Situational Analysis Of The Present State Of The Health Care Systems In Nigeria.

Audu Andrew Jatau
Dr. Yakubu Gorah Kajang
Dinatu .U. Davou (Mrs)
Joseph Philip Dangbin
Department of Physical & Health Education,
Federal College Of Education,
P.M.B. 27 Pankshin,
Plateau State.
And
Simon Yusuf Jatau
Department of Physical and Health Education,
Federal College of Education
Zuba – Abuja.

Abstract

This paper examines the present state of the health systems and the present health of the population in Nigeria. The paper also highlights the problems of availability and access to health facilities; problem of availability and quality of health services; barriers to access and utilization of health services; lack of medical personnel, and problem of drug supplies and distribution. The paper finally offers recommendations on ways to curtail the factors affecting the present health system.

The health services if Nigeria have evolved through a series of historical development including a succession of policies and plans, which had been introduced by previous administrations. The health services are judged unsatisfactory and inadequate in meeting the needs and demands of the public as reflected by the low state of health of the population.

The federal Ministry of Health – FMH (1988) stated that one of the goals of the National Health Policy (NHP) shall be a level of health that will enable all Nigerians achieve socially and economically productive lives. To this end, the national health systems shall be based on primary health care. Primary health care (PHC) according to FMH (1988) is essential health care based on policies that are practical, scientifically sound and socially acceptable to the individuals and families in the community and

country can afford to maintain at every stage of their development in the spirit of self – reliance and self – determination.

The NHP stated in one of its goals that is shall establish a comprehensive health care system, based on PHC that is promotive, protective, preventive, restorative and rehabilitative to every citizen of the country within the available resources so that individuals and communities are assured of productivity, social well – being and enjoyment of living. Going by this goal, it means the main health problems of Nigerians would be addressed by providing promotive, preventive, curative and rehabilitative health services, thereby achieving health for all by the year 2000. To what extent has this goal been achieved?

This goal of the NHP as laudable as it is, has not been fully implemented and it is even far from being achieved. This is so because Nigeria is noted for its ability to formulate wonderful policies, but lack the ability to implement and follow – up. The state of the health care system and the state of the health of Nigerians at present, as reflected by the low status of the health of the population leaves much to be desired. This paper therefore discusses the present state of Nigerian health care system and the present state of the health of Nigerian populace.

The State of Health Care System

The health services as currently organized, show major defects which are widely organized (FMH, 1988). In the attempt to analyse the present state of the health system in Nigeria, this paper examines: availability of and access to health care facilities, availability and quality of health services, barriers to access and utilization of health services, availability of medical personnel and drug supplies and distribution.

Availability of and Access to Health Care Facilities

The FMH (1988) set the goal of achieving a level of health that will enable all Nigerians to achieve socially and economically productive lives and stated that the National Health system shall be based on Primary Health Care. To this end, it made provision for a health system with three tiers: Primary, secondary and tertiary. At the base, the primary tier consisting of health centers and clinics, as well as outreach services, focuses on health promotion, preventive health services and basic curative services. The secondary level, which is mainly composed of general hospitals, provides curative

services and some preventive services, while the tertiary tier provides more specialized curative, rehabilitative and reconstructive services.

Overall data, as reported by Hodges (2001), indicated that in 1999, there were 18,258 registered primary health facilities across the country, 3,275 secondary facilities and 29 tertiary facilities. Generally, it is fair to stated that, in terms of health infrastructure, the country is quite well covered. However, the fact that health facilities physically exist, in the sense of bricks and mortar, does not necessarily mean that they are functional. Many are poorly equipped and lacked essential supplies and qualified staff.

Many communities still do not have access to health facilities. Hodges (2001) further reported that 53 percent of the population lives within 1 km of a health center, clinic or hospital, and 73 per cent within 15km of town facilitates physical access. However, the National Population Council (2000) found in their study that one [illegible] rural communities are [illegible] health facilities by seasonal roads only.

In addition, logistic problems and the weakness of referral system mean that timely access to secondary and tertiary health facilities is much more problematic, especially in the rural areas. It is therefore surprising that the households survey of Hodges (2001), revealed that 9 per cent of the households did not have access to any health facility, health centre, clinic and hospital, 34 per cent had no access to a private doctor and 24 had no access to a pharmacy. This situation suggests that the present health system is not meeting the health needs and problems of Nigerian citizens.

Availability And Quality Of Health Services

Primary Health Care services are expected to provide basic preventive and health promotion services, as well as simple curative services. It is doubtful as to whether many Nigerians have access to such services. Hodges (2001) observed that the health care system has been plagued by problems of service quality, including unfriendly staff attitudes to clients, inadequate skills, decaying infrastructure and chronic shortages of essential drugs, the well known "out of – stock - syndrome (O.S.)". These problems have been documented in various localized [illegible], an evaluation study on [illegible] system initiative project in ten Local Government Area (LGAs) in Katsina, Kebbi and Uyo states as reported by IDS (1998), showed that many PHC facilities were dilapidated with little or no evidence of preventive maintenance or repair and [illegible] for consultation is

privacy. Most of the facilities visited by the evaluation team were not using prescribed diagnostic tools, sterilizing their instruments, or maintaining good standard of hygiene and cleanliness, and often they lacked sources of clean water.

Another study conducted by Chestrad (1999) in Ekiti, Ogun, Osun and Oyo state confirmed that no health service was reported to be available in more than 50 per cent of the subjects surveyed. Immunization was the services most widely available, but even in this case only 45 per cent of facilities had been providing immunization in the preceding year.

The poor availability of health services irked Adeyemi (2001), who remarked that in view of the high rate of maternal mortality and low level of antenatal care and delivery in health facilities, it is pertinent to note that Essential Obstetric Care (EOC) was available in only 1994 facilities nationwide. It must be noted that the poor health services found in Ekiti, Ogun, Osun, Oyo, Katsina, Kebbi and Uyo, is perfect reflection of the poor health services throughout the country.

In the same vein, the study of Odunlami (2001) revealed that equipment such as sphygmomanometres, thermometers, weighing scales, delivery kits, waste bins and mucous extractors were unavailable. Some did not have even a regular water supply and required their patients to provide their own water. Again, these problems highlighted point to the fact that the health services are judged to be unsatisfactory and inadequate in meeting the health needs and problems of the public.

Barriers to Access and Utilization of Health Services

It is not surprising that in these conditions, the public health system is poorly regarded by a significant part of the population. This explains why the Federal Office of Statistics (FOS) (2000) revealed that 26 per cent of those surveyed in Lagos state were not satisfied with the health care services. The main reasons advanced for non – satisfaction were cost of treatment (56%), non-availability of drug 33% and long wanting periods 33%. It is worthyof note that high medical charges have become a significant barrier to access. Since the late 80s as a result of the pressures on public finances and the dwindling budgetary resources available for health, fees have been introduced for most services at primary, secondary and tertiary levels in an attempt to generate additional fund and arrest the decline of the health system.

Coming at a time of spreading, deepening poverty and the decline of traditional extended family mechanism and in the absence of a national social security system, a great barrier to access has been erected that is insurmountable for many Nigerians.

Several factors may be attributable to the low level of utilization of PHC services. Among them are: illiteracy, lack of awareness, cultural factors, such as traditional attitudes about pregnancy and labour and the low status of women (Hodges, 2001). However, systemic difficulties in the health sector also appear to be key reasons for the non – use of PHC services. FOS (2000) indicated that long waiting times, the negative attitudes and poor skills of staff, the absence of drugs and unfriendly opening hours have all contributed to the low utilization of health services. Earlier Kale, Dare, and Fatumbi (1996) Found that access to PHC services has been adversely affected by the introduction o cost recovery schemes, including user fees for ante-natal and delivery services in most areas of the country. The impact of these fees on services utilization is particularly severe among the poor and vulnerable groups, who have resorted to the use of traditional medical practitioners and spiritual healers as alternative cheaper providers of health care. This suggests that the health services cannot carry the poor and the vulnerable along.

Availability of Medical Personnel

The public health care system has suffered haemorrhage of skilled personnel over the past two decades. United Nation Development Programme UNDP (2000) asserted that as a result of the failure of public sector salaries to keep pace with high inflation, the salaries of all categories of health workers declined steeply from the early 80s, causing the many better qualified personnel to enter private practices or go overseas. Hodges (2001) lends credence to the above and reported that due to poor incentive and remuneration of medical personnel, large numbers of Nigerian doctors, radiologists, dentists, nurses and other medical personnel left the country. In the case of medical students studying abroad, those who graduate refuse to return home. This brain drain has deprived the health sector of skilled personnel for policy analysis, planning, efficient medical services and management.

This exodus of skilled medical personnel has put Nigeria in a worse position, relative to the size of its population within sub – Saharan Africa. According to UNDP (2000), Sub – Saharan Africa had an average of 32 doctors per 100,000 populations, a ratio far lower than

any other region of the world. The figure for Nigeria was only 21.

Sequel to the exodus of qualified doctors to overseas leaving out few, waiting for consultation is unbearably long and in many cases consultations are only left to untrained assistants and maids (Hodges, 2001). On the other hand, low salaries of medical personnel have also sparked off frequent, protracted industrial action by health workers at all levels of the health system. This hampers the execution of the available health services.

Drug Supplies and Distribution

The Essential Drug Programme (EDP) was introduced in the late 80s and drug revolving funds were set up in line with the principles enunciated by African health ministers in the 1987 Bamako initiative. Even with these initiatives there has not been any real sustained improvement in the provision of drugs through the late 80s. To this end, Osibogun (1998) revealed that while 89 per cent of the LGAs had essential drugs, only 42 per cent of them had them continuously. In other words, well over half experienced the out – of – stock – syndrome.

Meanwhile, the shortages of drugs in the public health system, along with weak controls on the private importation and distribution of drugs, have created conditions propitious for the sale of fake, adulterated or expired drugs, which have very serious implications for public health (Hodges, 2001). Some of these fake, adulterated or expired drugs for instance reduce the effectiveness of genuine drugs by raising the resistance of organisms responsible for diseases such as malaria.

The State of Health of the Population

Nigeria, like many other developing countries, particularly in Africa, is still far from reducing mortality among children to a meaningful level, despite the advances in child survival strategies highlighted most notably by the drive for universal immunization against life – threatening, vaccine – preventable diseases. According to Hodges (2001), Nigeria has been one of the least successful of African countries in achieving improvements in child survival during the past four decades, which correspond with the period since the country's independence. A survey – conducted nation wide by FOS (2000) indicated that almost one in five Nigerian children dies before reaching age of five. This implies that, on the average, a baby born in Nigeria is about 30 times more at risk of death

before the age of five than a baby born in the industrialized countries.

Comparisons with developed countries also highlight how far Nigeria has to go to ensure that women do not die from avoidable causes in pregnancy and childbirth. The most recent available statistics indicate that about seven women die for complications in pregnancy and childbirth for every one thousand births (Hodges, 2001). The risks of maternal death in Nigeria are about 1000 times higher than in the developed countries.

Some experts estimate that the infant mortality rate may be as high as 100 to 160 per life birth in rural areas. Whichever figure is accepted, it means that out of every 12 children who are born alive, one or more of them dies before reaching the first birthday. This rate according to NHP (1988), is ten times as high as in most developed countries. It is much higher in some other developing countries, which have a similar level of socioeconomic development as Nigeria.

The health status if Nigerians reported by National Population Council 1991 –92) revealed the following:

Crude death rate: 16 per 1000 population.

Crude birth rate: 50 per 1000 population.

Childhood mortality rate: 144 per 144 per 1000 children aged 1 – 4 years.

Infant mortality rate 85 per 1000 life births life expectancy at birth: 50 years.

WHO (2000) revealed that between 1963 to 1991, crude death rate has decline from 16 to 14, while life expectancy in the same period (1963 to 1991), has increased from 36 to 53.2 years. Comparison reported by Kajang and Jatau (2003) revealed that while Nigerian's life expectancy was 53 years, Ghana's was 56 and Kenya's 59 years. In addition, infectious diseases, malnutrition and uncontrolled fertility are dominant features of Nigerian epidemiological pattern. This seems to suggest that after the implementation of NHP, the nation's health system has not met the health needs, aspirations and the yearning of Nigerians. This may be why health for all, Nigerians by the year 2000 was far from being realized.

Recommendations and Conclusion

Based on the poor state of the health system and the poor state of the health of Nigeria populace even after the implementation of NHP, the paper proffers the following recommendations:

1. Federal, States, and LGAs should make the three tiers of health care functional, affordable and accessible. This can be

achieved through constructing good roads that link the rural populace to PHCs and reducing the fees charged at the health centres.

2. The Federal Ministry of Health should review the National Health Policy from time to time and monitor its implementation from PHC primary level up to the tertiary level.

3. The Federal Government should improve on the states of the present health of Nigerians. This can be achieved by providing functional medical equipment and facilities, quality health care, and making drugs available in the health care system.

4. The sale of fake, adulterated and expired drugs should be curtailed to the barest minimum. This can be achieved by encouraging more advocacy groups not only NAFDAC dependent. In conclusion, the nation's health care system plagued with poor health facilities, lack of quality health care, and lack of accessibility to health services, inadequate medical personnel and poor supplies of drugs needs special attention. Since the health services are judged unsatisfactory and inadequate yielding a low state of health of Nigerians all hands must be on deck. This therefore, suggests, that the NHP is not properly implemented.

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