Primary Health Care in Nigeria- Current Status and Gaps in Services in Rural Communities and Possible Ways to address them.

Article by Okafor Chinyere Nkiruka[1], Nwobi Emmanuel A.[2]
[1]MPH Texila American University, Nigeria
[2]College of Medicine, University of Nigeria Enugu Campus,
Email: cnokafor76@yahoo.com

Abstract

Introduction: Primary health care, though supposed to be the bedrock of the country`s health care policy, is catering for less than 20% of the potential beneficiaries. This study is aimed at looking at the current status in primary health care services in rural communities in Nigeria, the gaps in services and possible ways to address them.

Methods: Secondary data was obtained from results of search for the National health policy review report 2008, National health and demographic survey, Millennium Development Goal, World and Africa report 2014 and UNDP 2014 report for Nigeria.

Results: Nigeria is still short of 2015 Primary Health Care targets with under 5 mortality rate at 94 deaths per 1000 live birth in 2012, maternal mortality at 350 maternal deaths per 100,000 live births and TB burden still at 5.0 per 100,000 in 2012. Challenges include amongst others poor financing, poor strategy and inter-sectorial collaboration.

Conclusion: Increase in government funding with good strategy and inter-sectorial collaboration while involving community will help in reducing the present gaps in primary health services.

KEYWORDS- Primary health care, rural communities, current status and gaps.

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Introduction

"HEALTH FOR ALL BY THE YEAR 2000" was a slogan recited by policy makers in the early 80`s following the Alma-Ata conference held in 1978 that prompted the vision of developing primary health care, whose goal was to address the major health problems in the community by providing health for all.[1] Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade.[2] Though it is supposed to be the bedrock of the country's health care policy, yet currently, it is catering for less than 20% of the potential beneficiaries.[3]

Definition of Terms

According to WHO (1978), "Primary Health Care (PHC) means essential health care based on practical, scientifically, sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost which the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".[1]

The national health policy and strategy to achieve health for all Nigerians was promulgated in 1988.[4] The overall policy objective is to strengthen the national health system such that it would be able to provide quality, efficient, accessible, effective and affordable health services that will provide the health status of Nigerians through the achievement of the health related millennium development goals (MDG) and PHC was declared they to attaining it.[4]

The health services based on PHC includes a program on information, education and communication of prevailing health problems, its prevention and control, promotion of food supply and proper nutrition, supply of safe water and basic sanitation, maternal and child care including family planning, immunization, prevention and control of locally endemic and

epidemic diseases, provision of essential drugs and supplies and a program on maternal and oral health.[4]

In Nigeria, PHC targets these goals; to reduce by 2/3 between 1990 and 2015 the under 5 mortality rate (U5MR), to reduce by ¾ between 1990 and 2015 the maternal mortality rate (MMR), to have halted by 2015 and began to reverse the spread of HIV/AIDS and to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.[4]

According to the MDG 2014 global report, U5MR dropped almost 50%, the MMR dropped by 45% (1990-2013), there is an increased access to antiretroviral therapy (ART) for HIV-infected people and averted deaths from malaria and other diseases.[5]

In the midst of all these developments, Nigeria is yet to achieve the goals of PHC services due to several factors. The aim of this article is to look at the current status of PHC services in Nigeria, current gaps in services and possible ways to address them.

Aims and Objectives

The aim is to review the current status of PHC services in Nigeria, the gaps and possible ways of addressing them.

Objectives

- To review the current status of PHC services in Nigeria.
- To look at the current gaps within the services especially in rural areas.
- To suggest possible ways of addressing the gaps.

Review of Articles

Brief History: In the 1930`s, international organizations, some governments, and non-governmental organizations (NGOs) sought methods to enhance social equity in order to improve the health of populations, reduce health disparities due to poverty and small scale attempts to provide community-based comprehensive care emerged in areas like China, India and Nigeria amongst others.[6]

The Alma-Ata declaration of 1978 promoted three key ideas, appropriate technology whichwas said to be out of social control, opposition to medical elitism whichfocused on general, grass roots, community approaches and health as both a means and a goal of development and required multi-sectorial efforts.[6] Few countries tried to implement comprehensive PHC with few successes, thus most countries moved to selective PHC as it was easier to train, deploy and manage staff, quicker to obtain and quantify results, lower program costs, easier to justify and obtain donor funds and measurable outputs, prompt results, technological solutions, easier accountability and time limited support.[6]

In Nigeria, essentially, three types of primary health centers are recognized within the primary health care system. These include: The Comprehensive Health Centers (CHC); the Primary Health Centers and the Basic Health Clinic (BHC).[7] Nigeria became one of the few countries in the developing world to have systematically decentralized the delivery of basic health services through local government administration[7] and in 1992, National Primary Health Care Development Agency was set up. This was to ensure its sustainability through mobilizing support nationally and internationally for PHC program implementations.[8]

Current Status of Primary Health Care in Nigeria

The evaluation of the PHC in Nigeria can be done by assessing the level of achievements of the goals.

- **Under 5 mortality rate**

One of the targets of the Millennium Development Goals (MDGs) is to reduce U5MR to 64 deaths per 1,000 live births and infant mortality to 30 deaths per 1,000 live births by 2015.[9]

Currently, the world is reducing U5MR faster than at any other time during the past two decades. However, regions such as Oceania, sub-Saharan Africa, Caucasus and Central Asia, and Southern Asia still fall short of the 2015 target. The pace of reduction would need to

quadruple in the period from 2013 to 2015 to meet the target of a two thirds reduction in the under-five mortality rate.[5] Sub-Saharan Africa continues to confront a tremendous challenge with its U5MR being the highest in the world, with about 16 times the average for developed regions. Nevertheless, the region has made remarkable progress since 1990, reducing child mortality rates by 45 percent.[11]

Nigeria has made some progress in reducing child mortality, although this has been slow. In 1990, the infant mortality rate (IMR) was estimated at 91 deaths per 1000 live births. However, by 2008 the IMR had fallen to 75 deaths per 1000 live births and by 2012 it further declined to 61 deaths per 1000 live births as against the 2015 target of 30.3 deaths per 1000 live births. Similarly, substantial improvements have occurred in the U5MR, from 191 deaths per 1000 live births in 2000, it dropped to 157 per 1000 in 2008; it dropped further to 94 deaths per 1000 live births in 2012. However, Nigeria is still short of the 2015 target of 63.7 deaths per 1000 live births.[10]
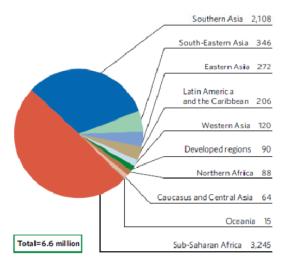

Figure 1: Number of under 5 deaths in 2012 by regions (thousands).

- **Maternal mortality rate**

Globally, the MMR dropped from 380 to 210 deaths per 100,000 live births between 1990 and 2013. However, this still falls far short of the MDG target to reduce the MMR by 3/4 by 2015. Despite progress in all world regions, the MMR in developing regions was 14 times higher than that of developed regions, (230 maternal deaths per 100,000 live births in 2013), and recorded only 16 maternal deaths per 100,000 live birth in 2013.[5] Sub-Saharan Africa had the highest MMR of developing regions, with 510 deaths per 100,000 live births.[11]

Nigeria has made steady progress in reducing maternal deaths with MMR falling from a height of 1000 deaths per 100,000 live births in 1990 to 800 deaths per 100,000 live births in 2004, 545 deaths per 100,000 live births in 2008 and 350 deaths per 100,000 live births in 2012. However, Nigeria's current status, estimated at 350 maternal deaths per 100,000 live births, is still 40.0% short of the 2015 target of 250 maternal deaths per 100,000 live births.[10]
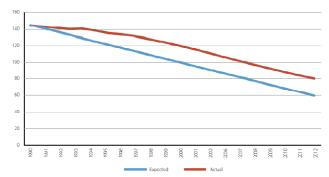
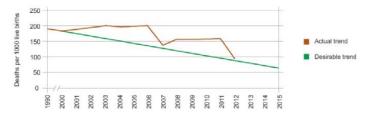**Figure 2:** Expected vs actual under 5 mortality rate.

Figure 3: Trend in under-five mortality rate – actual and desirable (1990–2012).
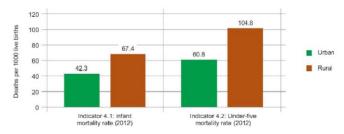

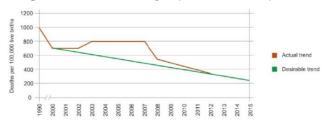**Figure 4:** Rural–urban disparity in child mortality (2012).

Figure 5: Trend in the maternal mortality rate (deaths per 100,000 live births) (1990–2012).

Table 1: Trends in and status of maternal mortality indicators

Indicator	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011[1]	2012[2]	2015 target
Target 5A															
5.1. Maternal mortality rate[a] (per 100,000 live births)	1000	704	704	704	800		800	800	800	545				350	250
5.2 Proportion of births attended by skilled health personnel (%)	45.0	42.0	42.0	37.30	36.30		36.30	43.50	43.50	43.50	38.90			48.70	53.60	100.0
Target 5B															
5.3 Contraceptive prevalence rate (%)					8.20		8.20	12.0	12.0	12.0	14.60			17.50	17.50	
5.4 Adolescent birth rate (5)					25.0		25.0							89.0	79.0	
5.5 Antenatal care coverage (at least one visit) (5)					61.0		61.0	58.0	58.0	58.0	54.50			68.20	67.70	
5.6 Unmet need for family planning (5)					17.0		17.0			20.20	20.20			19.40		

Source: Data from 1990 to 2008 are from FRN 2010b

Figure 6: Rural- urban disparities in the presence of a skilled birth attendant and antenatal care coverage (at least one visit).

- **HIV/AIDS**

Globally, the number of new HIV infections per 100 adults (aged 15 to 49) declined by 44 per cent between 2001 and 2012. Southern Africa and Central Africa, the two regions with the highest incidence, saw sharp declines of 48 per cent and 54 per cent, respectively.[5] Sub-Saharan Africa was the region where 70 per cent, 1.6 million cases, of the estimated number of new infections in 2012 occurred.There has been a rapid decline in AIDS-related mortality among children, due to effective interventions to prevent mother-to-child transmission. Nevertheless, about 210,000 children died of AIDS-related causes in 2012, compared to 320,000 in 2005.[11]

- **Malaria**

Between 2000 and 2012, the substantial expansion of malaria interventions led to a 42 per cent decline in malaria mortality rates globally. About 90 per cent of those averted deaths, 3 million, were children under age five in sub-Saharan Africa, thereby contributing substantially to the education in child mortality. Although malaria surveillance systems in most high-burden countries are weak, the latest trend analysis did indicate that the world was on track to achieving its MDG malaria target fully.[5]

The fight against malaria requires sustained political and financial commitment from both the international community and affected countries, as an estimated 3.4 billion people are still at risk of infection. Two countries, the Democratic Republic of the Congo and Nigeria, account for 40 per cent of malaria mortality worldwide.[11]

Malaria is arguably Nigeria's biggest disease burden, with over 90.0% of the population at risk of falling sick with two to three incidences of malaria per year; and contributing as much

as 30.0% to childhood mortality and 11.0% to maternal mortality. The vision is for a malaria-free Nigeria.[10]

- **Tuberculosis**

In 2012, there were an estimated 8.6 million additional cases of tuberculosis and a total 11.0 million people living with the disease. Globally, the number of new tuberculosis cases per 100,000 people has continued to fall, with a decline of about 2 per cent in 2012 compared to 2011. If this trend is sustained, the MDG target of halting the spread and reversing the incidence of tuberculosis will be achieved.[5]

Nigeria remains one of the 22 high TB burden countries responsible for 80.0% of the estimated global TB burden.[10] The TB burden is further compounded by the prevalence of HIV. The vision is 'Nigeria free of TB', with the goal to reduce the burden of TB by 2015 in line with the MDGs and the Stop TB partnership targets. The trend in the notification of TB has improved as a result of improvement in surveillance. Progress with TB shows that the prevalence of death rates associated with TB has decreased over time, from 15.74 per 100,000 in 2000, to 5.0 per 100,000 in 2012.[10]
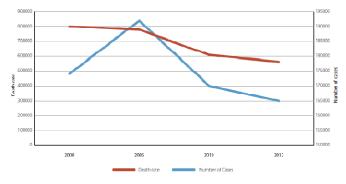

Figure 7: Estimated malaria cases and death rate in Africa excluding North Africa 2000-2012.
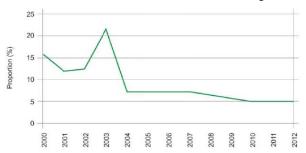

Figure 8: Trend in the prevalence and death rate associated with TB (2000–2012).

Table 2: Trends in and status of malaria, HIV/AIDS and Tuberculosis indicators

Indicator	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008	2010	2015 target
Target 6A												
6.1: HIV prevalence among pregnant young women aged 15–24 (%)		5.40	5.80	5.80	5.0	5.0	4.30	4.30	4.30	4.10	4.10	0
6.2: Proportion of the population aged 15–24 years with comprehensive correct knowledge of HIV/AIDS (%)					18.30	18.30	25.90	25.90	25.90		24.20	80.0
6.3: Young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner (%)					43.90	43.90	63.80	63.80	63.80		45.70	80.0
6.4: Children orphaned by HIV/AIDS (%)						1.80	1.97	1.97	1.97			

Indicator	2010	2011	2012	2015 target
Target 6B				
6.5: Proportion of the population with advanced HIV infection with access to antiretroviral drugs (%)	23.90	28.80	32.70	80.0

Indicator	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Target 6C													
6.6: Prevalence and death rates associated with malaria (per 100,000)	2024	1859	2203		1727	1157	1157	1157	1157				
6.7: Proportion of children under five sleeping under insecticide-treated bed nets (%)			2.20						5.50	10.90	16.40	18.0	
6.8: Prevalence and death rates associated with tuberculosis (per 100,000)	15.71	12.01	12.57	21.75	7.07	7.07	7.07	7.07			5.0	5.0	5.0

Sources: Data for 1990–2000 are from FRN (2010b)
1 NACA – National Agency for the Control of AIDS, Abuja
2 2011 data: NBS (2011a)
  2012 data: NBS (2013c)

Gaps

Some of the gaps/challenges found include the following:
- Poor financial management which has affected the provision of amenities for running of PHC and misappropriation of the little funds from the local government.
- Lack of access to effective treatment has resulted in an increase in the number of multidrug-resistant TB cases, antiretroviral therapy for persons living with HIV/AIDS and prevention of mother-to-child transmission. Only one out of three persons living with HIV/AIDS currently receives treatment; the situation varies across zones, ranging from 33.30% in the South East zone to 42.60% in the North West zone. Regarding the prevention of mother-to-child transmission, Nigeria currently achieves only 16.0%, against the 2015 target of 80.0%.[10]
- Lack of an effective strategy and inter-sectorial collaboration has resulted in poor health policy execution. This has led to inadequate commitment of sub-national levels of government (the states and LGAs) to the health care of the communities to provide facilities and equipment for the management of health centers.
- Socio-cultural and religious barriers in certain communities leading to underutilization of PHC services.
- Lack of good roads for easy accessibility to the primary health care centers.
- Inadequate use of ITN and dirty environment leading to increase in breeding of vectors.
- Inadequately trained health personnel (especially birth attendants) and their uneven distribution across the country leading to poor management of minor ailments like diarrhea. Lack of motivation of health workers from poor remuneration.
- Increase in home deliveries and failure to report for emergencies promptly to the health centers. A poor referral system.
- Much dependence on foreign agencies.

- Poor knowledge of HIV/AIDS among females from poor management of information systems.
- Lack of involvement of the communities in the health system of the community.

Possible ways of addressing them

- Increase in government funding to the health sector and appropriate distribution to various sections e.g. for drugs like ART, vaccines, health equipment etc.
- Advocacy on mosquito control interventions including the distribution of ITN and programs to expand indoor residual spraying. Initiation of larviciding, or the source reduction of mosquito infestations, by reducing human–insect contact, for example, through the establishment of a larviciding factory should be promoted. Initiatives promoting environmental management as an integral part of integrated vector control should be propagated.
- Emphasis should be given to the diagnosis and prompt treatment of malaria as part of effective case management, diagnosis and malaria prevention in pregnancy (through the affordable medicine facility for malaria). Government should ensure that Artemisininbased combination therapies are available at subsidized prices and education on its use. This will help to improve malaria case management at the community level as well as the in-home management of malaria by role model caregivers.
- Intensification of government efforts such as adoption of the integrated maternal, newborn and child health (IMNCH) strategy as part of the enhanced efforts to fast-track the achievement of reducing child mortality.
- Increasing the number and availability of skilled birth attendants by training of community health extension workers in basic essential maternal, newborn and child healthcare and the supply of essential maternal health commodities (misoprostol tablets), 'mama-kits' and midwifery kits nationwide.
- Enhancing emergency obstetric and newborn care services by providing adequate emergency obstetric and newborn care equipment and services, Expanding coverage of antenatal and post-natal care.
- Scaling up and strengthening regular mobile health services, re-orienting and re-training health workers for better professional services and attitudes.
- Improving the referral system by decentralizing ambulance services to rural areas, using improvised local ambulance services, engaging community volunteers and ensuring an effective two-way referral system.
- The shortfall in comprehensive correct knowledge of HIV/AIDS among females would have to be tackled through well-aligned gender-based sensitization and enlightenment. Sustaining the success in reversing the spread of HIV/AIDS requires well-targeted programs for prevention and control.

Conclusion

Poverty eradication and continuous evaluation to improve efforts on achieving the unachieved goals of PHC will require proper policy and effective interventions to reduce sharp subnational and rural-urban disparities. Critical attention should be given to the role of the state governments and local governments in this regard. Policies to address economic inequalities and promote social and health protection of the communities should be given priority both in the termination of 2015 and beyond so that the slogan, "HEALTH FOR ALL" may be achieved.

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