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NYSC AND RURAL HEALTH CARE DELIVERY IN NIGERIA

By

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Abstract

The National Youth Service Corps (NYSC) was established in 1973 with the principal aim of integrating Nigerian graduates. Since 1973, the scheme had played significant roles in manpower distribution, nation-building and acculturation in Nigeria. These achievements have come under serious threat due to the emergence of Boko Haram and other security challenges in the country. This paper is however, aimed at examining the role of the NYSC in the provisioning of health care services with an analysis view of the place of the NYSC medical team in rural health care delivery in many of the hard-to-reach areas in Nigeria. The paper adopts the historical and qualitative approaches in the collection of literature and its analysis. The literature and data used in the paper were sourced from the NYSC publications deposited at the NYSC Headquarters Library in Abuja and other related publications. Analysis of some of the publications retrieved from the NYSC repository revealed that in as much as the primary motive for the establishment of the scheme has come under heavy critique due to the security challenges in Nigeria, the scheme had more than ever before played a major role in the delivery of medical services to Nigerians in the rural areas. The paper submits if the primary health care facilities in the country are to be properly managed and serviced, corps members should be posted to the primary health centres in order to provide medical health care to the populations of Nigerians in the rural areas.

Keywords: NYSC, Nigeria, Health, Rural Areas, Security, Publications, Country

Introduction

The National Youth Service Corps (NYSC) came into existence in 1973. The scheme was targeted at spreading university graduates all over the country other than their state of origin in an attempt to stir the spirit of nationhood and nation-building in the country (Okafor and Ani, 2014). The birth of the scheme is attributable to the political antecedents in the country between 1960 and 1967 and the events of the Nigerian Civil War between 1967 and 1970 (Ebenezer, 2005). Suffice it to state that the uneven development among the various regions and states in the country shortly after independence was such that starved certain regions or states with certain services due to the high concentration of skilled Nigerians in some areas at the expense of others (Neke, 2021). University graduates and skilled Nigerians shortly after independence were concentrated in the major cities and university communities. According to the report of the National Manpower Board, about 40% of Nigeria's 57,000 skilled manpower with the exception of teachers shortly after independence were engaged in Lagos (National Manpower Board, 1970). This lop-sidedness in the spread of highly skilled manpower continued in the country until 1973 when the National Youth Service Scheme was birthed.

The scheme in Nigeria was patterned along with other similar youth schemes across the globe but with some changes to accommodate and address the uniqueness of the quagmire that necessitated its emergence in the country. Hence, the country became one of the 106 countries that adopted a non-military mandatory service or conscription (Okafor and Ani, 2014). The choice of a civilian mandatory service in Nigeria was precipitated by the desire to spur togetherness among young Nigerian graduates outside their geographical confines rather than limiting them to military garrisons or formation when the level of their interactions with their host communities will be limited. As a result of this, the National Youth Service Scheme in Nigeria requires all fresh

graduates who are not beyond the age of 30 at the time of graduation and has never served or are actively serving in any state-run security organisation to be mobilised.

In Africa, Nigeria, Ghana and Kenya are the major African nations with established national youth service schemes. The mandatory civilian scheme in Kenya is concerned with improving internal security, nation-building and disaster response while in Ghana and Nigeria for instance, newly qualified graduates are mandated to be given practical exposure to the jobs, both in the public and private sectors, as part of their civic responsibility to the state all over the country irrespective of their disciplines. The scheme has over the years allowed both government and private institutions to satisfy their manpower needs, and avail communities that would otherwise have difficulty in accessing mainstream development initiatives a chance to access improved social services through youth service to the community (GGA_AD, 2018).

Within the Nigerian context, the role of the National Youth Service Corp since its establishment in engineering national integration and both cultural and religious assimilations have been well documented and relatively active. It has been argued that sequel to the increasing waves of insecurity in the country and the deliberate decline by prospective corps members, a time has come for a rejig of an aspect of the scheme's objective to address new challenges in line with the growing annual number of graduates from the various universities in Nigeria. This implies that most parts of Nigeria are now equipped with trained manpower due to the numbers that have passed through the mandatory scheme over the years. Suffice it to say that from the scheme's humble beginning of about 2000 corps members in 1973 it has continued to grow more and more to the extent that in 1999 about 85, 000 corps members were mobilized. In 2016 and 2017, 260, 000 and 297, 293 graduates were mobilized respectively. The

figure in 2018 rose to 350, 000 (GGA_AD, 2018). For a scheme that has been able to push the above-illuminated graduates to the different parts of the country, it has however become necessary to interrogate the contribution of the scheme to other sectors other than national integration like rural health care delivery in Nigeria.

The Key Objectives of the National Youth Service Corps

The major aim of the National Youth Service Corps is tied to the breeding and development of mutual ties among Nigerian youths and the promotion of national unity (Annual Volumes of Laws of the Federal Republic of Nigeria containing Decrees and Subsidiary Legislations made in 1973, 1974). According to the National Youth Service Corps Decree 1973, the objectives of the scheme *inter alia* include:

I. To inculcate discipline in Nigerian youths by instilling in them a tradition of industry at work, and of patriotic and loyal service to the nation in any situation, they may find themselves;

ii. To raise their moral sense by allowing them to learn about higher ideals of national achievement and social and cultural improvement;

iii. To develop in them attitudes of mind, acquired through shared experience and suitable training, which will make them more amenable to mobilisation in the national interests;

iv. To develop common ties among them and promote national unity by ensuring that:

v. As far as possible youths are assigned to jobs in States other than their states of origin;

vi. Each group, assigned to work together, is as representative of the country as possible;

vii. The youths are exposed to the modes of living of people in different parts of the country to remove prejudices, eliminate ignorance, and confirm first-

hand the many similarities among Nigerians of all ethnic groups;

viii. To encourage members of the service corps to seek, at the end of their corps service, career employment all over the country thus promoting the free movement of labour;

ix. To induce employers partly through their experience with members of the service corps, to employ more readily qualified Nigerians irrespective of their States of origin; and

x. To enable Nigerian youths to acquire the spirit of self-reliance (Annual Volumes of Laws of the Federal Republic of Nigeria containing Decrees and Subsidiary Legislations made in 1973, 1974).

In addition, the objective of the scheme was further elaborated by Decree No.51 of 16th June 1993, where it was mandated to instil in corps members the zeal to contribute to the accelerated growth of the national economy; and to develop a sense of corporate existence and common destiny of the people of Nigeria (NYSC Handbook, 1995). The 1993 Decree added that corps members are to be encouraged to eschew religious intolerance by accommodating religious differences.

According to the NYSC Decree of 1973, Nigerian youths upon their graduation are to serve in the service corps for one year from the date specified in their call-up letters and are to make themselves available for service and shall present themselves at their posting places or authority as may be specified in their posting letter (Annual Volumes of Laws of the Federal Republic of Nigeria containing Decrees and Subsidiary Legislations made in 1973, 1974). The Decree specifies that corps members are to be deployed to hospitals, road construction, farming, water schemes, surveying and mapping, social and economic services, teaching, food storage and eradication of pests, rehabilitation of the destitute, development of sports, all government departments and statutory corporations suitable for new graduates,

development projects of local councils, the private sector of the Nigerian economy and such other undertakings and projects of the Federal Military Government. The decree further stipulates that before placing corps members in any of the undertakings or projects approved by the scheme, the Directorate is to take into cognizance the qualification of each member and vacancies existing, and the directorate shall not be compelled to deploy a member only to a particular undertaking or project (Annual Volumes of Laws of the Federal Republic of Nigeria containing Decrees and Subsidiary Legislations made in 1973, 1974). In addition, Okafor Chukwumeka and Ani Johnmary (2014), in a study outlined other factors that guide the scheme's posting or deployment policy. To them, the basic criteria for the deployment of corps members *inter alia* are:

a. The equality of states.
b. The ability of states to absorb the services of the corps members.
c. Posting on the concessional ground.
d. Posting on demand from various Federal Government establishments.
e. Posting of in-service trainees.
f. The supportive role of the government is also increasingly becoming a factor in the placement of corps members.
g. Deployment is affected by the academic and discipline of the participant and
h. The deployment of corps members has retained its traditional hue-with the majority of corps members going to the classrooms.

It is however, in pursuance of the objectives of the programme that the posting policy of the scheme is christened in order to avoid postings that would result in

a wastage of human resources and that corps members are as much as possible posted to areas relevant to their disciplines; although sometimes national need may override this consideration (NYSC Handbook, 1995). It is thus, cardinal that corps members are posted to areas that are different from their states of origin in an attempt to achieve national unity through the mobilisation of the Youths of Nigeria, by exposing them to live in other parts of the country and to learn at first hand the many similarities and diversities of culture and traditions of the various ethnic groups in the country, to eliminate any inherent prejudices. In this connection, corps members are to have no choice of where they would be posted to serve (NYSC Handbook, 1995).

The History of Modern Health Care Delivery in Nigeria

The historicity of modern medical health care and medicine in Nigeria is rooted in the 1860s (Nigeria – Health Country Studies, http://countrystudies.us/nigeria/50.htm). From available records, the earliest form of modern health care in Nigeria was provided by the medical teams that accompanied the missionaries, explorers and traders to cater for their well-being. The services of this medical team were not made available to Nigerians (Nigeria – Health Country Studies,). The first attempt at making the services available to the people was championed by Christian missionaries (Ajovi, 2010). It was however, the Roman Catholic Mission, the Church Missionary Society (Anglican) and the American Baptist Mission that took the lead in providing modern health care services to Nigerians, especially in the rural areas. It is on record that the first health care facility in the country was opened in 1880 as a dispensary in Obosi by the Church Missionary, and in 1886 in Onitsha and Ibadan respectively. According to Ajovi, the first hospital in the country was the Sacred Heart Hospital in Abeokuta established by the Roman Catholic Mission in 1885 (Ajovi, 2010). Suffice it to say that even though the Christian missions were the first to make medical services available to Nigeria,

the medical facilities and services were primarily used as incentives for winning converts and expanding their followership. Towards the end of the 19th century, a military hospital was established in Lokoja to provide medical care for the military garrison in the location (See Okafor and Ani, 2014). By 1954 almost all the hospitals in the Midwestern part of the country were operated by Roman Catholic missions. The next largest sponsors of mission hospitals were respectively, the Sudan United Mission, which concentrated on middle belt areas and the Sudan Interior Mission, which worked in the Islamic north (Nigeria – Health Country Studies, http://countrystudies.us/nigeria/50.htm). All through the colonial period, Christian missions played a major role in the provisioning of modern health care services in Nigeria. At the end of colonial rule, for instance, the Roman Catholic Mission accounted for about 40% of the total number of mission-based hospital beds by 1960 (Nigeria – Health Country Studies, http://countrystudies.us/nigeria/50.htm). The number of mission hospitals during this time exceeded the number of government hospitals in number, with 118 mission hospitals compared to 101 government hospitals. By 1979 the number of general hospitals grew to about 590 in the country. This comprises 562 general hospitals, 16 maternity / paediatric hospitals, 11 armed forces hospitals, 6 teaching hospitals, and 3 prison hospitals. These hospitals together, accounted for about 44,600 hospital beds in the country. During this period, the ownership of health establishments was divided between the federal, state, and local governments, in addition to the privately owned facilities (Nigeria – Health Country Studies, http://countrystudies.us/nigeria/50.htm). At the dawn of the 1980s for instance, a great majority of health facilities in the country were government owned amid a growing number of private facilities all through the1980s. By 1985 there were 84 health establishments owned by the federal government (accounting for 13 percent of hospital beds), 3,023 state-owned facilities (47 percent of hospital beds), 6,331 owned by local governments (11 percent of

hospital beds); and 1,436 privately owned health facilities (providing 14 percent of hospital beds) (Nigeria – Health Country Studies, http://countrystudies.us/nigeria/50.htm).

Table 1: The Number of Medical Staff in Nigeria in the 1980s and their ratio per 100, 000

Staff Category	Numbers in the Country	Per 100, 000
Physicians	39,210	30
Dentist	2,773	2
Nurses	124,626	100
Midwives	88,796	68
Pharmacists	12,072	11
Physiotherapists	796	0.62
Occupational Therapists	210	0.16
Medical Lab Technicians	3.059	3
Radiographers	519	0.42
Primary Care Workers	117,568	93

Source: Ajovi Scott-Emuakpor. 2010. The Evolution of Health Care Systems in Nigeria: Which Way Forward in the Twenty -First Century. *Nigerian Medical Journal*, Vol. 51, Issue 2. Retrieved from

https://www.nigeriamedj.com/article.asp?issn=03001652;year=2010;volume=51;issue=2;spage=53;epage=65;aulast=Scott-Em

Table 2: Statistics on the Mortality Rate in Nigeria between 1960 and 2010#

Type of Mortality	1960	1980	1990	2000	2010
Perinatal Mortality (per 1000)	100 – 110	33	100	110 – 120	100 – 115
Infant Mortality (per 1000)	190	150 – 160	100 – 110	200 – 21	96 – 100
Under 5 Mortality (per 1000)	318	200 – 210	170 – 180	240 – 250	180 – 200

Source: Ajovi Scott-Emuakpor. 2010. The Evolution of Health Care Systems in Nigeria: Which Way Forward in the Twenty -First Century. *Nigerian Medical Journal*, Vol. 51, Issue 2. Retrieved from https://www.nigeriamedj.com/article.asp?issn=03001652;year=2010;volume=51;issue=2;spage=53;epage=65;aulast=Scott-Em

Despite the increased number of health facilities in the country by the 1980s, there were still some geographical disequilibrium in the distribution of medical facilities among the regions coupled with the inadequacy of the facilities in rural areas in spite of the increase in the numbers of the health facilities. By the 1980s for example, there was an estimated ratio of about 3,800 people per hospital in the north (Borno, Kaduna, Kano, Niger, and Sokoto states); 2,200 per hospital in the Middle Belt (Bauchi, Benue, Gongola, Kwara, and Plateau states); 1,300 per hospital in the southeast (Anambra, Cross River, Imo, and Rivers states); and 800 per hospital in the southwest (Bendel, Lagos, Ogun, Ondo, and Oyo states). For example, in 1980 there were an estimated 2,600 people per physician in Lagos State, compared with 38,000 per physician in the much more rural Ondo State (Nigeria – Health Country Studies, http://countrystudies.us/nigeria/50.htm). These statistics vary especially in the urban and rural areas. Research has shown that approximately 80 percent of the population of the illuminated state was in rural areas. The relative absence of medical doctors and facilities in rural areas is attributable to the choice of many doctors to live in the cities. As a result of this, many of the doctors who worked in rural areas were there as part of their required service in the National Youth Service Corps but few, however, remained in remote areas beyond their required term.

The Evolution of the Primary Health Care Policies

The Primary Health Care (PHC) policy in Nigeria was launched in August 1987, the Federal Government under the administration of President Ibrahim Babangida. The policy objective of the programme was inter alia aimed at accelerating health care personnel development, improving collection and monitoring of health data, ensuring the accessibility of essential drugs in every part of the country, implementing of an Expanded Programme on Immunization (EPI), the promotion of health sensitization across the country,

the development of a national family health programme, improved nutrition throughout the country and widespread promotion of oral rehydration therapy for the treatment of diarrheal disease in infants and children. The policy was labelled as the cornerstone of health policy. The programme was structured to be implemented through the collaboration between the Federal Ministry of Health and the Local Government Councils with the aid of a direct grant from the Federal Government.

Among the objectives of the programme, the Expanded Programme on Immunization made the greatest progress within the shortest period. This was because the immunization programme was focused on four major childhood diseases: pertussis, diphtheria, measles, polio, and tetanus and tuberculosis. The EPI aimed to drastically expand the proportion of immunized children younger than two from about 20% to 50% before 1990 and to 90 % by the end of 1990 (Nigeria – Health Country Studies, http://countrystudies.us/nigeria/50.htm). Launched in March 1988, the program by August 1989 was said to have been established in more than 300 of 449 LGAs. Although the program was said to have made much progress, its goal of 90 percent coverage was probably excessively ambitious, especially in view of the economic strains of structural adjustment that permeated the Nigerian economy throughout the late 1980s.

The government's population control program also came partially under the PHC. By the late 1980s, the official policy was strongly to encourage women to have no more than four children, which would represent a substantial reduction from the estimated fertility rate of almost seven children per woman in 1987. No official sanctions were attached to the government's population policy, but birth control information and contraceptive supplies were available in many

health facilities. The federal government also sought to improve the availability of pharmaceutical drugs. Foreign exchange had to be released for essential drug imports, so the government attempted to encourage local drug manufacture; because raw materials for local drug manufacture had to be imported, however, costs were reduced only partially. For Nigeria both to limit its foreign exchange expenditures and simultaneously to implement the massive expansion in primary health care, foreign assistance would probably be needed. Despite advances against many infectious diseases, Nigeria's population continued through the 1980s to be subject to several major diseases, some of which occurred in acute outbreaks causing hundreds or thousands of deaths, while others recurred chronically, causing large-scale infection and debilitation. Among the former were cerebrospinal meningitis, yellow fever, Lassa fever and, most recently, AIDS; the latter included malaria, guinea worm, schistosomiasis (bilharzia), and onchocerciasis (river blindness). Malnutrition and its attendant diseases also continued to be a refractory problem among infants and children in many areas, despite the nation's economic and agricultural advances.

Among the worst of the acute diseases was cerebrospinal meningitis, a potentially fatal inflammation of the membranes of the brain and spinal cord, which can recur in periodic epidemic outbreaks. Northern Nigeria is one of the most heavily populated regions in what is considered the meningitis belt of Africa, stretching from Senegal to Sudan and all areas have a long dry season and low humidity between December and April. The disease plagued the northern and middle belt areas in 1986 and 1989, generally appearing during the cool, dry harmattan season when people spend more time indoors, promoting contagious spread. Paralysis, and often death, can occur within forty-eight hours of the first symptoms. In response to the outbreaks, the federal and state governments in 1989 attempted mass immunization in the

affected regions. Authorities pointed, however, to the difficulty of storing vaccines in the harsh conditions of northern areas, many of which also had poor roads and inadequate medical facilities (Nigeria – Health Country Studies, http://countrystudies.us/nigeria/50.htm).

NYSC and Rural Health Care Delivery in Nigeria

Despite the flaws of the NYSC, it has remained a critical player in the health sector. In Kogi State, for instance, the scheme's medical team has been responsible for the delivery of rural health care services in the rural areas at the Local Government Area especially in the Ibaji, Bassa and Dekina axis. This was in recognition of the contribution of the scheme's medical team to the health sector in the state that the State created an NYSC/Medical Team project to prioritize and provide the services of more doctors, nurses, laboratory scientists and pharmacists at primary healthcare centres in the state (Nigeria Health Watc, 2017). The state commissioner recommended this project to other states at the National Council on Health in 2017 due to the successes it has recorded in the state (Nigeria Health Watch, 2017). This was due to the fact that the availability of the medical teams in most of the health centres and clinics in the state has over the years given the rural population the confidence to patronise the primary health centres in the various Local Governments rather than patronizing quacks and chemist who often parade themselves as medical practitioners in rural centres.

The above development is not unique to Kogi state. According to Zeluwa in a study of Primary Health Care in 2012 in Nasarawa state, it was reported that the NYSC medical team was mostly responsible for rural health care delivery in the state. This was as a result of the high concentration of medical doctors in the urban centres or cities. Zeluwa argued that this was partly attributed to the fact that the availability of doctors is not a necessity in the primary health care

centres except in the comprehensive primary health care centres which are not commonly found in the rural area (Zeluwa, 2012). Be that as it may, the comprehensive primary health care clinics and others in the state are heavily dependent on the yearly rotated medical doctors and health personnel provided by the National Youth Service Corps.

Suffice it to say that many states in the country have keyed into the utilization of corps medical teams from the National Youth Service Corps in the course of their mandatory service to make rural healthcare services accessible to Nigerians in the rural areas. This has been the case in Cross Rivers where the programme has been used to ensure the presence of doctors in the primary health care facilities in the state. This was made possible by the yearly posting of medical teams to the state. Although the number of doctors and other health professionals often posted to the state varies from year to year. Their contributions to the delivery of rural healthcare services are immeasurable (World Bank Group, 2010). According to a World Bank Report, it was revealed that in most cases, there is often less than one doctor per Local Government Area, the composition of other health personnel under the available doctors in the various Local Government Areas has over the years relatively made their services available to the rural communities (World Bank Group, 2010). This was because they provide services in all facilities in the Local Government Areas but are usually based in either the Local Government Headquarters or in the largest PHC facility (World Bank Group, 2010).

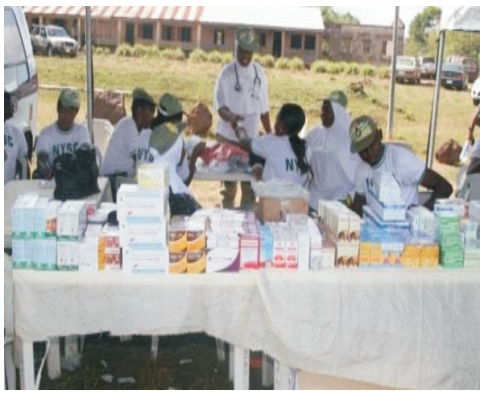
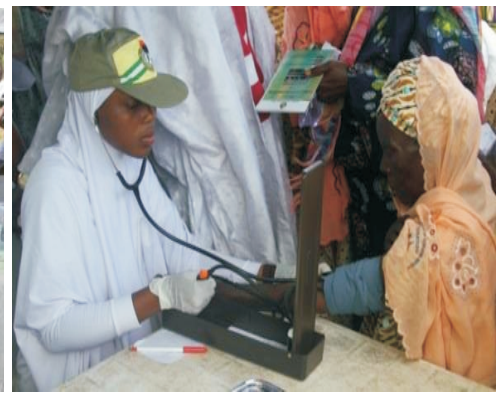
In a study carried out by Col. Obasa, it was revealed that as early as the 1980s, most of the states in Nigeria were dependent on the services of the Medical Team of the National Youth Service Corps for rural healthcare delivery (Obasa, 1995). In the defunct Bendel state for instance, in 1982/83 many of the rural health schemes depended on the youth corps medical doctors and their

teams for successful operation as more than seventeen mobile clinics in the rural communities in the state were manned exclusively by the scheme's medical team (Obasa, 1995). In a similar vein, it was reported that most of the states in the northern part of the country are dependent on the scheme for staffing its health care centres and clinics.

In 2014, the NYSC Health Initiative for Rural Dwellers was launched by the Director-General (Brig Gen JB Olawumi). The Health Initiative for Rural Dwellers (HIRD) programme is designed to provide timely health intervention to the large population of Nigerians in rural areas. The initiative is however intended to reach out to the core rural areas in order to enhance the accessibility of health care services by rural dwellers and to sensitize Nigerians in such areas on disease prevention, provide first aid services, monitor cases and provide appropriate referral when necessary (NYSC Health Initiative for Rural Dwellers, 2014). With the aid of the initiative thousands of rural dwellers and other underserved Nigerians, many of whom would not have gotten access to proper health care without this program has benefitted from the services of the National Youth Service Corps medical teams in their various location (Why Nigeria Needs NYSC, 2018).


NYSC Medical Personnel attending to people at Ese-Ofin.


NYSC Medical Personnel on their way to Ese-Ofin

NYSC Medical Personnel attending to people at Igbo- Iwu

Since the flag-off ceremony in the Kwara state, the HIRD team in the state has carried out several outreaches to the Igbo Iwu community. In 2014 for example the team attended to the health needs of 527 persons out of which 540 were treated, while two were referred. Principal among the cases treated was malaria, hypertension, typhoid, blood sugar level, arthritis, upper respiratory infection, and peptic ulcer (NYSC Initiative for Rural Dwellers, 2014). In order to fully utilise the initiative and make rural health care available in Lagos state, the NYSC partnered with the Lagos state Ministry of Health, Primary Health Care Board, Omron Healthcare Ltd Nigeria, and Ministry of Rural Development to flag off the HIRD in the state. A key testimony of the Initiate was the Ese-Offin outreach which was held at Ese-Offin Community Primary School where residents of Egan-Oromi, Itogbesa, Ojota, Ishagira and Ese-Ofin communities under Otto-Awori Local Government were treated. The importance of this was that all these communities were located on the island and could hardly go to the cities for medical care NYSC Initiative for Rural Dwellers).

Conclusion

This paper contends that the NYSC had played a major role in bringing rural healthcare services to the doorsteps of many of the hard-to-reach areas in Nigeria. The paper argues that the NYSC aside been one of the major integrative apparatus in Nigeria had been a major source through which most of the health facilities in the rural area are manned and managed due to the high concentration of medical doctors in the state capitals, and urban and township areas in the country. It is however, the submission of this paper that amid the growing advocacy for a rejig of the motive and purpose of the National Youth Service Corps, the Scheme's medical teams should be formally saddled with the responsibility of providing rural health care all through the country.

Recommendation

This paper recommends that the NYSC remains the only tool at the disposal of the Nigerian Government through which the hard-to-reach areas in the country could be reached. Sequel to the foregoing, Corp members whose fields are medically related should be posted to the rural areas to service the Primary Health Care Centres with adequate accommodation and allowance in order to provide medical services to Nigerians in the remote areas.

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