

RURAL PRACTICE: THE NIGERIAN EXPERIENCE

Twenty years ago, doctors in Nigeria were berated for failing to serve in the rural areas. Studies, however, showed that they were willing to work anywhere in the nation, as long as they were placed in situations where they could use their skills, live fairly comfortably and where they were able to rear their children.

At present, 3 000 Nigerian doctors are living and working in the United States and numerous countries in Europe and the Middle East, as well as other African countries, because they are unable to find jobs and postgraduate training posts in the nation's teaching and general hospitals. Yet there is a great shortage of doctors in most parts of Nigeria. The main reason for this situation is that doctors, trained in teaching hospitals in urban areas, were sent to work, unsupervised, in ill-equipped rural hospitals where they considered themselves a danger to the people.

The Nigerian plan of health system reform

In 1975, Nigeria's health service system was restructured. Each tier of Government — local, state and federal — was to be responsible for primary, secondary and tertiary care, respectively. Each tier of government had considerable autonomy in planning and implementing its own services and the Federal Government ensured that all three tiers of the services were linked into a National Health System.

Primary services consisted of village and health centre services. Secondary health care was provided by general hospitals and received referrals from health centres. Tertiary services provided by the teaching hospitals dealt with cases beyond the capabilities of the general hospitals.

By this design, 85% of the nation's health problems would be addressed within the primary system (health centres for a population of about 10 000); 10% within the secondary phase (general hospitals in each local governmental area (LGA) with a population of 100 000 to 250 000); and 5% in the tertiary system (a teaching hospital in each state for 3-5 million people).

Training of doctors

Training these doctors means a radical change in content and methods. The quality and success of medical education cannot be measured by the ability of graduates to pass the British or American examinations. Reforms must be carried out so that the educational system produces doctors with skills specific to African needs.

Professor Olikoye Ransome-Kuti

Chairman of the World Health Organisation "Better Health in Africa" Panel and former Minister of Health in Nigeria

Initial, post-graduate training should take place in academic primary and secondary health care complexes. This implies that newly-qualified doctors must begin their medical career by spending the pre-registration period divided between the primary health care services and as house officers in a general hospital.

Teachers with the knowledge, the will, and the skill to emphasise training to care for communities are required. Super-specialist-specialists are not suitable for service within the secondary health system. The primary health team consists of community health officers, assistants and aides, village health workers and traditional birth attendants. Teaching hospitals will be de-emphasised as the professional life of most of the registered doctors will be within the primary and secondary health systems where 95% of the nation's health problems need to be solved.

This will also ensure that the tertiary system functions as it is supposed to do, treating only those few cases that cannot be treated in general hospitals.

Successful implementation

One of the reasons that Nigeria's reformed health care service has not been fully successful is that such reforms require a period of advocacy in which the reasons for the reforms and their implementation are discussed and publicised widely. There needs to be national consensus on the adoption of reform. Universities can also play a significant role in the successful implementation of a new model for public health.

Another key ingredient to the success of such reforms lies in new styles of leadership which encourage controversy, questioning, discussion and research. African health systems do not permit leaders to emerge; frequently they are discouraged. People with leadership qualities are afraid to demonstrate their abilities, because hierarchical management styles and values — which exhibit authority rather than leadership — constrain leadership.

The Zambians, who are implementing the most spectacular health reform process on the African continent, believe that an effective basis for adapting to a turbulent policy environment is a system of Leadership, Accountability and Partnership (LAP). This LAP system stresses co-operation rather than competition, promotes diversity in policy responses to health concerns, encourages innovations, does not fear to make mistakes and creates the mechanism for conflict resolution.

Conclusion

As the doctor prepares to step into the community with new skills, he must do so within a reformed system of health care. At last the process of reform is gathering pace throughout the world and especially in sub-Saharan Africa. ●

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Contact: Ronelle van Loggerenberg, Didasko, PO Box 667, Pretoria

Tel: (012) 319-2646 Fax: (012) 319-2646 E-mail: rvanlogg@medic.up.ac.za