19th Bassey Andah Memorial Lecture

THE CHALLENGES OF HEALTH CARE DELIVERY FOR ALL AGES IN NIGERIA

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Extended abstract
Professor Bassey Andah was the Deputy Vice-Chancellor (Administration) of the University of Ibadan at the time I left for my sabbatical leave in the university in July 1997 and died while still holding that office. He had the reputation of versatility in his chosen discipline of anthropology and archeology; and applied these to the widest realms of knowledge and its seeking, for the human mind; with emphasis on the African person. Such depth and breadth, as he pursued, is in the very nature of health and its pursuit for the humankind; the subject of this lecture - health for all the Nigerian people of every age.

Every normal human endeavour without any exception, would fairly easily be seen if looked at closely enough, as seeking nothing else than the health, happiness, well-being and fulfilment of the human person – the very meaning of health, and its services. However, in practice, it is only those activities and services that are immediately seen to be directed to relieving sickness or preventing it, that are usually referred to as health care and services. Organizationally also, health care is provided in any country at the three levels of the national or tertiary; the regional, state, or secondary; and the local government, "district" or primary health care (PHC) systems. In spite of all those, in 1978 at the Alma Ata Conference on primary health care, the whole world agreed that the purpose of all health care services must be to achieve health for all (HFA) the people in the given polity, and eventually, of the world. The world was further reminded that in order to do so, such national health services must be based on a proper primary health care system that is properly linked up with and supported by all the higher levels of the three-tier health system; in a two-way referral system. Apart from those directly recognized health services, all the other howsoever else health-related systems and services should be linked up with these health services through a programme of inter-sectoral collaboration and integration for PHC and HFA. This later inter-sectoral collaboration, as of the first sentence of this paragraph, literally, means every human endeavour!

Nigeria and her various leaders have made great efforts at this new understanding of the health services, with some reasonable and sometimes most celebrated things to show for it, especially in terms of numbers and "statistics". However, in spite of all these, the national health system has failed to deliver the PHC and HFA agenda and targets. In this lecture, and in the humanitarian spirit of Professor Andah, we are going to again highlight these great efforts of past Nigerian health care leaders to praise them duly; and thereafter only, we will point out some of the principles as well as the remaining things to do in order to more reasonably pursue the true PHC & HFA agenda in Nigeria, the topic of this lecture. This will essentially mean the understanding of the different medical and health professions and their specializations, the understanding of the difference between all the public service programmes involving any and all of these in the usual vertical programmes of "public health" and the application of these in the single specializations of community medicine, nursing and midwifery as constitutes community health and primary health care; and then linking these up properly with all the other vertical public health and down with all the auxiliary community health extension services of the local governments. Obviously, it is not yet ANYTHING near "UHURU" here, in these regards!

INTRODUCTION

It is obviously a valued privilege for me to be invited to give the 19th Professor Bassey Andah Memorial Lecture. I sincerely thank those who thought of doing this to me. Having seen the many excellent people who had been given this honour in the past, I am indeed filled with some trepidation as to whether I will be able to satisfy what perhaps a sizeable number of people here may be expecting to get out of me in the exercise. So, I trust God alone to help me do so!

Professor Andah was professor of anthropology and archeology as well as the Deputy Vice-Chancellor (Administration) of the University of Ibadan at the time of his death. He was someone that all of us who valued academics, the African spirit and service to humanity as a whole, cherished. I was not able to be part of his obsequies, physically, at that time; being out of the country then. Therefore, being asked to give a memorial lecture in his honour can only be a great privilege indeed!

All fields of human learning and services are related to human health; and are actually servants thereof (i.e., of wellbeing and happiness of mankind).[1] All humanity must now begin to realize this fact. There is not a single area of human learning that cannot be applied *openly and officially* to the public's health and well-being in the modern world – education, agriculture and nutrition, public works, technology, information, security and safety, government, industry, law, sociology, psychology, anthropology, physics, forestry, etc. In a similar but obviously reverse order, there is no aspect of the human being or his life and civilization that cannot be studied by anthropology. Such was the versatility of Professor Andah with his application of his anthropology and archeology; as he demonstrated during his lifetime in all his endeavours, including those documented in his over 100 published works.

The choice of providing health care and achieving health for all Nigerians, and for all their ages, as the subject of this 19th memorial lecture, is obviously in keeping with this holistic approach of Professor Andah in all his pursuits. Therefore, in preparing and delivering this lecture, it is important for me to observe that Nigerian leaders have put in great efforts in establishing many agencies and programmes in these regards. We, in Nigeria, have also produced far more health workers of all categories per capita than most African countries have done. We are by far very much more endowed with natural resources than many of these other African or other developing countries are. Yet our health indices are far lower than that of many of these, even poorer and/or even war-torn, countries. Indeed, the group within which Nigeria finds itself when these indices are given is invariably in the circle of the very worst; mostly, the war-torn countries[2]. Does this ever begin to say something to Nigerians about their country? I wonder!

With all these seemingly good numbers, volumes and "statistics" in our favour and yet the worst health indices, it should be obvious to anybody with any true desire to pursue the health-for-all agenda in Nigeria through a nationally well-organized health system as recommended at Alma-Ata, that there must be some basic things that we have not gotten right. It will be clear that it is something that requires NOT much more of quantities, volumes, numbers and "statistics", as we have had in the past. On the contrary, what we will need NOW will be more of understanding of some basic principles and practices that exist or are used by these other countries, as best practices, in these regards; and so, to apply them to our own situation! Figure 1 below shows

some of the most common community or merely overall health care indices in some countries around the world.

Table 1. Sample of community health indices of countries across the world for 2015

Variables	**Nigeria**	**Ghana**	**Kenya**	**Liberia**	**Singapore***
MM Ratio/100,000 life births	814 (596 – 1,180)	319 (216 – 458)	510 (344 – 754)	725 (527 – 1,030)	10 (6- 17)
Infants MR/ 1,000 life births	69 (54.8 to 86.2)	42.4 (35.1 – 51.5)	36.5 (32 – 42)	52.9 (42.6- 67.3)	2.1 (2.0- 2.5)
Crude death rate	11.9	8.1	8.3	8.0	4.5
Crude birth rate	41.2	30.9	24.9	35.5	9.9

Variables	**India**	**Sierra-Leone**	**Malaysia***	**Cuba***	**Fiji***
MM ratio/100,000 life births	174 (139 – 217)	1,360 (999 – 1,980)	40 (32- 53)	39 (33-47)	30 (23-41)
Infants MR/1,000 life births	36.2 (3.5- 38.9)	86.2 (72.8- 98.9)	7 (6.8-7.3)	4.3(4.1- 4.4)	19.1 (16.7- 21.9)
Crude death rate	7.9	16.8	5	8.5	6.9
Crude birth rate	20.4	36.6	17.7	9.5	20.4

Variables	**South Africa**	**Morocco**	**Ireland***	**U. K***
MM Ratio/100,000 life births	138 (124 – 154)	121 (93 – 142)	8 (6-11)	9 (8-11)
Infants MR/ 1,000 life births	35.5 (31.6 – 39.8)	24.1 (18.2 – 31.6)	3.1 (2.8- 3.5)	3.7 (3.6- 3.9)
Crude death rate	11.1	6.4	5.9	8.9
Crude birth rate	20.9	22.7	15.4	12.2

Data is from WHO Global Observatory Data.

*Countries with district or zonal community nursing and midwifery services

It clearly shows that only countries (developed or developing) with fully and correctly organized national health care systems as recommended at Alma-Ata and Riga have achieved or are achieving such PHC/HFA-tending statistics.

Even though many factors contribute to the health indices reflected in this Table 1 – the overall political systems, the two-way referral system functionalities, the overall economic status of the countries, health care insurance and the health care financing systems – the most important factor in all of these for the good health indices would seem to me to be the overall good organization of the local government or district health systems. This means having competent physician-lead health manpower and above all, the district or zonal community nursing and midwifery systems for every one of their local governments. Our colonial and immediate post-colonial health system had tried to ensure that the medical officer of health (MOH) led the local government/district health system[3] at least by law. However, the community/district nursing system had never been in place in the country[4]. The present health system since the military incursions into the health system had brought the MOH-led LGA health services to an end; with very stiff resistances to its restoration from many (to my mind rather ignorant and selfish) reasons.

Besides not attempting to properly restore the leadership and proper functionality of the district/LGA health system through the office of the MOH and the establishment of the office of the district/zonal community nursing and midwifery system, the past efforts of the Nigerian leaders in the government health services at the political level had included the attempted use of the National Youth Corps Service health workers for the running of these local government/PHC services. This author was used in this exercise both as an NYSC doctor as well as in the supervision of the officers later[5,6]. It also includes the recent efforts at revisiting these issues within the Federal Ministerial Committee for the Re-vitalization of Primary Health Services in Nigeria inaugurated on the 21st of January, 2017; but which has remained in abandonment since April of the same year[7]. We must change those past derailments of the organization and methods rather thoroughly; and that is where our problem lies. We must begin to realize that PHC/HFA implies decentralization of authority and functions and all the necessary "bottom-up" paradigms that is the heart of the PHC revolution! We will continue to ignore those principles and methods (those world's best practices), only to our continued wastage of our lives and resources. We can only pray that all those who howsoever have found their ways to the corridors of power where these decisions are made (both at the state and federal governments) will heed these simple statements of facts as well as find the courage to have them effected.

What is needed to achieve primary health care at the LGA level, with its full two-way referral system and the inter-sectoral integration and collaboration for PHC and HFA, are fairly easy and simple, **but for the political will to do so**. For these very reasons, the rest of this lecture will not be very long. We can only pray that those who are able to get the politicians to do these right things – through policies, legislations, organizational/strategic frameworks and implementation guidelines, and the political will at every level, to do so – will be able to persuade them to do so in a no-winner-no-looser (but the win-win) manner; for the common good of all Nigerians.

NO NEED TO RE-DISCOVER THE WHEELS

As would be very easily discernible to most people, no matter how one believes that human beings came about on this earth, the first sickness of that mankind must be loneliness. For those

who believe in the Divine Genesis history of the Tora of the Jewish religion (as well as the related religions of Christianity and Islam), this loneliness of the first mankind, Adam, was the reason for God to create a mate for him[8]. If on the contrary, one opts to believe that human beings came about by some absolute evolution from other material things[9], one such person would have first similarly evolved. So, such first person would naturally also experience loneliness as his first disease. The provision or evolution of a companion, to provide loving and compassionate help to one another in all their human needs, would obviously be seen as the first forms of human (health) care to come in place.

In the organized human services and culture, the provision to anybody of a loving and assuring presence or companionship, and helping such a person (especially if he is a child, a sick or other incapacitated person) to do the very things that such one should be able to do for him or herself, if he had the capacity and/or knowledge to do so, is exactly what **nursing** is. This is what makes nursing the first, most essential and primary health care profession. As we will all know, the best nurse that anybody may wish to have in this world is a loving mother; and for mankind as a whole, a loving and caring mother-wife! Neither human or community development nor the professionalization of nursing since the time of Florence Nightingale[10] has changed any of these facts. It was only natural also for midwifery to develop straight from nursing as the provision of a loving presence, assurance and care to a pregnant woman, that such midwife will follow the pregnant woman all through the pregnancy, to ensure that it remains normal; and to assist her in everything that she will need, including the normal delivery of the baby as the case may be. The midwife (even more so than the nurse, because of the rapidly progressive dangers and death often involved thereof) will need to be able to identify when that pregnancy is no longer normal. She will need thereafter to rapidly get that pregnant woman to the place that she will obtain obstetric or emergency antenatal, delivery and post-delivery services.

These simple facts of history has kept nursing and midwifery as the primary health profession(s). We miss to know and to acknowledge those facts only to our very own detriment! It will therefore be very easy to realize that until we have looked for and attended to the fundamental need for primary and fully professional (health care or community) nursing and midwifery, we cannot be taken as being any serious in regard of getting health care to all Nigerians everywhere that they are. Later here in this lecture, we will address many issues of the usual numbers, volume, quantity and "statistics" that we have had in Nigeria in regard of community or primary health care nursing and midwifery; but with nothing in terms of related health indices in the country to show for them. This, no doubt, is the reason for our national non-performance, as far as the Nigerian health services, and especially of PHC, are concerned. This will therefore eventually constitute the thrust of this memorial lecture. In its regard, there will be no need for any of us to try to discover "a Nigerian wheel" or "to re-discover the wheel of the global PHC"; for indeed, that had been a well-established thing.

The development of the rest of the health care professions and services flow naturally from this base of community nursing and midwifery. Human needs, both in health and especially in sickness, do not remain in the domain of the things that people would be able to have the knowledge and/or capacity to do for themselves. Even for those few who will have such knowledge or ability, like the medical doctors, because these levels of needs and services are in the realms of "matters of life and death", it is usually not allowable for such a person to do so for

himself. He may also not do so for anyone to whom he is significantly emotionally related. That is the ethics of the medical and dental professions. This then, also, is the big difference between the medical and nursing professions. Besides this division and the limitation of duties there-related, nothing stops ANYBODY to learn anything about the human body and life; as well as what may be done to it for the purposes of its health, happiness and utmost fulfilment – the objective of the human health services. However, one may not do so ethically or legally at any higher levels, except one belonged to the given (medical and dental) professions. This fact is what lifts up the medical profession and leaves it at a pedestal that those who would howsoever train to be in it must be people of the most serious integrity; as well as ever growing humility. Else, such a place will also neither see health nor the needed team to produce it! We will return to this need and its implication again, later in this discuss.

Between the medical and nursing professions, everything concerning human health and their services had been learnt and practiced; including the production of medicines for clinical use; such as in apothecary as the junior or lower arm of the medical profession at its onset. All these happened up till 1420, when Emperor Fredrick II of Germany and King of Sicily, who apparently had interest in that latter, separated apothecary from medicine by decree[11]. Apothecary had thereafter, embraced alchemy and all its modern expansions to become the pharmacy profession of today. It has also expanded to involve all issues of medicines for other animals and plants; as well as the control of all the other agents (as pests) against the interests of man, animal and plant health and well-being. This is the nature of today's pharmacy profession; less than a third of whose semi-independent practice in still within the direct human health or the clinical professional practices.

As human knowledge and skills kept expanding, the level of knowledge and skills needed to practice all of medicine made it impossible for any one man to learn and to practice them all. Hence the place of specialization in the nursing and medical professions. So also grew the necessity to train others, initially at the technical levels only, to do the non-directly patient, life and death, health care issues. The organization of all these health care services and professionals into the appropriate medical and/or public health teams have developed over time and has been well practiced all over the world. There are, once in a while, little misunderstandings and human frictions in these relationships and functions globally. However, the level and rate of their occurrence in Nigeria is the most unprecedented, worldwide. Therefore, if we are going to achieve and to have health-for-all in Nigeria, the root causes of these frictions in the Nigerian situation must be found and properly dealt with. We will briefly touch on this before we end this lecture also.

THE ORGANIZATION OF THE NATIONAL HEALTH SYSTEMS UP TILL ALMA-ATA

Human health care services started in individual nursing, midwifery and medical health care, based on the prevailing traditional understandings of disease causation in the various places. It did so right up till after Hippocrates brought the principles of objective science into it. However, as scientific medicine progressed, so also increased its cost. As such, many of the poor and underprivileged portions of the society had difficulty accessing it. Then came the group

organization of the medical and health care services around churches and other houses of religion for these poor people[10,12,13].

However, the birth of the present unbroken history of public health came about in 1374, with the birth of the port and international health care at the seaport of Venice; with the related quarantine laws against any suspected importation of infectious diseases by ships to that city state[10]. This sanitary public health services soon spread beyond the seaports to embrace the environmental health and food hygiene of the food items; and the other ethics of trading (e.g., accuracy of weighing scales) in the markets and other commercial food houses. The growth of the humanitarian spirit and community organization that was part of the industrial revolution saw to the demands that resulted in the governments beginning to provide clinical public health services to the people, as the religious bodies had tried to do before then. This resulted in the reportedly first public hospital, established for the clinical public health services at large, at the Pennsylvania Hospital in the USA in 1751[10]. The introduction and expansion of these clinical, government-provided, health services occurred in Europe from the 1790s, along with the effects of the French Revolution[13].

The expansion of the understanding of health and disease prevention by James Lind (by preventive nutrition) and Edward Jenner (by immunization) on the one hand, and of John Howard (in the prison reform and health services) and Bernardino Ramazzini (in occupational health)[10] eventually resulted in aspects of what are today referred to generally as preventive medicine and social medicine, respectively. However, the pulling up together of sanitary public health, preventive medicine, social medicine and the most essential and basic clinical medical care for individuals, to be provided statutorily by the local governments to the people, was only to be achieved first in the United Kingdom in 1847/48[10]. These followed in the same trend of the social reformation movements that earlier saw to the poor law reforms of Edwin Chadwick. The doctors and nurses (primarily; and health inspectors, also) had the social, professional and statutory responsibilities to see that the people in the local government areas get the services that they need in all these public health realms, and as optimally as possible.

It was fairly easy to provide these preventive, social and primary clinical services to those who would come for them at the centres provided for these. Same was the case in the homes and commercial facilities for the statutory (environmental) health inspections. These community medical and health services were also comprehensively possible in the captive communities of the schools, factories and prisons. However, those needing these services in their homes because of their physical disabilities were only to be reached when William Rathbone introduced the paradigm of community nursing to that public health practice in 1859[10]. According to Rathbone, the community nurse should not be required to look after more than 2,000 population size communities at that time in 1859; as she was to act as that community's "mother" in relation with all their health care and well-being. However, in the modern world and in the places where these best practices have been maintained, this population has varied from 2,000 to 7,000; depending on the population density of such communities, rural or urban[14]. This oversight or full scale provision of the entire community medical and health care services of the local government area, preferably statutorily, has remained the basis of the best LGA/community and PHC services to date; with the types of community health indices as shown in Table 1 earlier here. In those places, it has produced as good or even better health service indices, even in the poorest of

such countries, as compared with most of the richer and technically more advanced countries. Its full attainment in practice has however varied from one country to the other. It was, and still is, this introduction of the statutory community nursing (and later, nursing and midwifery by the same person, naturally) that achieved the total community health care of everybody in the statutory communities. It is able to keep the well persons maximally well, at home or visiting the clinic only for preventive health care; but with community rounds to ensure that this is and keeps being indeed the case. It is able to get the sick but ambulatory or meaningfully benefitted by hospitalization to do so promptly. Above all, it is to get the chronically sick who may be at home but not needing to be admitted to a hospital to do so and to remain as maximally well as possible, have their drug given (and observedly taken) by a well prepared home member as the family's auxiliary nurse. The community nurse-midwife on these community rounds is also able to get any needed health behavioural modifications at the personal and whole family level for their very illness as well as the chronically sick person's health facility preventive care appointments kept – the basis of any true PHC and HFA.

With the evolution of countries as more than the city-states of old, came about the national health systems; that is, beyond the local government. These have also developed the secondary health services for the regional or state governments (as the federating units of those countries). Tertiary health care has also similarly developed for the national governments. The LGA/PHC services have revolved around the medical officers of health (the MOH, or howsoever else designated) as the statutory community physicians, with the district/zonal community nurse-midwives for the smaller divisions of those LGAs or community medical districts. The central doctor for the **secondary health** system (or **primary medical** services) only got the role of the specialist primary care or family physician recommended in 1920[15] by the Lord Dawson's Committee for this central role. This eventually got enacted into law (in the 1946-1948 era) in the British National Health Act[10].

While part of the organ systems and human population group-based specialist medicine and nursing care still remain within the secondary health care in the generalist ranges of those (viz, general surgery, general obstetrics, etc), part of these as well as the rest of the single system or sophisticated aspects of the population group medical and nursing services properly now belong to the tertiary health care system – see Fig 1. With time, some of these tertiary care specialties of medicine are referred to as super-specialist medical practices; and their greater refinements and sub-specializations are still in progress. It has however been known that all these aspects of the health care system must fit honourably and mutually respectfully together; with emphasis for government provision for those of these services that relate to the largest portion of the underprivileged or marginalized polity as priority. Full scale tertiary health care at its exact financial value may only be provided by the private sector; or by a public-private partnership arrangements by the governments. Universal health insurance may be helpful in this regard; but it is not as easy as it may apparently seem.

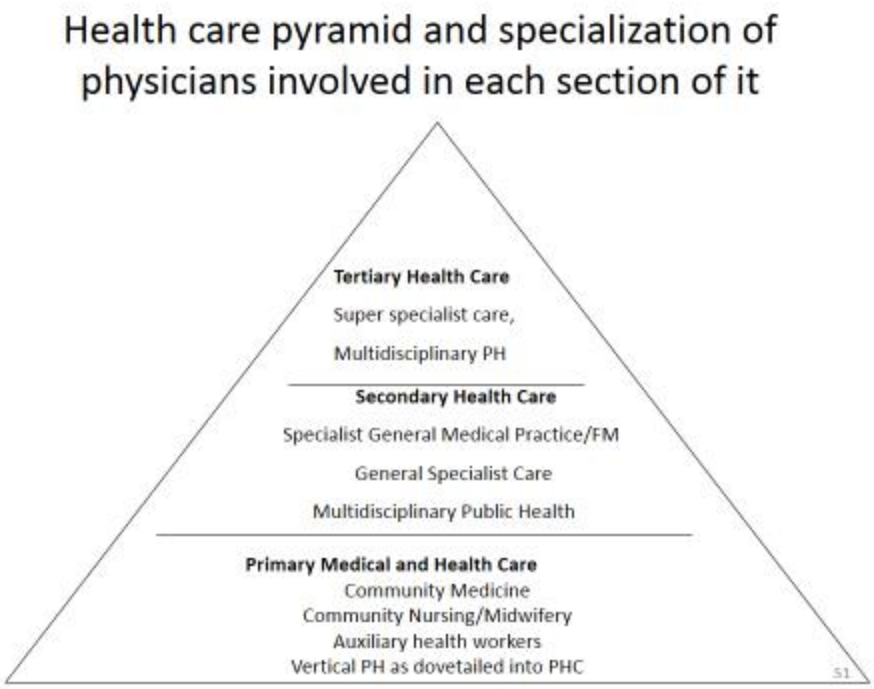

Fig. 1. Health care pyramid of the doctors, nurse-midwives and all the other personnel in it

ALMA-ATA AND THE MODERN NATIONAL HEALTH SERVICES

The international conference on primary health care[16] that gave the final framework for the health-for-all agenda of the original Constitution of the World Health Organization[17], stated clearly that all national health services must be based on primary health care, if they are to attain this objective. The Nigerian public health services, being organized as the usual three-tier system of primary, secondary and tertiary health systems, keeps saying that these three levels are the primary responsibilities of the LGAs, the state and the federal governments respectively; but only on a concurrent, non-justiciable, basis. The colonial public health laws of the country[3] had made the provision of the medical officer of health mandatory for every LGA; otherwise by default, the office will be served by the most senior doctor in the government hospital serving that LGA. Yet, the post-independence government legislations had not followed this practice. Worse still, Ralph Schram in his history of the Nigerian health services[4] observed that the statutory community (district or zonal) nursing and midwifery practice had never been exercised in Nigeria. Nigerian nurses who went to the UK to learn these, on return and finding no framework for its excellent practice, were very easily frustrated out of the health service.

An example of an LGA in a developing country in the modern world with such community health care is shown in Tables 2 and 3 below, for some of the organizational and health indices as at the time that this author was part of the work force in that PHC system. The Federal Government of Nigeria through its National Primary Health Care Development Agency (NPHCDA) has proposed that the national primary health care has to be ward-based; meaning the current Nigerian political wards. Incidentally, these wards vary in populations from 5,000 to

12,000 persons on the average, in the rural and urban areas; far beyond what such community nurse-midwives who are the primary providers of PHC can do in the modern world's best practices. However, this practice is not even attemptedly meaningfully in place in any state or LGA in Nigeria that I know. This is still the same with the mere office of the statutory community nurse-midwife who ensures these services in the places that they are working globally. Worse still, even though the National Council on Health since 2014 had been reported to have approved the provision of one medical officer of health for every LGA[18], and rehearsed in at least 2 other councils after it, this has neither been put to legislation nationally nor has any state on its own thereafter made any progress in that direction; as of the truly federating regional governments of the pre-independence era.

Table 2. Community health nursing areas of the Rewa Local Government Medical Area of the Fiji Islands in 1999[19]

Station/Physical facility base	Nursing District or zone (with 1 community nurse each)	Population
Nausori Comprehensive Health Centre (Hq) (Central District) – 1 MOH, 3 other physicians, 2 medical assistants, 2 dental officers, etc	Nausori Zone	5313
	Kuku Zone	5212
	Nageledamu Zone	5037
	Davuilevu Zone	6809
	Sawani Zone	5103
	Wainibuku Zone	6519
Naulu Nursing Station	Naulu District	4671
Baulevu Nursing Station	Baulevu District	4475
Namara Nursing Station	Namara District	3549
Wainibokasi Hospital and District (Later became a comprehensive health centre; 1 medical doctor, 1 medical assistant)	Wainibokasi Zone	5061
	Navaka District	3378
Nailililli Nursing Station	Nailililli District	3644
Mokani Primary Health Centre & District (with one medical officer & clinic nurse)	Mokani Zone	3889
	Luvuluvu Zone	4825

NB: **District nurse** – a community health care area nurse-midwife at a nursing station, with no immediate physician support at that station.
Zone(al) nurse – a community health care area nurse-midwife at a medical/health centre base, with immediate physician (or assistant/auxiliary medical officer) support there.

Table 3. Community health status indices in a resource-poor developing nation with national health services based on a functioning PHC system (Fiji Islands, 1999)[19]

Community health index	Value (national survey by this author)
Crude birth rate	16 per 1,000
Crude death rate	4 per 1,000
Infant mortality rate	11 per 1,000

Maternal mortality rate	<1 per 1,000
Contraceptive prevalence rate	37% of WCBA
Immunization rates – BCG & Polio 0	99%
DPT 3	96%
HIB 3	85% (only recently introduced then)
Measles	88%
Under 5s weight below 3rd percentile of normal	5%
Native communities with trained volunteer workers	79%
Native communities with self-owned dispensaries	37%
Native communities with health/dev. committees	59%
Non-native communities with trained V workers	11%
Non-native communities with dispensaries	16%
Non-native communities with hlth/dev. committees	3%

NB. All local governments in Fiji are headed by MOHs with several GP and community medicine-inclined doctors in the central or district headquarters of the LGAs; and complete community nursing and midwifery in districts and zones, properly paid and supplied for these services.

In addition to all the above, both of our involvement in disciplinary public health and community medicine in Nigeria from the time of our National Youth Service Corps as a medical officer of health for Ankpa LGA in then Benue State and as sabbatical leave visiting lecturer at the Fiji Medical School and medical officer of health for their Rewa Medical Sub-division (Figs 2 & 3 below)[5,6,14], show us that these things (and a lot more) are easily doable in the country.

Fig. 2. Dr. Asuzu as NYSC MOH for Ankpa LGA **in 1978**; extending health services to a village in the Ogugu District as part of the MOH duties for universal health care in the LGA.

Fig 3. Prof. Asuzu discussing with community elders and section on women and children waiting for health care screening (as MOH of Rewa Medical Sub-division) in the Fiji Islands during a community health day in 1999.

In concluding this picture of community health care at the LGA level as originated in the UK in the 1800s[10], its attempt in Nigeria in the colonial era[3], the attempt to return to something near it with NYSC Medical Officers of Health in the late 1970s[5,6] and its full practice in some countries of the world still such as in Fiji[14,19], it can be clearly stated that great efforts had been put in place by past Nigerian leaders in the health sector in that direction. However, these had neither followed the practical examples of the good old UK health system that we inherited[3-5,18] nor that of any of the best practices around the world[10,14,19] in the very ways that make them indigenous to us or our various federating units.

The lesson from these best practices for those who have not had a firsthand experience of them can be summarized as follows:

1. For each of the three levels of the national health system to properly and sustainable perform its function at a mutually challengeable way, each must be headed by medical doctors as the apex of the health professions. Some of the subdivisions or districts within these LGAs and their physical facilities would also be best to be run by medical or dental officers up to the senior medical officer cadre, as far as these can be found, for the best performance of these services. This must be the clear objective of the governments; the extent to which this is achievable depending on the prevailing circumstances.
2. For true community health care to be achieved at the LGA level, the LGAs need to be divided STATUTORILY into community nursing and midwifery districts and zones; as the principal producers of community health care.
3. Auxiliary community and general practice physicians as well as auxiliary community nurses (BUT NEVER OF MIDWIVES BUT ONLY COMPETENT BIRTH ATTENDANTS IN THAT REGARD)[4] should be found and trained WITH THE FULL COMMUNITY PARTICIPATION BUT FOR ONLY THOSE CLEARLY LIMITED

AND KNOWABLE COMMUNITIES AND FACILITIES WHERE THESE PROFESSIONAL COMMUNITY PHYSICIAS AND NURSES MAY NOT BE FOUND.

4. The starting point for any genuine community health work is with the de-jure census for the determination of the total denominator populations of all the sections of the communities for all the statutory community health services – the total population, total males and females, infants, pre-school aged children, school-aged children (in school and out of school), women of reproductive ages, the elderly and all the categories of the chronically ill and disabled. The determination of all the chronically ill and disabled members of such communities allows for the creation of the at-risk register for all these people, the prescription of their life-long health care plan by competent physicians and their home-based community rounds by the community nurse-midwife on 3 of the 5 working days of the week. These rounds are to ensure that the chronically ill subjects are living at the maximum level of their health possible at the given time. By this, they would be taking their medication, if so prescribed, keeping all the prescribed behavioural modifications by self and family and keeping to their health facility follow-up appointments as may be prescribed. A family member is usually trained to provide the auxiliary nursing services of such family member, including the custody of their drugs and ensured observed intake thereof. During these community rounds by the community nurse-midwife, any other health behavioural inadequacies observed, by anybody and in any place in the community, are counseled on for those concerned. This will include pregnant women who had not registered in time for ante-natal care, any environmental health violations, forced feeding of children, etc.
5. It is only by this thorough professional community health care, especially the community nursing and midwifery care, that any persons, families, communities, local governments, states and nations are or will be able to attain health-for-all. It is not impossible for any country or state to set the policy, produce the strategic framework and implementation guidelines to do this – ONLY IF THEY WILL SIMPLY STOP PLAYING DIRTY POLITICS WITH THEIR PEOPLE and so, provide the needed political will to do so. Virtually all the states in the southern and lower north-central states of this country can surely do this, if their citizens rise up and hold their governments to it. All the other states can do the same, only that they will make more use of the auxiliary medical and nursing officers than any of these other states to do so. Foreign partners are not the ones to teach them how to do this; nor will these be achievable by the vertical public (and some so-called community) health programmes (foreign and local) that has become the real shame of our national health services.

The big efforts that had been made to improve our health systems, or even to establish PHC, will now be listed below and followed with what was their problems and limitations; based on the world's best practices in these regards. We will then outline what we believe should be put in place at policy, legislation and their strategic frameworks and implementation guidelines, if we are going to meaningfully pursue the PHC and HFA agenda of the modern world's health community.

AT THE LOCAL GOVERNMENT LEVEL

The already established provisions:

1. Every LGA health service is to be called PHC (not "medicine and health", as before); and run as the primary responsibility of the local government.
2. All the component services of PHC are to be provided there; with the assistance of some senior staff that may be posted to assist them by the state government to do so.
3. The principal officers meant to provide these services are the community health officers (CHOs) and the community health extension officers (CHEWs); who were initially to work as such auxiliaries, but later changed both in name and implementation to be otherwise.

The persisting problems

1. The principal health professionals (the community medical and nursing-midwifery officers, specialist or otherwise) who run community health services in the best practices around the world, are not properly provided for nor even emphasized in these services; at least as the ideal to aspire to. Hence, PHC in Nigeria continues to be seen as well as run as the inferior health services for the unimportant people of the country: "free but not available", "to be provided or actually posted there but absent"; for both health workers and services
2. The most functional unit of the provision of PHC – the community nurse-midwives and their nursing zones and districts – have never been acceptably discussed in the country; nor the staff and modalities of their practices. The closest to this is the "political ward-based PHC" but I do not know anywhere that it is working as in the practices whose results are shown in Tables 2 and 3 above.
3. The CHOs and CHEWs, who in the best world's practices, their numbers are clearly determinable, and their candidates are identified and selected for training through full community involvement, trained as auxiliary community medical and nursing officers, respectively, and made to function as such, is otherwise in Nigeria. Thus, they would rather run the services largely as parallel health services to the normal world orthodox health services; with no responsibility to ANY communities that they serve, independent of any community medical and nursing services and with no avenues for their healthy up-grade training to the full community nurses (or eventually nurse-midwives) or medical officers as may be possible for some of them.
4. The selection of the CHOs and CHEWs (as the community health practice auxiliaries that they are) through community participation, **and for the clearly noted communities only, that clearly need such personnel**[20], has never been the case in Nigeria. So, we neither know how many of such workers are needed, nor the communities that they are being trained for. Unlike in the best practices where these workers are selected, trained and posted only to the places where the needed community physicians or nurses MAY NOT BE FOUND, we train them at random and non-stop in the country. We also have developed no healthy avenues for those of them who understand what professional community health work is, and wishing to be properly absorbed into it have made up their erstwhile previously inadequate general education for it, to go ahead to do so. Thus, these avalanche of people are ending up either unemployed, unemployable, freely leaving these government services and/or setting up their own private but unpredictable practices or organizing very unprecedented training programmes for their already somehow

obviously accepted alternative but yet unclear health systems in the country of their own. At the 1st National conference on human resources for health in 2011, the statistics provided from the Planning, Research and Statistics Division of the Federal Ministry of Health[21] showed that over 47,000 CHEWs had been trained in the country, only some 11,000 of which are traceable as to what they were doing in the public health services! As for the CHOs, the number was over 17,000 trained, only some 6,000 of which were traceable in any public health services in the country. Yet our health indices are not improving any significantly; and we are still producing these officers, even with greater speed and in greater numbers; when they are not retained in the public health services nor even traceable thereafter!

5. The other complementary health workers – laboratory technologists, radiographers or medical imaging technologists, environmental inspection officers, public health nutritionists, community pharmacists or pharmacy technicians, community dental officers or at least their appropriate auxiliaries, community rehabilitative assistants (CRAs), etc – are not properly identified nor trained and deployed to work as in those best world practices here.
6. In the few cases where such physicians or nurse/midwives are found, willing to work in the community/PHC services, there are no proper structural systems organizations, provisions for their proper training or at least orientation, nor the provision to them of even the minimum tools for these statutory community health work. These include, most especially, the proper organization of the LGA services for the community medical and nursing services (for example, the medical districts/sub-districts and zones or of the nursing-midwifery ones), general conditions of service to be able to live and/or work in these difficult situations by these officers, good and well maintained transport systems for their supportive extension services to all the officers and physical health units of the LGA by the medical officers of health or their delegate. Others are ambulances (at least one per LGA) for the transportation of needful patients within and outside the LGA and promptly paid transport allowances for the community nurse/midwives for their community rounds and related services, the very basis of achieving HFA!
7. Because of the failure to provide for specialist or otherwise properly orientated community medical officers (or some reasonable extensions of it) for the PHC services, the practice of **inter-sectoral cooperation and coordination** with all the other health-related agencies for the attainment of HFA in the LGA remains an impossibility. These agencies include public works (especially with the sanitary/LG) engineer, agriculture, education, information, security (police), and the traditional, socio-cultural and civil leaderships; at the very least.

AT THE STATE GOVERNMENT LEVEL

<u>The already established provisions</u>

1. Each state was required to create the directorate of PHC since the 1980s to facilitate the practice of PHC in the states' LGAs. Lately ONLY, these states are now being encouraged or required to develop state PHC (development) agencies, with the possibility of some direct funding from federal allocation (from the Health Act) to do so.

2. All medical and nursing schools were mandated to include PHC in their curricula; and some leadership posts in nursing in the state ministries of health will be unattainable by any nurse except she had obtained the community/PHC training certificate.
3. At least one school of health technology is required to be owned by each state and to train the community health extension workers there.

The problems

1. The provision of a fully functional general hospital by the state government for each LGA (or even a comprehensive health centre whose general hospital component will be looked after by a specialist, or otherwise at least very experienced, general medical practitioner) is not specified anywhere in our health system; and so, left to the caprices of the state governments. In some places or for some times, there may even be general hospitals run by nurses only.
2. Without properly organized and effective general medical practice (i.e., **primary medical** care coverage or **secondary health** care) to take off the weight of any fallouts from the PHC system, and close to the people within their LGAs, many state governments are busy competing with the federal government to provide all sorts of dysfunctional tertiary health care services. They do this for the very reasons of meeting the obvious need from the combined failures of the primary and secondary health services. Ironically, had these effective PHC and SHC services been established and working well, there would have been no enormous need for these state tertiary hospitals in the first place; nor the need to compete with the federal government for their provision.
3. The two-way (and mutually check-mating) referral system between the PHC and SHC on the one hand and the SHC and THC on the other, possible because they are each superintended by their relevant specialist physicians, does not exist in the country. As the Riga Conference on PHC[22], midway to the year 2000 from Alma-Ata, had observed, without this two-way referral system providing the PHC primary support system, it will be impossible for it to work as due!

AT THE FEDERAL LEVEL

The existing provisions

1. The development for the first time in Nigeria of a national health policy based on PHC in 1988, at least in theory; with the aim of doing this properly in the country.
2. The creation of the National Primary Health Care Development Agency (NPHCDA) as a vital tool for the promotion of PHC in the country.
3. The recent signing of the National Health Act in 2014[23]; with provision for funds for implementing PHC in the country; but which is taking so very long to get it to any functionality at all.
4. The numerous (though externally expertly influenced and funded; and therefore invariably vertical) programmes aimed at PHC implemented from the NPHCDA at Abuja; with a lot of statistics of numbers of staff and equipment and money expended, but with little or no measurable (or especially commensurate) health service functionality, sustainability or reasonable health index improvement outcomes. These have no basis of any sustainability without developing the states and LGA capacities for these programmes and services as due.

5. The continuous training of CHOs at the various federal training institutions, independent and with no reasonable links with the overall health professionals and systems, nor any communities of their envisaged specific practices, as surely the Nigerian-factor alternative PHC system; compared with the world's best practices in these regards.

The problems

1. The efforts that resulted in the very famous production of the Nigerian national health policy, as a first of its kind in the history of the country as a nation and based on PHC, failed to reproduce, if not advance, the minimal public health acts of the country, even if only at the level of the colonial era, for the health services of the LGAs. The efforts to produce one by a draft approved at a National Council on Health in 1999[24], failed to be effected for reasons yet to be known. However, this is most likely because while the overall national health acts and policies may be made at the national level, the public health acts in the country were made by the regional governments of the properly federating units then; unlike the present Nigerian state governments, that do not quite operate as such competent federating units. Largely as a matter of these non-federating unit capabilities by the states, they themselves have by and large failed to re-enact or upgrade and implement these old regional public health acts as due.
2. The NPHCDA has continued to function as a PHC IMPLEMENTATION agency, instead of a DEVELOPMENT one. The agency has kept creating or receiving programmes and finances from international development partners (or some national ones) and going directly to implement those in their sponsors' self-chosen places or communities. In virtually all the cases, the NPHCDA has been bypassing the state governments as well as many times, the LGAs and communities themselves. As I am reliably informed at a recent job assistance at the Federal Ministry of Health, besides the fact that everybody can see these naturally in the country, less that 20% of the "PHC" facilities built in these ways are functioning in ANY ways. Even in those "functioning 20%", none of these has functioned at their intended full capacity. Only partial efforts to develop the state PHCDAs have started with the enactment of the National Health Act; an activity that should have been the priority of the NPHCDA from its very creation! Meanwhile, nothing in any of these recent actions has discussed the functionality and sustainability of the PHC itself at the LGA level, as in the best world best practices. Only individual states can make these decisions and implement them properly.
3. One of the funniest implementation of PHC from the federal government level through the NPHCDA that has happened, was the so-called community midwifery service scheme[25]. In this programme, the NPHCDA was largely to get a National Youth Service Corp type, but rapidly trained young girls as midwives but with no nursing training as yet. Without any requisite field experience, these young and unmarried, singly midwifery-only but not nursing qualified girls, were to be posted to various very remote places where they will be functioning as the sole midwives there; with counterpart salary payments required by the programme from the state or local governments. After some years of such services, the state or LGA was to take over the payment of the salaries and other conditions of service of those young girls. Anybody who had properly trained in, understands community health, or worked where these have been properly practiced, would easily tell that such a plan was a disaster - both for those girls as well as to any African nation that tries to do so. This is so because the years of marriageability of these

young ladies, where the fairly early marriage of such young girls in whom much has been invested is of such great importance, is being wasted where these cannot take place in any meaningful ways! Moreover, community nurse-midwives are usually very experienced nurse-midwives who eventually act as **health matriarchs** (*the communities' mothers in relation with their health and welfare*, as William Rathbone described them as long ago as 1859!)[10]. Moreover, no local government as currently being run in Nigeria can take over and sustain the funding and services of such health workers. Many of the state governments are also not likely to absorb such staff, with the indigene/non-indigene discrimination in the state government employments in this country, even in the most desperately under-served states in the country!

4. Both the Federal Government and especially the NPHCDA keep insisting that the PHC and the health services as provided from the states in the country should be the same in all the states. Anybody who has lived in such big and variegated countries (as Nigeria surely is) would know that this is never ever going to happen; and to insist that this must be the case, is EXACTLY how to ensure that the health services in such possibly frontline states for this progression, and country as a whole, will never improve as they ought.
5. Failure to repair the creation of a so-called PHC work force, unlike and parallel with the internationally accepted best world model of creating these auxiliary work force, is such a sore issue in the Nigerian health services. This was created from the federal level, and is surely a continuing problem in these regards. Even the Nigerian history teaches us enough of these things. The assistant medical officers produced at the Yaba Medical School, eventually all got their advancements to full-fledged medical doctors through the British conjoint further training programmes organized for them in the UK; and most of those doctors have proven to be some of the best full-fledged doctors that this country has ever produced – the likes of Profs. TO Ogunlesi, JO Mabayoje, Drs. Michael Okpara, Christopher Okojie, to name just a few! The other such trainings (like the Kano Medical School one) trained such staff for only the time that they were needed; and they practiced only in that region as was fashioned and licensed for; etc. The application of a similar principle and phasing out of the programmes or retaining them only for carefully community selected fellows, where they still need them, is an urgent necessity in the country.

OTHER PROBLEMS MILITATING AGAINST PHC AND THE OVERALL NATIONAL HEALTH SERVICES

1. These include the absence of truly federating units in a large country such as Nigeria surely is; and the unitary governance of the country; limiting state freedoms and the fast-tracking of their particular health systems as in the pre-independence and immediate post-independent era of much growth in these regards. At that time, the federating units were even able to fashion out and train some of their own health workers whose licenses will be limited to those regions, such as the then Kano Medical School[4].
2. Failure to provide for conditions of service that will help to attract and keep health workers, especially those in community and rural health services, in their given government places of work nationally. Apart from salaries, due work status advancements, transportation, housing, security, other social amenities within those

health facilities, as well as continuing professional education facilities, had been pointed out as some of these needs even within this country[26].

3. Consistent failure to understand the differences between the usually vertical public health services of the government health services beyond the LGAs and the inevitable vertically, horizontally and totally integrated community health services of the disciplinary public health and community medicine (or nursing and midwifery) that constitute the needed work at the LGA level; and to provide for their proper provision in the country. This fault is both of the supposed specialists in these disciplines (who have never had exposure to these actual practices where they exist) as well as the other leaders in the health professions.
4. The lack of emotional intelligence nor improvement in training in that regard, which make Nigerian doctors unable to provide the healthy leadership of the health system, needs to be addressed as urgently as possible by everybody who should be concerned with this need. This primarily should begin with the Medical and Dental Council of Nigeria (MDCN), the Nigeria Medical Association, National Post-Graduate Medical College of Nigeria, the overall political, religious and traditional leaderships in this country and the other bodies like the Universities Commission that should respect and cooperate with the MDCN and medical schools in doing this; rather than creating other monstrosities against the medical profession and medical education in the country.
5. The overall moral, academic, professional, ethical, religious, spiritual and cultural decadence plus economic corruption in the country that is driving every Tom, Dick and Harry to want to become millionaires, to earn as much as everybody else is earning from the government, even with grossly in-equivalent qualifications or training, job responsibilities, descriptions or requirements. The role of the growing (Western) Secular Humanist ways of thinking and living in the world, even in the corrupted religions of these days - of instant and only worldly attainments, fulfilments and satisfaction that is at the back of these unhealthy human relationships - ought to be addressed non-the-less.
6. The non-viability of the LGAs, and even most of the states as federating units, as presently constituted in the country needs to be addressed as well. These factors notwithstanding, any state rulers who decide that they will do their best to govern their people well in spite of these limitations, can surely make reasonable progress in these regards.
7. Overall ethical, moral, religious and financial corruption in governance in Nigeria that make politicians power-drunk and people-disorientated needs to be addressed as soonest as possible. In the countries with the best health services and indices, the rulers love the people, are with them, do not terrorize them; and they plan the state services for the maximum good of the people. I suppose that both hard work, continuous vocalization by any remaining few of the sane elites, and prayers to God by everyone, to bring this last evil of the country to an end will be useful in these regards; but surely not ANY prayers at all that are without those vocal and other physical redress actions.

WHERE DO WE GO FROM HERE?

From what we have explored here, I believe that it would have become obvious that the following will be needed, and in the order in which we put them here now, if we are going to be

able to provide PHC and HFA in Nigeria; or more easily, any states whose politicians will ever be truly interested in doing this:

1. Any state that is able to convince itself that it ought to be a truly federating unit in Nigeria, and therefore to be fully responsible (except if provided for in an exclusive federal legislative list) for the normal/general health, education and all the social services of her people, should wake up and determine how it should do this, even with the prevailing funding limitations. In the health sector, they must provide the framework to provide functional and properly staffed general hospitals for each LGA, a functional state PHCDA and a functional, professionally well-staffed local government PHC services, following the best practices as described above. All the states in Nigeria have more than enough medical doctors to do these, if only the governments will become more people-responsive and so get their priorities right. In one of the states in the North that I had the privilege to go to facilitate the PHC programme lately, with all the foreign development partners that the Federal Government has directed to concentrate their efforts in helping with the PHC services there, they are already doing their bests in these regards! But without the needed radical commitment from the state government in developing and supporting the proper system by themselves, there will be no talk of sustainability of these programmes if and when these foreign agencies leave those programmes.
2. In setting up their LGA/PHC/HFA services, these states must endeavour to do it according to the world's best practices, with properly trained, or at least properly orientated community physicians (as MOHs), nurses and midwives as statutorily ought; and the other health practitioner groups; and the auxiliaries as such – as closely and supportively supervised extension workers only.
3. The states and all men and women of goodwill in this country should beg as well as assist the Federal Government and the power-brokers there to realize as well as accept the fact, that the Federal Government and her agencies have no direct business with PHC whatsoever!; except to assist **the federating units independently and evenly/equitably,** in developing it for their individual LGAs; as is their state or federating unit primary duty to do. The Federal Government and her agencies have no business collecting, directing and howsoever spending resources meant as "community-service" ones; precisely because it is the furthest government from those communities and knows very little about them; nor do the people know them, as is usually the case in all meaningful community hearth services. In the very area of PHC, it will be flouting the most essential element of it - of community involvement up to the level of self-ownership and self-reliance - to continue to do so. Moreover, social justice demands that all international development partners assistances to Nigeria are EQUALLY AND EQUITABLY DIRECTED TO ALL THE NIGERIAN STATES. Otherwise, the Federal Character content of our constitution will be violated thereof
4. As the federating units that they are, the state governments should run fast with the present state primary health care development agencies (SPHCDAs) drive; and so, establish the best well-formed, informed and properly manned ones of them, for their respective states. In states that still, because of the prevailing national poor conditions of the public services, are not able to bring back their so very many medical doctors now working with all sorts of international agencies and programmes, MUST learn to use the doctors working in those state PHCDAs to do this work of the medical officers of health for all those/their LGAs while remaining with the SPHCDAs better conditions of service.

5. There are no states in Nigeria where we cannot find at least a few retired nurse-midwives to employ at reasonable/meaningful salaries and conditions of service, to provide the LGA community nursing and midwifery sister/superintendent for the overall LGA/PHC services. Many of them can, in addition, have and provide at least one or a few others to provide model community nursing and midwifery services for one or a few other community nursing and midwifery zones or districts in each of the LGAs. The states MUST endeavour to divide their LGAs into the universally accepted community nursing and midwifery zones or districts of 2,000 to 7,000 people – depending on their population densities – for this purpose of properly organized community and primary health care services. This may or may not be within the present so-called ward-based PHC system of the NPHCDA/FGN. The rest of these zones or districts for which such retired nurse-midwives or even fresh experienced ones cannot be found, should then determine how many such communities are, and deploy any of their willing CHEWs there. These should of course be after their proper orientation to the work of the community nurse (but not midwife, without being retrained and certified as **competent birth attendant**s) to do so.
6. The state leaders, all men and women of good will, and especially the medical doctors, midwives and nurses and their councils, should be persuaded to stop complaining about the seed of destruction of the health care system created by the establishment of auxiliary community health workers in parallel with the entire health system, and agree to develop bridging programmes AND THEIR NEEDED STANDARDS to allow those of them who make themselves worthy of such conversion to quickly and most competently advance into the normal nursing and medical professions. Experiences in the Nigerian medical and health services history[3-6], as well as of similar ones in other parts of the world[19-20], show amply that those who get into these proper health professions from these auxiliary or assistant positions, usually prove to be better, more humane, emotionally intelligent and successful professionals in those regards. It does not pay ANYBODY that we stay and look at this on-going destruction of the universal health professions and services in Nigeria because of a previous error. Surely the doctors, as the world undisputed leaders of the health professions, will be the ones with the greatest guilt that this continues to be the case.
7. All the PHC implementation-related agencies at Abuja should be assisted to get dismantled (whether of PHC as a whole, immunization, community mobilization, etc) and be reabsorbed and streamlined into the monitoring, true development, facilitating and policy-only agencies or departments that they should be at such national level of our existence. These functions belong to the LGAs, as assisted by the federating units or state agencies or units in those regards; no more, no less.
8. The utmost process of the national all-round restructuring that we have merely achieved in bits and pieces in the past, by less than nationally charitable motives, and not originating from any universal desire for **the common good** of ALL Nigerians – in 1952 and 1963 respectively – should now be firmly, courageously, comprehensively and charitably addressed in the interest of the common good and the common man of this country; rather than for the selfish few politicians. When we do this, PHC and the entire national health system will begin to work and do so very well indeed. Every state or region and every citizen of this country will become the better for it, rather than the few selfish political jobbers.

IN CONCLUSION

Having said all the above, I may only add that having had the firsthand experience of PHC in places that it actually worked and still works, as well as in being a teacher and researcher of the history of medicine and the health services and systems, I will make myself available to any state or persons that ask or query me about what I have said here – whether in their interest to advance PHC or perhaps to teach me better in those regards – for I am always a ready student thereof. In the modern world that is now a global village, we can do this mutual querying or assistances to one another in advancing PHC and HFA in any state, LGA or country, and without moving an inch from wherever we may currently be residing. May God help us to do this as well as see true PHC and HFA in Nigeria in our life time.

May God bless the name and person of Professor Bassey Andah; and may his legacy live on. May He bless the Bassey Andah Foundation and all her operators and cooperators, as they seek and continuously sustain this legacy. May He bless all Nigerians of goodwill; and grant us PHC and HFA in this country.

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