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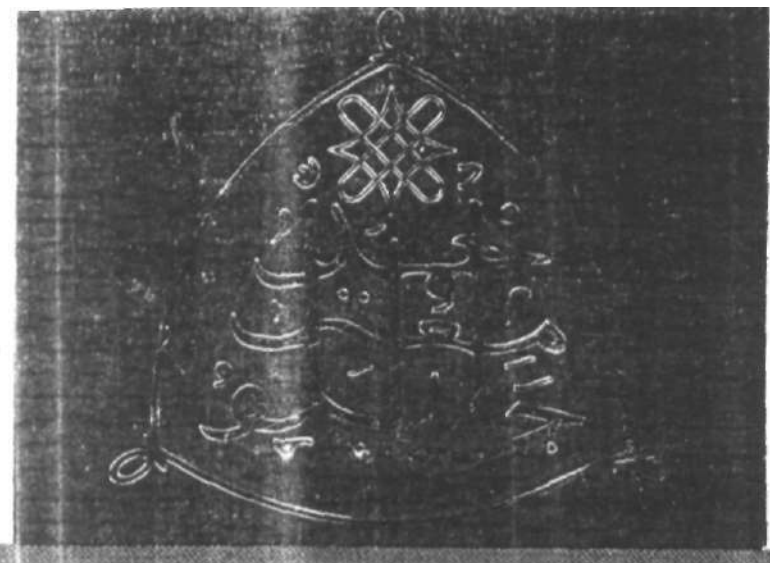

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"HEALTH FOR ALL": AN ATTAINABLE COAL

OR AN IDEALISTIC DREAM

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ABSTRACT

The concept of "health for all" envisages the attainment of a level of health that permits all people of Nigeria to lead a socially and economically productive life and this goal has been guiding health strategics all over the world for the past two decades. However, in the present day heterogeneous world, where wide disparities in health and social conditions exist between and within countries and regions, achievements in health are disturbingly dissimilar in the era of technology. This paper therefore reflects prevailing health inequalities across the globe and attempts to address some of these global health determinants and related global injustices. The paper would also present a health promotion perspective that would advance the ideal of "health for all".

INTRODUCTION

The concept of "health for all", which envisages the attainment of a health level that permits all people to lead a socially and economically productive life has been the ideal, guiding health strategies all over the world for the past two decades (Nanpudakam, 1998). However, we continue to live in a world with enormous health disparities. For example, the life expectancy in Japan is 80 years, in Malawi, it is 40 years, while in Nigeria it is 51 years (WHO; 1997). The under five mortality rate in Norway is 4/1,000; in Sierra Leone, it is 316/1,000 (WHO, 1997). This situation is actually worse than the figures suggest, because average rate tends to mask inequalities within a country, which affect the poor disproportionately (Dwyer, 2003), and disadvantaged population group, in general, as great as, if not greater, than ever (Oldenburg, 2002).

Although the "health for all in the twenty-first century", a World Health Organization (WHO) draft policy set forth at the Alma Ata Conference in 1978, was developed to help attain the goal of "health for all", it has made little impact in the relatively poor countries (WHO; 1998). This is important, because as recounted by Jha et al (2004), poverty, poor health and global insecurity are inexorably interrelated. Moreover, inadequate nutrition, poor sanitation, and crowded living conditions associated with poverty, when combined with a lack of access to care, render the world's poor particularly susceptible to disease. In turn, the onset of illness or disease arguably contributes to poverty (Heitkamp, 1998).

In contrast, improving the health status of "all", including the poor, helps the poor to better withstand economic downturns and protects households from sliding into poverty as a result of catastrophic medical bills (World Bank, 2001). Better health also has macroeconomic implication. Countries with higher levels of tropical diseases have slower income growth and failed public health systems, plus poor disease surveillance programmes that can contribute to the rapid spread of infectious illnesses (WHO, 2002). Poor health not only increases poverty, but it is said to contribute to failed states, which spreads terrorism (WHO; 2002).

One of the most effective instruments in the fight against global poverty is the control of major diseases (Emmot, 2003; WHO; 2002). Disease control not only contributes to better health but also enables individuals to earn more income and is a powerful enabler of education, which also raises income. While critics will point out that it is poor governance and corruption that contribute to ill health, the spread of disease and insecurity (as for example, what is currently happening in Zimbabwe) (Jha et al, 2004). It is noteworthy that health interventions often work better in difficult settings than do most traditional aid programmes (Emmott, 2003; Jha, and Mills, 2002). Indeed, the progress of health improvement in some developing countries has been considerably quicker than equivalent progress in the last 100 years (Emmott, 2003).

EVOLUTION OF HEALTH AND THE HEALTH STATUS OF PEOPLE IN NIGERIA

The health services of Nigeria have evolved through a series of historical developments, including a succession of policies and plans which had been introduced by previous administrations (National Health Policy, 1988). The health services are judged to be unsatisfactory and inadequate in meeting the needs and demands of the public as reflected by the low state of health of the population (Population Newsletter, 1997; NHP, 1988). The first attempt at planning ahead for the development of health services in Nigeria was made in 1946 as part of the exercise which produced the overall ten year plan for development and welfare, covering all aspects of governmental activities in the country. Since Nigeria was still a colonial territory, the proponents of this plan were mainly expatriate officials. It was not an integrated development plan in the current sense of the word (NHP, 1988). These schemes were not properly co-oriented nor were they related to any overall economic target. Nevertheless, it was a modest, realistic, well thoughtout plan for its time and purpose, and it served as the basis for subsequent health plans (WHO; 1997).

Since the country became independent in 1960, health policy has been enunciated in various forms, either in the National Development Plan or as Government decisions on specific problems. The health components of the second National Development Plan 1970-1974, identified and aimed at correcting some of the deficiencies in the health services (NHP, 1988). In the third Development Plan, 1975 – 1980, there was also a deliberate attempt to draw up a comprehensive national health policy, dealing with such issues as healthy man power development, the provision of comprehensive health care services based on the Basic Health Services Scheme, disease control, efficient utilization of health resources, and management (WHO, 1998). The health policy content of the fifth National Development Plan is being reflected in the current Health Policy of Nigeria (NHP, 1996).

The health services in Nigeria as currently organized show the following major defects, which are widely recognized:-

(a) The coverage is inadequate. It is estimated that no more than 35% of the population has access to modern health care services, while rural communities and the urban poor are not well served (NHP; 1996; WHO; 2002).

(b) The orientation of the services is inappropriate with a disproportionately high investment on curative services to the detriment of preventive services.

(c) The management of the services often shows major weaknesses resulting in waste and inefficiency, as shown by failure to meet targets and goals. With several different levels of government, voluntary organizations and other agencies providing health care, the various inputs are poorly co-ordinated.

(d) The involvement of the community is minimal at critical points in the decision-making process. Because the communities are not well informed on matters affecting their health, they are often unable to make rational choice, as for example in the rejection of polio vaccine by large number of people due to lack of necessary and adequate education regarding its importance.

(e) The lack of health statistics is a major constraint at all stages of planning, monitoring and evaluation of health services.

(f) The financial resources allocated to health services, especially to some priority areas, are far too inadequate to permit them to function effectively.

(g) The basic infrastracture and logistic supports are often defective owing to inadequate maintenance of buildings, medical equipment and vehicles, unreliable supply of water or its total lack and epileptic nature of electricity supply; and the poor management of drugs, vaccines and supplies system.

(h) Medical equipment are far inadequate and the few ones were less effective due to lack of maintenance.

(i) Whilst this list is an accurate summary of the broad range of defects in the health services, there are also encouraging cases in which dynamic health administrators, professional persons and lay members of the communities have successfully corrected these faults within local, state and national levels. Such successful programmes include total eradication of most of the six child killer diseases and a host of other diseases. These provide useful models of what can be done with limited resources inspite of various constraints.

THE STATE OF HEALTH OF THE POPULATION

It is not possible to make an accurate assessment of the health status of Nigerians. This is because there is no system of collecting basic health statistics on births, deaths the occurrence of major diseases and utilization of other methods of advanced technology in data collection were grossly inadequate. (NHP, 1988; Population Newsletter, 1997; Bradly, 1990). The best available estimates are obtained from a few centres where such data are collected from sample surveys, from institutional records and from special studies (NHP, 1988; Beyer, 1995).

(a) The limited health statistics indicate the general poor state of health of the population as shown below:

Crude Death Rate:
16 per 1000 population
Crude Birth Rates:
50 per 1000 population
Childhood Mortality Rate: 144 per 1000 children; Infant Mortality Rates: 85 per 1000 live births; life expectancy: 50 years
Sources: Nigeria Fertility Survey 1981 – 82 . World Demographic Record; Population Newsletter, 1997.

(b) Some experts estimate that the infant mortality rate may be as high as 100 – 160 per 1000 live births in rural areas (WHO, 1997). Whichever figure is accepted, it means that our of every 12 children who are born alive, one or more of them dies before reaching the first birthday. This rate, according to population Report (1992), is ten times as high as in most developing countries; it is much higher than in some other developing countries, which have a similar level of socio-economic development as in Nigeria (NHP, 1988). Children in the age group 1 to 4 years similarly die at a rate which is at least 40 times as high as in the developed countries. In some parts of the country, 25% or more of children die before their fifth birth day (World Bank, 2001). Child birth, which should mostly be a normal process with minimal loss of life, is associated with a significant mortality among Nigerian women (WHO, 1997; NHP; 1985).

PATTERNS OF ILL HEALTH AND THEIR DETERMINANTS

Most of the deaths and serious illnesses, which occur among Nigerians, are due to conditions which are easily preventable or which can be treated with simple remedies (Population Newsletter, 1997). Communicable diseases, especially those which are associated with inadequate environmental sanitation and poor hygiene, predominate and are often compounded by malnutrition. Lack of timely, inadequate state of art in technological advancement and inappropriate care often increases the risk of serious complications in the course of minor ailments (WHO; 1997). The current high rates of morbidity and mortality can be substantially reduced by a more rational application of available resources, even at this time of financial stringencies (WHO, 2003).

The World Health Organization estimates that there are about 1.1 billion daily smokers in the world, equivalent to one third of all persons aged 15 years or over. Eight hundred million of those smokers are male, and 700 million live in developing countries out of which Nigeria have about 1.2 million smokers (Heitkamp, 1998; WHO, 2002). Epidemiological research has shown that smoking increases markedly the risk of developing cancer of the lungs and of the upper-aerodigestive track and slightly less so the risk of cardiovascular disease (WHO, 2003). However, because cardiovascular disease is more common death than other causes related to smoking, the impact of smoking is greatest in increasing the number of deaths due to cardiovascular disease. In developing countries, smoking-related death amounted to 1.6 million, half of which occurred in China. By 2020, smoking is expected to cause 8.4 million deaths annually, of which 6 million will be in the developing world, Nigeria inclusive. That year, smoking will be the leading cause of death in the world (WHO, 2002). The net annual contribution of alcohol consumption to mortality is 775,000 deaths, 640,000 in developing countries. Data on alcohol consumption confirm that it has been rising rapidly in many developing countries, particularly in Nigeria (WHO, 1997; PN, 1997).

With regards to diet, there is strong evidence linking high levels of saturated fat intake to the incidence of cardiovascular disease, especially ischemic heart disease and stroke. Epidemiological evidence suggests that high levels of saturated fat intake also increase the risk of developing certain types of cancer (e.g of lung, breast, rectum and prostate) and that a high salt intake is related to an increased incidence of stomach cancer and a higher blood pressure which may lead to stroke (PN; 1997). These health problems would have been prevented if Nigerians were well informed and utilized technological advances in physical fitness programs. Electrical tread mills, bicycle ergometres, weight machines and many other exercise machines were made available by technology. However, poor economic status of Nigerians made it impossible to acquire the machines or open enough fitness laboratories for prevention of degenerative diseases.

Accidents and violent events leading to injury or death are another aspect of behaviour influencing morbidity and mortality. Road traffic accidents were the ninth most important cause of death world wide (PN, 1997; WHO, 2003). Between 1968 and 1985, road traffic fatalities increased by 150 percent in Asia and 300 percent in the market – economy countries of Europe. (Samiel, 2000).

Traditionally in Nigeria, injuries have been a neglected public health problem, because authorities do not perceive them as amenable to intervention. However, much is known about effective interventions to reduce injuries and control interpersonal violence. Public health and other authorities must take the lead in adopting measures to reduce morbidity and mortality associated with preventable injuries and violence in Nigeria; particularly, in order to achieve health for all Nigerians (Okuofu 1997).

There is another growing threat to human immunodeficiency virus (HIV). Because sexual

intercourse is the main form of transmission of HIV, behavioural factors are at the root of the epidemic and need to be addressed if the epidemic is to be brought under control. Although basic information on the prevalence of HIV infection and AIDS is generally poor, it is estimated that between 2000 and 2003, another 1.5 million persons had become infected with HIV in Africa (Jha et al; 2004). The high prevalence of HIV infection in some developing countries is resulting in increased mortality. The economic and social consequences of the AIDS epidemic impose major burdens on countries that are ill-prepared to face them. There is an urgent need to combat the further spread of the disease through sex with multiple partners and by reducing the likelihood of transmitting through the treatment of sexually transmitted disease (WHO; 1997).

Although, many countries face major challenges in maintaining the gains made in reducing mortality or in achieving further reductions, current knowledge provides a good basis for the design and implementation of effective interventions. Given that a number of behavioural factors have a very significant influence on health and longevity; public health authorities have the responsibility of promoting those behaviours that are most likely to enhance the chances of the population for a long and healthier life. The means to do so exists, but the will to intervene must be strengthened (PN, 1997).

HEALTH PROMOTION AND THE CHALLENGES OF THE 21ST CENTURY

Despite considerable progress made in increasing life expectancy world wide due to technological advancement in the field of medicine, especially in the developed countries, in Nigeria, such increase is minimal. However, there is no acceptable level of mortality, and no government considers the level of mortality in a country to be fully satisfactory. However, government characterized levels of mortality as "acceptable", considering the level of the resources available for reducing mortality. As of 2000, 73 countries world wide viewed their mortality levels as acceptable and 107 countries considered them to be unacceptable. Not surprisingly, 86 percent of the countries that regarded their mortality levels as unacceptable were developing countries, Nigeria inclusive (WHO, 2002).

Since the 1960s, the concept of development has evolved from a narrowly focused economic view to one stressing the social aspects and environmental sustainability of development. The quest to integrate economic and social factors into development has given impetus to a strategy emphasizing health, family planning, nutrition, education, safe drinking water, sanitation, adequate shelter, poverty eradication and sustainable economic growth (WHO; 2004). A key intersection of health promotion and development in 21st century concerns has been the environm Drinking water, sanitation, pollution, deforestat desertification, depletion of the ozone layer, emerge of new diseases (such as AIDS) and the climatic cha are major determinants of health (WHO; 2002).

Nigeria as a developing nation is at most risk fr traditional health hazards, including lack of safe w and sanitation, poor housing and shelter, unsafe f and high prevalence of disease vectors (Emmott, 20 Developing Countries, Nigeria inclusive, undergo rapid industrialization, are at risk from traditional well as modern hazards, such as pollution, hazard wastes, unsafe pesticides and other chemic workplace hazards and traffic accidents. A furt threat is the potentially deleterious impact of glob climate change, including changes in the distribution infectious and vector-borne diseases due to temperatu change (WHO; 2003; PN, 1997). Poor environment quality is linked to diarrheal diseases, respirato infections and a variety of parasitic diseases, as well cardiovascular diseases and cancer (Oldenburg, 2002).

In recent decades monumental changes have take place in health promotion and development. As result, a new perspective has emerged that positione health at the heart of development. Health and lo mortality are not merely intermediate objectives o milestones on the path to socio-economic development Rather, good health and long life are increasingly being recognized as goals in themselves as well as being among the fundamental pillars of development and attainment of "health for all" (WHO, 2003).

To change life style as well as the social, economic, and environmental conditions that determine health, the most effective health promotion efforts are likely to involve comprehensive approaches that combine public policy efforts, the creation of supportive environments, community action, the development of personal skills and a reorientation of health services that would involve high utilization of advanced technology in the field of medicine. In addition, the creation of new partnerships for health between different sectors at all levels of society and government needs to be promoted (WHO; 1998). At the Forth International Conference on Health Promotion, held in Jakarta, Indonesia (WHO, 2002), in July 1997, which focused on the theme "New Players for a new era – leading health promotion in the twenty-first century", the conference the following five priorities for health promotion in the 21st century were identified:

1. Promote Social responsibility for health.
2. Increase investments for health development, especially for groups such as women, children, older persons, the indigenous, the poor, and marginalized populations.

3. Consolidate and expand partnerships for health to enable the sharing of expertise, skills and resources.
4. Increase community capacity and empower the individual.
5. Secure an infrastructure (medical equipment) for health promotion through new funding mechanisms, intersectoral collaboration, and training of local leadership.

Heitkamp (1998) notes that promoting health supports the right of individual to the highest attainable standard of health. To achieve this, Heitkamp stresses that importance of the people's participation in their health, the recognition of different socio-cultural values and beliefs that are prevalent throughout the world, and that health development has a sustainable effect only when it is implemented comprehensively and includes:

- Personal development: Skill improvement
- Community development: Empowerment of people
- Organizational development: Technological advancement.
- Political development: Will prowess.

The recognition that health is intimately related to economic status, education, physical living conditions, culture, history, issues of gender and human rights, the level of peace and safety, and the life people live, is not entirely new. The health sector has been making its way towards this position for a very long time (Samiel, 2000). The connection between living conditions and health status has been documented since the early nineteenth century, as has the role of the co-operative society in minimizing illness and its consequences. To ensure that the ideal of the freedom of the individual to be at ease so he or she may realize his or her full potential in societies that create health, there is a need to recognize the following:

- that there are multiple and diverse forces within society which create or undermine health, and
- that most of the factors which are essential for a healthy community reside outside the formal health sector.

Hence, actions directed towards creating healthy societies with healthy people must tap multiple power sources and involve broad collaboration and alliances. Some of these strategies include the establishment of innovative public health policies, the creation of supportive environments, the empowerment of communities through community action, the promotion of personal health skills, the reorientation of health services, and the need to create alliances. The health promotion approach, which respects all people's rights to healthy living and is based on the recognition that health is the result of an interconnection between all aspects of life, provides a framework for fostering "health for all" by encouraging and enabling full participation of the various sectors, such as machine manufacturing industrials, agriculture and food industries etc., interest groups, and communities in a society towards co-operation and harmony (George, 1995).

CONCLUSION

The concept of "health for all", envisages the attainment of a level of health that permits all the people of the world to lead a socially and economically productive life. This goal has been guiding health strategies all over the world for the past two decades (Nampudakam, 1998; Akinjide, 1997). However, in the present day heterogeneous world, where wide disparities in health and social conditions exist between and within the country and different communities, achievements in health are disturbingly dissimilar in the era of technology. Presently, because of the implications of poverty and poor health status for all, and the prevailing economic inequalities that are accompanied by widening or stagnant health inequalities, the whole country has realized that, despite commendable progress recorded in several aspects, "health for all" has to be set in a new perspective. This paper has presented health promotion perspective that could advance the ideal of "health for all" in the era of technology. It has also discussed the different national and international documents that have focused on health promotion, namely the Otawa and Jakarta Declaration, and the 51st World Health Assembly (Nampudakam, 1998). These international conferences that have marked the way for health promotion have been guide posts of an energetic movement to strengthen health worldwide and Nigeria in particular. The Otawa Charter on Health Promotion has been a world wide source of guidance for health promotion through its five strategies:

1. Building health policy.
2. Creating supportive elements.
3. Strengthening Community action.
4. Developing personal skills.
5. Reorienting health services.

The Jakarta Declaration on "leading health promotion, into the twenty-first century" identifies five priorities in the next millennium:

1. Promote social responsibility for health.
2. Increase investments for health development.
3. Consolidate and expand partnerships for health.
4. Increase community capacity and empower the individual in matters of health.
5. Secure an infrastructure for health promotion.

However, even though progress has been made over the past 20 years in achieving the goal of "health for all", a number of factors have prevented the ultimate attainment of "health for all", with health being most adversely affected in the relatively poorer countries. In addition, achieving this goal may be influenced by new threats and challenges that will prevail in the twenty-

first century (World Health Organisation, 1998). Nonetheless, future dedicated efforts expended by health educators and related professional groups to support the world health organisation health promotion and Nigerian health promotion strategies are likely to advance this goal inspite of the daunting challenges that lie ahead. In particular, the degree of understanding and commitment demonstrated by health educators to addressing the prevailing injustices and social determinants of health that lie upstream from the health care system and are rooted in the economic, social and cultural fabric of our society (Population Report, 1992; National Policy on population, 1998), and their involvement in broad collaborations and alliances, could profoundly affect and transform our ability to successfully reach this goal.

To this end, and in the context of an increasingly globalized but polarized world, in addressing this obligation, improvements in health for privileged groups might suggest what could, with political and professional will, be possible for all.

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