The case concerning the ubiquitous nature and limitations of private medical enterprise in Nigeria as put forth by Alubo (2001) is difficult to deny. What would make the argument stronger are reports on actual utilization, as well as a more detailed description of the cultural and political forces that inform care-seeking choices.

In a recent study of illness seeking for pre-school age children in three rural local government areas (LGAs) in southern Nigeria, it was found that 50% of parents had sought either first line or subsequent care from patent medicine vendors (PMVs) compared with only 13% at government facilities and 14% at private clinics (Salako et al. 2001). A review of treatment seeking for pre-school children with ‘fever’ in Lagos found a similar pattern, 36% PMV, 22% private and 29% government (Brieger et al. 2002). While the latter study indicates that urban residents have a greater choice of care, both settings show that PMVs form the bulk of private medical enterprise and overall care options.

The public–private dichotomy and concerns about quality of care may be no more evident than in the area of continuing education opportunities for health staff. In two rural local governments areas (LGAs) of Oyo State it was found that whereas 46% of LGA health department staff had experienced in-service training in the past 5 years, only 11% of private facility staff had such an opportunity (Onuoha and Brieger 1992–93). Although the public sector does benefit more from access to training, often through donor-supported programmes, the sustainability of interventions that result from such training is not high. As Alubo (2001) rightly noted, primary health care in Nigeria was essentially reinvented in 1986 by renaming the old LGA Health and Medical Departments, Primary Health Care Departments. The subsequent federally sponsored drive to train volunteer village health workers and their trainers has little to show. In many LGAs the village health workers are no longer supervised and have dropped out (Ewoigbokhan and Brieger 1993–94), or where they exist, they have little access to medicines to stock their drug kits (Brieger et al. 1994–95).

Training is desired by the PMV as well, although discrimination or simple avoidance by the formal health sector often leaves them without access to up-to-date information on illness management (Oshiname and Brieger 1992). The strong distinction between medicine shops and medicine hawkers made by Alubo (2001) is often not matched in reality. A motorcycle provides the shop keeper with the opportunity to run a ‘mobile clinic’ in remote villages thus, giving the appearance of hawking to those who are not familiar with the rural health care ‘system’. While noting the more even spread of mission hospitals in all regions of Nigeria (Alubo 2001), one should also be aware that PMVs are even more widely distributed. Laws concerning the licensing and functioning of PMVs have not changed substantially in nearly 50 years, and any effort to address private medical enterprise in Nigeria’s health policy should start with the PMV sub-sector.

There may be ethnic variations in care seeking as demonstrated in a recent dissertation. Again in rural Oyo State it was found that 34% of Yoruba farm hamlet residents used a government clinic for a recent illness, compared with 21% of the cattle herding Fulani living in the same area. In contrast 37% of Fulani attended a private clinic compared with 24% of the Yoruba. Social, political and economic factors informed these choices (Otusanya 2001). Reference was made to the concern about ‘superstition’ influencing seeking of western orthodox care (Alubo 2001). When framed in a more culturally sensitive way, one can see that local interpretations of illness are a major influence in treatment choices in Nigeria, whether it be beliefs that western medicine has no cure for guinea worm (Ramakrishna et al. 1985–86) or a mother’s interpretation of the signs and symptoms of her child’s diarrhoea episode (Okunribido et al. 1997–98).

In conclusion, while private medical enterprise is a major component of Nigeria’s health care, the form it takes relies primarily on the PMV who can be likened to the village health worker of the private sector. Until health policy-makers take account of the role of these small entrepreneurs, the focus of the policy debate about health will remain on physicians, whether they receive their salary from the state, from fees, or as Alubo (2001) adroitly points out, from both. In addition, physicians will define the debate in orthodox medical terms, ignoring the ethnic and cultural influences that guide health
seeking at the grassroots. A democratization of the health care debate is needed that involves the community and alternative providers.

References

Author’s response: Facing the dilemmas of private medicine
OGOH ALUBO

Department of Sociology, University of Jos, Jos, Nigeria

The nature of health care in Nigeria continues to attract attention, more often for its inadequacies than for any new initiatives. Attempts must continue to unravel not just why meaningful progress is long frustrated but also how the ‘system’ works. The reaction of William Brieger to my essay (Alubo 2001) might have been borne out of this latter motive.

Brieger provides some information about utilization of patent medical vendors (PMVs) in the Southwest. This region is generally more developed than others, with up to 44.5 and 66% of the Southwest having access to safe water and electricity, respectively; the comparable figures are as low as 23.18 and 14.3% in the Northwest (IDEA 2000: 157). The same wide differences exist especially in maternal mortality and child survival (Wall 1998; National Planning Commission and UNICEF 2001). Information from other regions is necessary for a more complete picture.

There is little question that private medical enterprise in general and the itinerant vendors in particular – whether on motorcycles or foot, or in buses and trains – would continue to be an important component of the health care system. There is, however, the persistent problem of competence and unethical practices, all of which paint a picture of a free-for-all enterprise (Alubo 1985, 1994a; Stock 1985; Pole 1989). In effect, this situation puts the potential to do good almost on a par with that to cause harm, such as the 1990 paracetamol deaths of over 100 children (Alubo 1994b). Herein then lies the dilemma: balancing availability with risks.

Brieger has shown that the public service health workers have more access to continuing education than their private medical enterprise counterparts, even if the former have little to show for such training. It is uncertain if private medical enterprise workers, particularly the itinerant type to which PMVs belong, would benefit any more from training. Driven mainly by money, they sell drugs with little regard for dosage, or even the nature of ailment (Stock 1985; Alubo 1994). Perhaps, more stringent regulation, such as the recent crackdown on counterfeits might yield greater results.

I agree with Brieger that the discourse on health must include all providers. Unfortunately, the debate continues to be monopolized by the professionals, especially physicians who, through their associations, not only insist that the health minister must be a doctor, but that no health policies be made without conferring with them (Alubo 1948b). In a context of agitation for continued control of health matters by physicians and other professionals and the willingness of politicians (as their military predecessors) to go along, Nigeria might have a long wait before any democratization of the health debate. In the interim, the dilemmas of private medical enterprise and all its ramifications would have to be faced and hopefully resolved.

References