INTRODUCTION

It is a pity that 30 years after Alma Ata, Nigeria’s health statistics have not shown any significant changes and in deed in some cases have become worse. Life expectancy for example has declined from about 52 years in 1978 to 48 years in 2008. It is true that many more Primary Health Centres have been built and much more money budgeted and spent for PHC in Nigeria, the results have not justified the overall investment, except in the area of immunization against the 6 common childhood diseases. Even here, recent decline in coverage and loss of momentum has become worrisome.

Certainly, the reasons for this unsatisfactory outcome of PHC services in Nigeria are many but the inadequate supply and availability of essential drugs and supply represent a critical reason. Why is this so? A review of several causative factors will help illuminate the problem.

POOR BUDGETARY ALLOCATION

From the analysis of the scanty data available, it is evident that the allocation of financial resources for the purchase of essential drugs and supply for the Primary Healthcare Centres has been generally on the decline. In some cases, there have been some increase in the total allocation, but when this is adjusted for inflation and exchange rate deterioration, the general trend is a decline. In all cases, this decline is accentuated by the population explosion leading to a dismal Per Capita allocation.

With the increased focus on the immunization of children through the National Programme on Immunization (NPI), much of the spending resided in this area, buoyed by International donor contribution. As a consequence, there has been insufficient budget allocation to other essential medicines. In most of the health centres and other Primary Health Care Centres,
many of the essential drugs remain out of stock. Except for dressings and Iodine tincture and some tins of analgesic tablets, not much else could be found. In some instances, the workers at the centres complained that the drugs bought by LGA’s were too few and got quickly exhausted. The overall impression has been that the local government authorities did not pay enough attention to providing essential medicines and supply to the health centres. There was greater focus on meeting personnel emoluments and not much left for essential medicines. Our investigation revealed that many patients including pregnant women were asked to go and buy their drugs and other supplies from the private pharmacies and patent medicine shops. And usually, many never returned to the health centres or maternity centres either to continue treatment or to be delivered of their babies.
DIVERSION OF PRODUCTS

It has been established that a significant proportion of essential medicines and supplies meant for the PHC are misappropriated or diverted. This diversion is at two levels; at the local government drug store level and at the primary health care level. Health workers especially the store keepers and those at the dispensaries divert some of these items either for personal use or by outright theft as some of the items delivered to the health centres have been found in the open drug markets. The matters is worsened by poor supervision because in many cases, there are no Pharmacists to provide supervisory oversight and even the other health care staff assigned with such duties sometimes is negligent or even collude to divert the medicines and supplies. Similar situation exists in some State medical stores and general hospitals.

POOR VALUE FOR MONEY

Because of the poor procurement procedure adopted by the local government authorities in the purchase of these medicines and accessories, the scanty budget is sub optimized. In many instances, there is no tendering system and no bidding. The local government authorities just select party members or friends and ask them to supply these items. These people then go to the open markets or to the local medicine dealers, including the itinerant hawkers and procure these items, with heavy mark ups to accommodate a long chain of interested parties.

Again, instances abound where fake or substandard drugs are purchased either out of ignorance or a desire to maximize personal gains. In a number of health care centres, we find a lot of expired medicines and investigations reveal that some of the items were only recently supplied, which suggests that they were already short dated at the time of purchase. Once more, the paucity of supervision by appropriate pharmaceutical or healthcare professional gives room for this unsavoury practice which short changes the system.

We found that in a few States where Drug Revolving Fund Scheme operates, some of the LGA authorities refuse to buy from them because, opportunities for “lading” and “cladding” do not exist. This happens even in States, where there is a law that compels all to patronize the Central Medical Stores. Thus, these corruptive tendencies became a major stumbling block for the availability of quality essential drugs and supplies for PHC services in Nigeria.
Ideally and perhaps constitutionally, the PHC services are essentially the responsibility of the 3rd tier of government – Local Government Councils. But we all know that for a long time, the local governments did nothing else but pay teachers salaries and other local government staff. Because of several interruptions in the flow of LGA funds, many local government Chairmen and their Councilors (when possible) did not have proper control of their funds. The Constitutional requirement to operate joint accounts with the states left them at the mercy of the State governments.

Until the EFCC began to enquire on how the States ran these joint accounts, the local governments were entirely at the mercy of the States. Today, many of the Local Government Councils have begun to take control of their resources and in fairness to them, some improvement has been noticed in their statutory responsibilities.

But perhaps because of our own political history, where the military more or less operated a unitary system of government, and the subsequent ‘hangover’ even during the constitutional democratic governance, responsibility for Primary Health Care services has been diffuse and sometimes conflicting. It has been seen that all tiers of government in one-way or the other venture into PHC services. Some State governments have been known to undertake to build and supply medicines and consumables to Primary Health Care Centres. They have either done it as an extension of their budget plans or they have claimed to do it on behalf of the local governments, justifying sometimes, the seizure of local government funds. The Federal Government on its own perhaps irked by the poor performance of the local governments have tended to intervene. The recent compulsory deduction of money from LGA’s to build new health centres across the country by the Federal Government is a case in point. As I write this, the building of the health centres is stalemated as the local governments under the auspices of ALGON, with subtle nudging by the State governments have challenged the ‘illegal’ deductions while the contractors have gone to the court to ask to be paid for work done.

In my opinion, there is nothing wrong with both the Federal and State Governments supporting Primary Healthcare Services as PHC has been shown all over the world to be the foundation of a good healthcare system. For example, it is certain, that the level of coverage...
of immunization achieved by the NPI would have been almost impossible for the local governments to achieve alone. But the problem is that some of the interventions are not well coordinated. Sometimes, it creates vacuum and gives the local governments opportunity to evade responsibility as they hesitate to provide drugs and other supplies to the health centres, hoping that others would do so. At other times, they hope on donor agencies and voluntary organizations to come to their aid. As a result, we have seen situations of supply extremities. There is a high level of supply, once in a while as drugs and consumables arrive from different sources, then followed by a long spell of poor or no supply as each tier hopes or expects that the other is maintaining supply. It is therefore apparent that some level of coordination is necessary to determine who does what and when, so that supply is maintained at an optimum level. Perhaps, the National Primary Health Care development agency will have a role to play here.

**LOCAL AVAILABILITY OF ESSENTIAL DRUGS**

In the best of times, a major challenge for the optimum performance of the PHC services in Nigeria is the local availability of Quality Essential Drugs by the Pharmaceutical Industry. Whereas no nation can be self sufficient in the production of all drugs, given that new diseases are emerging by the day, and some of the older ones are making a remarkable come back, it is important that nations seek self sufficiency in the production of ESSENTIAL DRUGS. By WHO standards, Essential drugs are those drugs which the nation must have in sufficient quantities at all times for the management of the most common ailments that afflict the greater number of its population. The Essential Drugs list programme is derived from this concept. It is understandable that the essential drug classification is unique to each country. What may be regarded as non-essential in Nigeria may be essential in the United States of America due to each country’s disease patterns and level of development.

The Nigerian Pharmaceutical Industry has grown from a state of mere importation in its early years to when rudimentary manufacturing began in the 1958 to 1971 time frame. By the early 1990’s the drug manufacturing companies had reached 50 and today, there are nearly 150 manufacturers. About 70% of the pharmaceutical industries in Nigeria are engaged in secondary manufacturing, which involves the processing of medicinal substances with formulated additives into pharmaceutical dosage forms of all types. The rest 30% are engaged mainly in tertiary manufacturing which primarily embraces the packaging of finished
dosage forms of all types in manners appropriate for their intended use and in conformity with the nature of the preparation involved, the expected condition of their transportation, storage and subsequent handling. There is virtually no primary manufacture or bulk production going on in Nigeria today, though our sister country Ghana now has a company that is into primary manufacture.

As far back as 1990, available capacity for producing essential drugs especially the solid and liquid non-sterile has been considerable. Up to 50% of national drug requirements could be produced by the local industry. The government of Nigeria had recognized this fact, hence the National Drug Policy of 1990 stated amongst other things, a cardinal objective on page 11, Chapter 4, Section 2, Subsection 4: “To improve local capacity in drug manufacturing” and went on to state one of its targets on page 12, Chapter 4, Section 3, Subsection 7 “…to increase patronage of local industry when procuring drugs so that by 1995, 50% of our procurement would come from local manufacturers and 75% by the year 2000”.

However, low capacity utilization has dogged the industry from the late 1980s when production remained consistently below 40% capacity due to several oscillating factors. Beyond the national industrial malaise of perennial inadequacies in industrial infrastructure and utilities such as electricity, diesel, LPFO, water and transportation, the industry has faced stiff competition from importation of finished products from all over the world particularly India and China. The introduction of the World Trade Agreement (WTO) agreements and the globalization of Trade have made Nigeria to become a major destination for drugs and supplies from all over the world. What is more, a substantial part of these imports are sub-standard and some are outright fakes.

The local industry has thus faced severe competition and was really in decline until the advent of the revamped NAFDAC in 2001, which waged a relentless war against sub-standard and fake drugs. Today, the incidence of fake drugs has declined considerably and the ability of the local industry to supply Quality Essential Medicine to the PHC has been largely restored. But three problems still persist.
Firstly, capacity for production of sterile products like injections, infusions and vaccines is low and the country still depends on large scale imports for these, creating challenge of speed of delivery and product integrity.

Secondly, is that we still have a poor distribution system for drugs. Drugs still pass through many channels before they get to the final consumer and in some cases they pass through unqualified hands. The danger here is that they could be mishandled, for example, exposed to too much heat or too much moisture. Also, the multiple intermediaries could lead to cost escalation.

Thirdly, the patronage of locally made drugs by the governments is still below par, certainly below the 75% envisaged by the 1990 Drugs Policy document. Governments still import drugs from abroad, drugs which are locally available. Sometimes, they claim it is the condition imposed by the donors. But how do we justify those bought with the national wealth. Purchasing drugs direct from local manufacturers or accredited distributors of those drugs not locally manufactured will achieve many positive things for the PHC services in Nigeria:

1. The quality of the products can be guaranteed since there will be no intermediaries and possible manhandling.
2. Speed of supply is assured as the drugs are already in the finished goods warehouses.
3. Better pricing is assured as multiple mark ups are eliminated. Even then prices can still be negotiated downwards.
4. Jobs are created and taxes are paid, helping the national economy.
5. In the event of any problems with efficacy or safety, it will be easy to locate the local supplier and recalls can be much easier.
WHERE DO WE WANT TO BE

In all sincerity, I am appalled that our health statistics have not shown much improvement over the years. Malaria is still ravaging us with vehemence. Infant and maternal mortalities remain amongst the worst even in Africa, not to talk of the world. Despite the very strong efforts on immunization of children, Nigeria remains one of the very few countries still harbouring the wild polio virus. Every year, our children die unnecessarily due to meningitis. It is my submission that if we must truly change this awful picture, Nigeria must truly focus on Primary Healthcare and do all that it takes to make it functional and successful. We must take healthcare to the people, waiting for them in hospitals or even in the health centres may not yield the result. We need to move to the communities and into their homes. Many Nigerians still do not appreciate what they must do to keep themselves healthy due to ignorance, poverty and low esteem. Many in the rural areas cannot find transport to the hospitals. Some indulge in criminal self-medication until they run out of steam. Others think it is a waste of time and effort, it will take a whole day to see a Doctor (if you find one) and then when they prescribe the drugs, the Pharmacist (if you find one) or the Nurse tells you it is out of stock or encourages you to visit him or her at home. What then is the need to waste time going to the hospitals? If we must transform Primary Health Centres services and ensure that we overcome the challenges of making quality essential drugs and supply available, I recommend as follows:

1. The Federal, State and Local Governments need to agree on pooling funds together for the execution of PHC services. The National Council on Health should work with ALGON to work out the contribution of each tier and the specific role of each contributor. An agreed formula should be implemented in a consistent manner. It should be made clear to all that unless we have a functioning Primary Health Care system across the nation, our teaching and specialist hospitals will remain glorified health centres.

2. Many more health centres should be built, close to where the people live and work. Nigeria may borrow from the Redeemed Christian Church that has a vision that every worshipper should have a Redeemed Church within 5 minutes of walk from their homes or offices. If a non-governmental organization that does not receive oil revenue or tax can do this, I believe Nigeria can do it, if we have the will.
3. Drug procurement for the PHC must be adequately budgeted for using the pooled resources advocated above. The donor contributions will be additional.

4. Procurement of essential drugs and supplies should be tendered for and purchased as much as in practicable direct from the manufacturers or accredited representatives of overseas manufacturers. No more open purchases or patronage of itinerant drug hawkers.

5. Professional Pharmacists and other appropriate healthcare workers must be involved in the development of the list of drugs; purchase, storage, distribution and dispensing of the drugs and necessary supplies.

6. Proper record keeping must be established with adequate supervision.

7. Regular Financial Audit must be undertaken to ensure cost effective utilization of the drugs and supplies. Additional outcome audits must also be undertaken to assess impact on the health of the community.

8. A high level of Enlightenment Campaign must be undertaken to achieve the following.
   
a. Bringing health consciousness among the People
b. Teaching simple ways of keeping healthy
c. Inviting the People to visit the Primary health Centre
   - Indicating the locations and assuring that health care professionals are on duty and that there are sufficient drugs.
d. Preparing the people to adopt preventive measures before the outbreak of several epidemics like meningitis.

9. The health care workers that provide the PHC services must be trained retrained and equipped to carry out the very basic but very essential service. They also must be well remunerated and motivated. They should be paid special allowances to keep them in the rural areas and their make to assignment attractive.
10. All the Health Ministers, Commissioners for Health in States, Councillors for Health in LGA’s must be made to undergo training to enable them understand the concept of PHC and its critical role in reversing our current National Health Status. It must not be assumed that they understand that the PHC Services should take precedence over secondary and tertiary health care services.

CONCLUSION

It is medicines that make health care delivery credible. Many people who go to health institutions and see the best doctors or undertake the most rigorous tests and investigations go home unhappy if they do not have medicines prescribed or recommend for them. They feel very sad when drugs are prescribed and they cannot receive them either because the drugs are out of stock or they cannot afford them.

It is therefore critical that any health care system must take the issue of making quality drugs and essential hospital consumables available in the right qualities and right pricing very seriously. It becomes even much more important in the primary health care service set up. It is here that the disease progression must be stopped and people enabled to return to work speedily. In addition, it is here that the expectation of the people to take drugs home after a visit is highest and it is here in many cases that the people cannot afford to pay for expensive medicines or other high hospital costs.

In this discourse we have identified that poor and inadequate budgetary allocation, diversion of products, poor value for money, uncoordinated governmental actions and the local availability of quality essential medicines constitute the major challenges affecting the sustained availability of essential medicines and supply for PHC Services in Nigeria. To deal with the challenges and enable Nigeria run a PHC service level that will reverse our poor health statistics we have proposed ten remedies. It is our hope that our leaders in the health sector – both political and professional will pursue these recommendations for the good of all.
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