainly expatriate officials, It included 24 major schemes designed to extend the work of existing government departments but it was not an integrated development plan in the current sense of the word. These schemes were not properly co-ordinated nor were they related to any overall economic target. Nevertheless, it was a modest, realistic, well thought out plan for its time and purpose and it served as the basis for subsequent health plans.

2.2.2 Since the country became independent in 1960, health policies have been enunciated in various forms, either in the National Development Plans or as Government decisions on specific health problems.

2.2.3 The health component of the 2nd National Development Plan 1970-1974, identified and aimed at correcting some of the deficiencies in the health services.

2.2.4 In the 3rd Development Plan (1975-1980) there was a deliberate attempt to draw up a comprehensive National Health Policy dealing with such issues as health manpower development, the provision of comprehensive health care services based on the Basic Health Services Scheme, disease control, efficient utilization of health resources, medical research, health planning and management.

2.2.5 The health policy content of the 4th National Development Plan is being reflected in this draft proposal.

2.3 <u>The State of the Health Services</u>

The health services as currently organized show major defects which are widely recognized:

2.3.1 The <u>coverage</u> is inadequate. It is estimated that no more than 35% of the population has access to modern health care services. Rural communities and the urban poor are not well served.

2.3.2 The <u>orientation</u> of the services is inappropriate with a disproportionately high investment on curative services of the detriment of preventive services.

2.3.3 The <u>management</u> of the services often show major weaknesses resulting in waste and inefficiency, as shown by the failure to meet targets and goals. With several different governmental, voluntary organizations and other agencies providing health care, the various inputs are poorly co-ordinated.

2.3.4 The involvement of the community is minimal at critical points in the decision-making process. Because the communities are not well informed on matters affecting their health, they are often unable to make rational choices.

2.3.5 The lack of basic health statistics is a major constraint at all stages of planning, monitoring and evaluation of health services.

2.3.6 The financial resources allocated to the health services, especially to some priority areas are inadequate to permit them to function effectively.

2.3.7 The basic infrastructure and logistic supports are often defective owing to inadequate maintenance of buildings, medical equipment and vehicles, unreliable supply of water and electricity, and the poor management of the systems for procuring, storing and distributing drugs, vaccines and other supplies.

Whilst this list of defects is an accurate summary of the broad range of the health services, there are also encouraging cases in which dynamic health administrators, professional persons and lay members of the communities have successfully corrected these faults within their local areas. Such successful programmes provide useful models of what can be done with limited resources in spite of various constraints.

2.4 The State of Health of the Population

It is not possible to make an accurate assessment of the health states of Nigerians. This is because there is no system of collecting basic health statistics on births, deaths, the occurence of major diseases and other health indicators on a country-wide basis. The best available estimates are obtained by extrapolation from the limited information obtained from a few centres where such data are collected, from sample surveys, from institutional records and from special studies.

2.4.1 The limited health statistics indicate the general poor state of health of the Nigerian population:

Crude Death Rate	-	16 per 1000 population
Crude Birth Rate	-	50 per 1000 population
Childhood Mortality Rate	-	144 per 1000 children aged 1 - 5 years
Infant Mortality Rate	-	85 per 1000 live births
Life Expectancy at Birth	-	50 years

Source: Nigerian Fertility Record.

Some experts estimate that the infant mortality rate may be as high as 100 to 160 per 1000 live births. Whichever figure is accepted, it means that out of every 12 Nigerian children who are born alive, one or more of them dies before reaching the first birthday. This rate is ten times as high as high as in most developed countries; it is much higher than in some other developing countries which have a similar level of socio-economic development as in Nigeria.

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Children in the age group 1 to 4 years similarly die at a rate which is at least 40 times as high as in the developed countries. In some parts of the country, 25% or more of children die before their fifth birthday. Childbirth which should mostly be a normal process with minimal loss of life, is associated with a significant mortality among Nigerian women.

2.4.2 Patterns of ill health and their determinants

Most of the deaths and serious illness which occur among Nigerians are due to conditions which are easily prevented or which can be treated with simple remedies. Communicable diseases, especially those which are associated with inadequate environmental sanitation and poor personal hygiene, predominate and are often compounded by malnutrition. Lack of timely risk of serious complications occurring in the course of minor ailments. The current high rates of morbidity and mortality can be substantially reduced by a more rational application of available resources, even at this time of financial stringencies.

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CHAPTER 3

FUNDAMENTAL PRINCIPLES UNDERLYING THE NATIONAL HEALTH POLICY

> The 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.

3. The national philosophy is founded on the principles of social justice and equity. This philosophy is clearly enunciated in the 2nd National Development Plan, 1970 - 1974 which described the five national objectives to make Nigeria:-

i. a free and democratice society;

ii. a just and egalitarian society;

iii. a united, strong and self reliant nation;

iv. a great and dynamic economy;

v. 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.

3.1. The National Health Policy has been formulated in the context of those national goals and philosophy. Since health development contributes to and results from socio-economic development, the two sectors shall be mutually supportive and together contribute to ultimate goals of the nation. Health development shall be seen not solely in humanitarian terms but as an essential component of the package of social and economic development as well as being an instrument of social justice and national security.

3.2 Primary Health Care as defined in the Alma Ata Declaration shall be the key to the development of the National Health Policy:-

> "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in 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."

3.3 <u>Implications</u>.

The adoption of the primary health care approach has a number of implications:-

3.3.1 The various governments of the Federation have responsibilities for the health of the people which shall be fulfilled by the provision of adequate health and social services. The citizens shall have the right and duty to participate individually and collectively in the planning and implementation of these services.

3.3.2 Health care shall be accorded higher priority in the allocation of the nation's resources than hitherto.

3.3.3 Health resources shall be equitably distributed giving preference to those at greater risk to their health and the under-served communities as a means of social justice and concern.

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3.3.4 Information on health shall be disseminated to all individuals and communities to enable them to have greater responsibility for their health.

3.3.5 Self-reliance shall be encouraged among individuals and communities as well as on a national scale.

3.3.6 Emphasis shall be placed on preventive and promotive measures which shall be integrated with treatment and rehabilitation in a multi-disciplinary and multi-sectoral approach.

3.3.7 All social and economic sectors shall cooperate in the effort to promote the health of the population.

3.3.8 That primary health care shall be 'scientifically sound' implies that all health practices and technologies, both orthodox and traditional shall be evaluated to determine their efficacy, safety and appropriateness.

CHAPTER 4

THE GOAL OF THE NATIONAL HEALTH POLICY

> The goal of the national health policy shall be level of health that will enable all Nigerians achieve socially and economically productive lives. The national health system shall be based on primary health care

4.1 "Health for all by year 2000" shall be accepted as a challenging goal. As a long-term policy and within available resources, the governments of the Federation shall provide a level of health care for all citizens to enable them to achieve socially and economically productive lives.

Within the overall fundamental obligation of the governments of the Federation and the nation's socio-economic development, the goal of the National Health Policy shall be to establish a comprehensive health care system, based on primary health care that is promotive, protective, preventive, restorative and rehabilitative to every citizen of the country within the available resources so that individuals and communities are assured of productivity, social well being and enjoyment of living.

4.2 The health services, based on primary health care shall include at least:-

i. education concerning prevailing health problems and the methods of preventing and controlling them;

ii. promotion of food supply and proper nutrition;

iii. an adequate supply of safe water and basic sanitation;

iv. material and child health care, including family planning;

In this context, family planning refers to services offered to couples to educate them about family life and to encourage them to achieve their wishes with regard to:

(a) Preventing unwanted pregnancies

(b) Securing desired pregnancies

(c) Spacing of pregnancies, and

(d) Limiting the size of the family in the interest of the health of the family. The methods prescribed shall be compatible with their culture and religious beliefs.

v. immunization against the major infectious diseases;

vi. prevention and control of locally endemic diseases;

vii. appropriate treatment of common diseases and injuries; and

viii. provision of essential drugs and supplies.

4.3 A Health System Based on Primary Health Care

The health system shall:-

4.3.1 reflect and evolve from the economic conditions and socio-cultural and political chacteristics of the communities and shall be based on the application of the relevant results of social biomedical and health systems research and public health experience;

4.3.2 address the main problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

4.3.3 involve, in addition to the health sector, all related sectors and aspects of state and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications, water supply and sanitation and other sectors; and demand the coordinated effrots of all those sectors;

4.3.4 promote maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, State, Federal and other available resources; and to this end should develop through appropriate education the ability of communities to participate;

4.3.5 be sustained by a referral system that ensures support to primary health care level in communities by providing guidance and more complex health care, leading to the progressive provision of comprehensive health care for all, and giving priority to those most in need; to this end full use shall be made of all public and private health institutions concerned, as well as the universities, i including all relevant faculties in addition to health faculties;

4.3.6 rely, 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 need of the community.

4.4 An Integrated System

The primary health care activities with the support of the referral system shall be co-ordinated so as to provide effective mechnisms for tackling priority health problems and for ensuring steady and systematic promotion in the health of Nigerians.

The health system shall provide the appropriate base for:-

4.4.1 Meeting the needs of high risk groups such as pregnant women, mothers and children;

4.4.2 Providing care for special groups such as school children, the handicapped, industrial and agricultural workers and the elderly;

4.4.3 Controlling major endemic and epidemic diseases like malaria, Tuberculosis and Leprosy, diarrhoeal diseases, onchocerciasis, and diseases associated with poor environmental sanitation.

CHAPTER 5

NATIONAL HEALTH CARE SYSTEM

Federal, State and Local Governments shall support in a coordinated manner a three-tier system of health care. Essential features of the system shall be its multisectoral inputs, community involvement and collaboration with non-governmental providers of health care.

5.1 Constitutional Background

In the constitution of 1979, Health is on the concurrent list of responsibility except the external health relations, quaratine and the control of drugs and poisons which are exclusively the responsibility of the Federal Government. The constitution also assigns specific responsibilities to Local Governments.

The national health care system is built on the basis of the three tier responsibilities of the Federal, State and Local Governments.

Annex II lists the responsibilities which shall be assigned to the Federal, State and Local Governments respectively.

5.2 Voluntary Agencies and the Private Sector

5.2.1 A variety of non-governmental agencies, especially religious bodies provide health care including both curative and preventive services.

5.2.2. Private practitioners also provide care although their services are mainly concentrated in urban areas.

5.2.3 Health care is also provided by private companies to staff members and their families.

5.3 A Co-ordinated System

5.3.1 In discharging the responsibilities assigned under the constitution, the Federal, State and Local Governments shall co-ordinate their efforts in order to provide the citizens with effective services at all levels.

5.3.2 The governments of the Federation shall work closely with voluntary agencies, private practitioners and other non-governmental agencies which provide health care to ensure that the services provided by theses other agencies are co-ordinated with those of the governments and are in line with the overall national health policy.

5.3.3 Mechanisms shall be established to ensure that all sectors related to health and all aspects of national and community development, in particular, agriculture, animal husbandry, rural development, food, industry, education, social development, housing, water supply and sanitation and communications are incolved and their activities which are relevant to health are co-ordinated.

5.4. Community Involvement

5.4.1 The governments of the Federation shall devise appropriate machanisms for involving the communities in the planning and implementation of health services.

5.4.2 Such mechanisms shall provide for appropriate constitutions at the community level with regard to local health services on the basis of increasing self-reliance. The traditional system and community organizations (cultural and religious associations) shall be fully utilized in reaching the people.

5.4.3. The State and Federal Ministries shall consult accredited groups and associations which represent the various interests within society. Apart from cultural and religious bodies, the various professional associations shall be involved.

5.5 Levels of Care

National Health Care System shall be developed at three levels viz:

5.5.1 Primary health care

5.5.1.1 Primary Health Care shall provide general health services of preventive, curative, promotive and rehabilitative nature, to the population as the entry point of the health care system. The provision of care at this level is largely the responsibility of local governments with the support of State Ministries of Health and within the overall national health policy. Private medical practitioners also provide health care at this level.

5.5.1.2 Nothing that traditional medicine is widely used in Nigeria, that there is no uniform system of traditional medicine in the country but that there are wide variations with each variant being strongly bound to the local culture and beliefs, the local health authorities shall where applicable seek the collaboration of the traditional practitioners in promoting their health programmes such as nutrition, environmental sanitation, personal hygiene, family planning and immunization. Traditional birth attendants shall be trained to improve their skills and to ensure their co-operation in making use of the referral system in dealing with high risk patients. The governments of the Federation shall seek to gain a better understanding of traditional healthpractices, and support research activities to evaluate them. Practices and technologies of proven value shall be adapted into the health care system and those that are harmful shall be discouraged.

5.5.2 Secondary health care

Secondary health care level shall provide specialized services to patients referred from the Primary Health Care level through out-patient and in-patient services at hospital centres for general medical, surgical and paediatric patients. It shall also serve as administrative headquarters overseeing the activities of the peripheral units. Such level of care shall be available at the intermediate level of the district, divisional, zonal or state. Adequate supportive services such as laboratory, diagnostic blood bank and physiotherapy shall be provided.

5.5.3. Tertiary health care

Tertiary health care, which consists of highly specialised services shall be provided by teaching hospitals and other specialist hospitals which provide care for specific disease, conditions of specific groups of persons e.g. Orthopaedic, Eye, Psychiatric, Maternity and paediatric hospitals. Care should be taken to ensure that these are evenly distributed geographically. Appropriate supporting services shall be incorporated into the development of these tertiary facilities to provide effective referral services, selected centres shall be encouraged to develop special expertise in the advanced modern technology thereby serving as a resource for evaluating and acapting these new developments in the context of local needs and opertunities.

5.5.4 In order to ensure that the primary health care services are appropriately supported by an efficient referral system, Ministries of Health shall review the resources allocated to and the facilities available at the secondary and tertiary levels. Whilst high priority shall be accorded to primary health care, within available resources, the secondary and tertiary levels shall be strengthened. The long term goal is that eventually all Nigerians shall have easy access not only to primary health care facilities but also to secondary and tertiary levels as required. Particular attention shall be placed on the needs of remote and isolated communities which have special logistic problems in providing access to the referral system.

CHAPTER 6

NATIONAL HEALTH STRATEGY

> The implementation of the national health policy and progress towards the achievement of the goals require the elaboration of strategies as the local, state and national levels The roles and responsibilities of the different arms of government shall be defined as in Annex II. A managerial process for health development shall be established.

6.1 The governments of the Federation shall translate the national health policy into strategies to achieve clearly stated objectives and, whenever possible, specific targets.

6.2 Roles and Functions of the Federal Ministry of Health

The Federal Ministry of Health shall:

6.2.1.1 take the necessary action to have the national health policy reviewed and adopted by the Federal Government;

6.2.1.2 devise a bread strategy for giving effect to the national health policy through the implementation by Federal, State and Local governments in accordance with provisions of the Constitution;

6.2.1.3 submit for the approval of the Federal Government a broad financial plan for giving effect to the Federal component of the health strategy;

6.2.1.4 formulate national health legislation as required, for the consideration of the Government;

6.2.1.5 aot as coordinating authority on all health work in Nigeria on behalf of the Federal Govern,ent, with a view to ensuring the implementation of the country's health policy;

6.2.1.6 assess the country's health situation and trends, to undertake the related epidemiological surveillance, and to report thereon to the governments;

6.2.1.7 promote an informed public opinion on matters of health;

6.2.1.8 support state governments, and through them local in developing strategies and plans of action to give effect to the national health policy as adopted by the Governments of the Federation;

6.2.1.9 allocate Federal resources in order to forster selected activities to be undertaken by States and local governments in implementing their health strategies;

6.2.1.10 issue guidelines and guiding principles to help States prepare, manage, monitor and ensure compliance with them by all concerned: health technology including equipment, supplies, drugs, biological products and vaccines, in conformity with national and international standards; the human environment; and the education, training, licensing and ethical practices of different categories of health workers;

6.2.1.11 promote research that is relevant to the implementation of Federal health policy and State health strategies, and, to this end, to establish suitable mechanisms to ensure adquate coordination among the research institutions and scientists concerned;

6.2.1.12 promote cooperation among scientific and professional groups as well as non-governmental organisations in order to attain the goals of the Federal health policy;

6.2.1.13 monitor and evaluate the implementation of the Federal health policy on behalf of the Government and report to it on the findings;

6.2.2 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, the national health policy shall be directed towards:-

6.2.2.1 ensuring technical cooperation on health with other nations of the region and the world at large;

6.2.2.2 ensuring the sharing of relevant information on health for improvement of international health and;

6.2.2.3 ensuring cooperation in international control of narcotic drugs, and psychotropic substances;

6.2.2.4 collaborating with United Nations agencies, organization of African Unit, West African Health Community, and other international agencies on regional or global health care improvement strategies without sacrificing the initiatives of national community and existing institional and other infrastructural arrangements.

6.2.2.5. working closely with other developing countries especially the neighbouring states within the region which have similar health problems in the spirit of technical cooperation among developing countries especially with regard to the exchange of technical and epidemiological information, the sharing of training and research facilities and the coordination of major intervention programmes for the control of communicable diseases.

6.3 Roles and Functions of State Ministries of Health

The State Minitries of health shall be strengthened so that they become the directing and coordinating authority on health work within the State.

6.3.1 Ensuring political commitment

6.3.1.1 The Ministries of Health shall channel activities into the strategy for health and coordinate them on behalf of the government.

6.3.1.2 The Ministries of Health shall take initiatives to ensure the commitment of their governments as a whole to the realization of the national health policy as adopted by all the Governments, of the Federation. In addition, on behalf of the State Government, they shall make efforts to ensure the support of public figures and bodies as appropriate, such as political, religious, trade union and civic leaders and influential non-governmental organisations. They shall mobilize popular support by involving individuals and families in their own health care and by involving them collectively in technical, supportive and financial community action for primary health care.

6.3.1.3 The Ministries of Health shall propose to their governments appropriate mechanisms for ensuring the action required in all relevant social and economic sectors, such as inter-ministerial committees and multisectoral State Health Committees. They shall deploy all means for ensuring the redistribution of resources for health so they become progressively equitable for all segments of the population throughtout the state.

6.3.1.4 The Ministries of Health shall advise on the introduction of health reforms, and enabling legislation as necessary - for example, to define the rights and obligations of people concerning their health, as well as those of various categories of health workers and institutions, to protect people from environmental hazards; and to permit communities to develop and manage their health and related social programmes and services. Care should be taken to avoid protracted deliberations on legistration as a substitute for action, and t ensure that people understand the nature of the legislation and approve of it.

6.3.2 <u>Ensuring economic support</u>

6.3.2.1 Ministries of Health shall seize all opportunities of gaining the support of economic planners on institutions by convincing them that health is essential for development and it contributes to production and by refuting the contention that the pursuit of health consists merely in the consumption of scarce resources for marginally useful medical care that has no impact on the health of the people.

6.3.2.2 Ministries of Health shall also display vigilance, employing specialized personnel if necessary, in order to ensure that health needs and protective measures are made integral parts of development projects, taking account of cost-effectiveness - for example in irrigation schemes, dams, and industrial development projects.

6.3.3 Winning over professional groups

To ensure the support of the health professions, Ministries of Health shall consider ways of involving them in practice of primary health care and in providing support and guidance to communities and community health workers. To this end they shall approach the health and health-related professional, professional organizations providing them with information, holding dialogues with them, impressing upon them their social professional organizations providing them with information, holding dialogues with them, impressing upon them their social responsibilities and indicating how they can best discharge these responsibilities. They shall also consider ways of providing tangible incentives.

6.3.4 Establishing a managerial process

Ministries of Health shall establish systematic permanent managerial processess for health development as outline in 7.7.

6.3.5 Public information and education

6.3.5.1 Ministries of Health shall assume a highly active role in disseminating the kind of information that can influence various target audiences. Thus, statements on the aims and potential socioeconomic benefits of the State strategy, as well as progress reports on its implementation, shall be disseminated to the public.

6.3.5.2 Ministries of Health in collaboration with Local Government shall promote health educational activities through health personnel and the mass media and in educational institutions of all types, with the aim of enlightening the whole population

on good health maintenance, the prevailing health problems in their state and community and on the most appropriate methods of preventing and controlling them.

6.3.6 Financial and material resources

Just as the succesful implementation of the State strategy shall mean mobilizing all possible human resources, it shall also depend on mobilizing all possible financial and material resources. This implies first of all making the most efficient use of existing resources. At the same time, additional resources shall undoubtedly have to be generated.

In this context Ministries of Health shall:

6.3.6.1 review the distribution of the State resources from all sources, with particular reference to primary health care vis-a-vis intermediate and central levels, urban versus rural areas, and to specific underserved groups;

6.3.6.2 reallocate these resources as euitably as possible or, if this proves impossible, at least allocate any additional resources - for the provision of primary health care, particularly for underserved population groups;

6.3.6.3 include an analysis of needs in terms of costs and materials in all consideration of health technology and of the establishment maintenance of the health infrastructure;

6.3.64 consider the benefit of various health programmes in relation to the cost, as well as the effectiveness of different technologies and different ways of organizing the health system in relation to cost;

6.3.6.5 estimate the order of magnitude of the total financial needs to implement the State health strategy;

6.3.6.6 attempt to secure additional resources for the strategy if necessary having shown they have made the best possible use of existing funds;

6.3.6.7 identify activities that might attract external support and Federal Government assistance;

6.3.6.8 present to their government a master plan for the use of all financial and material resources,

including for example government direct and indirect financing; social security and health insurance schemes; local community solutions in terms of energy, labour, materials and cash;

individual payments for service; and the use of external loans and grants.

6.3.7 Intersectoral Action

Ministries of Health have an important role in stimulating and coordinating action for health with other social and economic sectors concerned with State and community development, in particular agriculture animal husbandry, food, industry, education housing, water supply and sanitation, communication, social development and non-governmental agencies.

6.3.7.1 Ministries of health shall approach other sectors with a view to motivating them to take action in specific fields. Ministries of planning, finance and agriculture shall be approached, as appropriate, with a view to reasching a proper balance between food crops and cash crops. The agricultural and the housing and public works sectors shall be approached with respect to the provision of safe drinking-water and sanitation. Planning and development ministries shall be approached to ensure that proper attention is given to health aspects of development schemes, such as the prevention of certain parasitic diseases. The educational and cultural sectors shall be asked to participate in wide-ranging health educational activities in communities, schools, and other educational activities in communities, schools, and other education, training and cultural institutions, These responsible for public works and communications shall be requested to facilitate the provision of primary health care, through improved communications, particularly for dispersed populations. Access to the mass media shall be facilitated through Ministries of Information and the like. The industrial sector shall be made aware of the measures required to protect the environment from pollution and to prevent occupational diseases and injuries. The industrial sector shall also be requested, as the need arises, to consider the possibility of establishing industries for essential foods and drugs.

6.3.8 Coordination within the health sector

To achieve coordination within the health sector Ministries of Health shall pay attention to the following:

6.3.8.1 Collaboration between the various health services and and institutions, following agreement on allocation of responsibilities in order to make the most efficient use of resources. These shall include services and institutions belonging to government, the private sector, nongovernmental and voluntary organizations active in the health sector, and women's and youth organizations;

6.3.8.2 collaboration between the various levels of the health system following agreement on the distribution of functions and resources;

6.3.8.3 collaboration within and among the various categories of health workers following agreement on the division of labour.

6.3.9 Organizing primary health care in communities

In order to facilitate intersectoral collaboration, primary health care shall be organized taking account of administrative boundaries. Communities shall be helped to organize themselves; and responsibility, authority and appropriate budgets shall be delegated to them. The Ministries of Health shall provide guidelines and practical support as necessary to those communities that organise their own primary health care.

6.3.10 Referral system

6.3.10.1 Ministries of Health shall review the functions of the mechanisms and institutions in the health and related sectors particularly at the first referral level, and shall motivate staff and retrain them as necessary to provide support and guidance to communities and community health workers.

6.3.10.2 Ministries of Health shall develop a system of referral of patients and problems so that the first referral level is not overloaded with problems that could be dealt with by primary health care in the community, and so that patients and problems are referred back

back to those who sent them, accompanied by information on action taken and guidance for further action.

6.3.10.3 Ministries of Health shall review transport and communication facilities together with local authorities and representatives of the other ministries concerned, to permit the referral system to function efficiently.

6.3.11 Logistic system

Ministries of Health shall review their logistic system to ensure regular and timely distribution of supplies and equipment, as well as the availability of transport and its maintenance, starting with facilities in communities and working centrally through intermediate and central levels.

6.3.12 Health manpower

State Ministries of Health, in collaboration with the Federal Ministry of Health and other ministries and educational bodies concerned shall ensure the education and training of health manpower to perform functions that are relevant to the country's priority health problems along the guidelines shown in chapter 10.

Ministries of Health and other ministries concerned, for example for education, culture, labour, finance, and public administration, shall take steps to ensure that health workers are socially motivated and provided with the necessary incentives to serve rural communities.

6.3.13 Health care facilities

6.3.13.1 Ministries of Health, together with Ministries of Local Government and Public Works, shall review the distribution of existing health care facilities run by the State, local governments and other public, private and voluntary bodies, and shall work out and continually update State master plans of requirements for health centres and clinics and for first-referral hospitals. Accessibility to those most in need shall be the foundation of the master plans.

6.3.13.2 Ministries of Health shall review the functions staffing, planning, design, equipment, organization, and management of health centres and clinics and first-referral hospitals, in order to prepare them for their wider function in support of primary health care.

Before investing in buildings, the cost of running them shall be carefully considered.

6.3.14 Priority health programmes

Ministries of Health shall identify priority health programmes in the light of the essential programme elements of primary care and the epidemiological situation in the State, and shall ensure that the delivery of those programmes is given top priority by all concerned.

6.3.15 Health Technology

Ministries of Health shall make a systematic assessment of the health technology being considered for use in each priority programme, aimed at applying technology that is appropriate for the country or part of the country concerned (See chapter 11).

6.4 Roles and Functions of Local Government

* The constitution assigns to local government councils certain functions which are essential elements of primary health care - environmental sanitation, provision and maintenance of health services and the provision and maintenance of primary education.

With the general guidance, support and supervision of State Health Ministries, and in collaboration with the Ministries of Local Government, local government shall design and implement strategies to discharge the responsibilities assigned to them under the constitution and to meet the health needs of the local community.

6.4.1. Motivation of the Community

The Local Government shall elicit the support of formal and informal leaders, traditional chiefs, religious and cultural organizations and other influential persons and groups in support of community action for health.

6.4.2 Local Strategy for health

The Local Government Health Authorities shall:

* 6.4.2.1 determine how best to provide the essential elements of primary health care;

6.4.2.2 identify for each priority programme the activities to be carried out by the individuals and families, by the communities by the health service and by the other sectors;

6.4.2.3 identify the support action required for each component of the programme;

6.4.2.4 provide relevant health information to the people on such matters as personal hygiene, environmental sanitation, prevention and control of communicable diseases and such matters where a change in the life style of the people can have significant impact on their health status;

6.4.2.5 design and operate mechanisms for involving the communities in the crtitical decisions about the health services;

6.4.2.6 mobilize resources to support the health programme. This shall include the use of voluntary effort and other traditional methods of achieving community goals;

6.4.2.7 ensure that the essential infrastructure for the health programme is available and well maintained. With regard to physical facilities the emphasis should be on making sure that they meet the requirements for providing services but are not over elaborate to the point where their maintenance constitutes a drain on the resources.

6.4.2.8 collect relevant data about the health resources, the health status of the community and about their health behaviour including the utilization of health services. Such data shall form the basis of the information for the management of the local health services.

PART II - PROGRAMME OF ACTION AND STRATEGY OF IMPLEMENTATION

CHAPTER 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. Experience has shown repeadtedly that many well conceived health schemes fail to meet expectations 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.

7.1 The National Managerial Processes

A national managerial process shall be established to include the following elements:-

7.1.1. The national health policy comprising the goals, priorities, main directions towards priority goals, that are suited to the social needs and economic conditions in the different States of Nigeria and form part of national, social and economic development apolicies.

7.1.2 Programming - the translation of these policies through various stages of the planning at the local, state and national levels into strategies to achieve clearly state objectives.

7.1.3 Programme budgeting - the allocation of health resources by the governments of the Federation for the implemetation of these strategies.

7.1.4 Plan of action - describing strategies to be followed and the main lines of action to be taken in the health and other sectors to implement these strategies.

7.1.5 Detailed programming - the conversion of strategies and plans of action into detailed programmes that specify objectives and targets, and the technology, manpower, infrastructure, financial resources, and time required for their implementation through the health system.

7.1.6 Implementation - the translation of detailed programmes into action so that they come into operation as integral parts of the health system; the day-to-day management of programmes and the services and institutions for delivering them, and the continuing follow-up of activities to ensure that they are proceeding as planned and are on schedule.

7.1.7 Evaluation, of developmental health strategies and operational programmes for their implementation, in order progressively to improve their effectiveness and increase their efficinecy.

7.1.8 Repregramming, as necessary, with a view to improving the master plan of action or some of its components, or preparing new ones as required, as part of a continuous managerial processes for national health development.

7.1.9 Relevant and sensitive information, to support all these components at all stages.

7.2 National Health Planning System

7.2.1 Scope and Purpose

The national health planning system shall form an integral part of the National Health Policy and any ensuing legislation. It will be an imporant administrative framework for assigning duties and responsibilities as well as determining the working relationships between different levels of health management.

7.2.2 The national health planning system shall relate to the determination of broad policy and priorities, and their translation into forward plans for the utilisation of resources. It shall not be concerned with detailed planning of individual projects or developments, but only with determining their priority and timing and the resources to be allocated to them.

7.2.3.1 The research, analytical and considerative processes which result in strategic policy choices and long term o objectives shall be a continuous process which cannot appropriately be fitted into an annual cycle, though an annual summary of long term aims and objectives shall be produced as background to programming decisions;

7.2.3.2 the programming and budgetting process shall result in decisions to put into effect specific cources of action within a definite timescale as a means of achieving the long term aims, and to allocate resources to them. This process which gives rise to the preparation of financial estimates, budgets and operating targets, shall be subject to annual revision and up-dating in a formal planning cycle.

7.3 National Health Planning and Development Guidelines

7.3.1 The Federal Ministry of Health shall by regulations issue guidelines concerning national health polices, plans and programmes, and shall, as it deems appropriate, by regulartion revise such guidelines.

7.3.2 The Federal Ministry of Health shall include in the guidelines issued:

i. standards respecting the appropriate supply, distribution, and organisation of health resources;

ii. a statement of national health planning goals, objectives and targets developed after consideration of the priorities, stated above. The goals, objectives and target to the maximum extent practicable, shall be expressed in quantitative terms.

7.6.6.1 The structure of a state health planning and development unit;

7.6.6.2 the conduct of the planning and development processess;

7.6.6.3 the performance of state health planning and development functions; and

7.6.6.4 the planning performance of Local Government Health authority.

7.7 Managerial Process at State Level

7.7.1 To permit them to develop and implement their strategies, Ministries of Health shall establish a permanent, systematic, managerial process for health development which shall lead to the definition of clearly stated objectives as part of the State strategy and, wherever possible, specific targets. They shall facilitate the preferential allocation of health resources for the implementation of the State strategy, and shall indicate the main lines of action to be taken in the health other sectors to implement it. They shall specify the detailed measures required to build up or strengthen the health system based on primary Health care for the delivery of state programmes. The managerial process shall also specify the action to be taken so that detailed programmes become operational as integral parts of the health of the health system, as well as the day-to-day management of programmes and the services and institutions delivery them. Finally, it shall specify the process of evaluation to be applied with a view to improving effectiveness and increasing efficiency, leading to modification or updating of the State strategy as necessary. Health manpower planning and management shall be an inseparable feature of the process. For all the above, the support of relevant and sensitive information will be organized as an integral part of the health system.

7.7.2 Ministries of Health shall establish permanent mechnisms to develop and apply their managerial process and to provide adequate training to all those who need it. These may include mechanisms in ministries themselves, as well as all networks of individuals and institutions, to share the managerial research, developement and training efforts required for health development.

7.8 State Health Advisory Committee

7.8.1 There shall be established an advisory committee in each State known as the State Health Advisory Committee. The Committee shall advise the State Government on health policy and programmes and be chaired by the Commissioner of Health.

7.8.2 The State Health Advisory Committee shall consist of representatives of:

i. State Ministry of Health;
ii. State Hospital Management Board;
iii. State Ministry of Local Government;
iv. State Ministry of Education (for school health);
v. Non-governmental organizations;
vi. Federal Health Institutions;
vii. Health related ministries;
viii. Professional bodies.

7.8.3 A State Health Advisory Council shall perform the following functions:

7.8.3.1 review annually and co-ordinate the long-term health plan and annual health plan of the State;

ii. National Institution of Medical Research
iii. Medical Schools
iv. Schools of allied health professionals
v. Non-governmental organisation
vi. Professional associations

7.6 Planning Function By The Federal Ministry of Health

7.6.1 The Federal Ministry of Health shall service the National Council on Health and have multidisciplinary staff with expertise in at least the following:

i. health administration;
ii. health statistics;
iii. health planning;
iv. epidemiology;
v. development and use of health resources (health economics)

7.6.2 The Federal Ministry of Health shall prepare and submit annual review, health plans and long-term health plans that detail the health problems, and needs of the country.
Each plan shall also detail the goals and objectives, priorities and implementation and evaluation procedures of solving the health problems and meeting the health needs of the country.

7.6.3 Each plan shall be made up of the State health plans submitted by every State Ministry of Health. Such plans shall contain such revisions of the State health plans to achieve the appropriate coordination or to deal more effectively with the national health needs.

7.6.4 The Federal Ministry of Health shall assemble and analyse the following data and indicate how their quality can be improved:

7.6.4.1 the state of health of the nation and its determinanants;

7.6.4.2 the state of the health care delivery system in the country and the use of the services by the public;

7.6.4.3 the effect, the health care delivery has on the health of the general public;

7.6.4.4 the number, type and location of the health resources including health service manpower and facilities;

7.6.4.5 the pattern of utilization of the health resources; and

7.6.4.6 the environmental and occupational exposure factors affecting immediate and long-term health condition;

7.6.5. The Federal Ministry of Health shall also provide guidelines on planning approaches, methodologies, policies and standards appropriate planning and development of health resources.

7.6.6 The Federal Ministry of Health shall also provide guidelines for the organisation and operation of state health planning and development units including:

7.3.3 In issuing guidelines, the Federal Ministry of Health shall consult with and solicit for recommendations and comments from the National Council on Health, State Ministries of Edication and Local Government, professional association and special societies representing health organisations.

7.4 National Council on Health

7.4.1 The National Council on Health shall advise the Governments of the Federation with respect to:

7.4.1.1 the development of national guidelines;

7.4.1.2 the implementation and administration of the National Health Policy and

7.4.1.3 various technical matters on the organisation, delivery, and distribution of health services.

7.4.2 The Council shall be composed of the following members:

7.4.2.1 the Minister of Health (Chairman);

7.4.2.2 the Commissioners for Health

7.4.3 The Council shall be advised by the Technical Committee.

7.5 Technical Committee of the National Council on Health

7.5.1 The Technical Committee shall be composed of:

i. The Permanent Secretaries
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.

7.5.2 Expert Panels

The Technical Committee shall set up as required appropriate programme expert pannels including the represtatives of:

i. Health related Ministries of:

a. Agriculture, Rural Development and Water Resources

b. Education, Science and Technology
c. Labour, Social Development, Youth and Sports
d. Works and Housing
e. National Planning.
f. Finance

7.8.3.2 review and revise as necessary (but at least annually), the state health plan which shall include the health plans of the local government health authorities within the State;

7.8.3.3 review annually the budget of each such local government health authority;

7.8.3.4 advise the Health Planning Unit of the State generally on the performance of its functions;

7.9.1 State Health Planning Function

7.9.1.1 Each Ministry of Health shall establishe an appropriate mechanism for the implementation and planning of its development functions.

7.9.1.2 The State Ministry of Health shall submit an annual health plan that shall outline the health problems, needs, goals and objectives, implementation and evaluation procedures for the State. It also shall submit a long term health plan to the Federal Ministry of Health after the approval of the state Executive Council.

7.9.1.3 Each State Ministry of Health shall perform within the State the following functions:

i. conduct the health planning activities of the State and help in implementing and coordinating the various components of the State Health Plan;

ii. prepare, review and revise as necessary (but at least annually), a preliminary State Health Plan which shall include the local government health authorities plans;

iii. assist the State Health Advisory Committee of the State in the review of the State Health facilities plan and in the performance of its functions generally;

iv. review on a periodic basis but not less often than every three years), all institutional health services being offered in the State.

7.9.2 Technical assistance for State Health Services

7.9.2.1 The Federal Ministry of Health shall provide to the State Ministry of Health:

i. assistance in developing their health palns and approches to planning of various types of health services;

ii. technical materials, including methodologies, policies and standards appropriate for use in health planning;

iii. other tedhnical assistance as may be necessary in order that such institutions may properly perform their functions.

7.9.2.2 The Federal Minister shall include in the materials

i. specification of the minimum data needed to determine the health status of the nation and the determinants of such status;

ii. specification of the minimum data needed to determine the status of the health resources and services of the country;

iii. specification of the minimum data needed to describe the use of health resources and services within the country;

v. Guidelines for the organisation and operation of State Health Planning Units, Local Government Health Committee.

7.10 State Hospitals Management Board

The State Hospitals Management Board shall function under the general supervision of and policies established by the State Ministry of Health which shall maintain overall responsibility for the health services of the State.

7.10.1 The Board shall be responsible for the management of hospitals which come under the jurisdiction of the State Ministry of Health.

7.10.2 The Board shall collaborate with the Local Health Authorities and their respective health committees to ensure close integration and continuity of services from peripheral units (under the Local Health Authority) to the referral units which are administered by the Board.

7.10.3 The functions assigned to the Ministry, to the Board and to the Local Health Authorities shall be clearly demarcated with unambiguous delineation of responsibilities and powers.

7.10.4 The composition of the Board shall include representatives of the:

i. Ministry of Health;
ii. Community leaders;
iii. Professional associations;
iv. Staff members of hospitals and institutions managed by the Board;
v. Federal Health institutions, where appropriate;
vi. Non-governmental organisations.

7.10.5 The officials of the Board shall be selected with great care to ensure dynamic and efficient management of the programmes.

7.11 Local Government Health Committee

7.11.1 The Local Governments in consultation with the State Ministry of Health shall establish their Local Governments Advisory Committee covering each Local Government Area for the purpose of delivering health services to the communities.

7.11.2 The composition of each Local Government Health Committee shall include representatives of:

i. Local Government Council;
ii. State Health Management Board;
iii. Leaders of the Local Community;
iv. Non-governmental organizations;
v. Training institutions (including University institutions if appropriate);
vi. Representatives of the professional staff;
vii. Other health institutions.

The Local Government Health Committee of this composition shall effect the execution of the plans for health services within the specified Local Government Area. The State Commissioners for Local Government and Health shall review the membership and activities of the Local Government Health Committee once every three years and replace any member who may leave the committee any time during the tenure of office.

7.11.3 The functions of Local Government Health Committee shall include the following:

i. formulate project proposals;
ii. deliver directly health services within the area with community participation;
iii. collect basic data of services and resources.
iv. mobilise resources for health programme implementation in the spirit of self-reliance

CHAPTER 8

> The Federal and State Governments 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 under-served areas and groups. Community resources shall be mobilized in the spirit of self-help and self-reliance.

8.1 In the light of the importance of health in socio-economic development, all governments of the Federation shall review their financial allocation to health. High priority programmes for primary health care shall have the first call on any additional resources that may be available.

8.2 Within the health care system, efforts shall be made to redistribute financial allocation among promotive, preventive and curative health care services to ensure that more emphasis shall be placed on promotive and preventive services.

8.3 The governments of the Federation shall explore avenues for financing the health care system through health insurance schemes.

8.4 As a general policy, users shall pay for curative services but preventive services shall generally be subsidized; public assistance shall be provided to the socially and economically disadvantaged segments of the population.

8.5 The governments of the Federal shall encourage employers of labour to participate in and finance health care delivery to employees.

8.6 Within the right of individuals to participate in the economy of the nation private individuals shall be encouraged to establish and finance private health care services in under-served areas.

8.7 With the concept of self reliance, communities shall be encouraged to bear directly financing of health care or find local community solutions to health problems through contribution of labour and materials.

8.8 Mechanisms shall be established to undertake continuing studies on:

i the benefit of various health programmes in relation to the cost as well as the effectiveness of different technologies and ways of organising the health system in relation to the cost; and

ii. the inclusion of an analysis of needs in terms of cost, material and personnel in all consideration of health technology and of the establishment and maintenance of the health infrastructure.

CHAPTER 9

NATIONAL HEALTH INFORMATION SYSTEM

> The effective management of the health services demands the establishment of a national health information system. Basic demographic data are essential for planning and monitoring of the health services, Simple but efficient information system shall be established and supported to grow both in quality and quantity.

9.1 Background

The planning, monitoring and evaluation of health services are hampered by the dearth of reliable data on national scale. The basic demographic data about the size, structure and distribution of the population are unrealiable. There is no system for the registration of births and deaths on a national scale and hence it is not possible to calculate the simplest indicators like the crude birth rate, crude death rate, and infant mortality rate. The state of health of the population is assessed on the basis of scanty information which has been collected in a few limited surveys and research studies. The health services at the national, state and local levels cannot be managed efficiently on the basis of the available data.

9.2 A national health information system shall be established by the governments of the Federation. It shall be used as a management tool:-

9.2.1 To assess the state of the health of the population, to identify major health problems and set priorities on the local, state and national levels.

9.2.2 To monitor the progress towards stated goals and targets of the health services.

9.2.3 To provide indicators for evaluating the performance of the health services and their impact on the health status of the population.

9.2.4 To provide information to those who need to take action, to who supplied the data and to the general public.

9.3 Development of the Information System

9.3.1 The information system shall be developed in a phased manner starting with the simplest data which can be collected at the peripheral institutions. Efforts shall be made to implement community based systems for the collection of vital health statistics - births and deaths. Such data shall be used for planning and monitoring of health services at the local level.

9.3.2 The State Ministry of Health shall promote and support the collection of data by the Local Health Authorities to improve the quality and quantity of the information. The methods of collection and recording shall be standardized as far as possible to facilitate their collation and compar.....

9.3.3 As and when feasible, State Health Authorities shall use simple electronic data processing equipment for storage, retrieval and analysis of the data.

9.3.4 At the Federal level, in collaboration with the Federal Office of Statistics, the Statistics Unit of the Ministry of Health shall be responsible for obtaining, collating, analysing and interpreting health and related data on a national basis. The unit shall support the State Health Authorities in the development of their information systems.

9.4 For comprehensive monitoring and evaluation of health care minimum categories of indicators shall be as follows:

i. Health Policy Indicators
ii. Health Status Indicators
iii. Socio-economic indicators related to health and living standard
iv. Provision and utilisation of health care indicators.

The indicators that have been selected are based on the available resources, relevance to the health policy and availability of the information required.

The four main indicators shall be as defined below:

9.4.1. <u>Health Policy Indicators</u> shall include:

9.4.1.1 political commitment of "Health for all" especially enactment of any necessary legislation to effect the commitment;

9.4.1.2 financial resources allocation in terms of the proportion of the GNP spent on health; the proportion of the total governments' expenditure going to health and specifically to PHC; and per capital government expenditure on health described by States and Local Government areas;

9.4.1.3 distribution of health resources, financial, manpower, physical facilities to reflect the degree of equity by geography and by the urban/rural ratios;

9.4.1.4 degree of community involvement as indicated by the establishment of health development committees, community participation in health and health-related programmes and contribution towards health care;

9.4.1.5 organizational framework and managerial process.

9.4.2 <u>Health Status Indicators</u> shall include:

1. nutritional status as indicated by birth weight of babies, weight and height measurement of infants and children for age:
ii. infant mortality rate
iii. child (1-4 years) mortality rate
iv. Maternal Mortality rate
v. Crude death rate.
vi. Crude birth rate
vii. Life expectancy at birth and at 5 years of age

9.4.3 Social and Economic Indicators shall include

i. rate of population increase
ii. gross national or domestic product
iii. income distribution
iv. work conditions
v. adult literacy rate by sex
vi. food availability
vii. housing
viii. basic sanitation
ix. school enrolment by sex

9.4.4 Provision and Utilization of Health Care Indicators shall include:

Coverage by PHC:

i. Information and education concerning health; proportion of population with access to mass media outlets and measurement of health literacy activities to the community;

ii. Food and nutrition (see 9.4.2(i);

iii. Water Supply and Sanitation as above;

iv. Family Health indicators including proportion of children receiving child health services; proportion of pregnant women receiving ante-natal, postnatal care and proportion of eligible women receiving family planning advice;

v. Immunization indicators shall include the percentage of children at risk fully immunized against the major childhood diseases, the incidence of the six diseases in children, under 5 years age group and mortality rate due to the six diseases in children under 5 years age group.

vi. Prevention and Control of Endemic Diseases indicators to specify disease specific incidence and prevalence rate; mortality for selected number of diseases, proportion of mortality rates from communicable diseases, proportion of leprosy and tuberculosis detected, under regular treatment and lastly vector index

vii. Treatment of Common Disease and Injuries indicators including proportion of cases of diarrhoea in children under 5 years, proportion of fevers treated with chloroquine, proportion of respiratory infections treated with common antibiotic, proportion of malnutrition treated with supplementary feeds and proportion of injuries or accidents treated by first-aid or simple treatment;

viii. Provision of essential drugs-indicator of provision of essential drugs, vaccines and supplies, standard drug list and availability of such items;

ix. Coverage by referral system-indicator of proportion of population in a given area with access to the services within 5 kilometers or 1 hour travel time, the proportion of referred cases who made use of the service and availability of referral services e.g. paediatric, obstetric, surgical, medical etc.

9.5 The Principal Sources of Health Indicator Data

The principal data sources for proposed indicators shall be as follows:

i. Population and household censuses: as prepared and projected by the National population Commission and Federal Office of Statistics; household census will produce data on health related services such as housing, water supply, toilet facilities, overcrowding;

ii. Vital Events Register - Legal registration statistical recording and reporting of vital events such as births, deaths, marriages, divorces, There registration of vital events are available at appropriate state authority;

iii. Routine health service data dealing with morbidity and mortality data; immunisation, disease treatment, out-patient attendances, admissions etc. These records should be obtained from the records of health services in health institutions;

iv. Epidemiological Surveillance data to cover immunization record, notifiable diseases and indication of disease incidence and prevalence;

v. Disease Registers for specific morbidity and mortality shall be kept such as for cancer, sickle cell disease, handicapped persons, etc.;

vi. Budgettary Allocation data to be obtained from the Federal and State Ministries of Finance, and Planning; as well as the Local Government Authority;

vii. Community Surveys shall be undertaken in collaboration with the National Population Commission, Federal Office of Statistics or with appropriate University Departments;

viii. Other health data sources including registers of health institutions and of health personnel.

9.6 Level of Functions

9.6.1 Local Level:-

The Local Government Health Authority shall be responsible for collection of data in its area of jurisdiction.

9.6.2 State level:

State Ministry of Health will be responsible for collating health information from the Local Government Areas and preparing State Health Information data.

9.6.3 National Level:

The Federal Ministry of Health will be responsible for:

- the development, introduction and maintenance of effective national health information system;
- the central co-ordination of the health information data on 9.5 i-vii above;
- collecting, processing and presenting relevant and necessary information required both for national health planning and for monitoring the utilization of resources in accordance with national priorities and objectives.

CHAPTER 10

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 orther sectors having a bearing on health. The selection, training and deployment of health manpower shall reflect the national objectives with particular emphasis on the primary health care approach. Appropriate policies shall be evolved to source a more equitable distribution of health personnel throughout the country.

10.1. Ministries of health, in collaboration with other Ministries and educational bodies concerned, in particular Ministries of Education and the Universities, shall take steps at the highest government level to introduce the policy of educating and training health manpower to perform functions that are highly relevant to the country's priority health problems. In fulfilment of this policy they sahll review the functions of health personnel throughout the health system, and shall take the necessary measures to ensure their reorientation as necessary.

10.2. Ministries of Health, together with other Ministries concerned such as the Ministries of Labout, Employment and Productivity, National Planning, and Education, Science and Technology shall plan health manpower in specific response to the needs of the health system, with a view to placing at the disposal of the system the right kind of manpower in the right numbers at the right time and in the right place.

10.3. Ministries of Health and other Ministries and educational bodies concerned, such as Ministries of Education and Universities, shall review training in the light of projections for the number, types and quality of the different categories of health workers in supporting individuals and families to care for themselves. The training programmes shall promote the team approach to the delivery of health care. They shall make all efforts to introduce the necessary reforms in relevant training institutions so that in addition to their technical training health personnel shall become imbued with the national philosophy of health for all Nigerians as an integral part of social and economic development. In view of their scarcity, emphasis shall be given to the training of adequate numbers of "health managers" - that is, people who can generate schemes for such health development, and plan, programmes, budget implement, monitor, and evaluate them; who can bring together to these ends the specialised knowledge of all the other disciplines involved in the health political, social and economic sciences; and who can marshall, master, and summarize the information required for all these activities.

10.4 Efforts shall be made to secure a more equitable distribution of health personnel throughout the country. Needs of the underserved areas shall be given particular attention. To this end, appropriate personnel policies will be developed which shall take into account terms of appointment, salary structures and incentives to induce health personnel to serve in rural and underserved areas in any part of the country.

10.5 Traditional birth attendants shall be retrained in order to increase their skills and effectiveness and to promote their intergration with the primary health care system.

As judged appropriate, training programmes (courses, seminars, and workshops) shall be organised for other traditional medical practitioners. In particular, they shall be encouraged to support priority programmes such as nutrition, environmental sanitation, personal hygiene, oral rehydration and immunisations. They shall be instructed on how to make effective use of the referral system of orthodox medical care.

CHAPTER 11

NATIONAL HEALTH TECHNOLOGY

> The most appropriate health technologies shall be selected for use at all levels of the health care system. 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 on imports indigenous manufacturing capabilities shall be fostered.

11.1 The policy on national health technology shall be directed to ensuring the selection, development and application of appropriate technology at each level of health care. Appropriateness shall be judged on the basis of effectiveness, safety, the ability of the community to pay for it and the availabity of expertise to utilize it and maintain it.

11.2 A systematic assessment shall be made of health technology being considerad for use in each priority programme. This shall include measures for health promotion, disease prevention, diagnosis, therapy and rehabilitation.

11.3 The process of determining health technology shall also entail specifying for each programme what measures shall be taken by individuals and families in their home and what by communities; whether by individual or community behaviour or by specific technical measures. Measures to be taken by the health service at primary, secondary and tertiary levels, as well as those to be taken by sectors, shall be specified.

11.4 To arrive at appropriate technologies mechanisms for consultations with other relevant government departments, institutions as well as communities shall be stablished.

11.5 Emphasis shall be given to:-

11.5.1 Devising and applying appropriate technology for providing safe water supplies and basic sanitation in different ecological zones of the country. Preference shall be given to systems which can be adequately maintained by available expertise.

11.5.2 Fostering agricultural programmes including home gardening and food distribution mechanisms which shall promote and facilitate adequate nutrition of all segments of the population. Emphasis shall be placed on making the communities self-sufficient as far as possible with regard to essential food commodities.

11.5.3 Developing and using health education and information technologies for the promotion of healthy practices and behaviour. Such technologies shall be made compatible with local cultures.

11.6 Drugs, Vaccines, Dressings and Quality Control

National drug policies will be formulated to ensure the quantification of needs, procurement, production as necessary and feasible, distribution and management of essential drugs. Steps will be taken to:

11.6.1 Draw up a list of essential drugs and vaccines; and set up mechanisms to ensure that these drugs are available at all levels of the health care system.

11.6.2 Develop local capability to produce essential drugs, vaccines and dressings and to reduce the dependence on imports by offering suitable incentives to firms which are engaged in the local manufacture, research and development of drugs.

11.6.3 Keep surveillance on the quality of locally produced and imported drugs and prevent malpractices and develop a system of monitoring drugs with adverse side effects.

11.6.4 Intensify the control of drug abuse including efforts to regulate the sale of drugs.

11.6.5 Establish efficient systems for the procurement, storage and distribution of drugs and vaccines including a reliable "cold chain" for the latter.

11.6.6 Allocate resources for relevant drug research including traditional remedies.

11.6.7 Control the advertidement of drugs and other health related products.

11.7 Equipment

11.7.1. The selection, ordering and maintenance of equipment (e.g. x-ray machines, anaesthetic equipment; refrigerators; transportation), will be rationalised so as to obtain savings in the cost of purchase and maintenance as well as ensuring reliable service.

11.7.2 Ministries of Health shall co-operate by exchanging information, by standardisation of specifications and by the sharing of facilities for the maintenance of equipment.

11.8 Health Care Facilities

Ministries of Health, together with Ministries of works & Housing shall review the distribution and types of existing health care facilities and their status and shall work out a master plan of requirements for health centres, dispensaries and first referral hospitals. These plans will include repair, refurnishing up-dating and equipping of facilities in accordance with established guidelines for each type of facility. Proposals for adequate maintenance with community support and involvement to the extent feasible shall also be included in this master plan.

CHAPTER 12

RESEARCH

> Priorities for health service and biomedical research shall be reviewed 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 area and to strengthen the research capabilities of national institutions to enable them to undertake these essential tasks.

12.1 In collaboration with the Federal Ministry of Education, Science and Technology, the Ministry of Health shall review:-

12.1.1 The priorities for health services and biomedical research in Nigeria. Particular attention will be paid to practical, problem solving activities including the assessment of health technologies that are being selected for use in the health services.

12.1.2 The scope and content of activities in the field of biomedical and health services research at academic and other institutions.

12.1.3 Mechanisms for promoting and financing research activities that are judged to be of high priority, and co-ordinating the activities of the various scientists and institutions involved.

12.1.4 Mechanisms for the evaluation and dissemination of research findings and transfering the results into practical health action.

12.1.5 The training of research scientists, technicians and other support staff especially in priority disciplines where there are marked shortages e.g. epidemiology, medical biologists, etc.

12.1.6 The strengthening of Ministries of Health and other institutions to enhance their capabilities to undertake relevant research.

12.2 Biomedical and health services research shall cover the following areas:

12.2.1 Epidemiological research: to identify the major health problems and their determinants in different parts of the country and in different segments of the population;

12.2.2 Operational research: to test the efficacy of health technologies and various methods of applying them in the local situation;

12.2.3 Developmental Research: to develop new and improved tools for the prevention, treatment and control of diseases of local importance. This will include traditional medical practices so that useful ones can be incorporated into the health care system and the practitioners can be persuaded to abandon the use of any agents or procedures (including traditional surgical operations) which are shown to be unacceptably dangerous.

12.2.4 Basic biomedical research: to broaden fundamental knowledge of the biological and other sciences relevant to health.

The highest priority shall be accorded to epidemiological and operational research in support of primary health care programmes.

12.3 The Role of the Ministries of Health

In order to ensure that the priority problems in health shall be identified and addressed, and that the research results shall be adapted and applied, the Ministries of Health shall be closely involved in the planning, execution and evaluation of the research activities.

ANNEX I

MORBIDITY PATTERN

The common causes of morbidity in Nigeria are still preventable infectious diseases. The common cause of attendance at clinics and outpatients department of hospitals are shown in the table below:-

1.	Infective and parasitic diseases	38.2 per cent
1b.	Nutritional and metabolic diseases	1.8 per cent
2.	Respiratory diseases	12.7 per cent
3.	Diseases of nervous system and	9.9 per cent
4.	Ill-defined conditions	9.2 per cent
5.	Skin diseases	8.4 per cent
6.	Digestive System	4.7 per cent
7.	Accidents	3.1 per cent
8.	Muscles and skeletal diseases	2.9 per cent
9.	Genito urinary diseases	2.7 per cent
10.	Blood diseases - anaemia etc.	2. 5 per cent
11.	Others	3.9 per cent

The causes of admissions into hospitals are also shown below: for comparison:

1.	Infective and parasitic diseases	31.3 per cent
1b.	Nutritional and metabolic diseases	2.8 per cent
2.	Pregnancy and child birth	23.1 per cent
3.	Respiratory diseases	9.8 per cent
4.	Genito urinary diseases	5.8 per cent
5.	Accidents	5.3 per cent
6.	Digestive system diseases	5.0 per cent
7.	Diseases of nervous system	3.3 per cent
8.	Blood diseases	3.0 per cent
9.	Ill-defined conditions	5.2 per cent
10.	Skin diseases	2.4 per cent
11.	Others	5.0 per cent

Common types of infective and parasitic diseases in order of occurence are:-

1. Malaria
2. Dysentery and Diarrhoeal Diseases
3. Measles
4. Pneumonia
6. Whooping Cough
7. Schistosomiasis
8. Chicken Pox
9. Tuberculosis
10. Meningitis

THE MORTALITY RATE

The five commonest causes of death in hospitals in Nigeria are very similar to those on morbidity. There are as follows:-

i. Infective and parasitic diseases
ii. Diseases of respiratory system
iii. Accident, poisons and violence
iv. Diseases of circulatory system
v. Diseases of digestive system

ANNEX II

FEDERAL MINISTRY OF HEALTH

The Federal Ministry of Health shall be responsible for health care services and for training institutions or other services of common usage among the States or of national concern or character. Such services include:

i. Specialist Hospitals (Orthopaedic, Eye, Neuro-psychiatric)

ii. Teaching Hospitals
iii. National Laboratories
iv. Communicable and Endemic Diseases Control (Designated as National Programme)
v. International Health and Quarantine
vi. Regulation and Surveillance of standard of training of health personnel
vii. Regulation, Control and Surveillance of health care
viii. External Health Relations
ix. Drugs and Poison Control
x. National Intersectoral Health Care Linkages
xi. Primary Health Care Support (national planning, training, technical assistance, programme support)

State Ministry of Health

The State Ministry of Health shall be responsible for the health care system and training institutions as required for the well being of the people of the State.

To avoid overlapping of responsibilities, the State Government shall provide:

i. Specialist care in words of general hospitals for acute services

ii. General hospitals care services including out-patient care
iii. Training institutions especially for sub-professional level such technologists, technicians, assistant and aide levels
iv. Public health programmes
v. Intersectoral health care, linkages at State level; State public health laboratories
vi. Any health programmes of particular relevance to the State.
vii. Primary health care support (State planning, training, financial programming and operational support).

Local Governments

With the support of the State Ministry of Health, the Local Government shall be responsible for:

i. Community organised health and health related services

ii. The provision and maintenance of infrastructure to provide health services.

iii. The involvement of the local community in support of primary health care.

ASSIST IN PREPARATION OF

HEALTH PORTION OF

FIVE-YEAR DEVELOPMENT PLAN

FOR THE FEDERAL MINISTRY OF HEALTH

NIGERIA

VOLUME II

A Report Prepared By PRITECH Consultants:
DR. STELLA GOINGS
DR. NICHOLAS CUNNINGHAM

During The Period:
JULY 31 - AUGUST 17, 1986

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT
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OGUN STATE

MINISTRY OF HEALTH

DRAFT

STATE HEALTH PLAN

1987 - 1991

PREPARED BY:

OGUN STATE MINISTRY OF HEALTH
ABEOKUTA, NIGERIA,
AUGUST, 1986

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Acronyms and Abbreviations

1. CHO = Chief Health Officer of State Ministry of Health
2. CHW = Community Health Worker
3. CMO = Chief Medical Officer of State Ministry of Health
4. CNO = Chief Nursing Officer of State Ministry of Health
5. CPO = Chief Planning Officer of State Ministry of Health
6. EPI = Expanded Programme on Immunizations
7. LG = Local Government
8. NGO = Non-Governmental Organization
9. SCP = Senior Chief Pharmacist of State Ministry of Health
10. SHB = State Health Board
11. SMOH = State Ministry of Health
12. TBA = Traditional Birth Attendant
13. UTH = University Teaching Hospital
14. WHO = World Health Organization

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The Ogun State Government gratefully acknowledges the participation of external consultants from the Federal Ministry of Health (FMOH), the World Health Organization (WHO), the World Bank (WB), and the United States Agency for International Development (USAID), PRITECH.

I. Introduction

A. Executive Summary

In compliance with the National health Policy adopted by the Federal Government, and Guidelines prepared by the Federal Ministry of Health for the State level planning of the health sector, the officials of the State of Ogun prepared this draft State Health Development Plan covering the 1987 - 1991 period. The planning process relied largely on the participation and contribution not only of those who are directly responsible for health care delivery at state and local government levels, but also of those who are indirectly involved in the improvement of the general health status of the population.

It has mainly been an intersectoral, participatory process which benefited from the views, experience, and criticisms of a wide variety of professionals. An extensive information and data compilation effort provided the common analytical basis for problem identification and will be the foundation for the development and adoption of feasible and affordable solutions in line with the Federal guidelines and the national health policy and strategy.

The new planning process requires the active participation of all states in drawing up the National Health Plan for the next five-year period. State involvement during the preparation of previous plans, however, was limited to the submission of proposals for development projects. In carrying out this task, states were not offered the benefit of a nation-wide health policy and strategy statement providing a consistent reference framework throughout the planning process. The present attempt, reversing this practice is likely to be more conductive to increased efficiency in resources utilization, both at state and national levels. This document expresses the belief by the Ogun State Government that a common understanding of present and prospective resource constraints, and basic national policy priorities, is the strategy most likely to fulfil the nation's aspiration for Health for All by the Year 2000.

B. General Framework of the Planning Process

The State of Ogun is aware and deeply concerned about the prevailing economic and financial difficulties which severely limit the possibility of expanding the scope of its health interventions, programmes and activities. It is obvious that there is a growing need for the rational and efficacious use of the resources currently available to the health sector.

The Ogun State Health Development Plan (1987-1991) starts with a description of the present socio-economic, demographic background. Section II contains an analysis of health problems facing the population followed by section III which gives an extensive review of the existing health care system covering the organization and financing of the services, health resources (manpower, physical, financial, material) presently available, and levels of services output by facility. This review of the current system concludes with an analysis of major constraints reducing the effectiveness of the system. Section IV is devoted to a discussion of the service performance of the health system and Section V to the objectives, targets, and strategy adopted for the plan period. Resource

requirements of specific targets are analyzed in terms of institutional, manpower/training, physical/material, and managerial inputs. Section VI provides an analysis of the implications of the set targets, and attempts at indicating the financial resources which will have to be mobilized in order to match the requirements. Finally, Section VII sets forth some thoughts for plan monitoring and evaluation.

C. Geography/Climate

Ogun State, one of the three States created out of the former Western State in 1976, covers an area of 16,409.26 square kilometers. The State is bounded in the north by Oyo State, in the South by Lagos State and the Atlantic Ocean, in the west by the Republic of Benin and in the east by Ondo State.

Climatically, Ogun State is of tropical pattern with the rainy season starting about March and ending in November, followed by a dry season.

D. Socio-Economic Background

1. Administrative Structure

The highest policy making body in the State is the State Executive Council under the Chairmanship of the Military Governor. The Military Governor is the executive head of the State Government. He is assisted by ten Civil Commissioners. A Civil Commissioner is the political head of a government ministry, while the Permanent Secretary (who is a civil servant) is the administrative head and the accounting officer for the ministry.

The town of Abeokuta is the capital of Ogun State. The State is divided into ten Local Government Areas (listed with the local government headquarters in brackets):

Abeokuta Local Government Area	(Abeokuta)
Egbado South Local Government Area	(Ilaro)
Ijebu - Ode Local Government Area	(Ijebu-Ode)
Ijebu - Remo Local government Area	(Shagamu)
Ifo/Ota Local Government Area	(Ota)
Obafemi/Owode Local Government Area	(Owode)
Egbado North Local Government Area	(Aiyetoro)
Odeda Local Government Area	(Odeda)
Ijebu East Local Government Area	(Ogbere)
Ijebu North Local Government Area	(Ijebu-Igbo)

Each Local Government has a Chairman (who is a public servant) and the Chief Executive of the Local Government Area. He is assisted in the performance of his duties by four part-time members. Health Administration is facilitated by the arranging of the local government areas into five health zones:

Abeokuta HZ (LGAs: Abeokuta, Odeda, Obafemi/Owode)
Ifo/Ota HZ (LGAs: Ifo/Ota)
Ilaro HZ (LGAs: Egbado North, Egbado South)

Ijebu HZ (LGAs: Ijebu-Ode, Ijebu Ease, Ijebu North)
Shagamu HZ (LGAs: Ijebu-Remo)

2. Demographic Characteristics:

The people of any state serve as its most valuable asset and resource. Ogun State has an estimated 1986 population of 2,847,521. (Table 1) About two-thirds of this population live in the four local government areas of Abeokuta, Egbado south, Ijebu Ode, and Ijebu-Remo. It is reckoned that 68% of the population live in the rural area. According to the Ogun State Official Gazette No.21 Vol. II published on 22nd may, 1986, fifteen major towns were classified as urban, and twenty as semi-urban. All the remaining villages and hamlets are classified as rural.

The State is a homogenous one, inhabited predominantly by the Egbas, Egbados, Ijebus, Ijebu-Remos, Aworis, and Eguns, all belonging in the main to the Yoruba ethnic group. Citizens from other parts of Nigeria as well as expatriates also reside in the state in fairly large numbers.

Languages: Yoruba is the language of the predominant majority of the citizens of the State. English (the country's official language) is also widely spoken.

3. Economic Resources:

Agriculture

Agriculture is the principal occupation of the people of Ogun State. The major food crops include rice, maize, cassava, yam, plantain, and bananas, while the main cash crops are cocoa, kolanut, rubber, palm oil, and palm kernel. The State is the largest producer of kolanuts in the country and it also produces some rubber and timber of various species.

Industries

Ogun State is fairly developed industrially, because of its rich and diversified agricultural and mineral resources. The latter include limestone, chalk, phosphate, clay, and stone. Among the industries operating in the State are cement making, food canning, rubber foam and paint manufacturing.

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Table 1A

Date Begun _____ OGUN STATE

1986 POP^N DISTRIBUTION BY REGION AND AGE

AGE	1	2	3	4	5	6	7	8	9	10	11
1	ABEOKUTA	IFO/OTA	ODEDA	OBAFEMI/ OWODE	EGBADO NORTH	EGBADO SOUTH	IJEBU ODE	IJEBU NORTH	IJEBU EAST	IJEBU REMO	
0-4 2	57228	36612	28784	33996	32310	53593	47215	28606	28753	32742	
5-9 3	54060	34586	27190	32114	30522	50637	44602	27022	27161	36598	
10-14 4	[illegible]	26453	20796	24563	23344	38721	34113	20668	20774	27991	
15-19 5	29553	18779	14764	17437	16572	27489	24217	14672	14748	19871	
20-24 6	46120	29506	23197	27398	26039	43191	38051	23054	23172	31222	
25-29 7	46120	29506	23197	27398	26039	43191	38051	23054	23172	31222	
30-34 8	35372	22643	17801	21025	19982	33145	29200	17691	17782	23960	
35-39 9	25172	16104	12661	14953	14212	23573	20768	12582	12647	17041	
40-44 10	22933	14672	11535	13624	12948	21477	18921	11463	11522	15525	
45-49 11	15711	10051	7902	9333	8870	14713	12962	7853	7894	10636	
50-54 12	14677	9403	7392	8731	8298	13764	12126	7347	7384	9950	
55-59 13	7771	4972	3909	4616	4387	7278	6411	3885	3904	5261	
60-64 14	9203	6079	4779	5645	5365	8899	7840	4750	4774	6432	
65+ 15	16936	10835	8518	10061	9562	15860	13972	8466	8509	11465	
TOTAL 16	[illegible]	270201	212425	250894	238450	395521	348450	211113	212196	285917	
17											
18							Grand	Total	284:521	or	
19									2847511		
20											
21	Pop by	Region									
22		Abeokuta R =		885663							
23		Ifo/Ota R =		270201							
24		Egbado R =		633971							
25		Ijebu R =		771759							
26		Sagurid R =		285917							
27											
28											
29											
30											
31											

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Table 1B

OGUN STATE

Date Begun _____

1990 CST POP'N DISTRIBUTION

	1 CAT	2 ACCT	3 DATE	4 Ex/Dep	5 Bill ?	6 FUND	7 CK #	8 Comment	9	10	11
1	ABEOKUTA	IFO/OTA	ODEDA	OBAFEMI/ OWODE	EGBADO N	EDIDADO S	WUBU/OGB ~~EGBADO~~ E	WUBU NGB	WUBU CRST	WUBU REMO	
0-4 2	63417	41851	32402	38861	36933	61262	53971	32700	32867	44286	
5-9 3	61796	39535	31081	36710	34889	57871	50984	30900	31048	41835	
10-14 4	47264	30238	23772	28077	26685	44262	38995	23626	23747	31997	
15-19 5	33553	21466	16876	14932	18944	31422	27683	16772	16858	22713	
20-24 6	52719	33728	26516	31318	29765	49371	43496	26353	26488	35690	
25-29 7	52719	33728	26516	31318	29765	49371	43496	26353	26488	35690	
30-34 8	40457	25883	20348	24034	22842	37887	33379	20223	20327	27389	
35-39 9	28774	18408	14472	17093	16245	26949	23739	14383	14457	19479	
40-44 10	26215	16771	13185	15573	14801	24550	21628	13104	13171	17747	
45-49 11	17959	11490	9033	10669	10140	16819	14817	8977	9023	12158	
50-54 12	16801	10749	8456	9981	9485	15734	13861	8398	8441	11374	
55-59 13	8833	5683	4468	5277	5015	8319	7329	4440	4463	6014	
60-64 14	10862	6949	5463	6453	6133	10173	8962	5430	5458	7354	
65+ 15	19359	12385	9737	11501	10930	18130	15972	9677	9727	13106	
TOTAL 16	482779	308866	242822	286797	272572	452118	398313	241325	242542	326833	
17											
18											
19											
20											
21											
22											
23											
24											
25											
26											
27											
28											
29											
30											
31											

Table 1C

OGDEN STATE POPULATION ESTIMATES
1953 - 1985 - 1990

Date Begun _____

	Age	1963 ♂	1963 ♀	1963 T	1980 ♂	1980 ♀	1980 T	1985 ♂	1985 ♀	1985 T	
	1	2	3	4	5	6	7	8	9	10	11
1	0-4	103265	106899	210164	156201	162576	318777	182841	190308	373152	
2	5-9	99547	98964	198511	150566	150567	301133	176249	176244	352493	
3	10-14	80689	71097	151786	122069	108250	230319	142891	126715	269606	
4	15-19	59683	48174	107857	89928	73578	163506	105267	86128	191395	
5	20-24	75761	93568	169329	115607	141297	256904	135326	165399	300725	
6	25-29	71063	98370	169433	107900	149004	256904	126304	174421	300725	
7	30-34	58820	71118	129938	88717	108431	197148	103849	126927	230776	
8	35-39	45091	47373	92464	68705	71510	140215	80425	83707	164132	
9	40-44	43221	41030	84251	65150	62596	127746	76263	73273	149,536	
10	45-49	30283	27398	57681	45509	42008	87517	53271	49174	102445	
11	50-54	27723	26312	54035	41754	40116	81870	48876	46959	95835	
12	55-59	14676	13790	28466	22510	20778	43288	26349	24323	50672	
13	60-64	18339	16515	34854	28054	24879	52933	32840	29,122	61962	
14	65+	31454	30743	62197	48113	46226	94339	56320	54111	110431	
15	TOTAL	759615	791351	1550966	1150783	1201816	2352600	1347074	1406816	2753889	
16		1986 ♂	1986 ♀	1986 T	1990 ♂	1990 ♀	1990 T				
17	0-4	189061	196778	385839	216115	224936	441051				
18	5-9	182241	182242	364483	208319	208319	416638				
19	10-14	147749	131023	278772	168891	149772	318663				
20	15-19	108847	89056	197903	124422	101799	226221				
21	20-24	139927	171022	310949	159950	195494	355444				
22	25-29	130598	180351	310949	149286	206158	355444				
23	30-34	107380	131242	238622	122746	150022	272768				
24	35-39	83159	86553	169712	95059	98938	193997				
25	40-44	78856	75764	154620	90140	86606	176746				
26	45-49	55082	50846	105928	62964	58121	121085				
27	50-54	50538	48556	99094	57770	55504	113274				
28	55-59	27245	25149	52394	31144	28748	59892				
29	60-64	33957	30112	64069	38816	34421	73237				
30	65+	58235	55951	114186	66568	63957	130525				
31	TOTAL	1392875	1454645	2847521	1592190	1662795	3254986				

Pop formula: $P_t = P_0 (1 + r)^t$

where r = growth percentage
P_t = Pop. at time t
P_0 = Pop. at time 0

P_0 = Pop. at base yr.

1963 - 1980 r = 2.5 **
1985 - 1990 r = 3.2 **
r = 3.4

* Not Pop. Bureau
** Pop. Bureau Estimates

Infrastructure

(a) Roads

The State is serviced by a network of good motorable roads. The Express way from Lagos to Ibadan passes through Ogun State with access at Shagamu. Two major roads linking to the Northern States, two others linking to the Eastern States of Nigeria, make Ogun State easily accessible by road to all parts of the country.

The Idi-Iroko border which falls within the State serves as the gateway for thousands of foreigners coming into Nigeria by land through the Republic of Benin. The Lafenwa Railway Station in Abeokuta has also grown to become an important market center as all train services from Lagos to other parts of the country pass through it.

(b) Water Supply

Water for industry is available in all the urban towns of the State. An elaborate water scheme is being executed to provide water for the remaining towns and villages and to increase the supply in many of those already supplied with pipe borne water.

(c) Electricity

Most of the urban towns are provided with electricity. the rural electrification scheme of the State government will provide other areas with electricity within the next few years.

4. Education:

Besides expanding the base of primary, secondary and tertiary education, the State Government is giving great priority to vocational and technical education. The State Government has established a Polytechnic at Abeokuta which will provide the middle-level manpower needed for the industrial development of the State. There are about eight technical colleges, offering among them twenty-two different courses. There is also the Ogun State University which has been established at Ago-Lwoye.

5. Tourist Attractions:

Tourist attractions in the State include the Olumo rock, Oba's Palace at Ake, the Centenary hall, all in Abeokuta and the Obanta Cenotaph at Ijebu-Ode. The Olumo rock, according to history, served as a refuge for early Egba settlers. It is regarded as a protective shrine, and yearly sacrifices are made to its deity.

The Oba's Palace at Ake, built in 1854 as the official residence of the Alake, the traditional ruler of Egba land, is noted for its heavy concentration of antiquities and relics.

6. Financial Situation: State Revenue and Expenditure

The analysis of the financial situation of Ogun State is carried out below on the basis of the two-tier administrative system e.g. the State Government and the local governments. The following tables 2 and 3 depict respectively the total actual expenditure and revenue of the State Government for the 1981-1985 period. Tables 4 and 5 contain revenue and expenditure data for the 10 local governments of the Ogun State.

(a) State Government Revenue and Expenditure

Total revenue of the State Government, as is the case in all other states in Nigeria, is composed of two main components: internally generated revenue, and the statutory allocation from the Federal Account. The latter has so far been the more important component, thus presently accounting for two-thirds of total available resources. There has been however, a visible relative increase in the share of the internally generated revenue. Indeed, the share of internally generated in total revenue passed from a low of 7.8% in 1981 to 16.1% in 1982 and to 24.3% in 1983 before hitting a record high of 48.4% in 1984. It remained somewhat stable in 1985 at 48%. Against this ascending trend, Federal Government statutory allocations experienced a consistent decline from 1981 through 1984, before a substantial increase occurred in 1985. In view of the considerably high share of the statutory allocations, State Government total revenue was adversely affected from this decline until 1984 when internally generated revenue had already reached a critical proportion of the total. It, thus, became possible not only to compensate for the shortfall, but also to raise the overall financial availability to the state by 19%. The rise in 1985 which reached 46% was accounted for equally by internal and statutory revenues.

It will be noted that taxation has been the predominant source of state-generated income until 1984 when efforts to diversify revenue become effective. Fiscal revenue represented 51% and 59% respectively in 1984 and 1985, and this compares with an average of 80% during the previous years of the period.

Although a significant revenue-generating development does not appear from the State Ministry of health (SMOH) cost recovery practice, the State Health Board (SHB) has experienced a major progress in this area. In 1983, its income increased by nearly 20-fold from a rather insignificant base level, but the rise continued six-fold in 1984 and doubled again in 1985. The share of SMOH and SHB in total internally generated revenue thus reached 2.8% in 1985 as against 0.3% in 1982.

A significant outcome arising from a comparison of total revenue with actual expenditure is the major shift to improved financial management practices which began in 1984. The former part of the period was characterized by constant deficit financing and international borrowing. Actual revenue as percent of actual expenditure fluctuated between 63% and 81%, the deficit reaching as high as 80 million Naira in 1981. A more prudent and cautious financial management practice has been operating since 1984 and is generating an annual budget surplus.

The expenditure pattern of the State Government has two predominant features:

(1) the consistently eroding ratio of capital to total expenditure which dropped to 14% in 1984 from 36% in 1981. In absolute terms, the drop was even more dramatic as the 1984 figure is bearly one-fourth that of 1981. The Department of Lands and Housing seems to be the only case to have improved its position both in absolute and relative terms. As a consequence of the sharp drop in investment funds, and the decrease, however smooth, of recurrent finance, the share of personnel emoluments in total recurrent expenditure climbed sharply from 69.5% in 1981 to 81.6% in 1984. In the health sector, this shift has tended to be detrimental to the functioning of the health care delivery system, as the share of salaries in recurrent expenditure reached as high as 98% in 1984. Procurement of expendable materials and supplies were greatly curtailed leading to a deteriorate services directly related to the emerging imbalance in the expenditure pattern.

(2) The breakdown of actual recurrent expenditure by selected departments is shown in table 2B. It will be noted that expenditure through the SMOH and the SHB was sustained at an increasing level from 1981 through 1983. A decrease of only 7% occurred in 1984 when total recurrent financing fell by 17.5%. In terms of percentage share in total recurrent expenditure, SMOH and SHB combined represented 10.9% in 1981, 12.3% in 1982 and 1983, and reached a high of 14% in 1984. During the same period the share of education declined from 5.8% to 2.6%. Agriculture experienced a decline until 1984 when its share suddenly moved upwards to 5.4% the highest during the period.

(b) Local Governments' Financial Situation

Tables 3 though 5 give the details concerning the finances of each of the 10 Local Governments in Ogun State. Unlike the data on the State Government, information on local governments in presently available only for 1984 and 1985. There has been, in each of the years reviewed, a project-tied contribution from the State Government.

Local Governments like the State government, have recently practiced a cautious and prudent financial management. Indeed, the coverage of expenditure by revenues was 116.1% in 1984 and 105.2% in 1985.

Table 5 shows the distribution of actual expenditure by selected sectors. It will be noted that nearly one-third of total recurrent expenditure has been devoted to health, while the share of education remained constant at 2.8%. Agriculture represented 3.7% in 1984 and 4.5% in 1985.

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Although slightly below the share observed in State Government expenditures for SMOH and SHB, health personnel expenditure in local governments' total recurrent expenditure absorbed nearly 94%, leaving insufficient resources for effective service output.

The distribution of total expenditure, however, indicates no significant characteristic feature, as capital expenditure amounted to 30% in 1984, but jumped to 60% in 1985. Agriculture has been the main sector receiving investment funds followed by health in 1984. Health was preceded by education in 1985.

Table 2A

OGUN STATE GOVERNMENT: ESTIMATED AND ACTUAL REVENUE 1981 - 1985

E: Estimated
A: Actual

(THOUSAND NAIRA)

REVENUE SOURCE	1981		1982		1983		1984		1985	
	E	A	E	A	E	A	E	A	E	A
NALLY GENERATED	37463.8	10891.1	58117.3	18486.0	74090.5	25573.1	98113.7	50797.6	132901.6	74041.8
Finance	15650.0	8861.0	20000.0	15566.9	28046.0	20024.0	35272.3	26010.6	49667 .9	44030.5
Local Government	68.7	89.1	73.6	10.5	5.2	31.5	18027.5	119.7	18003.0	16533.3
Land & Housing	12000.0	472. 9	30500.0	1248 .8	6550.0	2219.0	10640.0	2939.1	8060.0	3913.2
Fisheries/Forest/ Water Resource	3766.0	435.4	2450.0	521.4	3132.5	783.7	1606.0	168.6	2926.0	1337.8
State Health Board	281.1	-	250.0	7.7	261.0	150.5	260.0	915.9	1000.0	1836.5
Health	153.2	78.9	349.0	53.3	278.8	132.5	261.8	350.6	300.0	252.6
Other	5544.8	953.7	4494.7	1077.4	35817.0	2231.9	32046.1	20293.1	52944.7	6137.9
ORY ALLOCATION	140721.5	128327.8	159307.4	114572.1	100339.6	105358.8	109117.7	104941.9	111187.0	154140.9
ALL STATE GOV'T REVENUE	178185.3	139218.9	217424.7	133058.1	174430.1	130931.9	207231.4	155739.5	244088.6	228182.7
of internally ted in total State Revenue (%)		7.8		13.9		19.5		32.6		32.4
of SMOH & SHB in ally generated e (%)		0.7		0.3		1.1		2.5		2.8
Actual Revenue as total actual iture		63.0		81.2		73.9		113.9		143.1

Source: SMOF & EP

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Table 2B

OGUN STATE GOVERNMENT: ACTUAL EXPENDITURE BY CATEGORY AND SELECTED DEPARTMENTS, 1981 - 1985

A: Thousand Naira
B: As percent of total

ENDITURE CATEGORY / DEPARTMENT	1981		1982		1983		1984		1985	
	A	B	A	B	A	B	A	B	A	B
RECURRENT	139827.1	100.0	126928.5	100.0	142408.7	100.0	117564.6	100.0		
Health	3155.9	2.2	3553.5	2.8	3595.2	2.5	2176.8	1.9		
State Health Board	12169.6	8.7	12058.6	9.5	14053.1	9.9	14260.4	12.1		
Agriculture	6936.0	5.0	5682.8	4.5	5187.0	3.6	6335.7	5.4		
Education	8111.1	5.8	5843.5	4.6	3504.3	2.5	3069.7	2.6		
Local Govt.+SD	3872.9	2.8	1607.5	1.3	1551.8	1.0	1300.1	1.1		
Works & Transport	4138.0	3.0	4081.6	3.2	3893.4	2.7	4147.8	3.5		
Land & Housing	6235.9	4.5	8301.1	6.5	3683.6	2.6	3733.1	3.2		
Other	95207.7	68.0	85799.9	67.6	106940.3	75.1	82541.0	70.2		
CAPITAL EXPENDITURE	81306.5	100.0	36963.2	100.0	34817.0	100.0	19155.5	100.0		
Health	1525.3	1.9	520.0	1.4	306.9	0.9	285.9	1.5		
State Health Board	1863.8	2.3	572.5	1.5	368.8	1.0	209.5	1.1		
Agriculture	65.6	0.1	18.8	0.1	84.1	0.2	45.9	0.2		
Education	6684.0	8.2	1897.7	5.1	5977.2	17.2	3882.4	20.3		
Local Govt. + SD	442.7	0.5	100.0	0.2	514.2	1.5	102.5	0.5		
Works & Transport	13509.0	16.6	13499.5	36.5	11541.4	33.1	120.2	0.6		
Land & Housing	524.8	0.6	255.2	0.7	1668.2	4.8	2225.5	11.6		
Other	56691.3	69.7	20099.5	54.4	14356.2	41.2	12283.6	64.1		

(Continued on next page)

Table 2C

OGUN STATE GOVERNMENT: ACTUAL EXPENDITURE BY CATEGORY AND SELECTED DEPARTMENT

(Continued)

EXPENDITURE	1981	1982	1983	1984
	A	A	A	A
III. OVERALL TOTAL	221133.6	163891.7	177225.7	136720.1
Salaries as % total Recurrent	69.5	74.2	69.6	81.6
Share of salaries in the health sector as % recurrent expenditure	73.5	89.8	92.7	98.0

Source: SMOF & EP

Table 3

OGUN STATE: LOCAL GOVERNMENT ESTIMATED AND ACTUAL REVENUE: 1984 - 1985

(Thousand Naira)

E: Estimated
A: Actual

LOCAL GOVERNMENT	1984		1985	
	E	A	E	A
ABEOKUTA	4676.3	3950.2	7149.0	5053.4
IJEBU-ODE	6429.8	3268.1	7020.5	4664.6
EGBADO SOUTH	8405.9	2917.1	6353.0	4421.9
EGBADO NORTH	4480.4	1773.4	2462.0	2696.6
IJEBU NORTH	3297.6	1997.5	2966.8	2614.0
IFO/OTA	4755.2	2701.9	5370.6	3707.3
IJEBU REMO	6374.9	2993.1	5199.4	4199.9
OBAFEMI/OWODE	2509.2	1878.9	4410.2	2661.4
ODEDA	2447.3	1788.8	2520.7	2401.9
IJEBU EAST	1145.5	1573.9	2253.0	2331.0
TOTAL LOCAL GOV'TS	44522.0	24842.9	45705.1	34752.1
Internally Generated Revenue	—			
Statutory Allocation from Federal Government	—			
Project-tied contribution from State Government		200.0		500.0
Actual Revenue as % of total actual expenditure		116.1		105.2

Source: SMOLG & SD

TABLE 4:

OGUN STATE: LOCAL GOVERNMENT ACTUAL EXPENDITURE, 1984; 1985

(Thousand Naira)

LOCAL GOVT.	1984 Approved Estimate	1984 Salary	1984 Other Charges	1984 Total Recurrent	1984 Capital Exp.	1984 Total Exp Recurrent & Capital	1985 Approved Estimate	1985 Salary	1985 Other Charges	1985 Total Recurrent	1985 Capital Exp.	1985 Total Exp Recurrent & Capital
ABEOKUTA	4615.9	1630.7	309.2	1939.9	1393.4	3333.4	7143.4	1424.2	735.7	2159.9	1941.6	4105.4
IJEBU-ODE	6540.2	1335.0	245.6	1580.6	1158.9	2739.5	6940.2	1272.9	74.9	1347.8	2753.3	4101.1
EGBADO SOUTH	8672.2	1966.1	568.7	2534.8	240.8	2775.6	8424.0	1402.4	444.0	1846.4	2205.5	4051.9
" NORTH	2950.7	956.0	79.3	1035.3	432.7	1468.0	2417.9	766.4	32.6	799.0	2032.6	2831.6
IJEBU "	4471.6	860.9	183.6	1044.5	388.7	1433.2	4411.4	881.9	551.3	1433.2	1691.1	3124.3
IFO/OTA	5826.3	1270.5	366.9	1637.4	593.6	2231.0	5359.5	927.4	374.7	1302.1	2516.4	3818.5
IJEBU REMO	7107.2	1658.2	277.1	1935.3	947.6	2882.9	5453.1	1193.3	305.5	1498.8	2880.7	4379.6
OBAFEMI/OWODE	3982.4	1060.7	31.4	1092.1	493.1	1585.2	4408.5	800.5	287.7	1088.2	1362.9	2451.1
ODEDA	6426.0	1063.9	208.9	1272.8	113.6	1386.4	2516.4	784.0	82.4	866.4	1046.5	1912.8
IJEBU EAST	2144.3	675.7	51.7	727.4	830.7	1558.0	2247.6	690.8	37.4	728.2	1522.6	2250.7
TOTAL LG'S	52736.7	12477.7	2322.4	14800.1	6593.1	21393.2	49322.0	10143.8	2926.1	13069.9	19953.2	33023.0

Source: SMOLG & SD

Table 5

OGUN STATE: LOCAL GOVERNMENT ACTUAL EXPENDITURE BY CATEGORY AND SELECTED SECTORS, 1984 - 1985

A: Thousand Naira
B: As percent of total
B*. As percent of recurrent expenditure

TYPE OF EXPENDITURE / SELECTED SECTORS		RECURRENT EXPENDITURE		PERSONNEL EMOLUMENTS		CAPITAL EXPENDITURE		TOTAL EXPENDITURE	
		A	B	A	B*	A	B	A	B
HEALTH	84	4803.6	32.5	4509.3	93.9	659.8	10.0	5463.4	25.5
	85	4079.2	31.2	3848.7	94.3	1413.9	7.1	5493.1	16.6
EDUCATION	84	408.1	2.8	354.8	86.9	565.2	8.6	973.3	4.5
	85	365.1	2.8	241.7	66.2	1612.1	8.1	1977.2	6.0
AGRICULTURE	84	547.3	3.7	372.5	68.1	976.0	14.8	1523.3	7.1
	85	586.7	4.5	333.2	56.8	1682.2	8.4	2268.9	6.9
COMMUNITY DEV.	84	620.1	4.2	571.3	92.1	26.8	0.4	646.9	3.0
	85	590.8	4.5	516.0	87.3	151.9	0.8	742.6	2.2
OTHER	84	8421.0	56.8	6669.8	79.2	4365.3	66.2	12786.2	59.8
	85	7448.1	57.0	5204.2	69.9	15093.1	75.6	22541.4	68.3
TOTAL	84	14800.1	100.0	12477.7	84.3	6593.1	100.0	21393.3	100.0
	85	13069.9	100.0	10143.8	77.6	19953.2	100.0	33023.2	100.0

Source: SMOLG & SD

II. Health Status of the Population

A. State Data at a Glance

Location: Ogun State is located within tropical Nigeria; bounded on West by the Republic of Benin; on the South by Lagos State and the Atlantic Ocean; on the East by Ondo State and by Oyo State on the North.

Area: 16,409.26 Square Kilometer

DEMOGRAPHY (ESTIMATED)

1986 Estimated Population: 2,847,511

% Urban = 23%

Intercensorial Growth Rate = 3.4% P.A.

Children (0-4 Yrs) = 385,839

Women (15-44 yrs) = 733,988

Total Fertility Rate = 6.2

HEALTH STATUS INDICATORS (1986 Estimates)

Crude Birth Rate = 45 per thousand population

Crude Death Rate = 14 per thousand population

Infant Mortality Rate (0-1 years of age) = 120/1000 live births p.a.

Child Death Rate (aged 1-4 years) = Not Available

Life Expectancy at Birth (years) = Not Available

Health Services Indicators

Population per Physician = 15,400

Population per Nurse = 1,800

Main causes of Morbidity and Mortality = Malaria, Diarrhea, Respiratory Infectious, Accidents, other Infectious Diseases

Economic Indicators

Major Industries: Agriculture, Mining and Mineral processing; Pharmaceutical; Cocoa Production; Forestry

B. Health Problems

The pattern of morbidity and mortality in Ogun State appears not to deviate remarkably from overall estimates for the nation. While no precise age or disease specific data are presently available, a number of indicators (hospital case reports, out-patient visit statistics, experience and observation of State Ministry of Health personnel and village surveys done over the past years in the region) suggest that malaria, gastroenteritis/dysentery, pneumonia, measles together with nutritional and skin problems and accidents continue to constitute the major causes of morbidity. Case fatality data from health centers while incomplete indicate that malaria and other infectious diseases, respiratory diseases, and tetanus are the commonest causes of death. These conditions, together with child birth, genitourinary and nutrition related disorders also constitute the major causes of hospital admissions.

PROPORTIONAL INFECTIOUS DISEASE PATTERN
OF CASES SEEN AT COMPREHENSIVE CARE CENTERS
OGUN STATE * (1981-1985)

	1981 %	1982 %	1983 %	1984 %	1985 %
MALARIA	74.3	75.3	75.6	76.1	78.3
DYSENTARY/GASTROENTERITIS	5.8	5.9	7.9	7.9	6.0
MEASLES	8.8	8.7	6.6	6.3	6.3
PNEUMONIA (INCL. WHOOPING COUGH)	9.6	8.6	8.0	7.7	7.4
CHICKEN POX	0.5	0.4	0.9	0.9	1.5
SCHISTOSMIASIS	0.5	0.5	0.7	0.8	0.2
STD (GONORRHEA)	0.1	0.1	0.1	0.2	0.1
HEPATITIS	0.1	0.3	0.1	0.1	0.1
TETANUS	0.2	0.2	0.1	0.1	0.1

* Estimated Level of Reporting = 10%

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C. Current Indicator Levels

There is presently no accurate information available concerning infant or maternal mortality rates in Ogun State nor are fertility or birth rates yet being systematically measured. Nevertheless, it may be assumed that substantial overall reductions in mortality have occurred in association with improved maternal and child health services, the introduction of oral rehydration therapy (ORT), the expanded program for immunizations (EPI), and widespread Health Education Programs in the State.

In the absence of specific data, it may be assumed that:

- The infant mortality rate approximates the 1985 Federal Ministry of Health, nation wide estimate of 120/1000 live births,
- 25% (or more) of children die before their fifth birthday,
- Deaths in the under six year olds represent 1/2 of total deaths,
- The vast majority of these deaths are preventable i.e. by immunizations, better hygiene, improved nutrition and by early primary care intervention as for example with ORT.
- Maternal mortality (estimated at 15/1000 live births) is likewise largely preventable by better delivery of pre-natal and midwifery service.

Thus, the principal preventable mortality in the State involves child bearing women and young children and is susceptible to reduction by existing primary care methods.

III. Existing health Services Delivery System:

A. Organization and Administration of Services:

Health care services are provided by the State Ministry of Health (SMOH), the State Health Board (SHB), the Local governments (LG), private health Practitioners, Voluntary Organization (NGOs) and by Herbalists, spiritual Healers and Traditional Practitioners, including Traditional Birth Attendants (TBAs).

1. State Ministry of Health (SMOH)

An organizational chart of the Ministry of health is attached (Appendix B). The Commissioner is the political head of the Ministry while the Permanent Secretary is the Administrative head and the accounting officer. The Permanent Secretary is advised by Heads of Divisions and in turn advises the Commissioner. Policy issues are discussed by the Heads of Divisions and the permanent Secretary as chairman, before being referred to the Commissioner who in turn, as the need arises takes such policy issues to the State Executive Council through memoranda for consideration before finally becoming State Policy. the functions of the Ministry of health include the following:

(i) General formulation and control of health policies;
(ii) Legislation relating to health matters;
(iii) Supervision of medical and health training and research institutions in the State including:
- the Central Health Unit for training and research;
- the School of Health Technology;
- all Nursing and Midwifery schools.
(iv) The direct control of the statistical and epidemiological unit;
(v) External aid for health services in the State;
(vi) Pharmaceutical inspection and licensing control;
(vii) Registration and inspection of private hospitals and maternity homes;
(viii) Monitoring the activities of the State Health Board and the Health Zones;
(ix) Representation at the federal Level on all health matters and bodies including the Nigeria Medical Council, the Nursing and Midwifery Council of Nigeria, the Pharmaceutical Board of Nigeria, the Royal Society of Health, the West African Examinations Board and the National Council on Health;
(x) Liaison with the Federal Ministry of Health and International agencies and organizations on health matters;
(xi) Procurement of drugs for and administration of the drug revolving fund scheme.

2. State Health Board (SHB)

The State Health Board has recently been restructured within the Ministry of Health. Originally established in 1978 as a defacto autonomous division with a broad based of executive and administrative responsibilities, the State Health Board managed and controlled all medical facilities and their staffs. Governmental restructuring efforts in 1980 and

1985 have emphasized the need for clarity in the administrative chain of command with respect to health issues; and the need to consolidate a system which had become fragmented and duplicative. The current structure is expected to improve the overall functioning and cooperation by departments responsible for the administration of health activities.

The Commissioner for Health is the Chairman of the State Health Board (SHB). The Chief Medical Officer (CMO), the Chief pharmacist (SCP), the Chief Nursing Officer (CNO), and the Permanent Secretary (PS) Ministry of Health serve as members. The Executive Secretary to the State Health Board serves as a member Secretary to the Board of Directors.

The organizational chart of the State Health Board (Appendix B) does not reflect the presence of a Medical Services Division as clearly as that of the preventive Services Division. The fact, however, that there is no designated functionary for those divisions in the State Health Board does not mean that such services or such divisions do not exist. Theoretically, the Chief Medical Officer and the Chief health Officer, even though they are officers of the Ministry of Health, exercise both advisory and supervisory roles over the activities of the Medical and the Preventive Health Services of the State Health Board. Similarly the Preventive Health Services officer of the Ministry of Health is administratively able to coordinate preventive health services that go on under the umbrella of the State Health Board such as Health Education, Malaria Control, TB Control, Leprosy Control, EPI/ORT etc.

The main functions of the Board after its restructuring by the Office of the Military Governor 6/7/84 are:

1. To manage and control all health institutions taking charge of activities and preventive services of the State Government;
2. To execute the general health policies formulated by the Ministry of Health and approved by the Government;
3. To provide and standardize all hospital equipment in the State;
4. To appoint, post and discipline health personnel from grade 07;
5. To promote health personnel from Grade level 07 subject to the approval of the Military Governor;
6. To appoint, confirm, promote and discipline administrative employees Grade level 01 - 06;
7. To consider and collect the Annual estimates of the Zonal Health Boards;
8. to advise on revenue generation within and in keeping with Government Police on Health Services;
9. to initiate and control building programs of hospitals and health institutions in accordance with Government Policy and to maintain buildings and equipment use in health institutions.
10. to purchase equipment and food to be used in health institutions.

3. Zonal Health Boards:

The State Health Board functions through five Zonal Health Boards: Abeokuta, Ijebu-Ode, Ilaro, Shagamu, and Ota. Each Zonal Health Board is

comprised of the following members: Host Senior Medical Officer (Chairman), Host Senior Nursing Officer, Host senior Pharmacist, and an Administrative Assistant appointed by the State Health Board.

4. Local Governments:

Health services are provided by the ten Local Governments in the State, which have health departments within their organizational structure (Appendix B). The activities of the various Local Governments are monitored and supervised by the State Ministry of Local government and Community Development. There is no direct and clear cut supervisory mechanism linking the Ministry of Health and the MOLGCD. Local Governments are responsible for environmental sanitation in their areas of jurisdiction and also operate skeleton maternal and Child Health Services. Efforts are being directed towards increasing the capacity and capability of Local governments to run the Primary Health Care Programs.

5. University Teaching Hospital (UTH) Shagamu:

The Ogun State University Teaching Hospital has been established on the site of a former State Hospital in Shagamu. the University Teaching Hospital has established formal linkages with the State University System but is administrativaly the responsibility of the State Ministry of Health.

The University Teaching Hospital currently operate as a 96 bed facility supporting a full range of tertiary care departments. The institution is engaged in a phase of projected rapid expansion and anticipates the opening of another 62 bed ward later this year. Ogun State UTH is required to expand its facilities in order to retain its accreditation and plans to accommodate 265 beds by the end of 1986, 500 beds by 1988, and 1000 beds by 1990. Seventy three Medical Students are registered in the various clinical training programs and these are supported by the small core of full-time faculty supplemented by the part-time involvement of faculty from Nigeria's other medical schools and participation by members of the State Ministry of Health in the teaching program. As a part of this expansion, the University Teaching Hospital plans to "upgrade and use existing state health centers" to augment its own facilities and "provide a base for community health orientation in clinical training".

6. Government Health Facilities

The categorization of Health facilities in Ogun State is based on the referral system flow pattern. the first levels of contact are the health clinics followed by the Primary Health Centers and the Comprehensive Health Centers. these together form the Primary level of Health Care. Cases from the primary health care levels are referred to the district general hospitals, and State hospitals in that order. the trio i.e. Community, District, and State Hospital together form the secondary level of health care. Difficult cases from the State Hospitals are referred to the teaching hospitals which form the teaching level of health care.

The characteristics of the planning of health institution are as indicated:

A. Health Clinics:

These are makeup of dispensaries and maternity centers.

- Dispensaries: These are health facilities that are manned by dispensary assistants. There ar no inpatient beds. Minor ailments are seen and simple treatments such as wound dressings are undertaken here.
- Maternities: These are health facilities where maternity cases are handled. Midwives and ward maids are in attendance. Numbers of beds are limited to about seven. both dispensaries and maternities are controlled by the Local Governments. A doctor is not resident here but visits on appointment days only.

(1) Primary Health Centers:

General practice doctors are usually resident here. Numbers of beds are limited to fourteen. There are more activities than at the dispensaries and maternities. Minor operations such as hernia repair can be performed. Each center is equipped to serve a population of between 10-20,000. The Primary Health Center forms the base for Community Health workers - polyvalent workers who are trained for the delivery of Primary Health Care.

(2) Comprehensive Health Centers:

Are similar to Primary Health Centers except that:
(a) bed number is increased to 30
(b) the services of a Public Health/Community Health Physician are available
(c) serve a larger population
(d) are rural based.

B. Referral health System (Secondary Health Care):

(1) District Hospitals are located at Ijebu Ife, Odagbolu/Aiyepe Ipokea, and Isaga. They have the following characteristics:

(i) serve a population of up to 50,000
(ii) beds are between 40 and 60
(iii) serves peri-urban centers
(iv) generalists doctors man these hospitals but they may be more than one in number
(v) more complicated cases are referred here from the comprehensive health centers.

(2) General Hospitals:

(i) serves a population of up to 100,000
(ii) beds are in the range of 50 - 100

(iii) serves semi-urban centers
(iv) facilities are usually large than community/district hospitals
(v) experienced generalists doctors are in attendance
(vi) Better equipment is available in these kind of facilities.

(3) State Hospitals

(i) serves a population of up to 250,000
(ii) beds are in the range of 100 - 200 but may be more
(iii) services of specialist doctors, nurses and other health workers are available
(iv) equipment is sophisticated
(v) serves as training centers for pre-registration house officers (newly trained doctors) and for nurse and midwives.

C. Tertiary Level Health Care: Teaching Hospitals

(i) More specialized services are provided
(ii) Specialist doctors are in attendance
(iii) Training centers for doctors nurses, midwives and other high skilled health personnel.

Ogun State is fortunate in having build up a fairly extensive network of health facilities distributed through the ten Local Government Areas. Each Local Government Area has from 28 to 87 health clinics totally 3,736 beds. There are 1.3 Health Centers in each Local Government Area, totally 450 beds. In addition, there are 4 Comprehensive Health Centers with 224 beds, 65 hospitals with over 3,500 beds, and 39 non-governmental maternities with 301 beds. There are also 19 private out-patient clinics. Distribution of these facilities and the range of services offered are shown in tables 7 & 8.

7. Private Health Facilities:

These consist of Mission health facilities, private hospitals, and clinics as well as Maternity Homes. This group of health care providers are inspected and registered by the Ministry of Health and their activities are closely monitored by the Inspectorate Unit of the Ministry of Health for strict compliance with established standards of practice, equipment, and manpower. From the 10 care point of view of particular interest are the only two mission hospitals operating in the State. Sacred Heart Hospital is Abeokuta is a 300 bed, general hospital which carries out fee for service Maternal and Child Primary Care Programs (including 25,240 immunization services, 5,400 deliveries and 36,000 child welfare visits annually). Sacred Heart obtains much of its drugs and immunization via "Chanpharm" and operates 2 mobile unit Satellite 10 care programs at Ayetoro and at Ajebo on a weekly basis.

The hospital has recently opened a 250 bed auxiliary "chest hospital" which is designed to offer tuberculosis treatment and control services to the people of Ogun State. This facility is equipped with modern diagnostic

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equipment a complete laboratory and is attended by a full-time specialist in chest diseases. St. Joseph's Hospital, Ijebu-Igbo, is a 120 bed, general hospital that also carries out significant 10 care programs (Table 7).

8. Traditional Health - Care Providers:

This group of practitioners consists of Herbalists, Traditional Birth Attendants, Spiritual Healers of the various Religious Denominations, and other alternate sources of health care. An attempt has been made to identify and register herbalist and traditional Birth Attendants and there is a Committee made up of members of this group o health practitioners and officials of the Ministry of Health in the State, the purpose of which is to identify, standardize, and coordinate this type of care into the Western Medical Care System.

TABLE 6:

GOVERNMENT HEALTH FACILITIES

Local Government Area	Health Institutions	[illegible]
Abeokuta	- Primary Health Centre, Iberekodo. - Family Health Centre, Oke Ilewo. - School Health Service clinics. - ORT Clinic - Family Planning Training School* - Health Posts - Health Clinics	EPI/ORT - coverage above 82.1% MCH/FP Communicable Disease Control of Diarrhoea, Malaria, Tuberculosis, Leprosy, Guineaworm, Schistosomiasis. School Health Services. Health Education. Environmental Sanitation Limited curative services.
Ijebu-Ode	- School of Health Technology. - Primary Health Centre, Ala Idowa. - Family Health Centre. - MCH Clinic, Italapo. - School Health Clinics. - Health Clinics. - Health Posts. - Family Planning Clinics.	As above
Ijebu Remo	- Comprehensive Health Centre, Ishara. - Primary Health Centre, Ode Lemo and Ode Remo. - Family Health Centre, Sagamu. - School Health Clinics. - Family Planning Clinics. - Health Clinics - ORT Clinics	As Above
Egbado South	- Primary Health Centre, Idi-Iroko. - Family Health Centre, Ilaro. - Family Planning Clinics. - School Health Service Clinics - Health Posts	Local Government Area for the State Model Primary Health Care Programmes. EPI/ORT coverage above 82.1% MCH/FP Communicable Disease

Local Government Area	Health Institutions	Activities
Egbado South (cont.)		Control e.g. Diarrhoea, Malaria, Tuberculosis, Leprosy, Guineasworm, Schistosomiasis. School Health Services. Health Education. Environmental Sanitation. Limited Curative Services
Ijebu North	- Comprehensive Health Centre, Ijebu-Igbo - Primary Health Centre Ago Iwoye. - Health Posts. - Health Clinics. - Family Planning Clinics. - School Health Service Clinics.	EPI/ORT - coverage above 82.1% MCH/FP Communicable Diseases. Control of Diarrhoea, Malaria, Tuberculosis, Leprosy, guineaworm, Schistosomiasis. School Health Services. Health Education. Environmental Sanitation. Limited Curative Services.
Ijebu East	- Comprehensive Health Centre, Iwopin. - Primary Health Centre, Ogbere. - Health Clinics. - Health Posts. - Family Planning Clinics. - School Health Service Clinics.	As above
Owode/Obafemi	- Primary Health Centre, Owode. - Health Clinics. - Health Posts. - Family Planning Clincs. - School Health Service Clinics	
Odeda	- Primary Health Centre, Odeda. - Health Clinics. - Health Posts. - Family Planning Clinics - School Health Service Clinics	As Above

Local Government Area	Health Institutions	Activities
Egbado North	- Comprehensive Health Centre, Imeko. - Primary Health Centre, Aiyetoro. - Health Clinics. - Health Posts. - Family Planning Clinics. - School Health Service. Clinics.	
Ifo/Ota	- Primary Health Centre, Ifo. - Health Clinics. - Health Posts. - Family Planning Clinics. - School Health Service Clincs.	Model Practice Area for the Institute of Child Health, Lagos University Teaching Hospital's Primary Health Care Programme. EPI/ORT - coverage above 82.1% MCH/FP Communicable Disease control e.g. Diarrhoea, malaria, Tuberculosis. Leprosy, guineaworm, Schistosomiasis. School Health Services. Health Education. Environmental Sanitation. Limited curative services.

Table 7

OGUN STATE, NIGERIA (1986)

DISTRIBUTION OF EXISTING HEALTH FACILITIES BY SOURCE OF FUNDING

HEALTH ZONE	LOCAL GOV'T AREA	GOVERNMENT (FED, STATE, LGA)				PRIVATE SECTOR				NON-GOVERNMENT ORG.	
		PHC		REFERRAL		MATERNITY		REFERRAL		REFERRAL	
		NO	Beds *	No	Beds *	No	Beds *	No	Beds *	No	Beds *
ABEOKUTA	ABEOKUTA	40	320	6	417	10	106	27	1498	1	[illegible]
	ODEDA	35	289	-		-	-	-	-	-	-
	OBAFEMI/OWODE	31	240	-		1	25	-	-	-	-
IFO/OTA	IFO/OTA	36	288	1	100	5	57	13	298	-	-
ILARO	EGBADO SOUTH	86	696	1	238	5	58	-	-	-	-
	EGBADO NORTH	40	394	1	41	3	24	-	-	-	-
IJEBU	IJEBU-ODE	69	536	3	80	2	75	-	-	-	-
	IJEBU-EAST	56	424	2	80	1	74	-	-	-	-
	IJEBU-NORTH	28	264	0	-	6	41	9	360	-	-
SAGAMU	IJEBU-REMO	42	427	4	196	9	72	3	360	-	-
TOTALS		463	3878	18	1072	42	532	52	2516	1	[illegible]

* Estimated beds in 1986

TABLE 8

EXISTING HEALTH FACILITIES IN OGUN STATE, NIGERIA (1986)

HEALTH ZONES	LOCAL GOVERNMENT AREA (LGAS)	PRIMARY HEALTH CARE								REFERRAL HEALTH CARE					
		Health Posts	Health Clinics		Health Centers		Comprehe-nsive Health CTRS			Clinics		Hospitals		Tertiary Care Facilities	
			NO	Beds	No	Beds	No	Beds		No	Beds	No	Beds	No	Beds
ABEOKUTA	ABEOKUTA	1	47	376	2	50	-	-		1	-	31	2155	2	60
	ODEDA	1	33	264	1	25	-	-		-	-	-	-	-	-
	OBAFEMI/OWODE	1	30	240	1	25	-	-		-	-	-	-	-	-
IFO/OTA	IFO/OTA	-	40	320	1	25	-	-		-	-	14	398	-	-
ILARO	EGBADO SOUTH	1	88	704	2	50	-	-		-	-	1	238	-	-
	EGBADO NORTH	1	39	312	2	50	1	56		-	-	1	41	-	-
IJEBU	IJEBU-ODE	1	67	536	3	75	-	-		1	-	2	80*	-	-
	IJEBU-EAST	5	49	392	2	50	1	56		-	-	2	80*	-	-
	IJEBU-NORTH	4	28	224	1	25	1	56		-	-	9	360*	-	-
SAGAMU	IJEBU-REMO	1	46	368	3	75	1	56		1	-	5	460	1	96
TOTAL		16	467	3736	18	450	4	224	-	3	.	65	3812	3	156

* Estimated beds in 1986

TABLE 9

REGISTERED PRIVATE HEALTH INSTITUTIONS IN OGUN STATE BY TYPE AND LOCAL GOVERNMENT

LOCAL GOV'T	HOSPITALS (With Inpatient) Facilities					MATERNITY HOMES (Usually operated by Midwives)				OUT-PATIENT CLINICS			
	DOCTORS	GENERAL NURSES	MIDWIVES	BEDS	NO OF INSTITUTIONS	GENERAL NURSES	MIDWIVES	BEDS	NO OF INSTITUTIONS	DOCTORS	GENERAL NURSES	MIDWIVES	NO OF INSTITUTIONS
ABEOKUTA	30	81	58	552	14	5	33	96	12	8	13	4	8
OBAFEMI/ OWODE	N	I	L			-	4	6	1	N	I	L	
IJEBU-ODE	16	29	10	144	9	-	5	23	4	3	4	7	3
REMO	13	36	18	266	9	-	19	62	7	4	6	4	4
IFO/OTA	13	36	7	120	9	1	6	28	3	2	5	-	2
EGBADO SOUTH	1	7	-	30	1	1	12	42	5		N I	L	
EGBADO NORTH	N	I	L			-	4	16	2		N	I L	
IJEBU NORTH	9	26	10	239	3	-	10	28	5	2	2	1	2
IJEBU EAST	N	I	L			N	I	L			N	I L	
ODEDA	N	I	L			N	I	L			N	I L	
TOTAL	82	261	103	1351	45	7	93	301	39	19	31	18	19

* Includes initial negotiation and annual fees paid to the State Ministry of Health

B. Drug Revolving Account

1. At the inception of the Military Administration in Ogun State in January, 1984, there was much concern about the provision of adequate Health Care Delivery as there was acute shortage of Drugs in the hospital units compounded by the worsening economic situation. The Government seeing the critical condition of the Health situation voted an amount of #4 million, for an equivalent amount in Import License and imported a good quantity of commonly used drugs, surgical dressings, laboratory chemicals and reagents from the overseas manufacturers and set up a panel of seven (7) to review the Health Policy for the State.

ADVISORY PANEL - TERMS OF REFERENCE

2. The Panel which was headed by Professor Ogunlesi, a one time Professor of Medicine at the University of ibadan had as its terms of reference, the following guidelines:

(i) to review the Ogun State Health Care Policy in general and the free treatment policy in particular, in the present circumstances of the State economy, and to advise Government on such steps as may be necessary to restore and maintain an effective health care delivery system in the State.

(ii) a. to advise Government on the formulation and implementation of a realistic drug policy for Ogun State which will ensure a steady and progressive low of ESSENTIAL drugs, dressings, and other basic equipment within the Health Care Delivery System of the State.

b. to take into account, the formulation of such policy, the recent government investment of #4 million on drugs etc and to advise on ways and means of developing such an investment into a drug revolving fund.

(iii) a. to examine the feasibility of a State Health Insurance Scheme as one of the methods of (couldn't read) delivery system in Ogun State having regard for: the needs and demands of both the public and the private sectors of the population o the state and the present state of the economy of the state and to make appropriate recommendations.

(iv) to make any other recommendations as may be relevant and necessary with a view to ensuring that government objectives of health for all are realized as quickly as possible.

RECOMMENDATIONS

3. The panel in the light of investigation carried out and representations made to it submitted the following recommendations which were approved in principle and adopted by the Government.

Health Care Policy:

(i) Greater attention than hitherto should be given to Primary Health Care Services, especially in the area of Community Involvement and inter-Sectoral coordination.

(ii) Free treatment should be redefined to include all Primary Health Care Facilities and all Preventive Health Care facilities but should EXCLUDE drugs, must therefore be paid for.

(iii) Demonstrable improvement in health Management process should be mandatory on the State Health Board.

DRUG POLICY:

(iv) The State list of Essential Drugs should be prepared for:
(a) hospitals
(b) Primary Health Care Units.
It is necessary to mention here that since the setting up of the panel the National Council on Health had met, approved and adopted a list of Essential drugs for both the Primary and Secondary Health care Services. These lists have been adopted for use throughout the Federation.

(v) A State Drug formulary should be developed (An international one has been adopted for the Country by the National Council on Health at its meeting in Akure, Ondo State in July, 1985). A state Drug Manufacturing Company, with the Manufacturing unit at Shagamu at present should start production very soon.

(vi) The present #4 million investment should form the nucleus for:
(a) a bulk purchasing, self accounting Drug supply system.
(b) a drug revolving fund - initial capital of #10 million should be started.

(vii) Ogun State Citizens who are given drugs should pay for them for the time being.

(viii) Ultimately, a contributory Health Insurance Scheme for all Ogun State Citizens should be operated through an Insurance Company or a part of a National Insurance Scheme.

(ix) State Health Insurance Company, In the light of the Federal Government intention to evolve a National Insurance Policy, it has been recommended that the State Government should make "haste slowly" and while trying to study the possibilities of inviting a State Insurance Health Company, should wait and see what the Federal government would do before taking a final plunge.

ADOPTION OF RECOMMENDATIONS:

4. The Government while noting all the recommendations and findings, accepted the following in principle:

(i) Drugs should be paid for in all the State Health Care Units.

(ii) Every effort should be made to ensure that the recent #4 million investment in drugs is a loan recoverable in due course based on (i) above.

(iii) The drug Revolving Fund scheme is accepted as a way out of the present drug scarcity problem.

(iv) Efforts would be made to make the State Health Care Delivery of more preventive nature and touching more areas, in other words; there should be a shift of emphasis from Curative to Preventive Health Care Delivery.

(v) While efforts are made to do more preliminary work at evolving a State Health Insurance scheme whatever concrete step is finally taken would be based on the outcome of the June meeting on the National Council on Health which the panel had earlier mentioned.

(vi) The Commissioner for Health should study the report in greater detail and make further recommendations which should be in the interest of the overall State Health Delivery arrangement, for urgent implementation within the context of the present economic withdrawal.

(vii) Further to the effort of the Commissioner for Health, A Drug Management Committee was set up in the Ministry of Health. The Committee which would be responsible to the Commissioner for Health was changed with the responsibility for the effective Management and Distribution of Drugs in all the State's and Local Government's Health Institutions as well as Health Centers located in some of the state's Institution of Higher learning.

(viii) The Ministry of Health was also appointed as the Government agency that would purchase Drugs, Surgical dressings in bulk while the State Health Board would take them on charge, store centrally and sell them to the hospital patients and other State Government agencies. In addition to this, the proceeds form the Sale of Drugs would be transferred to the Ministry of Health which would keep and operate the Drug Revolving Account in any bank agreed to by the Government.

DRUG DISTRIBUTION:

5. The Central Medical Stores at Abeokuta is the depot where all the drugs, Surgical dressings, equipment, etc. are kept. It is also the depot from where the medicaments are despatched to all the hospitals and Health Centers in the State. The medicaments are kept at the Centers presently mainly for security reasons. this was due to the fact that at the time the drugs started arriving from the overseas countries in early 1985, most of the existing medical stores were not considered safe enough for the items and with the acute shortage of drugs in the State as at that time, any store located at any remote area could be a target for armed robbers. The present storage depot is not a warehouse built

for drugs storage, but office accommodation apartments for the temporary storage of the items pending the time that the State will be financially sound enough to construct a large warehouse at the center and the same time renovate the present zonal stores and fit in necessary Security Systems.

The Central Medical Stores presently supplies drugs, Surgical dressings, and hospital equipment to all the hospital units under the Government, the Teaching hospital at Shagamu, Local Government Councils, all other Government agencies requiring the use of drugs. The (couldn't read) grouped under five (5) zones as follows:

1. ABEOKUTA HEALTH ZONE

(i) State Hospital, Sokenu, Abeokuta
(ii) State Hospital, Idiaba, Abeokuta
(iii) Oba Ademola Maternity Hospital, Abeokuta
(iv) Primary Health Center, Iberekodo, Abeokuta
(v) Primary Health Center, Odeda
(vi) Primary health Center, Owode
(vii) Family Health Center, Oke-lewo, Abeokuta
(viii) Dental Center Abeokuta
(ix) Community Mental Health Center
(x) School Health Services Unit

2. IJEBU HEALTH ZONE

(i) State Hospital, Ijebu-Ode
(ii) General Hospital Ibiade
(iii) Primary health Center Ijebu-Igbo
(iv) Primary Health Center Ala Idowa
(v) Primary health Center Ogbere
(vi) Family Health Center
(vii) Comprehensive Health Center Iwopin
(viii) District Hospital Ijebu-Ife
(ix) Health Center Ago-Iwoye
(x) Community Mental Health Clinic - Ijebude
(xi) School Health Services Unit

3. SHAGAMU HEALTH ZONE

(i) State Hospital Iperu
(ii) District Hospital Aiyepe/Odogbolu
(iii) Comprehensive Health Center Ishara
(iv) Family Health Center
(v) Primary health Center Ode-Remo
(vi) Community Hospital Ikenne
(vii) Community Health Center Ode-Remo
(viii) Dental Center Sagamu
(ix) School Health Services Unit

4. OTTA HEALTH ZONE

(i) General Hospital Otta
(ii) Family Health Center
(iii) Primary health Center Ifo
(iv) Primary Health Center Idi-roko
(v) District Hospital Ipokia
(vi) School Health Services Unit

5. ILARO HEALTH ZONE

(i) State Hospital Ilaro
(ii) Family Health Center
(iii) Comprehensive Health Center Imeko
(iv) (couln't read)
(v) Family Health Center Ilaro
(vi) Dental Clinic Ilaro
(vii) School Health Services Unit

ISSUE PROCEDURE

6. Supplies are made to all the Health Institutions through the Stores Issues Vouchers (S.I.V.) which are completed in quadruplicates. The S.I.V.s indicate the quantity of each item of drugs issued, the price per unit, and the total value of the drugs issued out. One copy of the S.I.V.s should be forwarded immediately to the Higher Executive Officer (H.E.C.) (Accounts) in charge of this Drug Revolving Fund at the headquarters who is required to open a ledger Account for each health Institution in the State. The ledger account thus opened by the H.E.O. (Accounts) would be debited with the quantity and total value of the drugs issued to the respective Health Institutions while the Stock Account also maintained by the H.E.O (Accounts) at the headquarters would be correspondingly credited. Original and one copy of the S.I.V. wold accompany the drugs issued out to the Health Institutions. The Pharmacist and the Store keeper of each health Institution are required to sign two copies of the S.I.V.s as having received the items released, retain a copy of the S.I.V and return the Original to the Store Section at the Headquarters. As a means of dual control, the Pharmacy Division in each Health Institution should monitor the movement of drugs by recording issues so as to facilitate accounting procedure for an accurate balancing of stock of drugs at any point in time.

OBSERVATION

7. It has been observed that at times, the value of medicaments received by an institution may not be the same as the amount generated at the Institution even after the sale of the items might have been completed. This is because not all the items are money yielding. Some of the items received are not sold to the public, but go into the maintenance of the Service e.g. antiseptics used in the sanitation of the Hospital premises or in serving the patient e.g. the syringes and needles used in administering treatment as prescribed. There are also the losses of revenue through the treatment of patients exempted from payment of fees e.g. patients suffering from tuberculosis, leprosy, mental illness, also, prisoners and paupers.

BANK LODGEMENTS

8. Each Zonal Office is required to open a separate current account with the nominated bank at the Zonal Headquarters. the account is operated quite distinctly from all other accounts. Each health Institution pays all proceeds accruable from drugs into the Zonal Bank Account maintained by the Drug Revolving Fund. In stations where baking facilities exist, a designated officer (revenue collector) pays the drug proceeds into the bank daily. In the rural areas where their facilities do not exist, payments are made into the zonal office at weekly intervals but such designated officers are warned not to allow the proceeds to accumulate to such a huge sum that can attract the attention of robbers who will not mind killing i order to be able to steal the amount.

BANKING AT HEADQUARTERS

9. As mentioned earlier, the State Health Board sells the drugs through the hospital units and at the end of each month transfers all proceeds to the Ministry of Health which banks and controls the amount at the State headquarters. The signatories to the amount are:

(i) The Permanent Secretary, Ministry of Health
(ii) The Chief Pharmacist in the Ministry of Health who is Chairman of the Drug Management Committee and
(iii) The State Accountant General who represents the State's Ministry of Finance.

The Drug Revolving Account is kept in the bank acceptable to the State Government.

REPLENISHMENT OF STOCK IN THE HOSPITAL UNITS

10. As and when fresh supplies are required, each health Institution is required to accompany its requisition paper with a copy each of all bank tellers in respect of monies lodged into the zonal bank account. Each bank teller must be duly stamped by the bank into which money is paid and must be accompanied by details of the amount thus paid into the zonal account. Each requisition must be duly signed by either the Pharmacist in charge of the Pharmacy or the Medical Officer in charge of the Institution. Each Health Institution has free hand determining its minimum stock level and reorder level. For accounting purposes, each requisition paper must be supported with copies of proforma prepared by the Accounts division of the Ministry of Health. The proforma would show at a glance

(i) The Opening stock
(ii) Proceeds derived from the Sales of drugs and the value of the closing stocks of items of drugs on hand at the time of requisition for fresh supply.

Copies of the above documents are submitted to the HEO (Accounts) who would scrutinize the account that the amount on the cheque tallies with the total amount on the bank tellers submitted. Under no circumstances would checks issued by the Zonal office be returned as dishonored, officers who issue such checks

would apart from facing disciplinary measures be surcharged.

ACCOUNTING RECORDS REQUIRED AT THE ZONAL LEVEL HEALTH INSTITUTIONS AND HEADQUARTERS

11. The revenue Collecting Officer in each Health Institution is required to maintain a Revenue Collector's Cash Book which would show

(i) Particulars of receipts issued out to patients on daily basis.
(ii) The amount collected on each receipt showing the amount for drugs only and for the others (e.g. Lab fees, bed fees, etc.)
(iii) Total daily proceeds and lodgements. This cash book is expected to be balanced up daily. The revenue collector of each institution is also in addition, expected to maintain a Receipt Book Register showing details of Receipt Books collected from the HEO (Accounts) at the Headquarters and also details of the disposal of such receipt books.

ACCOUNTING RECORDS AT THE ZONAL LEVEL

12. The HEO (Accounts) Higher Executive Officer in charge of accounts attached to each Zonal Office is also required to maintain Control Cash book based on the revenue returns received from the Health Institutions within each Zone such that at any point in time, the HEO (Accounts) should be able to show at a glance, the position of the revolving fund maintained by him/her zone on behalf of the Drug Management Committee.

The HEO (Accounts) of each zonal office is expected to effect necessary reconciliation of the zonal Cash Book with the Bank Statements received in respect of the account maintained for the Drug Revolving Fund. Such reconciliation exercise should be carried out monthly and in any case, at least, quarterly with copies of the bank reconciliation statements submitted by hand to the Heads of the Accounting divisions in both the Ministry of Health and the State Health Board. (see Pro-forma Drug Revolving Fund Form 2 attached)

ACCOUNTING RECORDS AT THE HEADQUARTERS

(i) The HEO (accounts) in charge of the Drug Revolving Account will be required to maintain a receipt Book register showing particulars of the stock of Receipt Books (Treasury Book GA) collected from the Accountant-General's office or printed mainly for the Drug Revolving Account from the State's Printing Corporation. The register must show at a glance particulars of receipts issued to each Health Institution and the balance of stock on hand.

(ii) The HEO (accounts) should maintain a ledger account as prescribed above for each Health Institution (couldn't read). The ledger account must be balanced up monthly or at prescribed intervals and reconciled with the Control Cash book.

(iii) At overall Control Cash Book should be maintained by the HEO (Accounts) in charge of the Revolving Funds. This should indicate at

a glance, the value of drugs and other medical material being issued out to each health Institution on monthly basis vis-a-vis proceeds paid by each Health Institution into its zonal Bank Account maintained b=for the Drug Revolving Fund. The Control Cash Book should be balanced up monthly.

(iv) The HEO (Accounts) in charge of the Drug Revolving Fund at the Headquarters should also prepare monthly Bank Reconciliation Statement and submit same through its Chief Accountant to the Permanent Secretary, Ministry of Health, and the Drug Management Committee. The Accountant General receives details of bank lodgements made by the Ministry of Health and details of proceeds received from the hospital units at the end of each month from the Head of Accounts Division in the Ministry.

DRUG REVOLVING ACCOUNT

14. The State Health Board was the Government agent that was responsible for maintaining the account initially. It was in January, 1986 that the amount was transferred to the Ministry of Health which is not the agency operating the account.

(i) Amount transferred by the State Health Board to the Ministry of Health as at (couldn't read). December 1985 (couln't read) #615, 456.84

(ii) Balance of the amount in Bank as (?) Bank as at 30/6/86 (?) $1,833,289.32

(iii) Total amount withdrawn (?) form the Bank including (?) Bank charges (?) $1,182,281.37

COMMENT

15. Since an amount of about $4 million was spent in importing the drugs into the country late in 1984 (?) arriving into the country by the Middle of 1985, one would have expected that between middle of 1985 and June 1986 (one year), and amount of $4 million would have been realized from the Drug Sales. The amount realized during this period is actually, about $3 million ($3,015,570.69) judging from Balance as at 30/6/86 and the amount withdrawn so far (ii) & (iii) above. Actually the proceeds have been made available from the five Health Zonal Offices at the average of $200,000 per month.

The proceeds are in respect of drugs, laboratory fees, bed fees, x - ray fees, Dental fees, and Operation fees, these other areas apart from drugs are maintained from the Drug Revolving Account e.g. x - ray films, Dressings materials, laboratory reagents and Chemicals, and dental material. Below is a glance record of the proceeds generated in relation to the value of drugs and other materials supplied to the hospital units between january 1986 and June 1986.

There is no doubt that is the specimen formats for the Drug Revolving fund Nos. 1 and 2 are completed by the respective Health Units and Zonal Offices respectively strictly within the deadline specified, there should be no difficulty in c=rendering monthly returns. The returns on Format No. 1 relates to the movement of stock of drugs while format No. 2 provides at a glance, the Monthly Statement of Income and expenditure in respect of each Health Zone.

SUPPLY OF DRUGS TO TEACHING HOSPITALS AND THE LOCAL GOVERNMENT COUNCILS

16. As at present, drugs and other related items are sold to the Teaching Hospital at Sagamu and other Local Government Councils at the rate at which they are sold to the patients at the government hospitals. Arguments have been put forward for a reduction to be made to these Institutions on the cost prices so that they too may be able to pay for their overheads. The argument is a reasonable one.

As at present, the Government sells the drugs to patients after 50% increase might have been added to the cost prices. Serious consideration is being given to the allowance of 10% - 15% discount on the selling prices to these Institutions so that they too may be able to operate a drug revolving account which will not be at a loss.

WORKING RELATIONSHIP BETWEEN THE PHARMACIST IN THE MINISTRY OF HEALTH AND THE STATE HEALTH BOARD

17. It is the duty of the Health Management Board to control and manage all the health Institutions taking charge of curative and preventive services of the State Government. The Pharmacists in the State Health Board are therefore based in the Health Institutions where these services are being rendered. They give out the drugs to the patients in these two sectors and, in addition, execute General health Policies related to their discipline provided such policies have Government approval. Those in the Ministry of health are concerned with pharmaceutical Inspection and Licensing Control. In other words, they monitor the activities of the Pharmacies in the State Health board in order to ensure that they comply with the General health Policies of the Government and keep within the acceptable limits of Standard Pharmaceutical practice.

As there is presently shortage of pharmacists in the Government service and most of the hospital pharmacies in the (?) technologists, the list of those actually operating the drug Revolving account shall comprise of Pharmacists, Pharmaceutical technologists, Pharmacy technicians and Stores Officers. (See attached list containing the list of these officers still in the government Service and the total amount of emolument of these Officers).

PRIVATE PHARMACEUTICAL PREMISES

18. The private Pharmaceutical shops operating in the State operate their premises as private concerns and the financial aspect of their businesses are not in any way controlled by Government and they receive no subvention from the Government. The only areas where Government controls their practice are in the Laws Governing the practice of their trade. They must observe the Pharmacy Laws with regard to dispensing of prescriptions, sale of poisons, dangerous drugs, and

psychotropic substances, and they must renew their licenses annually. They have no patients/relationship ratio provided they may attend as many patients that call on them provided that the services rendered are within the law. The law allows them to sell on-the-counter drugs to all categories of patients and give professional advice where sought. all poisons sold must be recorded in accordance with the prescription of a Licensed and registered medical practitioner, registered and licensed dentist and registered and licensed veterinary surgeon.

Some of them carry out Manufacturing and wholesale activities only while the smaller ones carry out only dispensing and retail activities. (See the list of Private Pharmacies attached)

ALL ATTACHMENTS

(i) Drug Revolving Fund Form No. 1
(ii) Drug Revolving Fund Form No. 2
(iii) List of Private Pharmaceutical Premises
(iv) Inventory of Drugs at the Central Medical Stores
(v) List of Pharmacists, Pharmacy technicians and store officers operating the Drug Revolving (?)

C. Existing Health Resources and Facilities

1. Personnel Staffing level and distribution

The total number of Government workers in the health sector has been declining since the imposition of economic austerity measures including a hiring freeze in 1984. The general availability of health manpower has also been negatively effected by the fact that many Government trained personnel eventually join the private sector. In the professional categories this attrition rate is particularly high and may be accelerating. For example, in the first six months of 1986 287 of 1488 Government staff nurse and staff midwives have left their position.

Currently available data limits the ability to quantify the current attrition rates to professional staff, however, there is the widely held impression that attrition rates for non-professional staff have been significantly lower. These trends contribute to a disproportionate amount of current salary expenses going to service, maintenance and support personnel who are not engaged in the actual provision of health care.

Unfortunately this trend is likely to continue and will contribute to a short-fall in the public sector for some time to come. In addition, the demand for health services in government hospitals has resulted in a concentration of highly skilled workers in urban areas. As a result, progress in deploying high skilled workers to the areas of greatest need where they can support primary health care programs has been exceedingly slow.

The distribution of doctors, dentists and nurses shows a concentration in urban areas where only 23% of Ogun State's people live. It is likely that the distribution for pharmacists, laboratory technician and other key health providers follows the same pattern.

An analysis of current staffing strengths confirms that in key categories (ie. Doctors and Nurses) the State employs only a small fraction of the personnel who have been approved on the basis of anticipated need. (Table 11)

To counteract these problems of manpower distribution and short falls, the Ogun State Government has, in recent years, placed increasing priority on expanding and upgrading the availability of trained health workers.

TABLE II

GOVERNMENT AND NON-GOVERNMENT MANPOWER LEVELS AND DISTRIBUTION FOR SELECTED CATEGORIES

Professional Category	Headquarters	Abeokuta (Pop = 885,663)		Ijebu (Pop = 771,759)		Ilaro (Pop = 633,971)		Shagamu (Pop = 285,917		Ifo/Ota (Pop = 270,201		Ogun State (Pop = 2,847,511)	
		No.	Thousand Pop. per Staff	No.	Thousand Pop. per Staff	No.	Thousand Pop. per Staff	No.	Thousand Pop. per Staff	No.	Thousand Pop. per Staff	No.	Thousand Pop. per Staff
GOVERNMENT													
Doctors	3	34	26.0	21	36.8	11	57.6	9	31.8	9	30.0	87	32.7
Dentists	-	3	295.2	-	-	3	211.3	2	142.9	-	-	8	355.9
Nurses (including Midwives)	49	406	2.2	320	2.4	143	4.4	150	1.9	182	1.5	1250	2.3
NON-GOVERNMENTAL													
Doctors	-	38	23.3	30	25.7	1	664.0	17	16.8	15	18.0	98	29.1
Nurses	-	209	4.2	55	14.0	24	27.7	83	3.4	55	4.9	377	7.6
TOTAL GOVT & NON-GOVERNMENTAL													
Doctors	-	72	12.3	51	15.1	12.	52.8	26	11.0	24	11.3	185	15.4
Nurses	-	615	1.4	375	2.1	167	3.8	233	1.2	237	1.1	1627	1.8

2. Training Institutions

(a) School of Health Technology, Ilese

Established in 1976, the School of Technology was the first to provide basic training in Hygiene and Public Health in Ogun State. The School was originally located at Itamogiri but since 1982 has occupied an expanded site at Ilese. In the decade since its inception, the school has offered a wide range of educational, research and health planning activities. The educational programs are designed to provide training which is relevant to the current and future health problems of Nigeria.

(1) It is operated as a training unit by the State Ministry of Health. The school has graduated almost 1,200 trainees in a wide range of professional categories, including:
Public Health Superintendents
Public Health Nurse
Pharmacy Technicians
Medical Laboratory Assistants
Community Health Assistants
Community Health Aides, and
Rural Health Assistants.

(2) The curriculum emphasizes the practical skills needed to assess the health status of communities and to support diseases prevention and health promotion activities (Appendix E)
After serving a period of bond to the State Government, graduates fill a wide variety of job positions in the State and Local Government, private industry and individual private practices.

The same factors impacting on manpower throughout the health sector are affecting the operations of the school. Staff shortages have recently become critical and threaten continued availability of this training resource. Several major program areas are without regular staff (i.e. Pharmacy, Laboratory Technician) and the administrative section has been without a functional director for many months. In part, this erosion of staff support may be attributed to a general decline in the school's physical plant, water and electric supplies which have been curtailed, and transportation, laboratory equipment and supplies are in poor condition or non-existent.

Rehabilitation of the State resource is considered by the State Ministry of Health to be imperative.

(b) Schools of Nursing, Ijebu-Ode and Abeokuta:

(In preparation)

(c) In-Service Training Programs

(In preparation)

3. Physical Facilities by Level and Type

It is generally acknowledged that health care facilities in Ogun State are among the most modern in Nigeria. These have been described according to type and distribution in a previous section. The 463 government sponsored primary care facilities are augmented to some extent by 42 registered private maternity clinics and the outreach services of a single voluntary facility. However, the provision of comprehensive primary health care services to urban and rural populations is to an over whelming extent being provided under Government sponsorship. It is these Primary Health Care services which have been, and will continue, to form the backbone of the health delivery system.

Currently, the system is providing one health clinic for every 6000 population (this includes maternity clinics), and one health center for every 130,000 population.

Efforts will be necessary to address the substantive rehabilitation requirements and tour some proper maintenance of these facilities and equipment. A quantification of these rehabilitation and maintenance needs will be undertaken as a continuing part of the Ogun planning process.

Local Government area hospitals will continue to function as referral points for health clinics and health centers, while playing a role in the coordination of community based health services and serving as teaching hospitals and administrative foci for rural health activities.

Currently there are 71 referral facilities in Ogun State of which the majority (70%) are operated by non-government services. Collectively these provide one referral facility for every 40,000 population.

During the plan, period emphasis will be given to strengthening and improving the hospitals out-patient services while ensuring the provision of standardized quality care on the wards.

4. Financial Resources

An attempt has been made to provide a rather comprehensive picture of resource availability to the health sector. Data that could be collected and compiled at different expenditure sources were consolidated for the year 1984 and 1985, as shown in table 2c.

The coverage of the table is extended to encompass the financial resources devoted to safe water supply along side the sources that are traditionally engaged in health services delivery, such as the SMOH, SHB and the local governments. The argument justifying this approach is rooted in the definition of primary health care, one element of which concerns the supply of safe water to communities. It is, therefore, the function of

supplying safe water in sufficient quantity that is relevant, rather than the affiliation of the performing agency to any one of the government department specifically charged with health matters.

This attempt at constructing a reasonably complete picture of financial resources flowing into the health sector is at present limited to the official health sector. It does not cover household expenditure on health, nor the establishments currently engaged in private medical practice. This is due to a variety of reasons one of which is the relatively high cost of generating such information presently unavailable, while its bearing on the health sector planning at this time does not seem sufficient to justify the cost. It is, however, envisaged to develop within the improved managerial process for health development, over the plan period, adequate information systems which will readily enable a more comprehensive look in the future.

It appears from table 3 that over the 1984-1985 period, total official resources available to health increased by 14.8%, due mainly to a nearly three-fold increase in the capital expenditure devoted to safe water supply, while local government's health infrastructure development was also substantially stepped up. Recurrent expenditures fell by an insignificant amount with personnel emoluments absorbing, on the average, nearly 88% of total recurrent resources. The imbalance in favor of emoluments in the structure of recurrent health expenditure by the SMOH, SHB and local governments, which is presently in the order of 94% - 95% is dissimulated in the overall average, due to the relatively low share experienced by the State Water Corporation. The share of salaries in total recurrent expenditure by the State Water Corporation indeed dropped from 60% in 1984 to 55% in 1985.

Total official health resources related to population indicate that per capita official health expenditure reached 11.80 Naira in 1984 and increased to 13 Naira in 1985. In terms of recurrent expenditure, this would be in the order of 10 Naira which is a rather significant amount by all standards and in particular, in view of the low utilization rates currently experienced in the sector.

The distribution of official financial resources between recurrent and capital expenditure shows the current concentration on the former. Excluding the State Water Corporation, it appears that the SMOH, SHB and local governments taken together, devoted 95% and 93% of the available resources to recurrent expenditures in 1984 and 1985, respectively.

The bulk of financial resources originated from the SHB, followed by the State Water Corporation, Local Governments, and then by the State Ministry of Health.

5. Material, Equipment, Drugs and Supplies

A non-trivial proportion of the Ministry of health vehicles and equipment are inoperable because of difficulties securing adequate maintenance and repairs.

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Quantitative information on the general availability of medical supplies and equipment throughout the system is currently under development, but was not available for inclusion in this document. Data available from two of the Local government Areas (Ifo/Ota and Abeokuta) support the contention that medical supplies and drugs are being adequately distributed for present levels of utilization throughout the Primary Health Care system and that 20% buffer supplies are being maintained in inventories. This situation is directly attributable to the recent establishment of the Ogun State Drug Revolving Fund. Through this system an adequate and secure supply of drugs and medical/surgical equipment is maintained at the Central Medical Stores in Abeokuta. This depot, then, supplies the needs of health Centers and clinics as well as the State hospitals monthly.

Ogun State has placed emphasis on the timely and reliable distribution of Drugs and supplies through the Primary Health Care system. While still in its infancy, the impact of this recent innovation has been overwhelmingly positive and may be expected to contribute to a revitalized sense of confidence in the Primary Health Care system by the people of Ogun.

As previously discussed, the need for some strengthening of the accounting aspects of this approach has been recognized and will be addressed during the plan period.

Currently, an estimated 50% of the State Primary Health Care facilities are operating without a reliable source of electricity and potable water. The provision of these essential utilities is seen as a requirement for the delivery of high quality services and accordingly is to be incorporated into the long term objectives for the State.

IV. Service Performance

A. Coverage and Utilization

Ogun State has been diligent and aggressive in it's pursuit of improved population coverage with EPI, ORT and Family Planning services. These efforts have resulted in substantive gains statewide. Data available from six of the Local Governments is presented in Table 12. The 554,843 reported vaccine doses reported translate into an estimated statewide delivery of nearly 1 million doses. Coverage rates are as high as 100% in some areas, but selected pockets of low and inadequate coverage are readily apparent. Efforts targeting improved vaccine coverage are readily apparent. Efforts targeting improved vaccine coverage of these populations will be a priority during the current plan period.

Underutilization of public health facilities is acknowledged and recognized as an area where corrective action is indicated. Historically,k interruptions in the provision of drugs and supplies to these facilities, chronic shortages of trained personnel and limitations in the range of services provided have undermined public confidence in the ability of the public sector to provide for their needs. It is anticipated that some period of demonstrably sustained improvement must occur before restored confidence in public facilities will began positively to influence utilization rates.

BREAK-DOWN OF EPI IMMUNISATION COVERAGE TO-DATE (AS AT MAY 1986)

BY LOCAL GOVERNMENT AREAS (# and % Coverage of estimated target population)

LOCAL GOVERNMENT AREAS	EPI COMMENCEMENT DATES	BCG		DPT 1		DPT 2		DPT 3		POLIO 1		POLIO 2	
		0-1 YR	0-2 YRS	0-1 YR	0-2 YRS	0-1 YR	0-2 YRS	0-1 YR	0-2 YRS	0-1 YR	0-2 YRS	0-1 YR	0-2 YRS
ABEOKUTA	23/1/85	21,544	24,313	18,081	20,635	14,926	17,297	12,521	15,057	19,803	23,383	15,199	18,038
		113.4	83.8	95.2	71.2	78.6	59.6	65.9	51.9	104.2	80.6	80	62.2
IJEBU-ODE	1/8/85	6,850	9,025	5,467	7,807	4,685	6,268	3,681	5,253	16,960	10,410	4,151	6,402
		48.9	41.0	39.1	35.5	33.5	28.5	26.3	23.9	49.7	47.3	29.7	29.1
OBAFEMI/OWODE	13/1/85	1,175	1,547	1,074	1,526	836	1,253	542	923	1,118	1,718	834	1,319
		13.1	11.1	11.9	10.9	9.3	9,00	6.0	6.6	12.4	12.3	9.3	9.4
ODEDA	20/1/86	838	1,074	806	1,091	607	859	384	575	809	1,161	599	881
		10.5	9.0	10.1	9.1	7.6	7.2	4.8	14.8	10.1	9.7	7.5	7.3
IJEBU REMO	1/3/86	3,028	3,637	1,946	2,413	1,146	1,514	669	875	2,337	3,158	1,439	1,868
		25.2	20.2	16.2	13.4	9.6	8.4	5.6	4.9	19.5	17.5	~~1,439~~ 12.0	~~1,868~~ 10.4
EGBADO SOUTH	1/5/86	2,130	2,746	1,861	2,613	156	232	54	99	1,855	2,659	146 ~~12.0~~	192 ~~10.4~~
		14.2	11.9	12.4	11.4	1.0.	1.0	0.4	0.4	12.4	11.6	1 0 ~~146~~	0 8 ~~192~~
IJEBU-EAST	13/5/86												
IJEBU-NORTH	28/5/86	REPORTS OF FIRST MONTH OF ACTIVITIES STILL AWAITED											
IFO/OTA	12/6/86	LAUNCHED ON 12TH OF JUNE 1986											
EGBADO NORTH	3/7/86	TO BE LAUNCHED ON 3RD OF JULY, 1986											
GRAND TOTAL:-		35,565	42,342	29,235	36,085	22,356	27,423	17,851	22,782	22,882	42,489	22,368	28,700

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POLIO 3		MEASLES				TETANUS TOXOID FOR PREGNANCIES	
0-1 YR	0-2 YRS	0-1 YR	0-2 YRS	NEW CASES	COMPLETED CASES	1	2
11,939	14,658	8,639	12,630	30,828	10,338	21,160	17,471
62.8	50.5	45.5	43.6	106.3	35.6	92	76
3,429	5,363	2,725	5,955	12,635	3,541	3,932	2,440
24.5	24.4	19.5	27.1	57.4	16.1	21.8	13.6
533	904	413	986	2,420	558	589	362
5.9	6.5	4.6	7.0	17.3	4.0	4.9	3.0
387	566	308	655	1,667	318	291	148
4.8	4.7	3.9	5.5	13.9	2.7	2.9	1.5
377	501	522	1,157	4,927	203	1,248	477
3.1	2.8	4.4	6.4	27.4	1.1	8.3	3.2
55	80	435	1,083	3,826	54	995	37
0.4	0.3	2.9	4.7	16.6	0.2	5.2	0.3
16,720	22,072	13,042	22,466	56,303	15,012	28,215	20,935

Tables 13 and 14 examine respectively the utilization of publicly funded Maternal Child Health services and Referral level hospitals. While some problem with under reporting may have occurred, the reporting of only 4277 deliveries by all of the 600 plus public health facilities during the first 6 months of 1986, a time when over 100,000 pregnancies should have occurred, suggests that to a significant degree, available resources are being underutilized.

As a State policy, family planning has been fully integrated into the maternal and child health services. Initially, 90 family planning practitioners were trained at the University of Ibadan . In 1984, a family planning training center was established at the Primary Health Center, Iberekodo in Abeokuta Local Government Area. As of June 1986, a total of 258 family planning practitioners were trained including 38 Nurse tutors. There are 43 reporting clinics and on average of 974 monthly new acceptors.

B. Progress toward Primary Health Care objectives, and obstacles to continued performance.

The primary objectives of the Ogun State health care services are the prevention of premature death, the protection of the population from the hazards of avoidable and communicable diseases and the promotion of an increased awareness of health among the population through basic health education and the provision of curative care when needed.

The main thrust of health services delivery policy has been the establishment of a country-wide primary health care delivery system based on an assessment of community needs and at minimal cost to the government.

Historically, it has been difficult and has been achieved at the cost. During the Third and Fourth Five-year Development Plan period, Ogun State experienced a relatively rapid development of health facilities and manpower. Although both plans gave strong support to the development of basic health services, particularly in favor of peripheral rural communities, actual implementation data indicate the persistance of a bias in the distribution of resource favoring both urban communities and curative care. It is estimated that the share of preventive and promotive services total expenditures was and has remained in the order of 20%.

The onset of increasingly stringent economic and financial conditions prevailing in the country, and the ensuing reduction (in real terms) in budgetary allocations, inevitably led to the severe shortage of finance for the procurement and maintenance of necessary equipment and supplies. The rigidity commonly attached to payroll left no room for resource reallocation on this count. consequently, over the recent past, personnel emoluments consistently represented around 95% of the recurrent health expenditure. This situation adversely affected the operation of the system, as the absence of certain categories of staff resulted in the gradual erosion of service quality, and subsequently led to the under-utilization of existing facilities, particularly at the primary care level.

Table 13

Family Planning Coverage 1983-1985

Family Planning Method	1983 March -Dec	1984 Jan-Dec	1985(Jan-Dec)			1986 (Jan-June)		
			New Accep-tors	Cont Users	Total	New Acce-tors	Cont. Users	Total
Pills	72	1526	1740	1958	3698	1147	1869	3016
I.U.C.D.	132	1602	3543	4288	7831	2284	3892	6176
Injectables	6	183	314	354	668	56	157	213
Condoms	-	-	3674	1942	5616	2232	2218	4450
Foamy Tablets	-	-	256	156	412	291	219	510
Others	127	6788	1049	241	1290	306	66	372
Total	337	7099		19515				14,728

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VITAL STATISTICS - MATERNAL AND CHILD WELFARE SERVICES - BY LOCAL GOVERNMENT

TABLE 15

LOCAL GOVERNMENT AREAS	ANTE-NATAL CASES			DELIVERIES			BIRTHS						GRAND TOTAL	TOTAL ATTENDANCES INFANT TREATMENT		
	NEW	OLD	TOTAL	SINGLE	MULTIPLE	TOTAL	LIVE BIRTH MALE	LIVE BIRTH FEMALE	STILL BIRTH MALE	STILL BIRTH FEMALE	TOTAL MALE	TOTAL FEMALE		MALE	FEMALE	TOTAL
AKEOKUTA	1478	4577	6055	1067	19	1086	648	401	7	7	695	408	1103	1294	1290	2584
IPO/OTTA	742	2252	2994	431	5	436	230	193	11	2	241	195	436	1746	1828	3574
ODEDA	329	883	1212	190	1	191	101	102	1	1	102	103	205	4055	4108	8163
OBAFEMI/OWODE	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A
EGBADO NORTH	1705	8917	10622	1045	37	1082	559	530	6	11	565	541	1106	7126	7228	14354
EGBADO SOUTH	1384	6222	7606	658	29	687	418	463	6	5	424	468	892	5759	7002	12761
IJEBU-ODE	682	851	1533	155	-	155	64	90	1	-	65	90	155	1378	1798	3176
IJEBU-NORTH	204	761	965	136	-	136	61	73	1	1	62	74	136	2564	2582	5146
IJEBU-EAST	245	516	761	103	-	103	36	67	-	-	36	67	103	818	887	1705
IJEBU REMO	510	1826	2336	391	10	401	209	192	6	4	215	196	411	4630	31483	0390
TOTAL	7279	26805	34084	4176	101	4277	2366	2111	39	31	2405	2142	4547	29370	31483	60853

It is in the face of these major obstacles that the Ogun State Government has worked in concert with and participated in the Federal Government initiatives toward Primary Health Care. Implementation so far has been substantial and it is now clear that the range of Primary Health Care programs are to an ever increasing extent, available state-wide.

The infrastructural support for these program is well advanced although it is far from complete. Funds for the rehabilitation and maintenance of existing resources, when available, have been used. This has allowed Ogun to assume a leadership role in the numbers and distribution of primary health care facilities throughout the nation.

Ogun has also aggressively pursued the establishment of training facilities for health care professionals at every level. These facilities have been productive of trained workers, the majority of whom continue to serve the health needs of the population through Government or Private sector service. Despite these programs, any assessment of staffing requirements suggests that in selected categories (i.e. dentists, laboratory technicians) there are still significant manpower shortfalls.

Recent performance evaluations have emphasized Maternal and Child Health (MCH) and the Expanded Program for Immunization (EPI). In Ogun these programs currently provide service in all of the levels of primary health care facilities, including health posts, in very rural areas. These efforts have been greatly augmented by Ogun State's creative and demonstrably successfully approach to the problems of drug acquisition and distribution through the State's Revolving Drug Fund. The EPI program now covers a considerable proportion of its target populations and there is every reason to believe the trend towards every increasing immunization levels will continue.

Despite an impressive track record in Ogun State and the development of a realistic formulation for health planning both during the current five year plan period and into the future, it should be recognized that constraints to accomplishing PHC objectives are not entirely historical. Major problems have been recognized and until resolved will continue to represent a threat to the integrity of programs essential to the well being of the State's people.

These problems may be conceptualized in several areas. First, a major concern is the rapid increase in population growth which results from the combined effects of increased birth rate and a decreased crude death rate. The population in Ogun is expected to double in less than 30 years with a current projected growth rate of 3.2%. This population growth will have a significant impact on the rate of increase in demand for health services and will increasingly limit the resources available to provide health services for the people of Ogun.

Secondly, there are numerous administrative issues resulting as a by-product of Nigeria's stepwise progression towards a stable and service oriented Government. Numerous partial reorganizations while clearly designed to improve the structure of the health delivery system have unfortunately allowed for some fragmentation and duplication of administrative authority.

Thus, the consolidation of primary health care administration and the establishment of clear cut lines of authority at every level is currently recognized as a need and is being addressed. It is recognized that evolving a consistent nomenclature with clearly defined job descriptions and responsibilities will greatly augment these efforts. For example, the term Health Center implies a pre-established bed size and the provision of certain services. Facilities not possessing these attributes should not be referred to as Health Centers, but by a more appropriate term. These same principles apply to job descriptions and titles which, if uniformly, applied state-wide will facilitate management and administrative decision, making for uniformity in "terms of service", and coordination of the central planning processes.

A third area of significant concern has been highlighted as a direct result of the planning process. It has become clear that effective planning, implementation and evaluation have been hampered by an insufficient, or poorly organized flow of information to the Ministry and others with a "need to know". With the increasing complexities inherent in the administration of a growing health delivery system, the need for the establishment of an efficient system of Health Information has never been more acute. This System should emphasize the collection of pertinent data on the health of the population, the delivery of services, manpower and the condition of facilities. These data should then be subject to prompt consolidation and analysis with a timely flow of analyzed and interpreted information to those participating in planning or administering health care.

Manpower represents another area of potential limitation, and it should be emphasized that the multifactorial character of this issue will complicate the search for reasonable solutions. In selected categories, the Government has long had difficulty recruiting and/or retaining workers. Competition from the private sector, eroded conditions in the work place, unattractive remuneration and benefits policies, combined with a generalized deficiency in numbers of adequately skilled individuals have created a real problem of manpower shortages that may be expected to play a role in primary health care delivery potential for some time to come. Additionally, those workers who remain, confronted with less than optimal working conditions, interruption in the flow of drugs and supplies, and the subtle message from the community that there is reduced confidence in the services they are providing, may understandably be experiencing a lessening of morale and a concomitant reduction in individual productivity.

Finance and resource constraints must also be acknowledged. The objectives, policy, and strategy contained in the National Health Policy document duly reflect the major concerns of the Ogun State officials. The present State health Plan, based on the Primary Health Care strategy, will thus provide the essential instrument for restructuring and consolidating the health system with a view to delivering primary care mainly to the population at the periphery, and to those who still remain unserved and underserved.

Thus, the main thrust of the present plan will be to consolidate the health system, and to enhance its effectiveness by increasing the average utilization rates of the official facilities from their critically low present levels. This will be achieved primarily by restoring the credibility of the system through improved service quality, adequate manpower/equipment and materials balance, and

by assigning the highest priority to primary health care services.

Ensuring the endowment of the primary health care framework with appropriate skills equipment and supplies will be the major thrust of the development project during this fifth five-year plan. This activity will be complimented, where possible, with rehabilitation of primary health care facilities.

In so far as the financial requirements of the plan exceed the projected resource availability to the health sector, the State will consider mobilizing additional resources through World Bank loans. It is envisaged, in this context, that the debt servicing and repayment capacity of the State will significantly improve when the credibility of the health system will be restored, and subsequently when the system will be in a position to generate resources through various cost recovery and/or health insurance schemes. Evidence with respect to the preliminary evaluation of the recently initiated Drug Revolving Fund clearly indicates the preparedness of communities to pay for services and supplies provided that the charge remains reasonable and affordable, and above all, there exists a perception of tangible benefit in return of payment. This innovative experience of Ogun State indeed contains invaluable lessons for, and sheds substantial light on the design of future action aiming at fostering community participation in Nigeria.

V. Objectives, Targets and Strategy

A. Primary health Care Based Strategy and General Objectives (intersectoral, integrated approach)

The main thrust of the Ogun State Health Development Plan, which, as required, derives from the National Health Policy, would be on the concept of Primary Health Care in establishing a comprehensive and well integrated three-tier health care delivery system which would aim at a level of health care that would make it possible for all the citizens of the State to achieve socially and economically productive levels. The health care system will address the main problems in the community, providing promotive, preventive, curative, and rehabilitative services.

The broad objective of the State Health Development Plan therefore, will be to extend essential primary health care to the total population, with extensive community, intersectoral, financial and activity involvement.

The overall implementation strategy of the State Health Plan during the plan period will thus concentrate on the improvement of the utilization of existing facilities and staff, curtailing the further expansion of government resources(especially in those areas already identified as having an over-concentration of health care facilities), and expanding the role and participation of individuals and families in self-care, communities, non-government organizations, other relevant government sectors, and the private sector.

The provision of essential primary health care services will utilize all available human resources (community health workers, other health personnel as appropriate, traditional birth attendants, voluntary village health workers that can be paid in cash or kind by, or with the help of the communities themselves. A combination of methods, techniques and equipment that are socially and culturally acceptable, inexpensive and of high technical relevance will be used in the provision of primary health care.

Communication systems that will minimize the unnecessary dissipation of human effort and the general rundown of the limited transportation facilities will command active consideration.

All appropriate steps will be taken to ensure an adequate supply of essential drugs at affordable prices to the consumer throughout the State by sustaining the efficient and effective operation of the recently established drug revolving fund. (It will be desirable to align the operation of the drug revolving fund to the management of drug procurement and distribution).

The State Health Plan, in consonance with the overall national objectives for the Fifth National Development Plan, will ensure that all development efforts during the plan period are aimed at limiting additional provision of resources. Rather, steps will be taken to increase efficiency in the utilization of existing resources - making appropriate use of highly skilled staff at the secondary and tertiary levels, primarily for referral services and improving the standard of case management and quality control ensuring effective supervision and support,

and also providing adequate supplies, equipment and logistic support.

It is now self-evident that for the Ogun State health care system based on primary health care to function optimally in the delivery of health care programs to all sections of the population, the following points require serious consideration and constant vigilance: the appropriateness of the existing health infrastructure, the correct balance and mix of different categories of health manpower needed to each level of the health system, very clear specification of the technical content of programs for implementation, the appropriateness of the existing technology, institutional support and management.

In the plan period, necessary steps will be taken to ensure that actions taken at different levels of the State Health Care System are coherent and mutually supportive as such actions may relate to geographical spread and any level of imbalance as may be evident in the State, the quantity and quality of available manpower, definition of the function, scope and degree of sophistication of work to be undertaken at different levels, clear delineation of the role and responsibility coupled with accountability, within the State health infrastructure of the different levels of care-primary, secondary and tertiary-bearing in mind that primary health care is the main thrust of the State health care system.

In order to operate an effective comprehensive health care system as envisaged in the National Health Policy, against the back cloth of which the State Health Plan is being developed for Ogun State, the support needed at various levels of primary health care will embrace planning of health care delivery in its multiple dimensions. This means that there is a need for the redefinition of appropriate curricula for the training and in-service training of categories of health personnel with a view to aligning their orientation to the importance of implementing the primary health care as an integral part of the State health care system; a clear articulation of health activities together with appropriate job descriptions for the various cadres of health personnel, particularly the community health workers; the establishment of a carefully planned schedule for the provision of supplies and equipment, and the provision and maintenance of the right type of logistic support.

Guidance, support and supervision which would have to come from either a General Hospital/Comprehensive Health Center to the Primary/Family Health Centers, Health Clinics or Health Posts, and from the latter to the community and home levels should include the right type of human interaction between the health professional and the voluntary village health workers.

In keeping with the national health care strategy, as enunciated in the new National Health Policy, it is universally acknowledged in Ogun State that health development is not the preserve of the Ministry of Health and its agencies only. Other governmental agencies like agriculture, education, water corporation, local government and community development, information and culture, etc, also make some significant contributions to the improvement of the health status of the citizens of the State. This is the multi-sectoral concept implicit in the primary health care approach and which calls for a continuing dialogue between the health sector and other relevant agencies within the State.

Concerted efforts will be made in this plan period to increase the awareness of all health workers and those concerned in other sectors, as well as public opinion leaders in the State, of the importance of intersectoral collaboration in support of primary health care. Steps will be taken to establish, as necessary, mechanisms for better co-operation between health an related sectors, such as a State Health Advisory Council and Local Government Health Committees.

There will be the need for the health sector, through sustained advocacy at the highest policy-making level to ensure a continuing recognition of health as one of the priorities of government.

Alongside this effort, attempts will be made to ensure the most effective, equitable and efficient use of all resources available to the health sector within the development (capital investment) and recurrent budgets. There is the need for proper management of human resources, facilities and equipment, as well as control and accountability in the use of these resources.

It is also realized that there are often untapped sources of financing and support from within the community, the business and private sectors, and non-governmental organizations in the State. These offer real possibilities for absorbing certain financial or executing responsibilities in partnership with the government. Alternative approaches to the funding of health care costs, including fee-for-service and the feasibility of a state health insurance scheme, will be explored; all these to be in line with the national guidelines that may emerge from the Federal Government.

PROGRAM AREA	TARGETS/GOALS	INSTITUTIONAL REQUIREMENTS	COSTS
Immunization (EPI)	*Establishment and maintenance of an 80% rate of immunization for target groups: - Children (aged 0-4) - Pregnant Women	*Immunization materials (vaccines, syringes, swabs, etc) *Cold Chain Equipment - maintenance of existing cold chain materials -replacement of cold chain centers at 1 annually, *Evaluating of EPI activities by field survey teams	
Water supply and Sanitation	*Providing access to a safe drinking water supply for 80% of the population *Development of at least 200 public latrines by 1991 *Control of water borne diseases	*Ogun Water Corporation support -Salaries, allocation, equipment, and supplies. -Physical plan maintenance and rehabilitation -Capital development (pumps, plumbing, tanks, boreholes) *Construction by Local Government Areas of Public Latrines -maintenance and rehabilitation latrine facilities *Control activities for Schistosomiasis, Onchocerciasis, Dracunculosis and water borne acute diarrheal diseases	
Rehydration Therapy for control of Acute Diarrheal Diseases	Ensuring that 80% of Ogun Mothers are knowledgeable in the Preparation and use of ORT solution *Increasing private sector participation in the ORT program	*ORT Demonstration units and clinics -Materials, Staff salaries and maintenance -ORT supplies for demonstration purposes *Increased training of nurse educators *workshop in ORT for the private sector (physicians, midwives and pharmacists) *Integration of ORT into daily activities of all 1^0 care health facilities (see H/M)	

PROGRAM AREA	TARGETS/GOALS	INSTITUTIONAL REQUIREMENTS	COSTS
Child Spacing/Family Planning	*Achieve birth spacing of at least 2 years in 50% of married women of child bearing age by 1990 *Decrease the rate of population growth to at least 2.5% by 1985 *Reduce high risk pregnancies and the associate maternal and fetal mortality: -High risk pregnancies shall includes: 1)Births to mothers - 18 years or older than 35 years 2)Births of over fourth order 3)Births less than two years after last birth 4)Births to mothers with a history of complications of pregnancy *To maintain a high quality of Family Planning and Child spacing information and services	*External MCH/FP service (and supplies) from 43 functioning clinics to (40% coverage of existing 1^0 care clinics and centres. *In-service training for doctors, nurses, midwives and primary health care workers at 100 trainees annually *Maintenance of the Ogun State Family Planning Training Centre at Iberekodo *Community educational and communication programs *Coordination of manpower planning and training *Monitoring and evaluation (salaries and equipment)	
Health Maintenance	*Reduce child 0-5 mortality to 80/1000 LB *Reduce maternal mortality to 5/1000 LB *Extend growth monitoring to 80% of children 0-5 years old *Extend prenatal coverage to 80% of pregnant women *Preserve Breastfeeding for 18 months or longer for 80% of infants	*80% population coverage by 1^0 level facilities (health clinics and centres) *100% provision of minimal levels of (trained) staffing for the above: increase training capacity for TBAs and community health aides and assistants as needed *Year round stockage of all 1^0 care Essential Drugs (see Appendix F) to the above *Provision of 1^0 care equipment/supplies (scales, growth charts, simple screening tools and health education materials to all the above facilities)	

PROGRAM AREA	TARGETS/GOALS	INSTITUTIONAL REQUIREMENTS	COSTS
		*Regular immunization clinics (at least weekly) in EPI to all of the above *Daily (6 x Weekly) provision at all the above facilities of antenatal care, child welfare clinics and curative care for common ailments, including integrated nutrition counseling (including breast feeding promotion), malaria prophylaxis, growth monitoring, ORT, and simple screening tests (e.g. anema) are offered and recorded using growth charts. *Systematic sample morbidity/mortality monitoring via home visiting by staff and via collaboration with school teachers and students. *Referral of serious cases (including tuberculosis) and family planning candidates to appropriate facilities with reimbursement of travel expense as needed *Regular supervision by level 2 personnel	
Availability of Essential Drugs	*Maintenance and enhancement of Ogun State Revolving Drugs Fund *Establishment of a pharmacy education program *Organization and coordinationof revolving drug funds in the Local Goverment Areas to support primary care activities (see above)	*Procurement of adequate annual supply of drugs *Maintenance of drug buffer stock *Administration and management of drug revolving fund with emphasis in 1^0 care essential drug list *Development of a program in Pharmacy management and accounting tracing *Establishment of a Pharmacy Education Program for State, Local Government and Private Pharmacists	

PROGRAM AREA	TARGETS/GOALS	INSTITUTIONAL REQUIREMENTS	COSTS
Public Awareness (Health Education Program)	*To increase the level of public awareness in health matters *To provide an educational base from which the people of Ogun State and their health care provider can make enformed choices in health matters	-Establishment of a Health Library for health professionals -The development, procurement and distribution of primary health care education matetrials for public consumption -The organization of a Statewise Mass Media effort involving the input of public relations and advertising experts	
Mental Health Program	*To improve the level of oral health in Ogun State and to increase the provision for services	-Continuation of the School Health Education program in Oral Health -Establishment of water flouridation program at Ogun Water Corporation -Solicitation of voluntary orgainzation participation in a program of oral health education -Increased development of trained personnel	
Eye Care Program (Opthalmology)	*To provide adequate eye care services for Ogun State	*Development of trained eye care specialist *Provision of special materials and supplies *Epidemiology research to better define the prevalence nature and causes of eye diseases and blindness in Ogun State	
Mental Health Program	*The prevention, therapy and rehabilitation of cases of mental illnesses in Ogun State	*Maintenance and rehabilitation of existing hospital mental health clinics *Increased training of CHW and referral staff in community mental health *Organization and administration of a community mental health outreach program	

PROGRAM AREA	TARGETS/GOALS	INSTITUTIONAL REQUIREMENTS	COSTS
		- Development of an occupational hazards program including regular inspections of industrial sites an education in occupational medicine	
State Health Advisory Committee	*Administrative consolidation of all primary Health Care activities *Provide assistance in the Administrative and policy making processes of the Ministry of Health	- Organization and maintenance of a State Health Advisory Committee - Secretarial supports, administrative fees entertainment fees	
Logistic Support Program	*The provision of adequate logistic and communications supports for Ogun State Primary Health Care activities	- Vehicles (including Ambulance and motorcycles for Primary Health Care) procurement and maintenance (include spare parts) dirver pool (salaries and allowances) operating costs (gasoline, insureance, fees) (or equivalent contracts or allowances) - Telecommunication, radio receivers for Community Health Workers and Voluntary Workers. Improve communication (telephone utilities), with health zones and Local Government Area health providers	
Nutrition Program	*To provide adequate education in nutrition *To provide for nutritional supplementation needs	- Establishment and maintenance of a nutrition rehabilitation unit at the State Hospital in Abeokuta - Establishment and maintenance of nutrition clinics - Perpetuation and expansion of the Ogun State School Meals Program -Development of a program in nutrition research - Evaluation of nutrition content in native foods - Epidemiologic surveys to identify nutritional problems and the population	

PROGRAM AREA	TARGETS/GOALS	INSTITUTIONAL REQUIREMENTS	COSTS
Injury prevention and Case Management	*Reduction of injury related death and disability *Identification of High Risk Groups and the introduction of interventions targeting those at high isk *Emergency Medical Services throughout the Health Systems	*Vigorous pursuit of legislation and political measures to increase the use of vehicle seat-belts, motorcycle helmets and motor vehicle/road safety *Epidemiologic research to identify high risk populations *Establishment of a program of Emergency Medical Management for health care providers law enforcement agencies and ambulance drivers *Establishment and maintenance of a State-wide blood banking system	
Preventive and Endemic Disease Control	*A reduction in overall morbidity and mortality in Ogun State *The development and maintenance of adequate professional staffing for the provision of the above *Prevention/control of unnecessary serious infections (malaria, hepatitis) *Arrested Transmission/control of diseases of public health concern (TBC, Leprosy, Parasitic) *Continuing Education for 1[0] care workers in specific disease control methods	*Establishment and/or maintenance of specific disease program: 1)<u>Malaria Control Unit</u>: - Provision of laboratory supplies insecticides and larvicides for 5 health zones - Staff salaries and allowances - Provision of antimalaria drugs 2) <u>Sexually Transmitted Diseases (STD)</u> - Establishment and maintenance of "special treatment clinics" - Obtaining drug supplies and equipment - Training of STD workers - State STD Workshops - Epidemiologic studies and evaluation, "contact" tracing - Establishment of a "network" of STD clinics with an STD reference center at the State Hospital in Abeokuta	

PROGRAM AREA	TARGETS/GOALS	INSTITUTIONAL REQUIREMENTS	COSTS
		3)<u>Leprosy Control Program</u> - Maintenance of Ogun State 56 Leprosy treatment centers - Medical Supplies and Equipment - Improved case funding efforts - Community health education program - Development of rehabilitation facilities - Training of Medical Officers - Seminar and Workshops 4)<u>Tuberculois Control Program</u> - Maintenance of Ogun State Chest Clinics at Abeokuta and Ijebu-Ode - Maintain BCG immunization program - Establishment of a separate chest diseases treatment facility - Obtaining drugs and equipment - Improvement of laboratory diagnostic services - Direct smear Microscopy - Development of case finding and "contact tracing system" - Epidemiologic studies of TB prevalence - Initiate, encourage, and coordinate research program in TB 5)<u>Hepatitis Control Program</u> -Establishing a Hepatitis prevention program	

VI. Implications of the Plan

A. Program Implications

The overall goal of the planning process is to assess and redesign health services so that they more nearly fit the health needs of each Local Government Area population, reorganize management so as to promote effectiveness and efficiency, eliminate waste and maximize cost recovery and to mobilize Federal, State and non-government and local initiatives in order to extend primary care services to the vast majority and thereby promote health and substantially decrease mortality and morbidity from common preventable conditions.

Ogun State is not only blessed with a comparatively fertile physical, economic, and social environment from which to launch such an effort, but has already developed a variety of innovative approaches and programs related to this goal. The plan outlined above has been and will be further developed to explore these particular approaches. After all, while much has been learned about overall strategies towards implementation of truly effective primary care services, much remains to be discovered concerning what types of delivery system will prove to be practical in different environments. Areas still requiring further resolution include issues such as:

1. Integration of 1° care services (MCH, Child welfare, treatment of common conditions) which can only be developed over the course of time vs rapid categorical programs such as EPI.

2. Prioritization of budgeting between extensions of already costly 2nd and 3rd level mostly urban facilities (which are needed as referral facilities) and more cost-beneficial 1° care efforts which are so needed in the rural areas.

3. Development of areas of responsibility and mutually advantageous relationships between government, missionary, private for profit and traditional practitioners.

4. Design of combined curative-preventive 1° care services in such an accessible and acceptable manner that utilization by the population becomes sufficient to impact on State mortality and morbidity statistics and to justify the investments, local and state, of money and manpower.

5. Determination of most cost-beneficial transportation methods (governmental vs fee for service) for patient referral, drug distribution, supervision, evaluation and continuing education.

6. Balancing local initiatives and responsibility for health services (construction and maintenance of facilities, co-payment for drugs and personnel) with governmental inputs (training, drug supply, management) so that 1° care facilities are viewed as "belonging" to the community, yet services meet government and federal standards.

7. Preservation of local health customs, such as breast-feeding while

introducing new 1° care methods such as child spacing and ORT.

To understand these issues and develop ways of resolving them, it seems useful to build on some of the innovative approaches developed in Ogun State so that, within the overall Federal and State Ministry of Health guidelines and objectives, a variety of experiences and methods are practiced and evaluated. The following are examples of specific approaches that have been pioneered in the State, but require further experience and assessment for maximal usefulness to further planning:

1. Drug and Supply Resolving Fund:

   Now that this program has been successfully launched, it can and must be extended for the benefit of the 1° care initiative. Thus, the essential 1° care drug list will be taken to each Local Government Area where individual revolving funds can be set up to ensure consistent 365 day/year supply of the most basic drugs and supplies at each and every government health center. Close collaboration with the "Chanpharm" drug distribution system used by missionary hospitals could promote maximal learning, provide relief in emergency situations for both systems and effect potential cost savings in situation of over stockage or radical price differentials.

2. EPI is already in operation and providing regular immunization in a number of rural areas via Federal, State and voluntary (not-for-profit) facilities. Further development of an overall plan to integrate EPI into the regular weekly (or even daily) Maternal Child Health Services of all of these providers will need to be developed and carefully monitored with respect to cost-benefit, cold chain assurance and maximum coverage without duplication of services.

3. The Lagos University Institute of Child Health is conducting a major 10 health care cum research demonstration project in Ifo/Ota. Methods of integrated care, assessment of individual 1° care components, use of growth charts (home based health records) and methods of data gathering and outcome assessment using a sample community based system, will all need to be studied for relevance to the State-wide 1° care program. The potential of such demonstration projects for training will also be investigated.

4. An ambitious collaborative Ministry of Health/Voluntary non-profit hospital tuberculosis control program has been launched at Sacred Heart Hospital in Abeokuta. Methods developed for case-finding, referral, contact tracing, initial hospitalization and follow up treatment constitute not only a needed opportunity for the development of new cooperative links between governmental and non-governmental efforts in this vital endemic/epidemic disease area, but will provide essential data for future chest disease and other endemic disease area efforts.

5. The nascent Ogun State University Teaching Hospital has as one of its objectives, to collaborate in the training of community health officers and assistants with the Ilese Institute of Technology. Provided the

necessary financing can be found, a collaboration of this kind should greatly strengthen the quality and output of this needed component of 1° care personnel training for the state.

6. Historically, traditional health practitioners have played a role in the development of primary care in Ogun State. Two examples require mention:

   a) Traditional birth attendants (TBAs), who continue to perform a significant proportion of deliveries especially for a 60% rural population, are now generally practicing sterile umbilical cord care. This has reduced the incidence of neonatal tetanus to almost nil. Continued close monitoring and step-wise in service education of this large group of practitioners will need to be developed so as to improve their pre-and peri-natal assessment skills, their delivery technique, and to help them acquire smooth referral patterns (until such time as health center deliveries are extended to cover the entire rural population).

   b) Since Prof. Lambo's early revolutionary work, Aro has stood as a beacon of successful cross-cultural delivery of indigenous and western oriented mental health care. The Ministry of Health has extended the concept in its development of community-oriented therapeutic approach such as the one at the Mental health Clinic at Abeokuta. Such efforts need further evaluation so that 1° care preventive and follow-up psychiatric services can be extended state-wide.

Apart from some of these initiatives with primary care implication or potential, there are several other significant implications of this health plan. Change invariably implies re-evaluation of existing structure and emphasis. Redirecting health services in the direction of prevention, total population coverage and cost-benefit in outcome terms (mortality/morbidity), means taking a fresh look at existing services. Some of the issues that will need to be addressed in this process include:

1. Clarification of 1° care management authority and responsibility. The authority and responsibility for 1° care appears to be divided among the Ministry of Health, the State Health Board, and the Local Government Areas. While the precise redefinition of functions and responsibility will have to be discussed, negotiated and ultimately determined by the state executive council and military governor, it seems clear that more effective administration and cost-saving will require some definitive clarification. For example, while hospitals will remain under the State Board of Health, it might be appropriate for primary care professional staff (above grade level 6) to report to the State Ministry of Health while staff below this level report to the Local Government Area. Alternatively, all primary care staff could report in a matrix fashion: administratively to the local government area, professionally to the State Ministry of Health.

However, a 1° care health committee designated by the respective permanent secretaries (and by other relevant Ministries: Education, Information, etc) would meet monthly to assess, trouble shoot and plan.

B. Data Gathering

Information at all levels of government tend to be collected long after its usefulness has expired. Contrariwise, information needed for planning is often lacking. Also, comprehensive data is often gathered at great expense, and diminishing accuracy, when sampling at periodic intervals at a fraction of the cost and far greater validity, would do the job.

For primary care purposes, it is essential that data be collected on a target-population basis. For example, it is vital to know what % of each health zone's population is protected against each immunizable disease but much less useful to know how many doses of this and that have been used. The demographic and health-related rates necessary for good 1° care planning and delivery have been defined.

Obtaining the data will be facilitated by close collaboration between Ministry of health statistical personnel and the Institute of Child Health team that has been collecting this kind of data (using home-based records, sample home visiting, population surveys and the like). Of utmost importance, will be an ongoing assessment of the essential drug revolving fund distribution system so that deficiencies can be expeditious detected and corrected. Spot checking of all 1° care facility inventory on a monthly or bimonthly basis will be initially necessary and a system will be worked out to do this.

C. Drug Supply Distribution System

Overcoming the drug and immunization supply constraint is one of the quintessential requirements for success of the plan. Adequate personnel, travel budget and accounting systems will be ensured so that the revolving drug system can be extended to provide consistent inventory of all essential drugs at each health center and that cost recovery is efficient and can effectively maintain the revolving fund at each level. The question of how much of the cost of delivering the EPI services (excluding the vaccines which are free) will be covered by a fee-for-service, remains to be resolved. Costs of health maintenance need to be supported (e.g. by registration fees and/or sale of growth charts) so that health education materials, maintenance of equipment and incidental costs can be assumed. Experience in Mission hospitals suggests that minimal fees are acceptable by the population and may enhance awareness and appreciation for services offered.

D. Personnel

It has been established that the overall number of 1° care level professional personnel is close to, if not adequate to, meet the designated goals. It is difficult to assess the existing 1° care capacity of Ministry of Health personnel since specific levels of training (Community Health Officers, supervisors, assistants, and aides) is superimposed on nursing titles (staff nurse, staff midwife, etc). Nevertheless, it seems clear that while ultimately

certain cadres will have to be substantially increased, the more pressing problems are those related to: (a) distribution (Ilaro Health zone being the most deprived; (b) training (practicing 1° care in an integrated fashion requires both training and in-service experience in an appropriate demonstration unit) (c) job satisfaction (related to living conditions, adequate drugs and supplies, appropriate supervision and continuing education) (d) effective referral to 2° care facilities as needed.

Until demonstration programs have been developed where all of these functions can be witnessed, appreciated and ultimately duplicated, 1° care trainees will be in the position of trying to initiate change without truly believing in its possibility, i.e. pulling themselves up by their own bootstraps. Therefore the health plan will, in years 1 and 2, concentrate training in those sites where the appropriate model already exists or, with minimum input of the above elements, can easily be instituted. Expansion to other areas will then proceed rapidly based on these models and the successful training that they will foster. It should be recalled that 1° care in this environment is a labor-intensive effort, since it involves approximately 6000 deliveries and 200,000 visits (figuring 12 health maintenance and sick visits per 0-5 year old child) per annum for each 100,000 population.

E. Managerial Implications

In compliance with the constitutional mandate, Local Governments will assume primary responsibility for the implementation of the Primary Health Care strategy which so far has been partly shared with the SMOH and the SHB. In assuming this task, LG's will be entitled to a financial contribution from the relevant organization, e.g. SMOH and SHB, equivalent to the actual annual amount incurred during the preceding year.

At the LG level, there is need to consolidate the management of all health services run by the local government under a single management and administrative authority which would be held accountable and would undertake appropriate monitoring of efficiency and service quality control.

However, in professional, technical and health matters, the health management authority will be responsible to the SMOH. In such matters, the SMOH will carry supervisory authority, and will provide adequate support.

Thus, a form of matrix management will be instituted whereby professional responsibility is to the SMOH but day-to-day administration is under the authority of the LGA. The details of the managerial and administrative setup will be worked out at the State Government level possibly requesting expert advice from competent academic institutions and/or external agencies.

F. Financial Implications

The Position Paper on the Planning Programming and Budgeting for Health Development in the Fifth National Development Plan (1987 - 1991) contains a clear description of the economic and financial backdrop against which plan forecasts need to be elaborated. This is to convey a strong sense of realism to those responsible for planning sectoral activity over the 1987 - 1991 period. In order

to provide common ground to state planners, the Position Paper also contains a global assessment of the financial resources which are likely to be available to the Federal Government.

Projections regarding the utilization of Federal funds provide the ceiling for the maximum statutory allocations to State Governments from the Federal Account. State Governments are, therefore, expected to forecast activity levels in each and every sector, so that the financial implications of such forecasts remain within the boundaries of their total revenue. Financial projections at the federal level are based on an annual nominal (cash) growth rate of 5%, which, in real terms, might well imply a decline in resources available so far. Moreover, caution needs to be exercised in view of the prevailing economic and financial conditions, as a downward revision of the projected ceiling over the plan period could not be totally ruled out.

On the basis of the projected statutory allocations to state governments from the Federation Account estimated at 17.6 billion naira for the entire plan period, the share of Ogun State Government would be in the order of 616.6 million naira, or 123.3 million Niara per annum, assuming 3.5% of the total will be devoted to Ogun State as in the recent past.

Using the same assumption of constant share in total (3.8%) the statutory allocation of the 10 LGA's of the Ogun State from a Federal total of 5.4 billion Naira might reach 41.2 million Naira per annum.

Although no official estimates at State level indicating the likely course for internal revenue generation have been attempted so far, a conservative assumption might be to estimate an annual nominal growth of 5% of conformity with the Federal estimate.

As regards, the health sector, in particular, it would be realistic to assume that the sector will not be in a position to generate any substantial incremental revenue over the major part of the period, primarily due to the present poor service quality. It is, however, conceivable that once the managerial requirements and the equipment and supplies needed for appropriate functioning of the system are fully met, part of the financial burden currently lying on the State and Local governments will be adequately shared by the community. This, however, is not likely to happen until the credibility of the official health system is restored with effective rehabilitation and consolidation of the system, which might take more than half of the plan period.

It is worth noting at this point that in view of the high priority attached to the promotion of preventive services during the Fifth plan period, the amount of cost recovery from service payments accruing from such activity remains to be determined.

This, however, does not exclude the possibility of relatively high cost recovery on family planning supplies provided the charge remains affordable. Based on the above arguments, it would be unrealistic to expect the health sector to generate substantial incremental revenue before the two final years of the plan period. Given the growth ceiling, set for financial resources, and the rather extensive discussion on Ogun State's financial situation, resource

prospects over the next five-year period would dictate extreme caution. Activity in the health sector will mainly focus on rehabilitating the Primary Health Care-based system, carefully avoiding the creation of supplementary recurrent finance requirements. It will have to be assumed therefore that change of policy putting emphasis on Primary Health Care strategy will be mainly implemented by using the presently available manpower, and physical, financial resources. There is definite need for improving the managerial capabilities available to the system so as to increase the efficiency with which current resources are being used.

The major affordable financial implication of the plan will be to mobilize additional resources to finance the rehabilitation of facilities, equipment and materials including strengthening of adequate managerial capabilities. The amount, which for the next plan period, might reach 10-15 million Naira, on the basis of 1986 prices, will have to be bridged possibly by a World Bank loan to the sector. At the same time, measures to increase the cost-effectiveness of the system will contribute towards narrowing the resource gap.

VII. Implementation, Monitoring and Evaluation

The Ogun State Health Planning Process has been productive of a document elaborating a working plan which is consistent with the Nigerian national health policy. Efforts have been made to identify priority health problems and to enumerate them. The basic justification for the selection of goals and specific target and the relevance of these goals to the overall objectives of Primary Health Care have also been explored.

Obstacles to the development of cost estimates for the proposed program and the time constraints imposed on the planning process have had, as a net effect, limiting both cost and resource assessments. As a result, the Ogun Plan describes the health system which is desired and identifies, in a broad sense, the essential institutional requirements, but presents only gross budgetary estimates which have not been factored into the analysis of specific programs components and implications.

The draft document is now ready for comment and revision within the Ministry of Health and at higher Government levels. Efforts should be directed at securing input which will assist in:

1) a better elucidation of the data on which the plan is based;
2) a more detailed current estimate for costs and available resources for individual programs, areas, and;
3) a consolidation of alternative approaches from different branches of Government and from the private sector.

Planning, now begun, at Ogun is expected to continue as a dynamic process involving the political, organizational, and technical components of the Health delivery system and evolving to an ordering of programs through a rational system of prioritization. Numerous methodologic approaches may be brought to bear, but in Ogun, it is likely that consensus development techniques coupled with some elements of cost benefit analysis will continue to work well.

What now remains is for the strengthening of a plan of implementation. This

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is to begin with a critical examination of identified constraints. Political, social, cultural , and institutional constraints like the financial limitations need to be very clearly stated. This will form the basis for developing proposals for the removal, solution or circumventing of constraints and the identification of program areas which while attractive, may not be feasible.

For example, in Ogun, given a realistic assessment of the financial requirements of the planned primary health care activities, and the concurrently decelerating level of financial inputs, the feasibility of continued support for the University Teaching Hospital will be brought into question, and the overall strategy for continued development of physician personnel reviewed.

This ongoing process, the analysis of constraints, and program areas, will be used to selectively pair down the current long list of planned activities to those which are both relevant and practical. This consolidated list, along with an assessment of the managerial and support activities needed to accomplish them (detailed list of institutional requirements) will become in effect a blue print for program management. Finally, program budgets must be computed with as much precision as possible. Program activities may, then, be placed into a time sequence and examined for time constraints which might otherwise have remained obscure.

Throughout the Ogun Planning process emphasis has been placed on setting policy goals and specific targets. The next step will be to establish priorities and decide on the health objectives and operational goals. This step is really the setting of a schedule with identified milestones and intermediate targets for development activities. This will form the basis for short term monitoring and assessing the state of "development" of the program.

By developmental milestones, we mean the accomplishment of activities like the rehabilitation of the School of Technology Ilese or the expansion of curriculum at the University Teaching Hospital to include primary health care practicums or the training of additional primary health care nurse educators. These milestones are separate from the assessment of the programs "health intervention" such as the numbers of vaccines given, or numbers of mothers using ORT and the numbers of the Family Planning acceptors.

Ogun State already recognizes the assessing the impact of these health activities on the health status of the community requires, by its nature, a larger time frame and a set of predetermined epidemiologic and health status indicators, such as targeted infant mortality rates or life expectancy at birth. It seems that for consistency, it will be advisable to specify the indicators to be used in evaluating the program health impacts at the time when targets and objectives are somewhat better defined.

Regardless of when they are specified, it has become clear that the kind of Health Information and Planning system which will be required does not yet exist and will have to be built up. This means that reporting forms will have to be examined for the <u>relevance</u> of the data they collect and whenever necessary-redesigned. The <u>mechanisms</u> for <u>collecting</u>, <u>tabulating</u>, and <u>analyzing</u> this data must be carefully examined and streamlined. This will be done to facilitate the monitoring of health intervention and their impact.

Additionally, there seems to be a role for an "operations research" approach to monitoring the program activities both in terms of process (how things are being done) and performance or adherence to the schedule (i.e. are we right on schedule). To be effective, we know that the monitoring and evaluation tools we decide to use must be applied regularly and that the collection of health information data must be considered as important efforts toward these objectives which are fundamental to the success of Ogun Primary Health Care activities.

While thought in this area is still very much in a state of evolution, we realize the selected interventions may, by their nature, be facilitated through the involvement of outside consultants. For example, we have heard of computer models being used in Primary Health Care operations research, and feel that these may at some point be useful to Ogun State. Certainly the input of statistical expertise and expertise in Community Medicine from highly skilled Nigerians who are a part of the University system should be planned.

THE ESSENTIAL DRUG LIST

Anesthetics, local	- Lignocaine, topical, injections
Analgesics	- Acetylsalicylic acid, tablet. Paracetamol, tablet.
Anti-Allergic	- Chlorpheniramine, tablet, syrup. Promethazine, tablet.
Antidote	- Charcoal, activated, powder.
Anti-convulsant drug	- Diazepam, injection.
Anti-infective drugs	- Chloroquine, tablet, syrup, injection. Metronidazole, tablet. Piperazine, tablet syrup. Pyrantel, tablet, syrup Sulphadimidine, tablet, syrup.
Drugs affecting blood	- Iron, tablets, mixtures. Folic acid, tablet.
Dermatological drugs	- Neomycin plus bacitracin, dusting powder. Calamine, lotion. Benzoic acid plus Salicylic acid, ointment, cream.
Gastrointestinal drugs	- Magnesium t silicate compound, tablet, mixture. Lignocaine plus Betamethasone, ointment, cream, suppository. Hyoscine N-butylbromide, tablet.
Hormones	- Oral contraceptives.
Ophthalmological drug	- Chlortetracycline, eye ointment.
Oxytocic	- Ergometrine, tablet, injection.
Respiratory tract drug	- Ephedrine plus hydroxyzine plus theophylline, tablet.
Water/electrolyte balance	- Oral rehydration salts.
Immunologicals	- Anti-snake venom, injection. Tetanus Antitoxin, (ATS), injection.
Antiseptics	- Chlorhexidine, solution. Iodine, solution.

*The types of oral contraceptives distributed under the primary health care program will be determined by the prevailing National Family Planning Policy.

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Local Government Area	Health Institutions	Activities
Egbado North	- Comprehensive Health Centre, Imeko. - Primary Health Centre, Aiyetoro. - Health Clinics. - Health Posts. - Family Planning Clinics. - School Health Service. Clinics.	
Ifo/Ota	- Primary Health Centre, Ifo. - Health Clinics. - Health Posts. - Family Planning Clinics. - School Health Service Clincs.	Model Practice Area for the Institute of Child Health, Lagos University Teaching Hospital's Primary Health Care Programme. EPI/ORT - coverage above 82.1% MCH/FP Communicable Disease control e.g. Diarrhoea, malaria, Tuberculosis, Leprosy, guineaworm, Schistosomiasis. School Health Services. Health Education. Environmental Sanitation. Limited curative services.

Table 7

OGUN STATE, NIGERIA (1986)

DISTRIBUTION OF EXISTING HEALTH FACILITIES BY SOURCE OF FUNDING

HEALTH ZONE	LOCAL GOV'T AREA	GOVERNMENT (FED, STATE, LGA)				PRIVATE SECTOR				NON-GOVERNMENT ORG.	
		PHC		REFERRAL		MATERNITY		REFERRAL		REFERRAL	
		NO	Beds *	No	Beds *	No	Beds *	No	Beds *	No	Beds *
ABEOKUTA	ABEOKUTA	40	320	6	417	10	106	27	1498	1	[illegible]
	ODEDA	35	289	-		-	-	-	-	-	-
	OBAFEMI/OWODE	31	240	-		1	25	-	-	-	-
IFO/OTA	IFO/OTA	36	288	1	100	5	57	13	298	-	-
ILARO	EGBADO SOUTH	86	696	1	238	5	58	-	-	-	-
	EGBADO NORTH	40	394	1	41	3	24	-	-	-	-
IJEBU	IJEBU-ODE	69	536	3	80	2	75	-	-	-	-
	IJEBU-EAST	56	424	2	80	1	74	-	-	-	-
	IJEBU-NORTH	28	264	0	-	6	41	9	360	-	-
SAGAMU	IJEBU-REMO	42	427	4	196	9	72	3	360	-	-
	TOTALS	463	3878	18	1072	42	532	52	2516	1	[illegible]

* Estimated beds in 1986