CALL TO IMPROVE HEALTH CARE SERVICES IN THE RURAL COMMUNITIES IN NIGERIA

A MEMORANDUM SUBMITTED TO THE
JOINT COMMITTEE ON RURAL DEVELOPMENT AND HEALTH CARE SERVICES
HOUSE OF REPRESENTATIVES
NATIONAL ASSEMBLY, ABUJA, NIGERIA

ON

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BY

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MEMORANDUM ON THE

CALL TO IMPROVE HEALTH CARE SERVICES IN THE RURAL COMMUNITIES

To: **The Chairman, House of Representatives Joint Committee on Rural Development and Health Care Services, National Assembly, Abuja, Nigeria**

From: **Dr. Uzodinma ADIRIEJE, CEO/National Coordinator, Afrihealth Optonet Association**

Date: **24 May 2018**

Subject: **Improving Health Care Services in the Rural Communities in Nigeria**

PRESENTATION OUTLINE

I. PROTOCOLS

II. INTRODUCTION AND BACKGROUND

Two days ago, I returned from a week-long working visit to Sokoto as Technical Assistance to the Sokoto State Government; to support the Sokoto State Contributory Healthcare Management Agency (SOCHEMA) in commencing the implementation of the Sokoto State Healthcare Management Scheme. This is one effort to extend and expand the provision and accessibility of Health Care Services to all the residents of the State but most importantly those in the rural areas.

Like most States in Nigeria, Sokoto is essentially an agricultural state with traditional mode of production predominating and more than 90 percent of the population engaged in subsistence farming. It has a 2016 population estimate of 4,998,100. The health sector is characterized by wide disparities between the state capital and rural areas in status, service delivery, and resource availability. More health services are located in the Sokoto metropolis (Sokoto North and Sokoto South) than in the remaining 21 local governments outside the metropolis.

Aware that risk coverage is difficult to provide in States and countries with vast rural areas, scattered population and low money incomes; the Sokoto State government and people have included Community-Based Contributory Health Programme in the Scheme. This programme shall work with Ward Development Committees (WDCs), Leaders of Market Women Groups across the State, Community-Based Organizations [CBOs], Faith-based groups, Rural Artisans, etc., as entry point to increase uptake of primary health care (PHC) and outreach services by enrollees, especially in the rural areas of the State. The Scheme also aims to strengthen the functions of WDCs in the political wards of the State to provide stewardship role for health care services in their respective wards to ensure the success of the Scheme in providing the approved Basic Minimum Health Care Package [BMHCP] for every resident of Sokoto State.

The State is working to provide cover for all residents within the formal and informal sectors, including vulnerable persons [i.e. persons who due to their physical status (including age) cannot engage in any meaningful economic activity], such as physically challenged persons, persons aged 65 years and above, children under-five years of age, refugees, victims of human

trafficking, and pregnant women and orphans for who the State will bear responsibility for the BMHCP.

I have brought up the position of Sokoto State and its effort to provide health care for its rural dwellers because Sokoto is adjudged as the poorest State in Nigeria. So, if the poorest State in the country can afford to make such a noble effort towards assuring Universal Health Coverage (UHC) for its citizens, and so be on the positive highway towards achieving the Sustainable Development Goals (SDGs), it will follow naturally that every State in Nigeria can afford to do even better. So why not? Why is it that the Federal Government and States which are richer than Sokoto State have not instituted justiciable mechanisms to provide the BMHCP for all the residents of the Country/States? We will return to this shortly.

Nigeria currently has a population estimated of about 200 million. 1 in 10 Nigerian children below the age of five years die annually (2300 every day) Our Maternal Mortality Rate (MMR) of 814 per 100,000 live births by 2015 estimates makes Ghana a sub-regional destination of choice for health seekers including Nigerians, and paradise for expectant mothers at 319/100,000. In Italy, the MMR is 4/100,000. Life expectancy is 54 years in Nigeria and 62 years in Ghana. Nigeria's best ranked hospital is the Psychiatric Hospital in Aro (2091 position in the world and 6th best in Africa). Does this say anything about our mental state?

Our country appears to be giving life to the biblical saying that for the person who has less (and is not diligent), even the little he/she has shall be taken away; if we recall that our doctor/patient ratio is among the lowest in the world, and yet we are suffering brain drain in our health sector. Nearly 45% of physicians registered with the Nigerian Medical Council have left the country and a large chunk of Nurses will be retiring within a decade with no experienced hands to replace them. These catastrophic and perplexing healthcare indices are worsened by the continuing brain drain from Nigeria of qualified health care personnel seeking greener pastures or retirement abroad.

Within our shores, access to primary health care or qualified primary care personnel as well as to the BMHCP remains a mirage for the majority of the citizens. In the absence of fully implemented nationwide UHC, the next medical diagnosis is could mean a death sentence or

financial ruin. Presently, just about 5% of the population is enrolled in the National Health Insurance Scheme (NHIS) and mainly public service workers, our health systems is frequently embroiled in some industrial action in addition to being grossly under-equipped, ill-staffed and poorly funded by all the tiers of government. Most health care facilities especially in the rural areas are of less status than "mere consulting clinics". The private landscape is littered with stand-alone one-man operations and poor referral system which means most needy people will resort to the spiritualists and charlatans for health care needs.

III. HEALTH CARE SERVICES, RURAL COMMUNITIES AND THE SUSTAINABLE DEVELOPMENT GOALS (SDGs)

The 2016 national census estimates provided that 51.4% of Nigeria is rural. Nigeria is a high priority country for almost all the major preventable diseases including HIV/AIDS, TB, Malaria and these sicknesses occur and kill our compatriots mostly in the rural communities. Most health problems emanate from and exact their greatest impacts in rural areas. Fewer health care facilities and appropriate health services are available in rural areas. Death from ill-health and preventable diseases are more in the rural areas. Infrastructural and human development is least in the rural areas. Majority of us now living in the urban areas (including me) will eventually end our life destination in the rural areas. It therefore follows that the levels of development in our rural communities and availability and access to health care services in rural communities are very critical determinants of how well our country's SDG targets can be achieved. The more success we make in them, the more likely we can achieve our SDG targets. The possibility of the reverse should never be contemplated!

IV. OUR VIEWS AND SUPPORT FOR THE PROVISIONS OF THE BILL:

We are in tandem with the authors and sponsors of this Bill. We specially note and appreciate the emphasis of this Bill on several important issues including the following:

a. That 80% of those responsible for Nigeria's sustainable agriculture live in rural communities;

b. That Agriculture is pivotal to developing Nigeria's economy hence the Federal Government's 'Green Alternative 2016-2020' to build 23% of GDP from agriculture
c. That the farming population in the rural communities are key to realizing the 'Green Alternative', and need to be in good health in order to play such vital role;
d. That the 'Right to Health' is a basic human right of the farmers in the rural communities, which has been alluded to in various laws in Nigeria;
e. That poor health condition is a constraint to agricultural productivity
f. That there is a huge lack of equity in planning and distribution of health services

In order to realize the very objectives and intentions of the Bill therefore, we support 'Improving Health Care Services in the Rural Communities' and submit for your considerations, the following approaches that have worked in making this possible in other countries:

a. Provision of Rural Infrastructure and Incentives for Health Care Workers: We posit that in order to improve health care services in the rural communities, we MUST have the rural population as our target for partnerships/colloboration, advocacy and social mobilization, research and evidence-generation, capacity development, outreach intervention and routine monitoring and evaluation (M&E) of the health services and health service environments. The following approaches/stratagems have worked in several other countries and shall also work in Nigeria: Improve rural infrastructure by providing minimal infrastructure and amenities for basic comfort including reliable power supply, portable water supply, fairly good nursery and primary schools that will attract young health care professionals and help them make good family beginning in rural areas. This will also help our country reverse or at least stop/reduce the rural-to-urban drifts of health personnel and persistent lack of functional health systems in rural health facilities – factors that prevents us from attracting and retaining the right kind of health human resources including family physicians, nurses/midwives, pharmacists, medical laboratory scientists, etc. in each of the facilities. We have to also incentivize the posting to rural areas by paying them about twice the normal pay for those in the cities. Improved electricity supply to rural communities to encourage qualified health

professionals to serve there, and also support health commodities remain in good condition/temperature over time.

b. ***Accessibility of Health Care Facilities:*** **The importance of providing** good roads and safe bridges to make the health facilities accessible to the rural dwellers cannot be over-emphasized. The recent collapse of the close to 50 (fifty years) old bridge over Urasi River in Amaruru (in Orlu/Orsu/Oru East Federal Constituency of Imo State), which links Orsu LGA of Imo State and Nnewi South LGA of Anambra State has adversely affected access to health care services by Nigerians on both divides of the collapsed bridge. Voters and Nigerians on either side are no longer able to move to health facilities for care. This bridge constitutes a national/state emergency in order for our country to achieve the SDGs especially SDG3 as the fear of another cholera epidemic looms so large from the disaster, as well as grounded economic activities of Nigerian's who daily ply the Orlu-Ihioma-Amaruru-Ezinifite-Nnewi Road with the said bridge as the only link between the two States.

c. ***Compulsory Social Health Insurance Programme:*** Nigeria must START INVESTING IN CITIZENS WELFARE (emphasis mine) by providing free Health Care for all the vulnerable members of the Nigerian Population, while encouraging Civil Society Organizations (CSOs) should to perform their monitoring and supportive activities in all health facilities and their operations. We should invest in the health and health education for our rural dwellers thereby freeing their time, savings and energy to be deployed into economic ventures that will further improve national productivity for both national needs and export, thereby increasing the country's foreign exchange earnings, strengthening the naira and increase citizens purchasing power.

d. ***Promote Healthcare Investments and Universal Health Coverage (UHC):***
The National health Act provides for 1% of Nigeria's consolidated revenue to be deployed to health in addition to the routine budget. While one appreciates the National Assembly for this and for including this provision – even though late - in the

2018 National budget, it is still a sad commentary that Nigeria, which rolled out her resources to host African Union in 2001 to approve the allocation of a minimum of 15% of national budget to Health, has hitherto FAILED to comply with that agreement to which we appended our Presidential signature. We affirm that investments in health have a lot of multi-sectoral benefits for everybody. To this end, we urge our country to:

i. promote massive Health Education to citizenry especially to visit facilities for routine checks before ill-health occurs;
ii. promote PHC more vigorously as the pivot of our health systems;
iii. provide essential drugs and health commodities;
iv. ensure every child presented in a health facility receives complete due immunization before leaving hospital;
v. establish and encourage big companies to establish Community Health Insurance Scheme (CHIS) for cluster of communities; e.g. Shell established one in Rumuobiokani, Port Harcourt in 2007 and it's amazing that patients come from as far as Aba and Owerri to benefit from the scheme. This has reduced their annual family health expenditure to as low as N15, 000.00 (Fifteen Thousand naira only) including child delivery; while caesarian section under the scheme costs as low as N60, 000.00 (Sixty Thousand naira only). OTHER companies should be encouraged to do similar things in the communities as part of their Corporate Social Responsibility (CSR);
vi. institutionalize Palliative Care in our rural communities;
vii. provide functioning Health facilities in all political wards in Nigeria; and
viii. provide at least one functional model PHC (not just buildings) in every electoral ward with equipment for ultrasound, basic modern laboratory and diagnostic services, essential drugs supply, storage facilities;
ix. emphasis goog health worker attitude and insist that those with persistent bad/poor attitude to their work are penalized; and
x. promote periodic mobile health clinics that travel through communities as complementary to routine facility-based services

e. ***Policies have not failed, people have:*** There is a general belief that Nigeria's greatest challenges in achieving better welfare for her rural (and urban) population is not the absence of laws that provide for these. We agree so far. We therefore urge that we give life to all our existing laws regarding health care services and development of rural communities. We urge Federal, States and Local governments and all stakeholders to:

i. embrace and implement all existing policies on Health in Nigeria;

ii. support health care professionals to play their roles in UHC

iii. provide enough and appropriately-skilled staff in all health facilities

iv. engage for each PHC a general physician and a resident midwife attending to its patients, and encouraged to make necessary referrals;

v. harvest and secure data and information for all persons accessing services in our health facilities using the National Health Information Management corridor; and

vi. increase efforts on population control and the best health for the living.

V. CLOSING COMMENTS

We want to close our contemporary comment and contribution on this Bill via this memorandum, by REQUESTING that every ELECTED OFFICER OR POLITICAL APPOINTEE at the levels of The Presidency, National Assembly, State Governments, Federal and State Executive Councils, Senior Officials of all Ministries, Departments and Agencies, ADOPT one rural Primary Health Centre as the first place to seek for care when sick or seeking healthcare for self, families, friends and dependents. Short of requesting that these our greater compatriots should adopt one PHC in their respective constituencies and own/support its operational activities by providing commodities/drugs, equipment, staff salaries, other operational costs; we firmly believe that their patronage of such facilities will increase the profile, recognition and patronage of such facilities by health professionals, patients and other stakeholders.

So help us God!