Conference Theme: Integrating Medical Rehabilitation Services in Community and Primary Health Care in Nigeria and Sub-Sahara Africa

Sub-Theme

Integrating Medical Rehabilitation Services in Primary Health Care in Nigeria

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1. Introduction

The purpose of this paper is to provide justification for integrating medical rehabilitation services in Primary Health Care (PHC) in Nigeria by briefly reviewing the historical evolution of health care in Nigeria as a framework to understand where the system of health care currently operated is coming from and how the challenges that have prevented effective reforms have emerged. This historical review provides an opportunity to briefly conduct an appraisal of the Nigerian health care system journey so far and contextualize the source of the present challenges of an effective health care system.

It is believed that the majority of the population of Nigerians are at greater risk of injury and outcomes of diseases that predispose to disability and suffering today than ever before in the history of the health care system. The justification of a role for medical rehabilitation services in ameliorating the current high risk susceptibility for injury in mechanical trauma and special care in end of life disease trajectory is borne from the framework of the natural history of disease and the value of disability limitation and rehabilitation involved in the concept of levels of prevention and modes of intervention that defines preventive health care process.

The healthcare in Nigeria at this time needs reform that would reposition a number of healthcare professionals because of the evolving nature of its people and the epidemiological transition occurring. This is validated by the rapid changes in disease profile of the community taking place now. The aging population now constitute an important subgroup at risk for injuries and other morbidity are currently neglected.

2. Historical Evolution of Health Care System in Nigeria

The evolution of Medical/health care services in Nigeria can be traced back to three convenient periods; pre-colonial, colonial and post colonial eras. The pre-colonial era involved predominantly the practice of traditional care such as bone-setting and traditional birth attendants among others. However these practices have persisted till date, with some recognition given to Traditional Birth Attendants (TBA) and included into the main stream of health care at the primary level.

The colonial era spanned the period from the time of colonial rule to the time of independence in 1960 and the earliest organized medical care was set up by missionaries, initially around the coast of West Africa with the establishment of hospitals in Lagos, Abeokuta in 1859, military hospitals and St. Margaret's Hospital that eventually evolved into the temporary site for the University of Calabar Teaching Hospital. It must be mentioned that health services covering the general population was never the objective of colonial era health care scheme. The primary objective of setting up health care services was to provide exclusive health care to staff of the colonial administration and their families. However, the

missionaries provided limited health care services to members of the community as a means of impacting their community with the messages they intended to pass to the indigenes.

The first attempt of a conscious planning of health care to include the general population actually began with the introduction of the Ten-Year Development plan for Welfare (1946-1956 covering all aspects of governmental activities in the country. This was obviously proposed by expatriates. It was modest and realistic considering the time it was proposed. Colonial Medical services became Regional Medical services after the independence of 1960 and regionalization of health services continued until the creation of new states which resulted in the formation of State Health services/Ministries.

The second National Development Plan (1970 – 1974) recognized significant flaws in the Colonial development plan, with respect to its health care component and implementation strategies- there was serious shortages of manpower and infrastructure (Adeyemo, 2005). This was obvious, as a large proportion of the expatriates had to leave for their home countries. Now, the desirability to increase, significantly, the stock of doctors and para-medical personnel and their distribution were pointed out in the Second National Development Plan and specific policy issues were implemented to achieve this. This was again followed through with the third National Development Plan (1975-1980) (Attah, 1975). However, the Fourth National Development Plan (1981-1985) still observed serious shortages of manpower which were identified in the previous Plan, shortage of manpower, poor distribution of health care institution resulting to inadequate coverage and limited access, insufficient utilization and poor management of health facilities and an imbalance between Curative and Preventive Health Services (Adeyemo, 2005). Therefore, in the fourth National development Plan these issues were given prominence; thus the goal to pursue a comprehensive health care system which would offer promotive, protective, restorative and rehabilitative services to more people became the accepted national health care system. There was created the three tier Basic, Secondary and Tertiary health care system. Even though the Basic Health Services Scheme was conceived in the third development plan, the effective establishment and implementation came in the fourth development plan. At this time witnessed the formalization of the medical rehabilitation services and established the registration board to regulate and control the training of Medical Rehabilitation professionals.

All the while, in the desperate effort to provide the population of Nigeria with adequate health care, emphasis had been placed on curative medical care with the resultant domination of the entire health care system by medical doctors emphasizing clinical care for which they trained to apply. Since medical intervention has been the exclusive protocol for health care over the centuries, we still have diseases ravaging the population of the world including developing countries, most especially, and reducing quality of life for majority of population. For this reason, a new paradigm for health care needed to evolve, which is cheaper and more effective in correcting the error of an exclusively medical approach to health care.

It was in recognition of the failures of past and existing health care system to provide satisfactory health care that brought about the reform which introduced Primary Health Care (Newell, et al., 1975). Health facilities including human power resources were inadequate and inequitably distributed in favour of urban areas, whereas a sizable proportion of Nigerians live in the rural settings. This reform was geared towards redeeming the inadequate health resources and to increase the proportion of the population receiving health care to at least to 60%. This was the rationale for introducing the Primary Health Care scheme. Primary Health Care according to WHO is described as *"health service essential to life made universally accessible to individuals and families in the community by means that is acceptable to them, through their full participation and at a cost that the community can afford*". As a system which provides health care services (which includes not only medical services, but other services such as preventive health services offered by health promotion and education , disease surveillance, diagnostic and screening services, medical rehabilitation services), there are resources to be managed and quality output anticipated. Management imply the effective organization and utilization of human and material resources in a particular system for the achievement of identified objectives. Importantly, management of health relies on planning and administration. Again we observe medical doctors dominating the system. This is exactly how the present health care system came to be and there is room to evolve a method of operations that can provide more effective health care system.

3. Set Up of Primary Health Care at the Local Government

The concept of PHC was formulated to provide essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost which the country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. Primary Health Care forms an integral part of the Nigerian social and economic development (Adeyemo, 1995). It is the first level contact of the individual and community in the national health system as expressed in the constitution and National Policy document thus bringing health care as close as possible to where people live and work and contributes the first element of a continuing health care process. It is worthy of note that PHC is not exclusively medical, which some health care professionals want to believe that *Primary Care* is the same as Primary Health Care. The aims and objectives of Primary Health Care are as follows, to:

1. Make health services accessible and available to everyone wherever they live or work.

2. Tackle the health problems causing the highest mortality and morbidity at a cost that the community can afford.

3. Ensure that whatever technology is used must be within the ability of the community to use effectively and maintained.

4. Ensure that in implementing health programme, the community must be fully involved in planning the delivery and evaluation of the services in the spirit of self-reliance.

Basically, PHC is essentially aimed to prevent disease, cure disease and rehabilitate i.e. help people live full; normal lives after an illness or disability. Importantly, Primary Health Care is intended to provide general health services of preventive, promotive, curative and rehabilitative nature to the population as the entry point of the health care system. Provision of health care at Primary level is largely the responsibility of Local Governments with the support of State Ministries of Health and within the pivot of national health policy. Components of Primary Health Care are 10 and form the basis for the administrative activities to manage and organize all resources to achieve the set goals. The following are components of Primary Health Care. They include:

i. Education concerning prevailing health problems and the methods of preventing and

controlling them, which can only be achieved through health promotion and education activities;

ii. Promotion of food supply and proper nutrition;

iii. Adequate supply of safe water and basic sanitation;

iv. Material and child health care including family planning;

v. Immunization against the major infectious diseases;

vi. Prevention and control of locally endemic diseases;

vii. Appropriate treatment of common diseases and inquiries;

viii. Provision of essential drugs;

ix. Community mental health care; and

x. Dental Health.

In order to meet these objectives, there are clear administrative and management implications for the departments that is saddled with the responsibility of ensuring that members of the community are healthy. These components represent specific professional entities and skills acquired during training. The Primary Health Care is structured within the Local Government organizational setup to operate and meet its set aims and objectives, where the chairman of the LGA, at the apex, also the chief executive officer has political and administrative responsibilities to ensure that the constitutional rights of every citizen is protected. He in addition supervises the Local Government Secretary who reports to him. The health care delivery at the LGA is headed by a Supervisor of Health which is a political liaison between the executive and the health care department, while PHC is headed by a PHC Coordinator who invariably is a medical officer, and Assisted by a Deputy coordinator. The

PHC coordinator reports to the Supervisor who in turn reports to the LGA Secretary. The different components of the LGA PHC are manned by personnel of diverse specialty. There are three levels of operation of PHC in LGA. These include:

(1) Village level

(2) Ward/District level

(3) Local Government level.

The leadership of the PHC is faulty and requires reform. This is because such a complex organizational setup requires competent and experienced individuals to be able to plan and coordinate activities that are effective. It is very important and appropriate that when appointing such individuals, to head the PHC setup, professional competencies should be taken into consideration and not traditional sentiments and prejudices which the system has inherited over the years that clearly demonstrate timidity, and the weakness of colonial intimidation and oppression.

4. Justification for Integrating Medical Rehabilitation Services at the PHC Level

Community-based practice for medical rehabilitation therapists is essential in promoting health, improving quality of life and meeting the need of various categories of individuals, majority of live in the community. Therefore this community-based practice can only be coordinated effectively along the current PHC and coordinated at the LG secretariat by the PHC which includes, but not exclusive, programmes on immunization, distribution of Insecticide Treated Bed Nets, family and reproductive health such as family planning programmes and HIV and AIDS, Voluntary Counseling and Testing (VCT), monitoring and evaluation as currently implemented by professionals. Medical rehabilitation services has components of its practice that has relevance in all stages of the continuum of the natural history of disease etiology and providing services in the community in the preventive framework and follow up at the home clients after debilitating illness.

4.1 Evidence of Effectiveness of Medical Rehabilitation in Primary Health Care

These medical rehabilitation therapists are specifically trained to plan and implement rehabilitation services in disabling conditions such as stroke, pulmonary disability in tuberculosis recovery, post-operative recovery, palliative pain relief in cancer and low back pain conditions, among others. Apart from treatment modality offered the prevention of accidents in the workplace environment is equally important to reduce injuries. The question is “who goes home with these patients to follow up care continuum?” “Who is competent enough to provide these services?’ Well, the answer is very obvious. Preventive-practice would be even more valuable in preventing the need for surgical intervention in early diagnosis of most joint condition emerging from mechanical injuries. If as a result of inevitable circumstances leading to physical trauma requiring surgical intervention, the medical rehabilitation therapists should be the one who follows the client home to maintain

the continuum of care. There should be care beyond the clinical setting which require home visit, this constitute best practice in contemporary health care. This preventive health paradigm provides opportunity for cost saving on the part of the clients and reduced financial burden on the health system.

Table 1 Concept of level of prevention and modes of intervention in the continuum of disease progression

LEVELS OF PREVENTION	**PRIMARY PREVENTION**		**SECONDARY PREVENTION**	**TERTIARY PREVENTION**	
MODES OF INTERVENTION	HEALTH PROMOTION	SPECIFIC PROTECTION	EARLY DIAGNOSIS AND TREATMENT	DISABILITY LIMITATION	REHABILITATION
DISEASE PROGRESSION →					

The diagram provides contextual relationship between Level of Prevention and Modes of Intervention

This paper provides evidence for the integration of medical rehabilitation services in primary health care by considering the concept of Levels of prevention which provides information about levels at which medical rehabilitation services intervention can be successful to accomplish much to promote general health and well-being of the community. The framework of levels of prevention provides context in the types of interventions that may be applied and at what level of prevention in the period of the pathogenesis in the disease process (Park, 2005; Jekel, Elmore & Katz, 1996). Most health promotion activities are strategically designed at the level of primary prevention when the disease process is asymptomatic and has not been established. This framework provides evidence for injury-risk surveillance in the community targeting population at special risk such as children, worksites environment, individuals with special predispositions to prevent re-occurrence of morbidity that predispose to disability. Health Education provides protection against hazards in the workplace environment. In the context of Secondary Prevention, early detection/diagnosis serves the purpose of providing a type of surveillance so that when disease process is at its earliest phase, treatment becomes more effective to halt disease progression. Early diagnosis and treatment are the main interventions of disease control. Screening activities facilitate early detection. In the natural history of disease progression, especially when patients present late for treatment and the disease trajectory indicates that a serious health outcome is imminent, disability limitation intervention is applied. Rehabilitation has been described as the combined and coordinated use of medical, social, educational and vocational measures for training and retraining the individual to the highest possible level of functional ability.(WHO, 1969). Rehabilitation has the goal of restorative therapy where restoration of function is accomplished.

5. Conclusion and Recommendations

The medical rehabilitation has one basic context presently and the unit of practice providing policy recognition is in the tertiary clinic-based setting which does not exploit fully

the potential in the profession to contribute significantly to the health care system. This paper is proposing a revision of the status-quo and recommending integration of the practice in the PHC framework to adequately address issues requiring health promotion, limitation of disability and rehabilitation in injury and debilitating illnesses. There is a need to make the profession and its practices well known to the public. The regulatory body, The Medical Rehabilitation Therapist Registration Board of Nigeria should strategically enter into dialogue with various identified stakeholders, such as the government agency the National Primary Health Care Development Agency (NPHCDA) responsible for monitoring and supervising outcomes in PHC service delivery with a policy brief which should contain justification for the desired integration of MRS in PHC and mechanism of implementing the integration. The benefits of a repositioning of MRS to widen its scope through policy reform would strengthen the profession and make important professional resources available in its training to strengthen the present PHC scheme in the local government. There is no doubt that PHC need to be strategically strengthened to be able to attain optimal service delivery. Therefore, it is clear that the integration of MRS in PHC would provide effective delivery of health care in the community.

6. References

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