



PRIMARY HEALTH CENTERS: A Nation's Nightmare



An inappropriate delivery couch, in the labour room, at the Holy Trinity Health Center, Ikoto, Ijebu, Ogun State

After visiting 25 primary health centres across the six in South West Nigeria, ABIOSE ADELAJA ADAMS finds that paucity of funds and government policy put them in a state of total disrepair, leading to a largely inefficient healthcare delivery system at the grassroots

Forlorn and distant, in Ori Ire local government area, Oyo State, stood a faded metallic signpost. Hardly could the lettering on the post be deciphered as it had given way to harsh weather conditions. But, looking at the building it introduces, there is a clue that this is a health centre.

Shouting posters with messages like 'Immunization here', Oyo State breastfeeding week and other educative health posters on tuberculosis, malaria, written in Yoruba language, all hung at strategic points of the building, which desperately needed a new coat of paint.

This local government area is home to about 150,628 people whose main preoccupation is farming, and this health centre is one of those meant to meet the people's immediate health needs. It was 4.00 pm at the time of reporting and the hospital was under lock and key, apparently closed for the day.

But some domestic animals like cats and a family of goats, had taken over the corridor, resting from the scorching heat.

Such health facilities are meant to be the bedrock of public health services in many countries of the world. In 1978, Nigeria, along other World Health Organisation, WHO, member countries adopted the Alma Ata Declaration instituting the primary health centres as the basic structural and functional unit of the public health sector. Its aim is to provide accessible and affordable health for all, especially at the grassroots.

But the health centre in Ori Ire is not accessible to the people,

seeing that it already closed by 4.00 pm. As the reporter attempted to knock on the door, three men who sat on the pavement of

the balcony of an adjacent house playing a popular Yoruba game called 'ayo', volunteered help.

"They have close," a bare-chested dark man with a rotund belly said.

"She was here in the morning," another, also without a shirt, said while the third, a slender man in a sweat-soaked singlet, pointed in the distance and said "go there and ask for Mama Islamia or Aunty Rashida."

Aunty Rashida, as it turned out, is the community health worker in charge of the hospital. She was not at home.

Where do the women go?

Wura Ojo, 28 year-old firewood seller, who lives on the other side of the road opposite the facility, was stoking the fire on her stone mounted stove, when the reporter approached her.

With red and watery eyes, she looked up whilst also stamping her feet and chanting a song to calm the eight months old daughter strapped to her back the traditional African way. The baby coughed and cried inconsolably from the effect of the choking smoke.

"I have four children and all my children (were) born in ile alagbo (herbal home)," she said with a thick Ogbo-



An unhappy patient, dissatisfied at services rendered at a SURE-P assisted PHC, Ikogosi, Ekiti State

mosho ascent.

“All this hospital (is) good for abere (immunization).”

According to her, whenever she falls sick, she uses herbs. She bathes her children (aged between eight months and 5 years old) with herbs.

“My mother, (that) is how (she) e born us, “ she concluded, returning to her cooking.

Another woman who lives in the neighbourhood, 35 year old Shaki Isiaka, said the hospital attends to only minor ailments.

“I don’t book there when I had my last child (now 2 years old). I use General,” she disclosed, pointing towards the General Hospital, some distance away. Isiaka, a mother of three and a petty trader said the General Hospital offers better and reliable services as “they have more people (health workers) there.”

Some 30 minute drive away is another health centre in Okelerin, in Ogbomosho. This one is a beautiful duplex painted in lively lemon green.

With bold imprints on its walls, it is obvious the centre was refurbished and funded by the “2009 MDGs-NHIS Maternal and Child Health project”. But the beauty is only skin deep.

The Community Health Extension Worker, who was on afternoon shift, Cecilia Taiwo, 29, said the centre runs three shifts - morning, afternoon and night. But because it is short staffed, the night shift offers only skeletal services. “Only one person is here at night. Sometimes, (there could be) two. So our work at night is mostly to refer patients,” she said.

When asked how it copes in the event of a complicated birth requiring emergency obstetric intervention, she said “most times we refer them to another hospital (we have a bigger health centre or to the State hospital), because we don’t usually have much staff at night. But if there is no complication, one person can take the delivery.”

Giving a rough mental statistics, she estimates deliveries taken in a month to be up to 30. Although she was careful not to reveal fatalities, fear and concern was palpable in her voice as she said:

“we don’t pray for complication but one time when a woman was bleeding and we could not stop the bleeding, we referred her.” She didn’t state how successful the referral was and whether the ‘said woman’ survived.

A look around the facility, however, showed that it had no functional ambulance to aid referrals. Relatives of patients have to provide their own transport in the event of an emergency.

“We don’t have equipments. we want government to provide us with things like anti-bleeding drugs, circumcision kits, etc,” she said.

She also drew the reporter’s attention to a rechargeable lantern which she and her colleagues use in the labour room at night as a standby for the frequently experienced blackouts. The staff strength of the hospital is six community extension workers, six adhoc staff, headed by a matron.

Taiwo said that the state supplies the health centre with family planning commodities and women are responding to it. A functional borehole was seen at the

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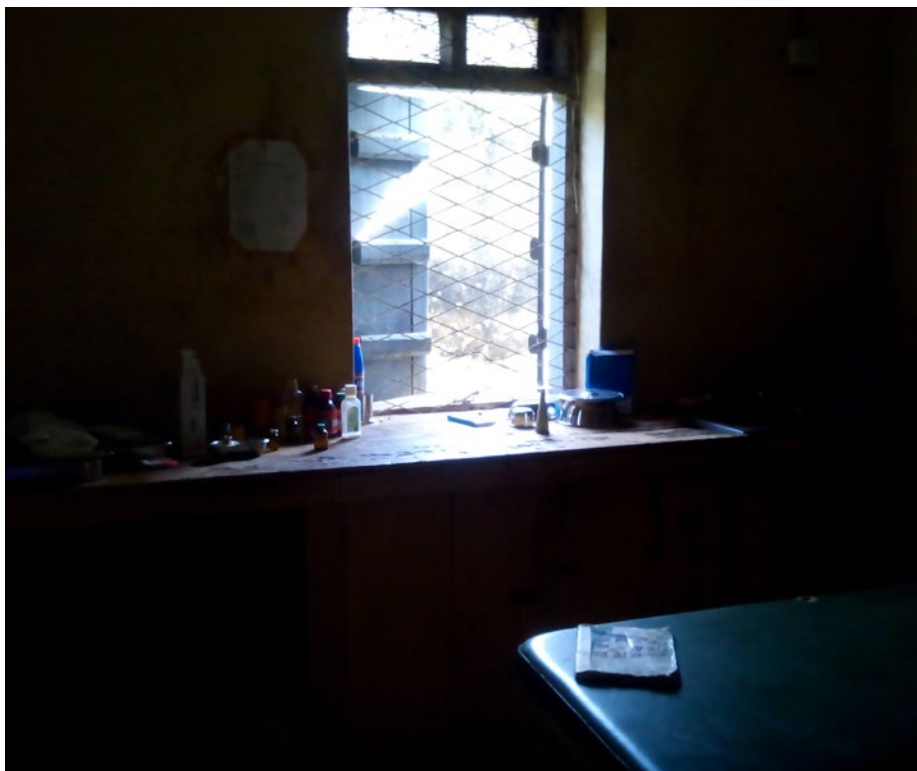
centre.

Even at that, none of these primary health centres measure up to any standard, Reviewing the blueprint of a PHC, it ought to be headed by one or more doctors, and have a pharmacist, a staff nurse and other paramedical support staff. It ought to have sufficient staffing to conduct outreach services such as immunization, basic curative care services, and maternal and child health services, preventive services, and monitoring and evaluation.

But the situation in the aforementioned facilities mirrors what obtains in several health centres across the country, especially in rural areas.

The federal ministry of health estimates that there are 23,000 basic health centres in the country, most of which are minimally functional, due to long years of





A paraphernalia of delivery items kept under poor hygiene standards

simple, cost effective interventions that are missing in the centres.

In 2007, some of the PHCs came alive after being resuscitated with funds from the country's debt relief gains. This is still evident in some of the facilities visited by our reporter. But that is about all that remains of what was meant to be a new lease of life – a repainted building, and a new banner/signpost hanging on the facility indicating the grantor's name. Hope kindled again when in 2012, when the federal government established the Subsidy Reinvestment Programme (SURE-P), and made some investments in social safety net programmes such as maternal and child health, roads, youth and women empowerment and so on. SURE - P said it set out in 2013 to identify some 500 PHCs across the country to refurbish, rehabilitate and stock with drugs and equipment.

The pilot centres are in Anambra, Bauchi, Bayelsa, Kaduna, Niger, Ogun, Zamfara and FCT, where 1,200 facilities (less than 1 per cent of all PHCs), were being supported with drugs and personnel for maternal and new born care. Our findings are that the thousands of other centres which are not supported are in a total state of disrepair - few or no skilled health workers, equipments, lab reagents, constant supply of drugs, inadequate funds as well as lack of simple necessities as water supply, electricity, thus making standard healthcare provision impossible. A visit to Apete Health Center in Egbeda council area in Ibadan Senatorial District, Oyo State, provides an exemplar of the

rot in the primary healthcare system.

What first strikes a visitor on coming close to this centre is the buckets arranged under the roof edges to collect rainwater.

This is a telltale sign of insufficient supply of portable, drinking water.

On entering this facility, three women were seen being attended to for minor ailments. One complained of sore throat, the other fever and the third was an aged woman with rheumatoid arthritis. While a young boy who was being given ORS (oral rehydration salt) for diarrhoea, lay weak in the emergency room, a community extension worker was seen taking blood pressure and writing a prescription for sore throat to a patient.

"The doctors are on strike and even when they are not on strike, they don't come here, they go to a bigger PHCs like Alakia", said the community health worker said, defending her apparently performing the role of a medical doctor. While interacting with the workers, the community health officer in charge, a woman who imply gave her name as Oguntoduwalked into the clinic.

According to her, they only work in morning and afternoon as they do not have the required staff strength and equipment to do night shifts. Deliveries are not common here for fear of hoodlums who come in to steal children, as the PHC is located in an unfenced school where miscreants hide out to smoke marijuana.

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In neighbouring Osun State, on November 8, 2013, the people of Osogbo received the gift of a newly renovated PHC. It was the first to be renovated of 21 PHCs in Olorunda local government area. It was also first to be equipped to provide emergency obstetric services, EmOC.

Three non governmental organizations – Osogbo Asheville, Raleigh (US Sisters Cities) and Xiangyang (Chinese Sister City), deemed it fit to overhaul the hitherto dilapidated structure to modern standard, providing it with instruments and beddings that would aid efficient medical services and emergency obstetric services.

EmOC is a package of medical interven-





No chairs inside, a pregnant woman peeps to see if its yet her turn

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Mrs Fajobi, matron-in-charge, Arakale health center, Akure, Ondo State

tions developed to treat the five direct obstetric complications—obstetric hemorrhage, obstructed labor, septicemia (infection), hypertensive disorders in pregnancy, and unsafe abortion which combine to cause 75 per cent of maternal deaths.

WHO introduced this idea as a backup for pregnancies that turn out to be eventful, as it has been found that around 15 per cent (one in six) of all pregnant women, develop a potentially life-threatening complication that calls for skilled care while some will require a major obstetrical intervention to survive.

Barely a year has passed since the grandiose tape-cutting ceremony to launch the centre and the community health worker on duty during this visit said the hospital's weighing scale is down to one.

Forceps (for manual vaginal assisted delivery, a component of the EmOC), vacuum aspirator and circumcision kits are lacking in the hospital.

“We need a lot of equipments. For example, we have only one weighing scale, so on immunization days the women have

to make a long queue to get their children weighed. This syphg (Blood Pressure apparatus) is not working well. Even light; we have not had light for a long time. We have been running on generator in the night and when there is no fuel we use torch,” the health worker lamented.

She added that the Utility (NEPA) bill has not been paid for two months despite memos and reminders to the local government.

Far away from Osun State is Holy Trinity Health Center, Ikoto, in Odogbolu, a semi-rural council area of Ogun State. A cornerstone indicating it was laid by former bishop of Lagos, Rt Reverend A.W. Howells, in March, 1957 welcomes visitors.

Only one member of staff was on duty when our reporter visited one early Thursday morning.

“My second is coming,” the middle aged man, a health attendant, said.

Inside the facility, it is a battle against dust from the reception area to the labour room, wards, walls, kitchen sink, floor. Everything is dusty.

Even the delivery apparatus had some stains that looked like coagulated blood



Building as old as the colonial era

which had been left unwashed. It would be noted that infection (septicaemia) is the second leading cause, of all maternal and new born deaths, accounting for about 17 per cent.

Apparently, residents shun the facility not wanting to add to their health challenges by atronising the centre. Not surprisingly, the health attendant said the centre had had only one birth in three months.

About 400 kilometers from Lagos, is Ipole, in Ekiti West local government area of Ekiti State. The town is known for its eerie quietude, thus the reporter's entry into the village was loud enough to draw anyone's attention.

While attempting to read the inscription on the signpost introducing the blue bungalow, a dark complexioned man in his early fifties, revved the engine of his motorbike speedily by.

"Good afternoon ma," he bellowed. "I am the one here," he said in Yoruba, alighting from his bike and hurriedly leading the way to the Health Center which was under lock and key. "I am the only one on duty," he repeated as though the first statement didn't register. It was 3.00 pm and he was seen signing in his name 'Olatunji Suluka', on the attendance register. The "Basic Health Center, Ipole-Iloro" has 12 workers, according to Suluka, but none else was on duty.

Guided by him around the facility, visible in the Pharmacy

were anti-malaria drugs (which is free for children under age 6) and adult from 65 above, family planning commodities, which are also free, anti-bleeding drugs, 85 bags of free MAMA Kits (which contains essential delivery things for pregnant women) and intravenous fluids.

The labour room appeared fairly clean, while the ward of four beds looked dusty with cobwebs crisscrossing the ceiling.

There had not been light in the facility for five months until a week before the visit. Meanwhile, water is sourced from rain, streams and rivers as borehole is nonfunctional.

Suluka, who introduced himself as a senior community health worker complained that he works alone most times, but calls his colleagues from other centres when he faces an obstetric emergency.

The health worker recounted one of the most challenging moments of his entire career thus: "One day a woman was bleeding, I gave her ergot (ergotmetrin stops bleeding during or after birth). but she was not responding, so after a while, I carried her on the bike and rushed her to Aramako (about 15 kilometers away)."

A community health extension worker is not a midwife and thus needs to be trained to attend to an obstetric emergency. Retraining to hone their skills is also important. In Suluka's case, after working as an hospital



“One day a woman was bleeding, I gave her ergot (ergotmetrin stops bleeding during or after birth). but she was not responding, so after a while, I carried her on the bike and rushed her to Aramako (about 15 kilometers away),” says a community health worker at a PHC in Ekiti West local government area.

Free delivery bags for women, but they don't come labourer/gardener, cleaner, driver, for nine years, he decided to go back to school where he spent three years studying Health Technology at the Ijero School of Health Technology in Ekiti.

Thus his career as a certified health worker commenced. When asked, Suluka said he was last went for training over a year ago.

Notably, births attended to by unskilled attendants like Sukula is largely responsible for high maternal death records in Nigeria.

By the WHO standard, the chances of survival of an emergency obstetric case in local community is very slim and gets slimmer if it occurs in the night, especially giving poor staffing and the rural environment.

Nigeria's Fourth National Development Plan of 1981-1985, put the responsibility

of health centres on the shoulders of the local government, but to be supported by federal and state governments, but the blame shifting game has been on for as long as this idea was conceived.

Local governments claim they have no money.

The federal government in an attempt to intervene established the National Primary Healthcare Development Agency, NPHDA. A sum of N19.4 billion was voted for it in the 2014 budget to support state agencies responsible for primary healthcare.

The matron-in-charge of Arakale Comprehensive Health Centre, in Akure, Ondo State, Florence Fajobi said the NPHDA started in 2014 in the state and they had just concluded on giving health centres a monthly allocation, which until

now received nothing.

On the other hand, Onigbinde John, the director of the primary health centre in Olorunda local government area, Osun State, said there are 14 health centres in the area and that some receive a monthly amount of up N1,000 (\$6) N2,000 (\$12), for its routine activities. “A PHC receives N1,000 in a month; some N2,000, while many don't even receive anything at all. The money is not much at all and it may not even be regular.”

He explained that the federal government is supposed to give councils the funds meant for primary health care directly, but lamented that this is not so. Speaking specifically in his own experience, “In Olorunda for instance, we receive imprest of N135,000 (\$787) in a month. Out of this,





Frontyard of a health center, at Osogbo, Osun State

N55,000 (\$333) is allocated for fuelling the director's vehicle; N45,000(\$272) is for carrying out routine activities such as family health, national program on Immunization, maternal and child health, health education , while N25,000 (\$151) is allocated to three deputy directors."

In Lagos State, the health commissioner, Jide Idris, said the local government cannot do it alone though health centres are directly under them.

"Funding is a major constraint. It costs a lot of money to provide staffing. At least three trained doctors and eight nurses are required to be on a 24-hour service," the commissioner observed.

Idris adds; "What we are doing now is to work with the private sector to upgrade this sector. Our intention is to create a framework where we can have the health insurance scheme."

The public relations officer of the Lagos Primary Healthcare Board said that the board "does not give any imprest to PHCs, but we are planning to give them from next year. It is already in the budget which we will defend very soon."

For the heads of the health centres, it is between a rock and a hard

place as the onus lies on them to generate money to cover running costs with or without funding.

At the health centre in Ijebu-Ode local government, the head of the facility, Bolanle Durodola Asoro, said the staff contribute money themselves to raise funds for operations.

"NEPA has cut our light for seven months because we are owing N250,000. We have connected it illegally many times but they keep cutting it. We usually tell women who want to give birth to bring money to buy fuel for the generator."

Pointing to the carpet, which is now punctured by shoe heels, she said she and other workers "among ourselves contrib-

uted money to fix this carpet, so that this place can look a little bit presentable."

Asoro, who was met while on night shift gave a month by month account of deliveries taken this year so far as 50.

"This place is too small. We need extension," she says adjusting her glasses.

"We need a standby generator to power our fridge which we use for immunization. This place is central for immunization as we give immunization everyday unlike other centres that do it once or twice a week," she stated further.

Pointing at a cramped room, she said "you see that ward, is for both male and female; It is not supposed to be so."

As if seizing a long awaited opportunity to pour out her anger and frustration, Asoro opened a floodgate of complaints.

"We only have four beds, it is too small for the flow chart of patients we receive here; no baby courts, mothers have to sleep by their baby side on the same bed. We do not have water, we used to beg for water from one man opposite us there, who has a bore hole. Our forceps and scissors are spoilt, no circumcision kits, no replacement. We do not have consultation room, so a patient cannot have confidentiality."





Ghost workers....no staff, no patients

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This facility is directly under the Ijebu Ode local government and has not received any allocation whatsoever, since her 30 months of heading the facility. Another center, in Oke-ife under the Ijebu-East local council, has a similar complaints. “We have not had light for six months. Bringing out two blue lamps, she displayed them saying: “See our lanterns, this is what we use when we are on night duty,” the community health worker Sade Ogunoiki, told our reporter. Attesting to this is Ademola Talabi, director of primary health-care in Ijebu East local government, said he had complained about the appalling state of things until he got blue in the face. “I have put this matter forward many times, but government always says there is no money, that is why they haven’t got any imprest. The staff contributes money amongst themselves and sometimes we have agencies like Global Fund supporting us.” According to him, there are 28 health centres in his local government – 27 are functioning but with minimal manpower, while one has closed down. Reeling out similar feeling is Modupe Shodunke, the Chief Nursing Officer in charge of the PHC at Alakia/Olode Ward in

Egbeda local council of Oyo State. “We are short of drugs, we are short of staff, we are short of money” she moaned. “The running costs is higher, we don’t make money because delivery in Oyo State is free of charge. We need fuel to power the generator, to keep the light running so we can do laboratory investigations both during the day and night. So, how does the centre run its operations? With a shrug of the shoulder, she said ruefully, Sometimes the community gives us monetary donations.” Left to their own devices and ingenuity, in some centres, the officers in charge have learnt smart ways of raising money. B.A. Adeyemi, the Matron-in-Charge of a SURE – P supported facility at Orita Obele, Ondo State also said she does not receive any imprest, but had devised ways of generating money to run the centre. “We mandate any woman in labour to buy five litres of fuel. We also ask the women to make a voluntary donation once they put to bed. They can give us soap, gloves, cotton wool or any equipments we need. We also make money from minor ailments, road traffic accident which



Instead of humans, a family of cats and goats seen at the terrace of a PHC, in Oyo State

we treat here. The community health committee also gave us money, which we used to pay our NEPA (electricity) prepaid meter bills. I also make money from circumcision,” she offered.

Seen in her office are donations of diapers from Procter and Gamble, a multinational manufacturer of product ranges in Nigeria.

The story appears to be a little different at LAUTECH primary centre in Olorunda local government in Osogbo, Osun State where, the Matron-in-Charge, Eunice Adeniran, said her facility gets an imprest of N10,000 monthly for running costs.

This website was not able to determine why or how some PHCs get subvention for government while others do not.

Who is to blame?

Emmanuel Otolorin, a professor of obstetrics and gynaecology, believes that neither the health centres nor the workers are to be blamed but the government of Nigeria.

“Health is on the concurrent list, meaning any of the three tiers of government can take it up, but it is often arrogated as the responsibility of the local government,” he observed.

Explaining further, Otolorin said: “Basic healthcare is what people need; it is like a pyramid, where more people at the bottom need basic healthcare, a few will require secondary, and then very few will need to be treated at the tertiary level, but in Nigeria, we have our pyramid turned upside down.”

“70 per cent of the budget goes into tertiary institution, meanwhile the health centres which reach more people get almost nothing,” he laments.

Apart from the big problem of funding, there is also the legalistic difficulty thrown up by the silence of the Nigerian Constitution on the rights of citizens to good health.

A look at the Constitution to ascertain who is failing in its responsibility to provide funding which is critical to quality healthcare provision makes this readily noticeable.

Health was mentioned in the 2nd and 4th schedule of the Constitution as well as under social objectives in Section 17, subsection 3 (d) which says “the state shall direct its policy towards ensuring that there are adequate medical facilities for everyone.”

Significantly, however, while other rights and freedoms are guaranteed in Chapter 4 of the Nigerian constitution, the section is silent on citizens rights to health. The absence of enforceable right to health makes it difficult to hold government accountable for its failure to provide life-saving healthcare services to its citizens especially pregnant women and children, who mostly access the PHCs.

“It means that we cannot really hold any tier of government solely responsible, and that is why we are pushing for the National Health Bill to be passed into law,” says Otolorin, who is also country director of Jhpiego Corporation, an affiliate of John Hopkins University, working to save

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mothers and children’s lives.

The Abuja Declaration therefore appears to be the main instrument through which government can be made accountable.

Nigeria is signatory to this 2000 Declaration which mandates African Heads of State to spend at least 15 per cent of their annual budget on health.

As a mark of improvement, spending on health in the 2013 budget is 6 per cent, the highest so far, yet this is less than the Declaration’s target.

Most children her age ought to be in 3rd grade of high school.

Implication

A report by the National Primary Healthcare Development Agency, claims that maternal mortality rate has fallen from 545 per 100,000 live births in 2008 to 350 per 100,000 live births in 2012. These figures appear unrealistic given the realities on ground.

However, the story of Christiana Akodu, 15, who is still in a primary school, exemplifies the far-reaching impact of losing a mother.

Hope for her education dimmed when her mother died ten years ago while giving birth to her fourth child. Ever since, she and her siblings have lived with their 76 year-old maternal grandmother.

“My father has a new wife. He send money but not all the time,” said Christiana, who was met untying bags of cassava (for making garri). Her grandmother is famous for Garri making, a business native to Ijebu-land. She added that she and her two sisters have dropped in and out

of school several times because of lack of money to buy books, stationery or pay for a romotional exam.

Still smartening from the death of her daughter, the grandmother was reluctant to talk about it, but manages to say, “Sola is not supposed to die, but we accept fate,” biting her lips as she repeats the last words.

This is one of the long term socioeco-



A mother and newborn curdle here after delivery, at Ikoto, Ijebu

conomic implication of maternal mortality. This is apart from the emotional trauma and psychological damage of losing a loved woman or child.

The chief executive officer of the NPH-DA, Mohammed Ado, admitted that Nigeria has made slow progress towards the 2015 targets of MDG 5 – “Improve maternal health”.

The reality on ground remains that only few of the facilities have drugs.

Asoro, head of the Ijebu-ode health centre said the hospital does not have Ergometrin and oxytocin. While the former is a drug administered during obstetric intervention to stop bleeding, the latter is used to induce labour. Even some SURE-P assisted facilities often run out of stock. For instance at the SURE-P supported Basic Health Center in Ikogosi, Ekiti West, when there is a stock out, drugs are sold through the ‘drug revolving fund’ project. The implication of this is that women stay away from the hospital.

At Fotedo Health Centre, Imobi, Ijebu East local government, relatives of pregnant women are mandated to fetch drums of water to clean up during deliv-

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ery. Sometimes, the woman herself goes to fetch the water.

“For there to be a national impact in improving maternal and child health which begins from the primary healthcare, an innovation like the SURE-P must be in all 774 local government of the country, not just a few local governments,” says Otolorin.

Way forward

“My recommendation is for the passage of the National Health Bill and its proper accountable implementation. Only then

can we achieve universal coverage and meet the millennium development goals. Already Nigeria cannot meet the MDGs 4 and 5.”

The National Health Bill, first introduced in 2004 and passed by the 6th National Assembly in 2011, aims to strengthen constitutional provisions for healthcare and mandates the federal government to devote one per cent of its consolidated revenue fund solely to finance primary health care.

The Bill defines the rights of health workers and users of health services/ facilities and thus provides Nigerians an opportunity to hold government accountable for their health, rights including equitable access to healthcare.