

from WHO's Health and Nutrition Tracking Service, who managed the surveillance team. "We had one guy who came in off the street as a volunteer and he turned out to be one of our best people. You really see what some people are capable of in an emergency."

Garfield says that surveys held after previous disasters have mainly measured aid provided. How many people received goods? How many villages were visited? For the first time, Garfield says, this survey asked questions to compare conditions before and after the cyclone. What kind of sanitation was in use? How far did people have to travel to seek health care? What kind of health problems did they have?

Some results were surprising, with most common health problems being diarrhoea and the common cold rather than the trauma and injuries that had been predicted. "We were expecting dramatic injuries but there were far fewer deep wounds caused by the cyclone than the Asian tsunami, where waves had a much greater force. A further surprising result was that the greatest health need was psychological support," says Garfield.

The survey revealed that twice as many women as men died during the cyclone, many falling into the flood

Fact file: Cyclone Nargis

Dead: 84 537

Missing: 53 836

Medical supplies dispatched by WHO and health cluster partners: more than 500 metric tonnes, including:

- 33 000 insecticide-treated bed nets
- 500 dengue fever disease kits to detect and confirm cases
- 30 000 surgical masks and gloves

Funds supplied immediately:

- US\$ 350 000 from SEARO's new emergency health fund
- US\$ 50 000 from WHO headquarters

Total needed to rebuild health facilities (75% of which were damaged or destroyed): US\$ 2 billion

waters since they were unable to clutch on to the trees for as long as the men. Other women died trying to save their children.

The data are being used to closely monitor recovery and reconstruction in Myanmar and will assist future relief efforts. "We don't usually have the information that permits us to answer questions such as: What difference did we make? How well did people recover? With this survey, we will be able to know when people get back to normal."

Work is already under way to develop this survey as a model for future relief efforts and to prepare a bank of

potential questions for different kinds of disasters.

Dr Eric Laroche, assistant director-general for the Health Action in Crises cluster at WHO, wants the Organization to strengthen its operational role in relief efforts by taking the lead on the ground, as it did in Myanmar.

"Some people say that WHO shouldn't be focusing on operational work," he says. "But that would be denying our historical role. WHO will be remembered for eradicating smallpox and for our anti-tobacco campaign, both of which assumed very much operational roles." ■

Nigeria still searching for right formula

Despite several attempts at reform over the past 30 years, Nigeria still lacks a clear and coordinated approach to primary health care. Michael Reid reports.

In 1990, Michael Asuzu held high hopes for the development in Nigeria of a primary health care (PHC) system based on community participation, using well-trained, well-equipped and motivated community health professionals.

Writing in the March 1990 issue of *World health* magazine, Asuzu, at the time a lecturer and consultant in the Department of Preventive and Social Medicine at the University College Hospital in Ibadan, enthused about a "bottom-up" grassroots PHC project in the hamlet of Elesu, 32 kilometres north of Ibadan. Members of Asuzu's university department had helped villagers develop a programme to control outbreaks of waterborne guinea-worm disease and adopt other PHC measures.

"We expect to be able to replicate this programme in any local community ready to take charge of its needs for PHC as the Elesu community has," he said. "This case history shows that, when community health development workers are available and willing to go out and assist communities, it is possible for them to come forward to request and be helped to provide community-owned and self-reliant PHC programmes for themselves."

Fast forward 18 years and Asuzu, now professor of Public Health and Community Medicine at the University of Ibadan, is less ebullient when discussing PHC in his country.

Addressing the Nigerian Academy of Science Seminar in Abuja in May this year, Asuzu said: "Nigeria has never

succeeded in establishing community medical and health services for very many reasons ... some limited levels [have] been practised in Nigeria, even during the colonial days, but never fully."

In June, Asuzu told the Nigerian Medical Students Association that Nigeria had in the mid-1980s joined the international push for PHC after the 1978 Alma-Ata Declaration of 'health for all'. "Some progress seemed to have been made with the health services between then and the mid-1990s," he said. "However, the health indices have been deteriorating since then [judging] by every health system evaluation [carried out] in the country. Unfortunately, Nigeria has never learnt or developed any system of authentic and full-scale community health care before Alma-Ata or after it. This explains why we have not made any success of the system."

The world health report 2000 ranked Nigeria 187 out of 191 countries for health service performance, a

situation that has not changed much since then, according to Asuzu, who cites several statistics to highlight the inadequacies in Nigeria's PHC system. Annual budget allocations to health have been persistently below 5% except for the years 1998–1999 and 2002–2003 when they were at or just above this level.

Infant mortality rates have been deteriorating from 85 per 1000 live births in 1982, 87 in 1990, 93 in 1991 to 100 in 2003, according to the Nigeria Demographic and Health Survey, 2003. And in 2007, the Federal Ministry of Health reported 110 deaths per 1000 live births.

Maternal mortality ratios are estimated at 1100 per 100 000 live births in WHO's *World health statistics 2008*.

Asuzu identifies five attempts at reform over the past 70 years:

- 1940s. The Nigerian Colonial Development Plan had a limited framework for a unitary health service.
- 1950s. Regional governments ran independent and sometimes parallel health systems to the federal government.
- 1960s. The Second National Development Plan in the post-independence era did not articulate a system with clear responsibilities for each level of government.
- 1970s. The ambitious Third National Development Plan had the Basic Health Services Scheme as its focus, but again failed to share responsibilities between the governments for resource generation, manpower development, health professional deployment and service delivery.
- 1980s. Following the Declaration of Alma-Ata, there were serious attempts at health system reform, based on the principles of PHC resulting in the National Health Policy in 1988. However, the policy failed to create a unified system of care or address finance and staffing for competent local leadership.

What are the reasons for Nigeria's failure to develop a successful PHC model? Asuzu says some are rooted in the country's colonial past, while others stem from a lack of political will and poor policy-making that failed to divide responsibilities effectively between



WHO health economist Dele Abegunde (second from right) visits members of a Village Health Committee in the Delta State of Nigeria in 1996.

federal, state and local government and resulted in PHC services lacking staff and funds.

Others say it was also mistaken to treat PHC as “the first level of care” since it was conceived as universal access to all types of care. “As a result, the potential of hospitals, for example, was not well leveraged,” says Nosa Orobaton, a Nigerian doctor who worked to implement primary health care in the 1980s.

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Nosa Orobaton

Another mistake was to focus on the health sector at the expense of other sectors, such as work, housing, agriculture and transport. “Future implementation of primary health care in Nigeria

will have to address the considerably more decentralized political system, a much more dominant private sector, increasing demand for a reliable health information system and expanded roles for non-health sectors,” says Orobaton, now a manager with the WHO-hosted partnership, Health Metrics Network.

Dele Abegunde, a Nigerian health economist working with WHO's Department of Chronic Diseases and Health Promotion, also refers to the misguided attempts to develop PHC in Nigeria. “Health care instituted by the colonialists was organized primarily to meet the needs of the colonialists. After independence, the new government naturally adopted the colonialist health system primarily responding to the needs of the post-colonial elites.”

“But there was no understanding of health care the way we understand it now. What the early policy-makers understood as health was hospitals somewhere – grand, big elephants – 50- to 100-bed hospitals. But the beds were empty because services were not designed to respond adequately to the needs of the people. The impact of that in the 1960s was that life expectancy did not improve and diseases were prevalent because secondary-care hospitals really didn't do much to prevent diseases. They cared for the people once they had them,” Abegunde says.

Early developments in PHC post-Alma Ata were encouraging, said Abegunde, a medical student during that period, between 1979 and 1984. “For the first time, rural communities

began to see that, well, we may not have 50-bed hospitals but we have a clinic where we can go to if we have a headache or a cough or a snakebite. Health needs of the larger rural population were gradually being met, and after a while people began to see the results, particularly in immunization programmes, diarrhoea in children, malaria treatment and acute respiratory infections.”

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Dele Abegunde

But early advances often lost momentum, Abegunde said, because communities were not encouraged to take control of PHC schemes themselves. “Initially, they did not put a lot of emphasis on community participation and ownership,” he said, adding that later on many doctors and nurses left the rural areas for better paid jobs in the cities.



Dr Michael Asuzu talking to the Village Health Committee (VHC) in the hamlet of Elesu, Nigeria, in the 1980s. The VHC and its village health workers (VHWs) became crucial in administering primary health care, including the prevention of guinea worm disease.

WHO/D. Henrioud

Abegunde says policy-makers and administrators should note the success of the PHC scheme in Elesu. After initial reluctance to adopt the monofilament water filtration system to control guinea-worm promoted by Asuzu’s team, the villagers embraced it once they had seen how it worked.

“The success in Elesu came from people’s own experience, being able to

see it and say, ‘wow this works, we did it!’ In future, primary health care planners should adopt this recipe as it has the potency to provide ownership and sustainability.”

Asuzu, too, remains optimistic that reforms of the health system and legislation governing that can deliver a sustainable PHC system. ■

The *Bulletin* at 60: from scientific organ to public health journal

The journal’s shift of focus from science to public health has been a 60-year journey, with twists and turns along the way, writes Brigit Ramsingh in this second instalment of a three-part series on the history of the *Bulletin*.

The *Bulletin of the World Health Organization* is recognized as one of the world’s pre-eminent public health journals, having maintained its role as the organization’s “principal scientific organ”. This dual focus has not sprung up overnight but has been the result of an evolutionary process over its 60-year history. Several changes to both its content and format and, crucially, the publication of several landmark articles have helped forge the journal’s unique identity.

When it was launched in 1948, as a deliberate continuation of the earlier *Bulletin of the League of Nations Health Organization*, the *Bulletin* was expected to have an important influence on medical opinion in the widest sense, and especially on the opinions of

those responsible for formulating and guiding medical theory and practice: that is, medical scientists and teachers, and public health administrators.

The first few issues of the *Bulletin* were distributed free to national health and research institutes, medical schools and faculty libraries, often in exchange for medical journals. Subscriptions were soon offered; in June 1948, there were almost 600 paid subscribers, though few were private individuals.

The work of WHO’s Expert Advisory Committees – external international experts invited to advise WHO on specific subjects – was the main “inspiration” for much of the *Bulletin*’s early content. The journal’s main function at that time was also to publish studies relevant to the Expert

Committees’ work and to cover subjects for which there were experts within the WHO secretariat.

The Executive Board believed the *Bulletin* should publish articles on the following six categories:

- laboratory studies on topics such as biological standardization and communicable diseases, one of the main objectives being to encourage the use of uniform methods to obtain comparable results;
- internationally significant studies of results achieved by specific disease control methods;
- studies of the geographical distribution of diseases;
- reports of surveys, especially those involving studies of relevant world literature and visits to countries;
- reports of original findings made in the course of field programmes; and
- review articles based primarily on surveys of literature summarizing the present state of knowledge in different fields