



Africa HEALTH

NIGERIA



Controlling the last know cluster of Ebola Virus Disease

Seasonal malaria chemoprevention: slow uptake of proven technology

Prevalence and costs of obesity

New medicines, better medicines, better use of medicines

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A glimpse of the future?

As the National Association of Resident Doctors embarked on the latest strike action to paralyse public sector health services, my mind went back to the 'seminal' conference which the National Medical Association called shortly after Dr. Osahon Enabulele had assumed office as President of the organisation. A high-octane, high energy meeting ensued with all parties invited, all parties present, and all parties seemingly agreeing that there had to be a better way to deliver Nigeria's health services than the stop start stop start rhythm induced by the constant strikes that had been plaguing the sector.

Fast forward to today and the situation seems to have got even worse. Public confidence in the public sector is at its lowest ebb. Or maybe better stated, public expectations from their health service is at its lowest ebb. This is indeed a sad state of affairs.

It was therefore exceedingly refreshing to turn up at the Musa Yar'Adua Conference Centre in Abuja on 18th June to attend a conference put together by the Nigeria Health Watch team under the title of the 'Future of Health Conference' with the subtitle 'Towards the Health System of our Dreams'.

The meeting featured a number of presentations from people who cared deeply about their profession and about their health service. How can Nigeria's maternal mortality be worse than it is in Somalia when someone like Ondo State's Commissioner of Health, Dr. Dayo Adeyanju was able to demonstrate that with a relatively small investment he was able to introduce a programme that dramatically reduced mortality in his state. Dr. Ola Soyinka had recently attended a town hall meeting in Abeokuta with his governor and fellow commissioners. He expected a grilling. But not one healthcare question was posed. 'We must change the mindset of Nigerians', he enthused. 'Too many people are putting bad health and healthcare down to the will of God.'

Please do read the report of the conference on page 7. If you are feeling depressed about aspects of healthcare in Nigeria, then here you will at least see any array of charismatic leaders who are committed and ready to find a way forward and regain the high ground for the health professions. Many good things are happening. Just that too often they are being overshadowed by strikes and other negative events.

Well done to the Nigeria Health Watch team!

Bryan Pearson

Ondo state begins implementation of HIV anti-stigma law

The government of southwestern Nigeria state of Ondo has announced it has commenced the implementation and enforcement of its HIV anti-stigma law. Under the law, individuals caught spreading the virus could spend up to 10 years in jail or pay a fine of N500 000, or both.

Introducing the law to health journalists in the state capital Akure, the Secretary to the State Government and Chairman, Ondo State Agency for the Control of AIDS, Dr. Aderotimi Adelola, noted that stigmatisation and discrimination are two major issues that are discouraging individuals infected with, living with and/or are affected by HIV from accessing health and social services.

Under the new law, he said anybody that

discriminates against people living with HIV would be regarded as having committed an offence and could be liable to a fine of N100 000 or imprisonment of six months or both.

Adelola said: 'Most times, the rights of people living with HIV are violated, causing them to suffer both the burden of the disease and the consequential loss of other rights. Stigmatisation and discrimination of people living with the virus may obstruct their access to treatment and may affect their employment, housing and other rights which he said adversely affect the vulnerability of others to be infected.'

In his remark, the State Commissioner for Information, Kayode Akinmade said the state is the first in Nigeria with a law that addresses many aspects of HIV response and will help promote public awareness about causes, modes of transmission, consequences, means of prevention, and control of HIV transmission, through a comprehensive education and information campaign.

Nigerian government reactivates Ebola response mechanism

Following the reemergence of Ebola Virus Disease (EVD) in Liberia, the federal government of Nigeria has directed states across the country to raise their alert level and report all suspected cases to the Health Ministry.

This directive was contained in a statement issued by Director, Press, at the Federal Ministry of Health, Ayo Adesugba, who also urged Nigerians not to panic. Instead, he urged citizens and all residents to be wary and vigilant.

He said: 'Members of the public are advised to observe basic hygiene and report any suspected case to the nearest health facility.'

'It must be noted that the main symptoms of the EVD are fever, severe headache, abdominal pain, vomiting and diarrhoea. Patients, in some cases, also have neurological symptoms of becoming confused and restless.'

To address the challenges of the development in Liberia, he announced that the Federal Ministry of Health is reactivating its response mechanism and increasing the level of its alertness.

'It would be recalled that new cases of the EVD had been reported in Liberia. This means that the country, which was certified Ebola-free by the World Health Organization (WHO) on 9th May 2015, has witnessed a resurgence of the disease,' the director said.

A 17-year-old boy from a village near the Liberian capital died of Ebola. He had no history of travelling out of Liberia and no history of coming into contact with any known EVD case. The boy has since been buried but Liberian health officials are worried that he may have transmitted the virus to many other people who came into contact with him.

'The resurgence of EVD in Liberia confirms that the EVD is still circulating in that country and transmission from person to person is possible,' Adesugba said in the statement.

Onchocerciasis threatens 50 million Nigerians



Photo credit: Serosing keratitis in onchocerciasis. © Ian Murdoch & Allen Foster. <http://www.celjournal.org/article/vision-2020-update-on-onchocerciasis/>

Nigeria's Federal Ministry of Health has stated that as high as 50 million Nigerians are risk of suffering from onchocerciasis, otherwise known as river blindness.

According to the Acting Director of Neglected Tropical Diseases (NTDs) Division of the Federal Ministry of Health, Dr. Ifeoma Anagbogu, out of the 50 million, only about 30 million are accessing treatment.

The director also revealed that about 20 million people who are supposed to be on treatment are not currently accessing it and in an effort to control the disease, Nigeria has been applying the mass administration of a medicine from a donor agency for the management of the disease.

'A person that stayed in a place that is identified to be risky and prone to the disease is given Mectizan, at least once annually for the cure and prevention of the disease,' she said.

She enjoined the Nigerian government to provide the necessary support to enable the division to take ownership of the prevention and management programme.

The life of a Nigerian surgeon

Shima Gyoh is a precious gem. There is little he hasn't seen or done in Nigeria's health service. Here he presents some private reflections on his service

My patient was admitted as an emergency from a remote village. He had not passed stool for three weeks, though he was passing flatus. His abdomen was distended and uncomfortable but not tender despite gentle obstructive bowel sounds. His hydration was reasonable; there was no pyrexia, and the pulse and blood pressure were also reasonable. The surgical team had time to resuscitate and do investigations, and these suggested subacute intestinal obstruction by a colonic mass at the splenic flexure. He needed an urgent laparotomy, though not the type with the sirens blaring.

Although the surgical load is heavy, our numbers are more than adequate to cope if only we had had everything working - uninterrupted water and power supply, adequate equipment, adequate number of anaesthetists and theatre nurses, adequate linen washed and sterilised immediately after use. In surgery alone there are nine consultants and nine senior residents. However, deficiencies in all these have reduced the consultants to having no more than one elective session per week - if it is not interrupted! Lists are often interrupted by:

- (a) Emergency operations where immediate saving of a life has to take precedence over elective curative procedures;
- (b) Power failures which result in inability to sterilise instruments and/or linen at a rate fast enough to cope with the needs of users, added to the fact that the quantities available are only marginal;
- (c) We have only one anaesthetist. Although the nurse anaesthetists do well on ketamine infusion anaesthesia, any surgeon wanting intubation has to wait when he is free and not too exhausted. While it is possible to teach nurse anaesthetists intubation, the skill associated with the use of a Boyle's machine requires a deeper background in science and anaesthesiology, and prolonged apprenticeship to an anaesthetist: something most institutions can ill afford.

A consultant surgeon having only one operating session per week amounts to severe under-employment

Shima Gyoh has held many posts ranging from village doctor to DG of Nigeria's Federal Ministry of Health and Chair of the Medical and Dental Council of Nigeria.



Photo from <https://onearch.tamu.edu/news/2013/2/12/africa-health-care/>

in the face of overwhelming needs. Patients for elective surgery, including cancer cases sometimes have to wait for days, while inpatient charges for those on admission mount.

Our patient was therefore on the standby for 3 days. He was starved and sometimes wheeled to the operating theatre, only to be brought back to give way to a more desperate emergency. It is exhausting and frustrating for both patients and doctors. The surgeon is often left to manage the distress of his patients, pleading one excuse after another to explain the apparently unending postponements. It is common to hang around for over six hours waiting to do an operation lasting one hour. A concerned surgeon's life is a disrupted one, but it's nothing compared to the anxiety and the physical and psychological suffering of their patients. In this patient, we were likely to do some resection of the large bowel. He came in quite anaemic. He had one unit of blood, and we needed to have two ready for the operation. It is not always easy to get blood.

I remember an 8-year-old girl with extensive burns involving the flexor surfaces of both arms, and the neck. We reached the critical stage when skin grafting must be done if we were to avoid fibrous healing and contractures that would be very difficult to correct, but her severe anaemia had to be corrected before surgery. Only the girl's grandmother was around, and, in those days, the public around that hospital in Zaria were so afraid of blood donation that they found alibis in their culture and religion to refuse donation. In the end,



I had to give my own blood if the grafting were ever to be done. I happen to be Group O Rh+ and often donate, usually for patients that need emergency life-saving operations.

I went to the haematology lab to donate. The laboratory scientist (or technician as they were then known) was quite diffident and nervous of doing a venopuncture on a senior colleague and he insisted he would call a haematologist, but I was afraid it might introduce unpredictable delay - I would not be able to wait - so he finally agreed to do it. I thought my watching his performance might increase his nervousness, so lay on my back, closed my eyes and let him get on with it.

He started in the left arm, but he soon complained the flow had stopped. He fiddled with the cannula in the vein, but it did not resume, so he told me he would stop. I heard a hiss as he let off the cuff on my arm.

The blood was insufficient, so I persuaded him to try the right arm. He experienced exactly the same problem. When he let off the cuff, I heard another hiss and passed out. When I came to, Professor Fleming, the tall fair haematologist was testing my reflexes. 'You are a lucky lad, you have just survived a cerebral air embolism!' I was admitted for a few hours in a bed in a dormitory ward among my patients (so doctors too can be ill!) As they crowded around me, I was overwhelmed by the mixture of incredulity and sympathy in their faces. Lack of special amenity wards gave me this highly memorable experience.

This was 42 years ago in Zaria and evacuated plastic bags for collecting blood were not in use at the hospital. We were using ordinary sterilised bottles with blood inlet and air outlet tubes. The blood inlet tube ends near the bottom of the bottle, and the air outlet has its end higher up, near the neck. This technician was quite senior, but for some reason, connected the blood inlet to the air outlet tube. The level of blood in the bottle rose and soon covered the mouth of the inlet tube situated near the bottom. The air in the bottle was therefore trapped, and got increasingly compressed as more blood flowed in. The flow soon stopped when the air pressure in the bottle equalled the pressure pushing the blood into the bottle. Frustrated, the man let off the arm cuff, and of course the compressed air was forced

into the vein and I heard the first hiss. The mistake was repeated in the right arm.

That was before the advent of the HIV virus. Twenty-seven years later, I was with a team of young doctors at Katsina-Ala in Benue State when we urgently needed blood to save the life of a 22-year-old woman with a ruptured ectopic pregnancy whose desperate clinical condition indicated that, without surgical intervention, she would be dead within a few hours. The country has no blood transfusion service, and patients or their relatives have to find donors, usually relatives or someone they pay to donate for their operations. This woman needed two units, but she had no relatives around and she had no means of getting anyone to donate. I was on a teaching visit and there were four other doctors with me. I offered to donate and my sample was taken. There being no other offer, we would have to make do with one unit.

After receiving no summons from haematology for what I felt was a long time, I left my colleagues to find out what was going on. On arrival, the technicians said they were just about to send for me. 'We have just read the result from the tests and you are HIV and Hepatitis B negative.' I sat on the couch and they took the blood, this time in an evacuated plastic bag. When I and the blood arrived back, my colleagues burst out rejoicing with relief, but it was not just for the blood! 'We did not offer to donate because we were terrified of the HIV test! If you had been found HIV positive, the news would have spread like wild fire round the state!' Most people were frightened of the HIV test that was not confidential. At operation, I found more than two litres of heavily blood-stained fluid and products in the peritoneal cavity. She did well and went home hale and hearty on the tenth postoperative day.

Over the years, I have developed the habit of checking with the operating theatre staff what instruments and sutures are available as soon as I book a case. Ability to do things well partially depend on having the correct working materials. There are three or four surgical instruments I love. I carry my own permanently in my diagnostic bag, and give them for sterilisation once I find they are not available in the operating theatre where I have booked a case. For example, the Gillie's combined forceps and scissors is great for suturing, as in intestinal anastomosis and skin closure, especially where skilled assistance is not available. Anyone can hold tissue taught while you suture and cut. Ordinary peritoneal suckers have one nozzle at the end, and strong suction can damage intestine weakened by inflammation or prolonged obstruction. I carry my own abdominal sucker that dissipates the suction pressure through multiple small perforations along its entire length.

For the best results, it is most important to use the correct sutures of specific sizes for the different tissues, and the supply is never reliable in all the theatres I have used all over the country. I therefore give patients a list of specified sutures needed for their operations

and they get the material from medical suppliers. I appeal to well-to-do patients to buy more than is needed for their surgery, explaining I would like to keep the excess for emergencies and for the financially disadvantaged. They are invariably happy to help. I do not take money to procure the material myself to avoid being suspected of cheating.

Nigerian surgeons in public service suffer the daily distress of seeing lovely children with serious, disfiguring, painful or early potentially lethal conditions still amenable to surgery having to go home without treatment because they lack funds. Poverty often pushes many patients to quacks where operations commonly end up with serious complications such as faecal and urinary fistulae, drastically reducing their quality of life. We do not know how many die, but any week we have an average of two survivors turning up for corrective surgery.

Most public institutions run on very thin budgets, and at any point in time nearly all wards have two or three patients being prevented from going home until their relatives bring the fees for their operations. The fees are heavily subsidised but the poverty is profound. In addition, the investigation and treatment of dangerous surgical diseases like cancer, fractures of major bones, complications of diabetes mellitus, and correction of serious mismanagement of many conditions are often blocked by inability to pay. Sometimes doctors and nurses make personal efforts to pay the bills for the most pathetic cases, but there are too many for poorly paid public employees to make a noticeable dent on the problem. The challenge can only be resolved by a comprehensive health insurance

scheme that covers the neediest in our society - the powerless and voiceless only cosmetically remembered in political rhetoric.

Running water and soap are indispensable for surgical work, but it is common to find both in short supply. In village hospitals, and often in teaching hospitals, we have to do with helpful persons pouring water over our hands and arms - pail scrubbing - for surgery. Most hospitals have an elevated plastic tank for extra storage and supply to the operating theatre, but even this often runs out during prolonged power failure, drought or lack of funds somewhere along the supply chain. Nevertheless, even pail-scrubbing combined with strict adherence to the aseptic ritual does give acceptably low-rate of wound infection as can be proved by investigating every case recorded in the wound infection register.

Road traffic accidents are quite a menace. It is ridiculous that the use of crash helmets is not being enforced in Nigeria at a time the motorcycle has become the commonest mode of transport for the majority. Cycle riders are largely reckless and do not observe any road discipline. They often suffer severe head injuries in crashes. Those who survive have unfortunate sequelae. The enforcement of use of safety belts in cars has also cooled off, and when they crash, you can always tell those who were 'unrestrained passengers' by the severity of their injuries, particularly the spine. Cord damage from many broken spines are worsened during inexpert extraction of victims from the wreck and their subsequent unprofessional handling. Paraplegia and incontinence of faeces and urine are soon followed by indolent bedsores, and the long-term management of these patients is difficult and expensive. To reduce these tragedies, the nation must put well-equipped ambulances with professionally trained crews to start patrolling one or two of our fast roads, and gradually expand the service in accordance with available resources.

What is my attitude to 'medical tourism'? When I deal with illness, my target is to get the patient well within the shortest time and at the lowest possible cost within available facilities. I will not insist on doing an operation if, for any reason, it is better done elsewhere and the patient can afford it. If he so wishes, it is part of his human rights and must not be abridged for any reason. One of the basic principles of medical ethics is that the patient's wish is supreme, ('*Voluntas aegroti suprema lex*').

Medical tourism can be controlled by long-term politico-economic planning that does not trample on anyone's right to choose.

For example, governments in developing countries should create suitable environments for high tech medicine to develop in both the private and the subsidised public sectors.

High-tech medicine is likely to develop faster in the country if Nigerian governments funded medical treatment only in Nigeria.



Highlights of the Future of Health Conference Abuja, Nigeria

Chris Alagboso reports from the Nigeria Health Watch conference

The prestigious Musa Yar'adua Centre in Abuja was the venue of the Future of Health Conference that was convened on 18th June 2015 by Nigeria Health Watch. The objective of the conference was to create a roadmap for a more innovative and proactive health sector for Nigeria.

It was a gathering of more than 400 participants who desire a stronger health system; there were also virtual participants who followed via social media using #nghlth15.

In his opening remark, the Head of Nigeria Health Watch, Dr. Chikwe Ihekweazu, noted that the Nigerian health sector is beleaguered with paucity of innovations when compared to other sectors of the economy, especially banking and telecommunications. He subsequently urged conference participants to proffer actionable solutions that would strengthen the nation's health sector.

Presentations were delivered at two broad sessions – one was focused on 'looking back' while the second was on 'looking forward'.

Shifting focus to primary healthcare

In his presentation, Ondo State Commissioner for Health, Dr. Dayo Adeyanju, said the present focus of the Nigerian health sector is on tertiary healthcare although, according to the expert, the immediate focus ought to be on fostering primary healthcare across the country. He also shared the success story of Ondo State government's Abiye Safe Motherhood Programme, which he said has helped to reduce maternal and child deaths in the state.

Towing this same line, Nnenna Ihebuzor, Director of Primary Healthcare Systems Development suggested the setting up of a primary healthcare centre to be present in every ward in Nigeria.



Strengthening regulations and promoting interprofessional harmony

In his speech, Professor Shima Gyoh spoke extensively on the consequences of a health system that lacks proper regulations. According to him, frequent changes in leadership are a major deterrent to sustained regulatory practices.

'Regulatory bodies are meant to protect the interest of the patients,' he said.

He called the attention of conference participants and industry stakeholders to the inadequate ambulance services in Nigeria and he urged government and partners to put together a stronger ambulance service.

'This has become necessary because most ambulance services in Nigeria only serve as horses as they only carry hospital staff on call or the deceased,' he said.

To address the endless and needless rivalry between different healthcare professionals, another speaker, Remi Adeseun suggested starting from the grassroots to instill the spirit of teamwork among healthcare professionals, and by training them together.

'There is no need for every healthcare provider to have their own private clinics – even those with only two beds,' said Dr. Femi Sumonu, a health finance expert. He called for a complete and systematic revamp of hospitals both in the private and public sector.

Innovation and free healthcare

Clare Omatseye called for the Uberization of the health sector. She said there is the need for Nigeria's creative minds to think ahead and use technology to improve the nation's health sector.

'This is because patients will demand for it if it's not given to them as they have arrived in the digital age while most healthcare service providers are still in the analogue age,' she said.

Already, she said foreign businessmen and their female counterparts are thinking of innovative ways of using technology to penetrate Nigeria's healthcare market.

'There is the need to see business opportunities in the health sector,' she concluded.

Dr. Iko Ibanga spoke on the need for healthcare professionals to embrace volunteering. This, according to him, is an avenue to care for those that cannot afford quality healthcare. Ibanga said he and other healthcare professionals have been involved in volunteering for more than 25 years.

Universal health coverage, political, professional, and financial accountability

Robert Yates, an advocate of universal health coverage from Chatham House, United Kingdom said unequivocally that Nigeria can afford and can achieve universal health coverage by appropriately investing revenues from the oil subsidy. He gave instances of countries that have lower GDPs than Nigeria's, but have successfully achieved universal health coverage.

'Will President Buhari become Nigeria's Primary Health Care hero?' he asked.

Speaking on the need for accountability, Fola Laoye from Hygeia Nigeria decried the poor performance of the Nigerian Health Insurance Scheme (NHIS) ten years after its launch with only an estimated 6 million covered. She said the scheme has never been audited nor presented any official account or report in this period.

While sharing his experience during his term as Commissioner for Health in Ogun State, Dr. Ola Soyinka recounted how none of the participants at a town hall meeting organised by the state government, asked any questions relating to healthcare delivery in the state. This he believes is due to the fact that most people have come



to blame God for bad health outcomes.

'Such mindset needs to be changed... Nigerians should begin to use quality healthcare delivery as a yardstick to measure performance of a government and to hold them accountable when things go wrong in the sector,' he said.

Nigeria's former Health Minister, Dr. Muhammad Pate, was the last speaker and he called on citizens to use all available channels to demand accountability in the health sector. He subsequently endorsed the #OpenMOH campaign to demand a transparent and open Ministry of health in Nigeria.

The travails of Nigerian patients in the hands of private diagnostic facilities

Paul Adepoju investigates the consequences of poor accreditation of Nigeria's private diagnostic centres

A twenty seven-year old male presented at a government-owned hospital in the southeastern part of Nigeria with a chronic cough and weight loss. Through the help of the hospital's laboratory, the patient was diagnosed with pulmonary tuberculosis and the consulting physician placed him on Anti-Cocks. Some weeks later however, he returned to the same hospital with abdominal pains. Further investigations were requested – lab and imaging. But this time, members of the Joint Health Sector Workers Union (JOHESU) were on strike which meant the only option was to refer the patient to a private diagnostic centre in the metropolis for ultrasound imaging.

The inconclusive result showed the patient had aortic aneurism. Although the patient did not know what aortic aneurism is all about, he went online and got scared when he read a Wikipedia article on the subject. He ran to his doctor and presented the result to him. Knowing the severity of the diagnosis, a departmental meeting was hurriedly convened. They brought in one of the country's best ultrasound experts who volunteered to re-conduct the investigation.

The second result showed there was no aortic aneurism.

The first investigator was summoned and he apologised profusely, putting the blame on his inexperienced intern.

This is a familiar story that healthcare professionals across Nigeria, especially those working with government-owned hospitals, can relate to and the frequency is increasing even as more strikes are recorded annually, thus forcing hospital managements to allow patients to visit private medical diagnosis facilities for treatment – even though they cannot totally vouch for results gotten from the private centers.

'We have no choice but to accept those results because the labs we can vouch for are shut, yet patient care must continue,' a top board member of a major teaching hospital in southwest region of Nigeria said.

'Whether workers are on strike or not, patients will be sick and our job is to take care of them to the best of our ability – and with what we can get even when the results of investigations are not reliable enough,' he said.

The quality of private healthcare practice has been

a serious subject in medical discourse in Nigeria and elsewhere. In February, online health news platform *HealthNewsNG.com* reported that out of over 10 000 medical laboratories in Nigeria, less than 3000 got licenses to operate from the Medical Laboratory Science Council of Nigeria. This simply means that 70% of laboratories in Nigeria, and by extension other diagnostic centres, don't have operating license. Yet the private health facilities continue to get patients and samples from public health facilities, especially when government health workers are on strike.

'Some of those that even have operating licenses, some of the very big names in Nigeria's private diagnostic industry cannot be totally trusted to provide reliable results because some of them outsource tests to the small mushroom ones,' said Tobi Lala, CEO of Khairos Labs, a new diagnostic company that provides medical investigation services to patients in the comfort of their homes.

Resource management

Lala believes that private diagnostic centres are fond of extremely managing resources because their goal is not primarily patient care but to make profits.

'Let's not forget that unlike government's hospitals that were set up just to provide citizens with access to quality healthcare, private diagnostic centers have one primary aim - to make profits and we've seen so many ridiculous ways some of them are going about making profit,' Lala said.

He noted that several of these profit-making strategies totally negate the tenets of good clinical practice and principles of quality assurance.

'This was one of the reasons why we launched our services - to connect patients to the very few private facilities that are offering reliable diagnostic services,' he said.

Investigations revealed that some of the private health diagnostic centres go as far as using archaic methods that have been extensively declared non-specific to make diagnosis and recommend treatment actions.

'Some of them generally adopt methods that are inexpensive and would allow them to make profits but at the detriment of the patient,' Lala said.

Public-private partnership failed

As a way of tackling this development and to ensure that qualitative diagnosis could be achieved even when the labs, radiology and other diagnostic departments are shut due to strikes, many hospital managements had been involved in various forms of public-private partnerships (PPPs). The University College Hospital Ibadan is one of such.

It set up a PPP laboratory hoping it would be able to process samples even when the hospital is on strike. However, the doors of the PPP lab is slammed shut anytime the health workers are on strike.

'Such strategy would not work as long as health workers in the hospital are the ones being engaged in such PPP arrangement because they are members of a professional body which could ask its members to go on strike any time,' said a top ranking member of the

Association of Medical Laboratory Scientists of Nigeria.

This simply means any strategy that entails using government health workers to work in any private arrangement would not be very effective. The other option would be for private medical facilities to employ well trained and appropriately qualified personnel. This also has its limitations.

'The cost of employing several qualified professionals is largely not something that owners of private facilities could afford. Take for instance the kinds of choices that the owner of a diagnostic center would have to make when it comes to recruiting staff. Even though they all know the appropriate persons to employ, they largely don't do it - instead, they employ under-qualified persons to man the labs because they cannot afford the professionals. A similar thing is happening in imaging and other aspects of healthcare. Even nursing is not exempted,' said Tobi.

He noted that this development could be the reason why several results that are issued by the private practitioners are left as inconclusive, suggesting further tests in order to make more money from the patient or as a way of protecting themselves against lawsuits.

Way forward

A cross section of health workers that responded to an inquiry about the negative impacts of the activities of private diagnostic centres on the quality of patient care said they are aware of it, but the responsibility is more in the hands of the government through the various regulatory agencies and the management of the various hospitals.

'There are professional bodies and regulatory councils that are originally saddled with the responsibility of ensuring that healthcare facilities, whether privately or publicly owned, adhere strictly to appropriate codes of conduct, attain a certain level of quality assurance, and employ duly qualified personnel.

'I believe when such laws are enforced, we will be able to identify the private practitioners that are posing real threats because as hard-to-believe as it may seem to be, there are still private practitioners that provide reliable results. Those ones should be the ones that the agencies should spare,' the hospital board member said.

Taking the conversation further, Lala said the long-term solution would be for the government to avert strikes and crises that could make it impossible for patients to get diagnostic procedures done at government hospitals. But in the short-term, he said each hospital should come up with a list of private healthcare service providers that they can trust.

'Such list should be made available to the consulting physicians. Now I'm not talking of the contact details of labs and investigation centres that would give a member of the hospital board some commission at the end of the month. No. What I'm talking about is to seek those private practitioners that are responsive and responsible. This is the only way we can ensure that patients don't suffer excessively for the country's inability to run an efficient healthcare system,' he said.