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COMMENTARY

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Child Health Care in Nigeria: Historical background

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Introduction

Protocol

Child care is a natural instinct of all animals, human beings inclusive; however, the highest level of care of health of the child is that of the mother because of the love and devotion given to children by mothers. It is the mother that is endowed with special knowledge of her child, and she provides a wide spectrum of services to her children. Historically therefore, where do we start with this discussion? Is it before the introduction of Western Scientific Medicine or are we talking about the modern scientific medicine? I made several assumptions in attempting to interpret this topic.

First, I assume that it is the orthodox scientific medicine as it relates to the well being of children that is referred to. Secondly, why history to paediatricians or physicians involved in child care? Well, history is not merely a biographical account of the previous years. It is a vital link that connects the past and the present, the present and the future. In this context the history of child health is relevant because it enables us understand the changing economic, political and sociological medical factors at play on which we can construct models based on the present situation of the state of child health, the levels of care provided and possibly predict the future trend of child care.

Before delving into the Western or Scientific medical perspectives of health care services to children I need to say a word or two about the Nigerian traditional care of the sick. Organised social structure existed before the Western civilization one of which is health care system. The health care system before advent of orthodox or Western medicine traditional care centered around individual knowledge not widely publicized, but confined to nuclear family. Specialist services existed in form of traditional birth attendants, bone setters etc. Infertility remedies abound. Herbalists took centre stage and are now being accorded recognition.

Protective measures for children against witchcraft included use of charms etc. Use of cow's urine among certain ethnic group to arrest convulsion, revival acts using hot objects application on the body of a convulsing child were used as forms of remedies. Similarly, cow dungs for treatment of umbilical cords of newborns were some of the accepted practices in child health care. Female genital mutilation was recognized forms of therapeutic measures while infanticides were used to rid children with congenital malformations such as hydrocephalus. High infant mortality rate was a strong motivator to having more children to make up for the wastage. Many of these practices were injurious.

Concept of Child Health Care

Child health care refers to the total package of the wellbeing of a child in a holistic manner through preventive, to keep the child away from adverse effects of all disorders, promotive, curative and rehabilitative measures when curative measures fail. To a Paediatrician the ultimate goal is to provide the optimum care for the child through the cycle of life from conception to adulthood in perfect state of HEALTH as defined by the World Health Organization.

Definition

The Federal Ministry of Health, Nigeria defined a child "as a person aged from birth to 18years" adopted from convention on the Right of the Child.

Historical perspectives of evolution of medical health services in Nigeria

Modern scientific medicine was introduced into Nigeria by the Portuguese for the Portuguese traders and sailors to the West Coast of Africa as far back as the 15th century but the traditional systems of care of the sick as practiced by the indigenous populations were not tampered with. By the 16th century the British and Scotish traders joined the Portuguese explorers for purpose of trade. These groups were also accompanied by doctors who looked after the sailors and traders exclusively. As the voyages of discovery by Europeans intensified in Nigeria the process of colonization run paripasu, with doctors looking after both traders and colonial masters at the exclusion of the local population. With the establishment of colonial rule the *civil servants came on board.*

The colonial administration extended its services to the military, traders, sailors and the European Civil Servants. Missionaries then came in and started establishing medical institutions. With passage of time Nigerians became aware of the benefits of these services and demanded the same. The colonial masters grudgingly granted modified medical services to the indigenous population by first providing them services, through auxiliaries with little knowledge or skill. Secondly, colonial government started developing African Hospitals distinct from European Hospitals. A third feature of colonial government health care to indigenous was the establishment of medical schools to train assistant medical officers who in turn were expected to provide care to the indigenous population. In Nigeria these were built in Kano and Yaba but phased out later.

The Missionaries on the other hand brought European medical services to the indigenous population in addition they built dispensaries and General Hospitals. By the time of Nigeria's independence in 1960 the general hospitals and some elements of specialist care like the Messey Street Children's Hospital in Lagos and elements of tertiary care were in place.

Evolution of Paediatrics and Child Health Care services

Evolution of Paediatric services in Nigeria followed the same pattern as those in Europe. In Europe these started in the 19th century after the French Revolution (1789 - 1815) when it was widely recognized that children needed special care because of the high infant mortality. Before then it was considered that sickness in infancy was normal developmental process. Paediatric services evolved to curb out child malnutrition and to prevent infectious diseases hence the development of first generation vaccines namely smallpox, tetanus, typhoid, diphtheria and BCG. Virtually all the pioneers in paediatrics cropped up from adult medicine. This development led to establishment of Paediatrics Teaching as specialization followed by establishment of children's hospitals in Europe.

Paediatric services and training in Nigeria

Services and training are inseparable. At independence and shortly thereafter paediatrics services were started in Lagos, the first Children's Hospital was established at Massey Street in Lagos. Nigerian pioneers in these fields included Drs. Animashaun, Ajenifuja, Fadahunsi and Ekpechi. Tertiary service started in UCH Ibadan followed by LUTH, Lagos. Prominent names at LUTH included Professor Collis and expatriate with Nigerians like Olukoye Ransome-Kuti. At UCH the pioneers included Drs. Hendrickse, Antia, Effiong etc. For more details the reader is referred to Faculty of Paediatrics Lecture 2001 by Dr. Okehialam.

In Ahmadu Bello University, the Department of Paediatrics was created in the Faculty of Medicine in 1969 when the pioneer batch of medical students entered into the clinical years of their training. Hitherto, children were lumped into female wards. The pioneer staff to whom I like to pay great tribute included Professor Sinette an African American who was the first head of Department, for a super brief period. He was succeeded by Professor Richard Dobbs with whom were Professor Huggey, Dr. Duggan later joined by other Britons, Dr. Brueton, Hargreaves, Nesbit and others. Professor M. B. Abdurrahman was the first Nigerian Head of Department from whom Professor Kunle Ijaiya took over. It is instructive that the first and second batch of the ABU Medical School produced paediatricians in the persons of Professor Ogala from the first batch and my humble self from the second batch of graduates. After my graduation in 1973 I enrolled into Residency Programme in 1975 - 1979 and was appointed Consultant Paediatrician in February 1980 following my success in the Part II final in May 1979.

Paediatric training

Decree No. 67 of September, 1979 gave full legal backing to the National Postgraduate Medical College of Nigeria (NPMCN) to function as a College.

The College actually started operation in 1969 under the joint supervision of Medical and Dental Council of Nigeria and the Federal Ministry of Health. Special tribute must be paid to the following pioneer Nigerian teachers, Drs. O. Ransume-Kuti Animashaun, Ajenifuja, Antia, Kaine, Okehialam, Lesi, Effiong among others.

At commencement the curriculum for the Primary examination involved general common medical science for all candidates irrespective of specialty. Paediatrics Faculty following the promulgation of Decree 67 which gave Faculties power to develop their curriculum opted to basic clinical science relevant to paediatrics. Assessment for Part 1 was based on written papers and clinical examinations until 1990 when practical was added to the part 1 examination. There was one year period of clinical attachment abroad after passing the Part I. I benefitted from this from October 1977 to November 1978.

Until 1985 when General Paediatrics was included in Part II examination which hitherto had only dissertation presentation and defense.

The West African Postgraduate Medical College followed suit. The West African Postgraduate Medical College was established in 1975 through a Treaty, later through the West African Health Community (ECOWAS) protocol to train post graduate medical doctors.

Preventive and Promotive Health Care services for children in Nigeria

In 1960 the year of Nigeria's independence, Professor Collis an expatriate professor of paediatrics working in Lagos proposed the establishment of Institute of Child Health in Nigeria. This proposal was approved by the Federal Government of Nigeria. Unilever donated Institutes of Child Health to be established in the three regions of Nigeria. These were established in Kaduna, northern region, Aba in the eastern region. These were later converted to schools for the training of community midwives. The western region was given the sum of fifty thousand sterling pounds to build the same but this was never to be. The allocation that was meant for Cameroon was transferred to Lagos when Cameroon seceded from Nigeria.

Following the military intervention in 1966 another attempt at establishing ICH was made in 1972. The then Federal Military Government decided to establish Institute of Child Health in every state of the Federation. This decision was later revised when the Federal Military Government directed that the Institute of Child Health be established in every Teaching Hospital in Nigeria and was to be affiliated to the regional University. This saw the emergence of the Institute of Child Health in Benin, Enugu, and Ibadan in addition to the existing one in Lagos. That of Zaria never saw the light.

The Civilian Administration of Shagari in 1980 approved in principle the buildings of six specialist children hospitals in various parts of the Federation. This plan was terminated in 1983 by the coming in of another military government under Gen. Buhari. National Hospital Abuja originally conceived for women and children now serves for both adults and children, men, women inclusive.

Child survival strategy

In 1983, far away in Manila at the International Paediatric Association Conference, James Grant the Executive Directors of UNICEF launched the Child Survival Revolution with emphasis on Growth Monitoring, Oral Rehydration Therapy, Breast feeding, Immunization and Female Education and Family Spacing. Nigerian Government actively participated in implementation of these:

Oral Rehydration Therapy; By 1993 the oral rehydration therapy, one of the components of Child Survival Strategy not only became a house hold word but death from severe dehydration due to diarrhoeal disease declined. An example of this success story was recorded in Yola, General Hospital in the then Gongola State. An ORT Demonstration Unit was established in May 1985. Between May and November 1984, the hospital recorded, 4,045 cases of childhood diarrhoea admitted in the hospital for treatment. Of this number 1,755 received intravenous fluid therapy and 79 died. In a comparable period May 1985 and November 1985 after the establishment of Diarrhoea Treatment Unit and the advocacy and campaign for the use of ORT, 4,229 cases of childhood diarrhoea were recorded and treated using Oral Rehydration Therapy. The number of admissions for diarrhea cases was reduced to 105 while death from diarrhoeal illness was down to 21 translating to 94% and 7% respectively. It is a statement of fact that ORT has become a household word and severely dehydrated children due to diarrhoeal diseases are hardly seen at the tertiary hospitals these days.

The campaign for Breast feeding was intensive through Baby Friendly Initiative, media campaign, posters, seminars and workshop enlightening the public.

Immunization:

Nigeria's attempt at immunization against six killer diseases took off under the Expanded Programme on Immunization in 1976 in South-Western Nigeria in Owo Local Government.

Drawing from the success of this pilot project, a national plan of operation of the EPI was drawn in 1978.

Lessons learnt from this implementation included:

Lack of community participation

Lack of funds

Frequent power failure affecting the cold chain

Political instability resulting in numerous strikes by health professionals.

The revised EPI in 1984 took cognizance of some of these factors in particular improvement in the cold box technology. The Federal Government ensured regular supply of vaccines and it is on record that in 1990 Nigeria achieved 80% vaccination coverage. Nigeria has expanded the immunization to include HBV, yellow fever under the National Programme on Immunization (NPI).

National population policy for development

In the 1980s demographic data revealed among other things high infant mortality rate among the low socio-economic group, and high fertility rate. The Federal Military Government reasoned that:

Empirical evidence from economically well nations showed that family planning was a motivator for high child survival.

Emancipation of women through few numbers of children will provide these women more opportunity to pursue formal education which will afford them opportunity to get gainful employment, and therefore empower them to look after their children better.

It therefore declared four children per mother . This declaration did not gain acceptability nationwide.

Nigerian Government formulated a refined population policy in 2001 after the Cairo International Conference on Population and Development. The policy states inter alia "**That couples have rights to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, the rights to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights document" (**principle 7.3 of ICPD POA). This policy incorporates reduction in both mother and infant morbidity and mortality.

World Summit for Children

The World Summit for Children of September, 1990, held in New York was attended by Nigeria's Military Vice-President. This summit attended by 71 heads of states and government set targets to be achieved in the following areas for child's health:

Eradication of polio

Elimination of neonatal tetanus (by 1995)

90% reduction in measles cases and a 95% reduction in measles death to pre immunization

Halving child death caused by diarrhoea and 25% reduction in incidence of diarrheal disease

One-third reduction of deaths caused by acute respiratory infections

Elimination of guinea worm

Elimination of Vitamin A deficiency

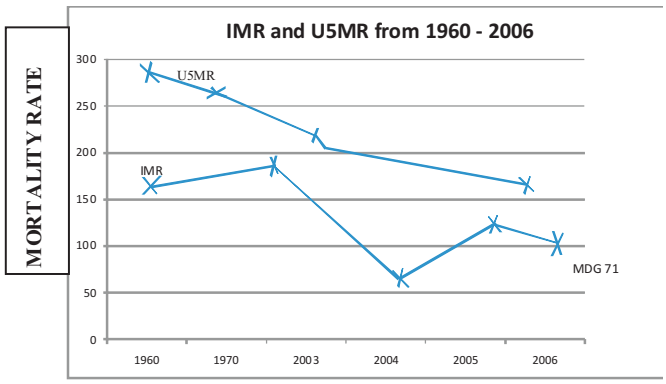
Reduction of low birth weight

Promotion of growth monitoring

Nigeria's attempt in actualizing these goals yielded below expectations except for Vitamin A fortifications and iodine salt.

Odds against survival

There had and still are many odds against survival of the Nigerian child. These include poor health status revealed by poor health and social indicators: Fig. 1



Years

Health Indicators Infant Mortality Rate

- High under five mortality rate
- High maternal Mortality Rate
- Low life Expectancy

Social Indicators

- High rate of Population growth
- Low gross Domestic Product
- Low adult Literacy rate by gender

Provision of Essential and Utilization Health Care Indicators

- Inadequate water supply
- Low access to health facilities
- Low immunization coverage
- Poor prevention and control of epidemic

Other factors militating against child survival include political instability, poverty etc.

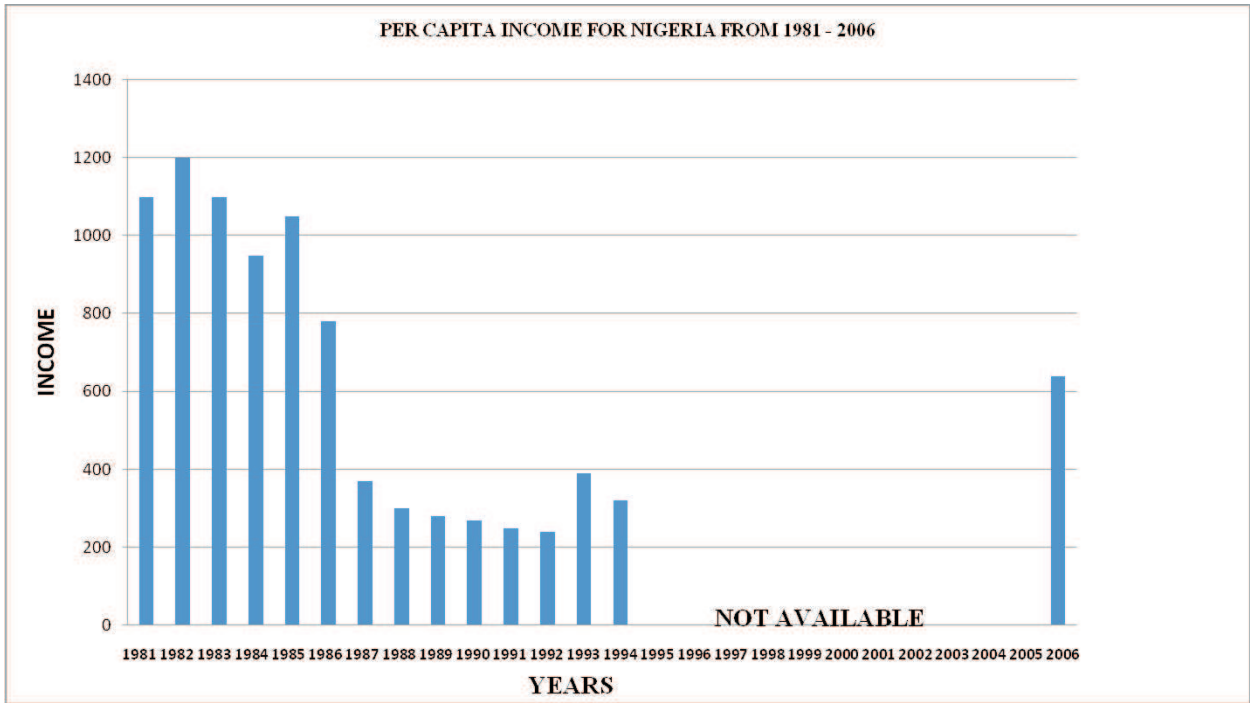
Poverty

Nigeria is a land of paradox rich in oil and minerals. The World Bank Report in 2000 titled "2000 Bank Atlas" ranked Nigeria as the 12th poorest country in the world with GNP per capita of 740 dollars at 1998, placing Nigeria in the category of ABSOLUTE POVERTY (fig 2). This report was in tandem with Federal Office of Statistics records captioned in table 1 below showing the magnitude of poverty.

Table 1: from Federal Office of Statistics depicting poverty trend in Nigeria 1980 - 1996

Year	Poverty Level(%)	Estimated population Million	Population at Poverty million
1980	27.2	65	17.7
1985	46.3	75	34.7
1992	42.7	91.5	39.2
1996	65.6	102.3	67.1

Fig 2: Trend of Per Capita Income for Nigeria (1981 - 2006)



In the 1960s agriculture was the main stay of Nigeria's economy. There was a dramatic increase in oil prices in 1973 - 4. Between 1981 and 1984 oil price collapsed when Nigeria became over dependent on oil. Structural Adjustment Programme was a child of the external shock of oil policy. Food production stagnated at around 3% lower than population growth rate of 3.02%.

Low income accelerates level of poverty, food becomes unaffordable to the majority of the populace. Malnutrition in childhood becomes rampant. Now it contributes over 50% of causes of childhood deaths.

Conclusion

Paediatric services in Nigeria started at Nigeria's Independence following similar pattern with that of Europe. Despite various Administrations efforts at improving child health care the journey so far has remain unimpressive. Several factors such as poverty, political instability, have contributed significantly to poor measurable health indicators in Nigeria. The rest of current situation and solutions will be taken by subsequent speakers.

I thank you warmly.

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