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Healthcare Development in Abuja and Its Socio-Economic Implications in the Area, 1976-2002

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Abstract
The paper examines healthcare development in Abuja between 1976 and 2002 and its socio-economic implications in the area. Up to 1976, the health situation in the area was deplorable. Communicable and water borne diseases were prevalent. Life expectancy was low and the standard of living was poor. It was in this regard that poverty was prevalent in the area. However, by 2002, there were two well-equipped tertiary healthcare institutions, a good number of general hospitals, health clinics, maternity homes and dispensaries spread all across the territory. By 2002, also, Abuja residents had access to healthcare services within 40 minutes walking distance on the average. Life expectancy also improved. Healthcare development was accompanied by a significant improvement in the socio-economic conditions in the territory. The paper establishes a nexus between healthcare development and socio-economic changes in the area within the period under consideration.
Keywords: Healthcare. Development. Abuja. Challenges. Implications.

1. Introduction

Abuja, the Federal Capital Territory (FCT) of Nigeria, is an 8,000 sq. km. land area located at the centre of the country. It is located between latitudes 7^0 25' and 9^0 20' north of the Equator and longitudes 6^0 45' and 7^0 39' east of Greenwich. It was carved out of three states of Nigeria by Decree 6 of February 5, 1976. The three states from which Abuja was excised were Plateau, Kwara and Niger (FCDA, 2005:18). Abuja was created as a replacement for Lagos, the former capital, which was faced with a number of challenges including traffic congestion, over population, its peripheral location at the extreme south-western corner of the country and the fact that the Yoruba people dominated and laid claim to the ownership of the area (Unumen, 2009: 91-102).

The creation of the new FCT in 1976 and the commencement of physical development in the Territory were accompanied by the socio-economic transformation of the area. In particular, the period between 1976 and 2002 witnessed significant progress in healthcare development in the territory. Healthcare development triggered off other socio-economic changes. The focus of this paper is healthcare development in Abuja and its socio-economic implications in area between 1976 and 2002.

2. Conceptual Clarifications

2.1. Health

Health has been defined as a state of complete physical and social well-being and not merely the absence of disease or infirmity (WHO, 1946:1). Being healthy is one of the goals most valued by people in both the developed and developing countries of the world (MCMH, 2004:12). Health is an asset to individuals and communities. Being healthy has intrinsic and instrumental values. In intrinsic terms, being healthy is central to human happiness and an important source of a person's well-being. In instrumental terms, being healthy contributes to economic progress, as a healthy population in more productive, lives longer and is more likely to save more than a sick population (WHO, 2015: 13).

2.2. Healthcare

Healthcare is the diagnosis, treatment and prevention of diseases, illnesses, injury and other physical and mental impairments in human beings. Healthcare is usually delivered by practitioners in medical and allied professions including medicine, midwifery, psychology, dentistry, optometry, pharmacy and other health professions (Wikipedia, 2015:1). Healthcare could be provided at the primary, secondary and/or tertiary levels. The objectives of healthcare include the prevention, treatment and management of illness. The ultimate goal of healthcare is the preservation of the mental and physical well-being of individuals and the public (Medical Dictionary, 2015).

2.3. Healthcare Development

Broadly defined, development in any phenomenon or situation is a state in which things are improving. It is an advancement and progress on existing situations (Unumen, 2009.15). Healthcare development, therefore, is a situation in which there is an improvement or progress in healthcare delivery. It is important to note that healthcare development is a package with different components, including establishment of healthcare institutions, health promotion, disease prevention, treatment of pathologies, reduction of premature deaths as well as providing care for people with chronic diseases, deficiencies, disabilities and other health-related

handicaps (MCMH, 2004:51). Other components of healthcare development are provision and administration of public healthcare, taking steps to develop health programmes, health insurance and mechanisms for financing and administration of health systems.

3. The Nexus between Health and Development

Studies about the positive correlations between health and development abound (WHO, 1973; WHOCMH, 2001; MCMH, 2004; Atun and Fitzpatrick 2005; Akpomuvie 2010; Odrakiewicz, 2012 and Ogbobine, 2012). These studies have demonstrated the two-way relationships between health, on the one hand and economic growth and/or development, on the other. While economic growth and/or development improve health, improved health could also significantly enhance economic productivity, and ultimately, economic growth (Atun and Fitzpatrick, 2005: 6).

There are several ways through which being healthy could contribute to development. Firstly, being healthy could contribute to economic growth as it reduces production losses caused by illness in workers, increases adult productivity, increases school attendance and improves learning among school children (MCMH, 2004:15). Secondly, being healthy is a major goal valued by human beings. Meeting people's choices is now considered an important aspect of development. Thirdly, being healthy is an essential part of human welfare. Fourthly, and according to WHO, "better health is central to human happiness and well being" (WHO, 2015:1). Summarising the different channels through which being healthy could contribute to development, Akpomuvie (2010:43) stated that:

> Health is central to community well-being as well as personal welfare. It has a strong influence on people's earning capacity and productivity; it affects educational performance (and thus determines employment prospects); and it is fundamental to people's ability to enjoy and appreciate all other aspects of life.

It is in acknowledgement of the positive correlation between being healthy development that, in both the developed and developing countries, the provision of health facilities are valued higher than other aspects of human needs including housing, money income, social status, education, family life and leisure (Akpomuvie, 2010:43). More importantly, perhaps, health is an asset, a component of human capital (MCMH, 2004:13). It is in acknowledgement of these positive contributions of health to development that Atun and Fitzpatrick (2005:7) have advocated that health expenditures should be considered as investment and not as mere costs. This paper focuses on how improvement in healthcare contributed to socio-economic development in Abuja area between 1976 and 2002.

4. The State of Healthcare and Health in Abuja by 1976

Generally, healthcare services in Abuja by 1976 were poor. By 1976, modern health facilities and/or institutions worth the name did not exist in the entire Territory. There was no hospital, clinic or maternity home (private or government) in the area. Available evidence also suggests that there was no registered chemist or even a patient medicine store within the territory. The modern health services in the area by 1976 consisted of eight inadequately equipped, poorly staffed poorly managed and unevenly located dispensaries and leprosy clinics (ABUIA, 1979: 56-57).

The few clinics were established and managed by local government councils. Each of the eight dispensaries usually had two staff made up of a Rural Health Assistant and an Attendant. Where a leprosy clinic was attached to the dispensaries, a Leprosy Assistant was added. As a result of this situation, only minor ailments and dressings could be treated in the dispensaries. Major cases were referred to very far away general hospitals in Suleja, Koto Karfe, Keffi and Nassarawa in the neighbouring states (Unumen 2014A: 238).

The situation was compounded because the few available dispensaries were unevenly distributed. As a rule, they were usually located at the District headquarters that were neither the centres of highest population nor centrally located within the Districts (Unumen, 2014A: 236). Unfortunately, due mainly to the long distances, sometimes the patients never survived the rigour of travelling to the neighbouring towns for treatment. It was in this regard that the majority of the people tended to rely more on traditional healers with the attendant risks or even go without any form of treatment at all with the dare consequences on their health situations (ABUIA, 1979: 57).

The lack of adequate health facilities and services had implications for the health situation of the people in the area within the period under consideration. Communicable and non-communicable diseases were prevalent in the area by 1976. Guinea worm, leprosy, yaws and river blindness were some of the diseases prevalent in the territory by 1976. It is not surprising, therefore, that life expectancy was very low. The bad health situation in turn contributed to the deplorable socio-economic conditions in the area by 1976. Firstly, poor health affected productivity and contributed in no small measure to the poverty that had become endemic in the territory by 1976. Widespread poverty meant that the standard of living was very poor. The poor standard of living in the area was reflected in the high level of illiteracy, which was as high as 91 percent in some places,

small hut-like houses built, bad clothes worn and poor food eaten (Maboguje and Abumere, 1984:14).

It is also important to note that the poor health situation in the area had demographic implications. By 1976, the FCT had more children that accounted for about 43 percent of the population. Adults, male and female, accounted for 50 percent and the aged, 7 percent (Unumen, 2009: 45). The fact that the aged (65 years and above) constituted only 7 percent of the population indicates that life span in the territory was short and life expectancy was very low. This situation arose mainly because of diseases, poor diets and extremely poor medical facilities and services (Unumen, 2009: 48). Also, the fact that the dependants (children and people over 65 years old) constituted 50% percent of the population, the same with the productive segment, meant that the dependency ratio was high. This situation also contributed to the poverty and poor standard of living in the area (Abumere, 1990:12). However, as shall be demonstrated in the next section of this paper, this situation changed considerably with the relocation of the nation's capital to the area in 1976 and the consequent transformation in the health sector of the territory.

5. Healthcare Development in Abuja, 1976 – 2002

Healthcare development in Abuja within the period under consideration consisted of the establishment of healthcare institutions, health man-power recruitment, training and retraining, health education, health promotion, primary healthcare development, immunization of children against the six killer childhood diseases, elimination of communicable and water borne diseases, all of which contributed to a significant improvement in the health of the people of the area by 2002.

5.1. Establishment of Health Institutions

The commencement of physical development in Abuja in 1980 was accompanied by the establishment of modern healthcare institutions, including hospitals, clinics, health centres, maternity homes and dispensaries. Four major bodies were involved in the establishment of health institutions in the area namely: the Federal Government of Nigeria, the Federal Capital Territory Administration made up of the Federal Capital Development Authority (FCDA) and the Ministry of Federal Capital Territory (MFCT) and private medical practitioners. The Federal Government built and managed the tertiary health institutions while the General Hospitals and secondary health establishments mere owned and managed by the FCT Administration. The dispensaries, health centres and maternity homes were established and managed by the different Area Council Administrations. Private health practitioners also established health centres, clinics and allied health institutions (Unumen, 2014A: 253-254).

The first major health institution to be established in the FCT was Garki Hospital, which started in Suleja as a staff clinic for the Federal Capital Development Authority (FCDA) in 1980. The clinic was relocated to Garki in 1982 following the movement of FCDA staff from Suleja to the Federal Capital City (FCC) that year and upgraded to the status of a health centre. In 1986, it was again upgraded to a full-fledged hospital and renamed Garki Hospital. By that year, in addition to Garki Hospital, there were three rural health centres, nine health centre and eighteen dispensaries in different parts of Abuja (IBC, 1998: 81).

Available evidence indicates that by 1992, the major hospitals in Abuja had risen to seven, namely: Garki General Hospital, Gwagwalada Specialist Hospital, Kubwa General Hospital, Rubochi General Hospital, Wuse General Hospital, Gwarimpa General Hospital and Karshi General Hospital (IBC, 1998: 82). Apart from Gwagwalada Specialist Hospital, which was established by the Federal Government, the other general hospitals were established and managed by the FCDA. By 1998, the number of health institutions in Abuja had increased significantly. That year, there were thirteen hospitals in Abuja. These included Garki General Hospital, Kubwa General Hospital, Rubochi General Hospital, Wuse General Hospital, Gwarimpa General Hospital, Abaji General Hospital, Kashi General Hospital and Nyanyan General Hospital. Others were Family Planning Clinic, National Institute for Pharmaceutical Research and Development, Gwagwalada Specialist Hospital and FSB National Hospital (IBC, 1998:82-84).

By 2002, there were 476 different categories of health institution in Abuja. Of this number, two were referral or tertiary health institutions, nine were secondary health establishments, also known as general hospitals, one was a family planning clinic and one was a research institute. Others were primary health establishments, which included health clinics, health centres, maternity homes and dispensaries. Out of the health institutions in the Territory by 2002, a good number were also owned and managed by private healthcare practitioners (Unumen, 2009: 214-216). Thus, by 2002, Abuja could be said to have been well-served with health institutions. By that year, Abuja residents had access to healthcare services within 40 minutes distance on the average (FCDA, 2005:18).

The health institutions in Abuja within the period under review provided specialist services in surgery, paediatrics, obstetrics and gynaecology to resident of the FCT. The private hospitals provided a wide range of specialized medical and allied services such as general consulting, ultra-sound services, scanning, X-ray, diagnostics, laboratory, ophthalmology, maternity care facility services and reproductive health services

(Unumen, 2009: 207). Thus, it could be concluded that health care delivery in Abuja by 2002 was good and commendable.

5.2. Manpower and Capacity Building

Another aspect of healthcare development, which received attention in Abuja within the period under consideration, was man-power-recruitment and capacity building. To manage and run the healthcare delivery programmes in the territory, there was constant recruitment, training and retraining of health and allied professionals. These included doctors, dentists, pharmacists, nurses, midwives, medical laboratory scientists, radiographers and nutritionists. Others were optometrists, hospital secretaries, physiotherapist, health officers, science officers, personnel officers, typists/sectaries and drivers. By 1998, there were 1, 488 health and allied workers in the employment of the FCT. Of this figure, 80 were medical doctors, 4 were dentists, 651 were nurses, midwives and nurse tutors and 26 were pharmacists (MFCT, 1998).

To improve the efficiency and professionalism of the health and allied workers, some of them were sent for further training and retraining. For example, in 1996, 8 medical doctors were sponsored for post-graduate fellowships at the national post-graduate medical college in different specialities. During the same period, 10 senior health officers of the Health Department were trained as Community Health Officers by the FCT Administration. Moreover, some officers of the Health Department were sponsored by the FCT Health Department for training in health planning while others were sponsored for post-graduate training in computer science in order to improve on data management in the health institutions (IBC, 1998: 91).

Another aspect of manpower development and capacity building in Abuja within the period under review was the establishment of a school of nursing and midwifery. This was done to enhance effective and efficient services in nursing and midwifery as an important component of healthcare delivery in the Territory. The school, which was located at Gwagwalada, trained professional nurses and midwives between 1993 and 2002. The graduants of the school added to quality healthcare delivery in the territory. (IBC, 1998: 92-94; Unumen 2009: 215).

5.3. Preventive Healthcare

One critical aspect of healthcare development in Abuja was preventive healthcare. The nation-wide Expanded Programme on Immunization (EPI) and Oral Re-hydration Therapy (ORT) were accorded the needed attention in the Territory. Available evidence indicates that by 1996 a total of 106, 411 children under two years of age had been immunized against the six most deadly childhood diseases in different parts of the FCT. In addition, by 1996, 54, 675 people in Abuja had been vaccinated against yellow fever and another 84,933 against cerebral-spinal meningitis (IBC, 1998: 94). To reduce infant mortality rate in the Territory, concerted efforts were also made to tackle and eliminate diarrhoea, which constituted one of the major causes of death of children below the age of five. To this end, Oral Re-hydration Therapy (ORT) centres were attached to both government and private hospitals in the territory. By 1997, Oral Re-hydration Therapy (ORT) Centres in both government and private health establishments in the FCT had risen to 126 (Unumen, 2009: 218).

5.4. Elimination of Communicable Diseases

As alluded to earlier, one major health challenge in Abuja by 1976 was the prevalence of communicable diseases. As a result, concerted and deliberate efforts were made to eliminate communicable diseases in the area between 1976 and 2002. In particular, the scourges of tuberculosis and leprosy were tackled by the FCT Administration in collaboration with Leprosy Mission International. To this end, in the 1990's search was carried out to detect and treat cases of leprosy and tuberculosis in all parts of Abuja. For example, in 1995 alone 65 new leprosy cases were discovered and treated. By the end of 1995 a total of 472 leprosy cases were successfully treated in the territory. In the same vain, considerable attention was paid to the eradication of the menace of guinea warm in the territory. In 1989, 779 cases of guinea warm were successfully treated while 736 cases were successfully treated in 1990. Similarly, in 1991, 194 guinea worm cases were treated in the FCT (MFCT, 1992: 44). Thus, by 2002, the FCT had been almost completely rid of leprosy and guinea worm.

5.5 Enlightenment Programmes

To promote healthy living, control and prevent diseases in the FCT within the period under consideration, the FCT Health Department incorporated enlightenment campaigns into its services. These campaigns educated the residents, especially the relatively less educated indigenous people in the rural areas, of the benefits of healthy living. In particular, exclusive beast-feeding for nursing mothers, the importance and need to immunize children, the benefit of family planning and methods as well as how to prevent and control HIV/AIDS were taught residents of Abuja. In addition, some private hospitals were equally involved in public health activities such as the EPI, control of Diarrhoea, DRT and the Baby friendly Hospital initiative and normal medical services (IBC, 1998:18).

As a consequence of the above health development package, the health status of the residents of the FCT could be said to have improved very significantly by 2002. By that year, life expectancy in the Territory rose to 52 years on the average for both men and women (FCDA, 2005: 18). Improvement in healthcare services and health status of the people of Abuja had socio-economic implications in area within the period under reviewed.

6. Challenges of Healthcare Services in Abuja, 1976 – 2002

Notwithstanding the remarkable development in healthcare and the general improvement in healthcare services in Abuja within the period under consideration, health care services in the area was beset with a number of challenges. One of the major challenges of healthcare services in the territory was that the tertiary health institutions as well as the general hospitals were concentrated in the major urban centres. Of the 14 major hospitals in Abuja by 2002, 4 were located within the FCC while the remaining 10 were located either in the Area Council Headquarters or the Area Development Headquarters. Only two, the one in Kubwa and Nyayan were located within the satellite towns of the FCC. The implication of this lopsided distribution of hospitals in the area was that the vast majority of the rural areas, which constituted over 70 percent of the land area of Abuja by 2002, had no easy access to the hospitals (FCDA, 2005: 39). Unfortunately, the majority of the rural dwellers were the indigenous people and the poor.

Another major challenge of health care services in Abuja was that, due to population explosion, the facilities in the hospitals were overstretched. By 2002 there was an estimated 6.7 million people in the FCT (FCDA, 2005: 76). The majority of this population were living in the squatter settlements and the satellite towns. These people were not taken into account when the hospitals in Abuja were built. However, by 2002, informal community dwellers (squatters) constituted 50 percent of the users of health services in the territory. The problem was compounded because people from neighbouring states preferred to patronise FCT hospitals because of the relatively cheaper cost and better quality of services (FCDA, 2005: 39). As a consequence, there was population-facilities mismatch, resulting in shortage of beds, low doctor-patient ratio, and general overstretch of the hospital facilities including the mortuaries.

Other challenges faced by healthcare delivery in Abuja by 2002 included epileptic power supply, inadequate blood banking services in the hospitals, depreciation of work tools, dilapidated facilities and the high sero-prevalence rate of HIV/AIDS, which was as high as 8.4% in the FCT (FCDA, 2005:39). This made the FCT the third highest in the country after Cross River and Benue states with 12 percent and 9.3 percent sero-prevalence rates respectively.

7. Socio-Economic Implications of Healthcare Development in Abuja

Notwithstanding the challenges, healthcare development in Abuja concomitantly resulted in socio-economic transformation in the area. To start with, improvement in healthcare was accompanied by a significant improvement in the education sector. By 1976, the educational level in Abuja, no matter how measured, was very low. About 80 percent of the population could neither read nor write having no form of western education at all. Only about 16 percent read up to primary school level. A negligible 0.1 percent of the population had university education. The literacy rate was less than twenty percent (Mobogunje and Abumere, 1984: 14-15). This situation changed dramatically by 2002. Primary and post primary school enrolments rose from 17, 943 and 335 in 1980 to 267,517 and over 43,749 respectively by 2002 (Unumen, 2009: 194-196). That year, adult literary rate was 50 percent while the overall literacy level rose to well over 56 percent (FCDA, 2005:36). Transformation in education triggered off a social change in the area. According to Unumen (2014A: 248-249), development of education at all levels, including adult literary of women and nomads and the resultant increase in the level of literary, changed the social and intellectual character of the entire people.

Closely related to the transformation in the education sector was the change in the occupation structure of the inhabitants of Abuja. By 1976, almost all the inhabitants in the area were engaged in present agriculture. Only 3.5 percent of the population comprised of mostly of teachers in the few primary schools and a few Local Authorities staff were engaged in wage employment in the area. Over 80 percent were engaged in peasant agriculture. However, by 2002, less than 29.1 percent of inhabitants of Abuja were engaged in agriculture. By 2002 also, over 47 percent of FCT population was engaged in wage employment. Thus, healthcare development was accompanied with an alteration of the social and intellectual character as well as the employment structure of the population of FCT (Unumen, 2014A: 250).

More importantly, the period under consideration witnessed the empowerment of the indigenous people who became employed in the Federal Government Ministries, Parastatals, Departments and Agencies. They also dominated welfare and health departments of FCDA and MFCT. (MFCT, 2002: 46 – 49). Closely related to the empowerment of the indigenous people was the revolution in the agricultural sector. According to Unumen, (2014B:123-151):

> With western education and other forms of training, the rural people were better able

to understand and supply agricultural information and innovation such as the application of fertilizers, insecticides and pesticides, pest control methods, operation of agricultural implements etc. This in turn led to improved contribution of the individual to his society.

Modernization of agriculture and provision of wage employment for the indigenous people contributed to their empowerment (Filaba, 2009: 103-112). With empowerment, the frontiers of ill health, illiteracy, poverty and the village settlement pattern in the area by 1976 changed tremendously. By 2002, the indigenous people in general and women in particular, gained dignity, self respect and a sense of belonging.

8. Conclusion

The focus of this paper is healthcare development in Abuja and its socio-economic implications in the area between 1976 and 2002. The development of healthcare in the FCT was accompanied by the socio-economic transformation of the area. A basic argument in this paper is that there is a nexus between healthcare development and socio-economic transformation in the area within the period under review. Healthcare development contributed to the elimination of the inhibitions of disease, sickness and ill health. With good health, people were able to acquire good education, which increased prospects of securing wage employment.

Education and good health in turn contributed to the modernization in the agricultural sector. In addition, the indigenous people were empowered. Some were employed in the Ministries, Parastatals, Departments and Agencies in the FCT. All these changed the social and occupational character of the society. With education, good health and empowerment, the circle of poverty that prevailed in the area by 1976 was successfully broken.

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