Drug power to the people

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In Nigeria, steps are being taken to increase community involvement in drug revolving funds and health actions through a process of decentralization. Communities are being encouraged to accept responsibilities in these areas and efforts are being made to overcome resistance to community empowerment among officials and health personnel.

The international adoption of the Bamako Initiative in 1987 led to Nigeria gaining technical and financial support for the implementation of primary health care. Concomitantly, the country began developing the use at community level of surplus funds generated from drug sales.

Of Nigeria’s 589 Local Government Areas, each of which is divided into 4-10 health districts, 53 were responding to the Bamako Initiative by 1995. Each health district has a health post, a health clinic and a health centre and has access to a referral facility. The health activities in each Local Government Area are controlled by a primary care management committee chaired by a politician. Below this level there are district and village development committees.

Teething troubles

In 1990, when Nigeria’s implementation of the Bamako Initiative began, the following circumstances prevailed.

Drugs were supplied directly from central drug stores to health facilities. District supervisors were responsible for receiving the drugs at the facilities on behalf of the communities, and were held accountable for the associated funds.

The funds generated by drug sales in each Local Government Area were deposited in its Bamako Initiative account.

It was intended that profits derived from drug sales should be shared between Local Government Areas, health districts, and villages or communities.

Unfortunately, various problems arose which affected efficiency, as outlined below.

- Success depended largely on the qualities of the district supervisors, who frequently failed in their duties. This led to facility staff collecting drugs from central stores, a breakdown in accountability, and decapitalization of district revolving funds.

- Once money had been paid into a Local Government Area’s Bamako Initiative account the withdrawal of profit for sharing between the three levels proved impossible because of government regulations.

- Some workers understood profit-sharing to mean that they should gain financially when they sold drugs.

- Large amounts of money accumulated in the Bamako Initiative accounts of certain Local Government Areas because profits were not
shared with the communities. At a time of financial stringency, some chief executives took funds from these accounts to pay salar-ies and meet other commitments, with the result that the drug revolving funds suffered serious decapitalization.

Little attention was given to equity in access to health care. Misuse and mismanagement of resources meant that services were denied, especially to people who were least able to pay for them. None of the Local Government Areas had a consistent and uniform policy for exemption from payment for services. Decisions on this matter were usually made by development committees, which had no means of ensuring implementation because health workers and resources were controlled by the Local Government Areas.

Decentralization

In 1993 a conference hosted by the National Primary Health Care Development Agency considered these issues and recommended that all funds generated in the Bamako Initiative programme should be retained at the level of generation. This was accepted by the Federal Government, with the consequence that drug revolving funds had to be operated at all levels of implementation. Each Local Government Area, district, and village or community received seed drugs and now runs a drug revolving fund. Each district has a bank account into which the proceeds from drug sales are paid, the authorized signatories being the chairman and treasurer of the district development committee and the district health supervisor. Village development committee are also encouraged to open bank accounts where local banks exist. Decisions on the use of drug revolving funds are made exclusively by committee members.

In conjunction with decentralization of the drug revolving funds a cash-and-carry system has been introduced whereby each village purchases drugs from its district, which in turn buys them from its Local Government Area. Only the Local Government Area is in direct contact with the drug manufacturers from whom the drugs are obtained.

Community empowerment

The most important feature of the new approach is the intention to achieve the great-est possible community participation in health activities through the district and village development committees. These bodies, together with health staff, now have joint responsibility for managing resources in their districts on the basis of guidelines, issued by the National Primary Health Care Development Agency, for the use of surplus funds generated by drug sales. The district supervisors calculate the needs for drug replenishment and cost them at the cash-and-carry prices set by the Local Government Areas. The committees discuss the matter and, if satisfied, approve the release of funds for the purchase of drugs.

Before decentralization was introduced the communities were advised about the additional responsibilities they would have to accept. The decentralization of resources makes the communities accountable, and committee members are aware that decapitalization of their drug revolving funds results in an inability to re-plenish stocks.

Decentralization has been accompanied by an improvement in the mobilization of community resources for health activities. Community

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funds have been used to build and renovate drug stores, and some communities have hired vehicles in which drugs can be brought to
their districts, rather than waiting for local government transport.

Where decentralization has been accompanied by the introduction of a community health monitoring system, communities have demonstrated an enhanced capacity to assess needs, health service performance, and health status. Some communities have protested to local governments about absenteeism among health personnel. One community requested the removal of a nurse who was running a private clinic at the expense of a public health facility.

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Although the profile of equity in access to health care has been raised, as yet there have been no concrete accomplishments in this regard. Development committees have been briefed to consider the subject and the Agency has made two proposals for exemption mechanisms that might be applied to persons unable to pay for health care. The final decisions on this matter are to remain with the committees.

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**Generic drugs make savings in malaria control**

Antimalarial drugs are often the most widely consumed and most expensive single items of expenditure in a national drug budget, and the essential drugs programme has a strong incentive to cooperate in making sure that they are used as rationally as possible. In virtually every case, generic drugs will be the most appropriate for malaria treatment. Their use in preference to more expensive proprietary products could make more funds available for other malaria control activities, such as training and education.

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