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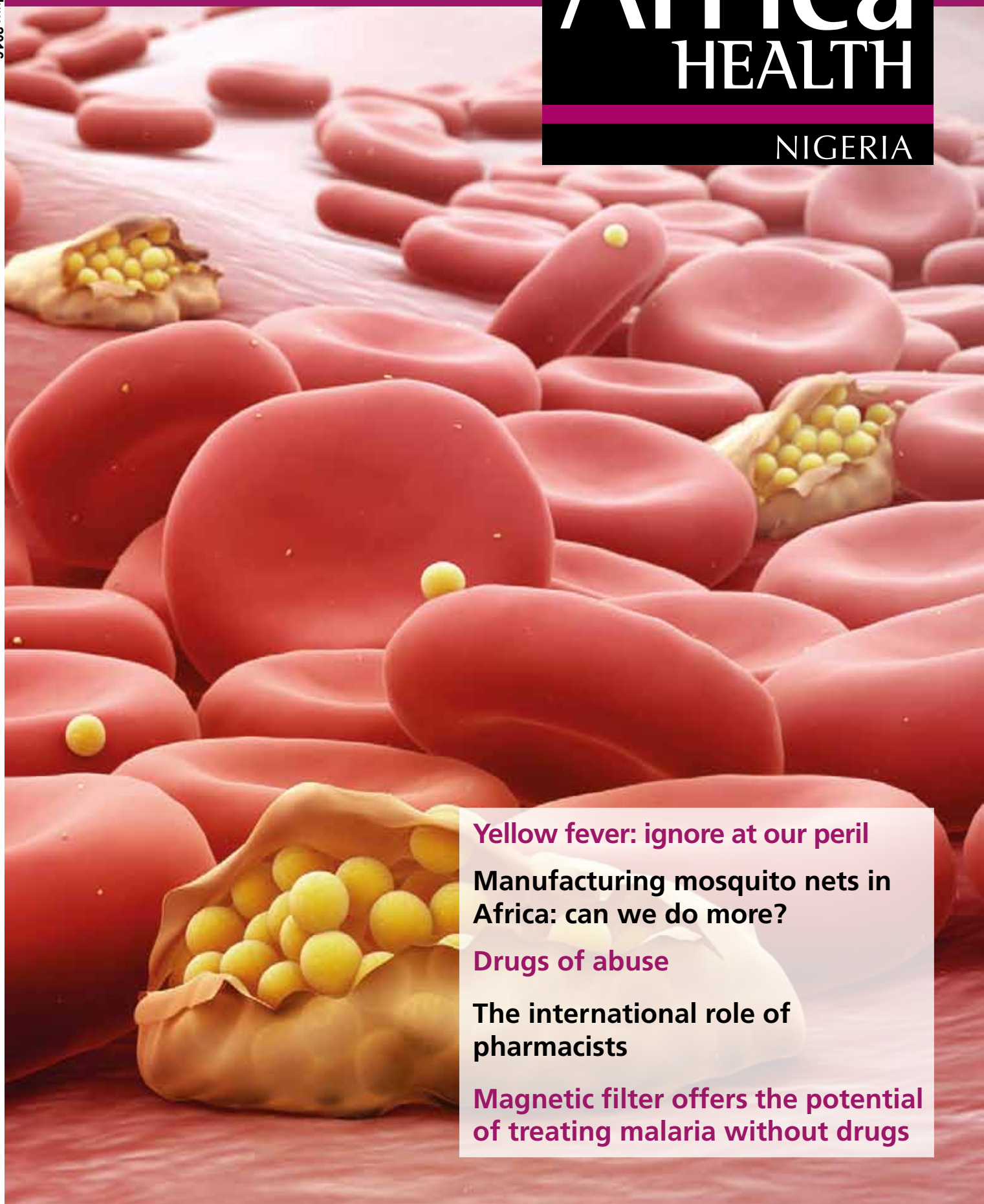

Yellow fever: ignore at our peril

Manufacturing mosquito nets in Africa: can we do more?

Drugs of abuse

The international role of pharmacists

Magnetic filter offers the potential of treating malaria without drugs

Contents

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Health for all… we have been here before

International health development has had its fair share of fads and slogans that in most instances tend to divert attention from what is important. One of the targets under the health-related Sustainable Development Goal – SDG 3, is to achieve Universal Health Coverage (UHC).

The World Health Organization (WHO) defines UHC as 'ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services'.

But the world has been in this situation before. Remember the World Health Assembly 1977 resolution of 'Health for All by the Year 2000'. The main social target of governments and of WHO was the attainment by all the world's people of a level of health that would permit them to lead a socially and economically productive life by the year 2000. It was envisaged that this global health goal would be implemented by ensuring access to essential primary health care and reduction by finite amounts of the burden of disease, disability and premature death.

It is on record that the Health for All (HFA) goal was never achieved due to several obstacles, in particular, the lack of political will to implement measures to achieve it. Fast-forward almost two decades after; the reworked HFA agenda in the guise of UHC claims to include improving financial access, as the major differentiating feature. Notwithstanding, as at then and now, it has been more about creating a movement in support of this concept, than taking concrete steps towards the reorientation of health services to achieve universal access.

Meanwhile, there are concerns that rather than policy reforms, management issues could be at the core of UHC. And the major problems faced by health managers at all levels may include: insufficient coordination to provide integrated service; inadequate information about finance and costs to improve efficiency; the problem of over- and under-utilisation of health services; and inadequate management of available human resources.

However, as the article in this issue on 'making the transition to universal health coverage' cautions: despite our presumptions, we need to further our knowledge on how to attain UHC within specific contexts. This would mean re-examining our initial hunches, as well as questioning the feasibility of transferring ideas from other jurisdictions, especially those from advanced nations.

Dr. Tarry Asoka

'Critical care in Nigeria is critical' says former Governor

A former state governor in Nigeria who is also a medical doctor, Dr. Emmanuel Uduaghan, has raised concerns over the state of critical care in the country. Fourty-three years after the first Intensive Care Unit was established in the Nigeria, the former governor said critical care in the country is still grappling with rendering optimal services.

While acknowledging that critical care is expensive across the world, Dr. Uduaghan said that the budgetary allocation committed to healthcare by the Nigerian government was very low compared to the 15% that was recommended by the World Health Organization.

Speaking on Challenges of Critical Care in Nigeria at the Annual General Meeting and Scientific Conference of the Critical Care Society of Nigeria, he recommended Public-Private Partnership as a possible solution to the change the status quo.

'There is need to increase manpower development, level of awareness on basic resuscitations among health workers,' he said.

He highlighted some of the challenges faced by critical care such as inadequate training, lack of infrastructure, poor maintenance of equipment among others. He added that effective healthcare financing can help to achieve effective critical care services in the country.

Nigeria's urine test for malaria wins US$25 000 Social Impact Prize

The Social Impact Prize of US$25 000 has been awarded to Dr. Eddy Agbo of Nigeria for his Urine Test for Malaria (UMT), which is a rapid non-blood diagnostic medical device that can diagnose malaria in less than 25 minutes.

More often than not, when fever is detected, anti-malaria medication is administered. However, not all fevers are due to malaria.

Also, the inability to quickly diagnose and commence malaria treatment can lead to various complications including kidney failure, build-up of lung fluid, aplastic anaemia, and even death.

Organisers of the award, African Innovation Foundation (AIF), noted that UMT detects malaria parasite proteins in the patient's urine with fever due to malaria.

'It is simple and affordable, and a potential game changer in managing malaria and saving lives across Africa,' organisers said in a statement.

Health insurance receives major boost in Nigeria at State and Federal levels

Photo credit: NY - http://nyphotographic.com/

At least seven States in Nigeria have taken proactive steps towards ensuring the wellbeing of its citizens by signing into law, a bill for the establishment of a State health insurance agency. The states include Lagos, Delta, Bauchi, Kaduna, Sokoto, Abia, and Anambra States.

In a related development, the National Health Insurance Scheme (NHIS) recently tackled health financing as a strategy to realise universal health coverage for Nigerians. It did this by putting in place plans to subsidise the amount of premium paid by all pregnant women and children under five years, who have registered in the Community-Based Social Health Insurance Programme (CBSHIP) for a period of three years in Bwari Area Council of the Federal Capital Territory, Abuja.

Flagging off the Bwari Area Council CBSHIP, the Acting Executive Secretary of the NHIS, Femi Akingbade, said that the target of the agency was to achieve the presidential mandate of ensuring universal coverage for Nigerians by the year 2025.

Health workers advised to collaborate to reduce mortality rates

In order to reduce avoidable deaths recorded in the Nigerian healthcare sector, health workers have been advised to collaborate.

This advice was given by the President of the Pharmaceutical Society of Nigeria, Pharm. Ahmed Yakasai.

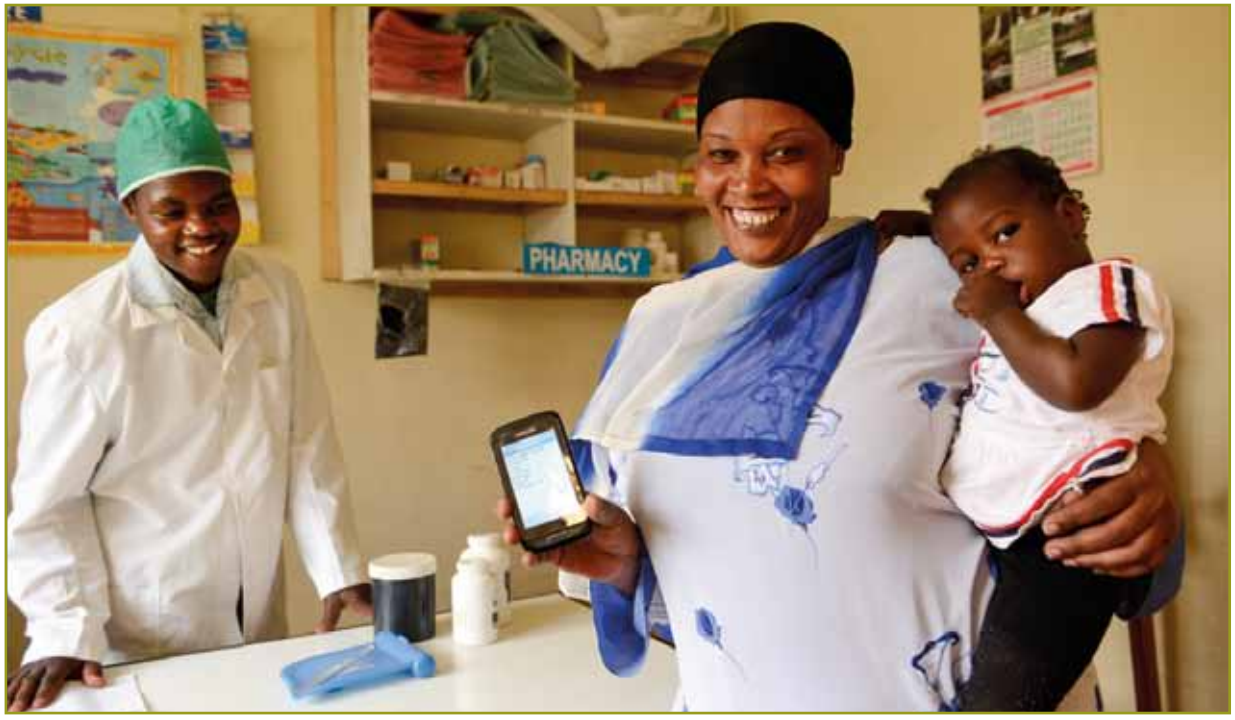
He noted that the recent collaboration between fellow pharmacists and other healthcare providers has started yielding positive results.

Speaking at the 10th annual scientific conference and exposition of the Nigerian Association of Pharmacists and Pharmaceutical Scientists in the Americas, which was held in Las Vegas, USA, he added that collaboration and team work were integral to the delivery of improved healthcare services in the country and reduction in mortality rate.

This is in line with the theme of the conference, 'Delivering Healthcare Through a Multidisciplinary Team Approach', which, according to Yakasi, 'is particularly interesting because clinical care is becoming increasingly complex with aging populations, increase in the incidence of chronic diseases like diabetes, cancer, HIV/AIDS and occurrence of co-morbidities'.

Deploying telemedicine to improve healthcare access in Nigeria and beyond

Chris Alagboso reports on the Doctor Gratis tele health platform that is serving many communities, and attracted quite a few Nigerian doctors as advisors



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According to AfricaPedia.com, Nigeria's doctor-patient ratio (per 100 000 people) is 28, which suggests that Nigeria does not have enough doctors – or other medical professionals – to meet for the health needs of its people. This index becomes worse by the consistent emigration of qualified medical professionals from the country to developed countries in search of better opportunities, leaving the care of the over 170 million citizens in the hands of the few thousand doctors that choose to stay behind and cope with the inadequate health infrastructure.

The imbalance between local demand for health services and available hands led to the search for newer and more efficient ways to fully utilise and maximise the health professionals Nigeria has. This prompted the desire for solutions that allow healthcare seekers to connect with healthcare providers on demand thus opening up opportunities for innovators to address a very important need while helping to alleviate the challenges faced by patients when they need to access care fast or get second opinion on a diagnosis or treatment course.

With Nigeria's peculiar and complex health system, telemedicine has become an area that will help drive universal access by creating affordable access to providers, it also becoming an avenue to put Nigeria's health innovation space under the continent's spotlight and there are numerous solutions in the Nigerian market with spotlight-worthy potentials.

Kangpe is a web and mobile application that connects patients with health experts and let users ask questions and get answers from real doctors. When they ask questions, they are able to get answers based on frequently asked questions. They can proceed to download the mobile app and have a real-time chat with an expert if they have more questions.

Another forward-thinking service takes telemedicine to the next level by making it possible for the patients to not only connect health experts, but also have live chat with them in order to ensure effective diagnosis. The service, Doctor Gratis (which translates to free doctor) was founded by Dr. Jacques Durand and it offers free telehealth services to users.

Speaking about the platform, Dr. Jacques said it is the first of its kind in Africa and offered in two languages.

'It's the first 'telemedicine without borders' available in all African countries both in English and French. We offer online consultations for free to anyone who has a

smartphone. Doctor Gratis means free doctor. We pay doctors to provide answers to your medical issues using the live chat system within our mobile application and our mini website.'

He started the service after working in Nigeria for about ten years and realising the potential and quality of doctors produced by the various medical institutions. The company originally launched in Indonesia and later some African countries using doctors from Nigeria. It was finally launched in Nigeria in 2015.

Speaking on the acceptance of the platform, Jacques said it's a service that is needed in every part of the world even in very developed nations and the doctors from Nigeria have helped patients from US and UK even though doctors from developed countries are better at offering online assistance.

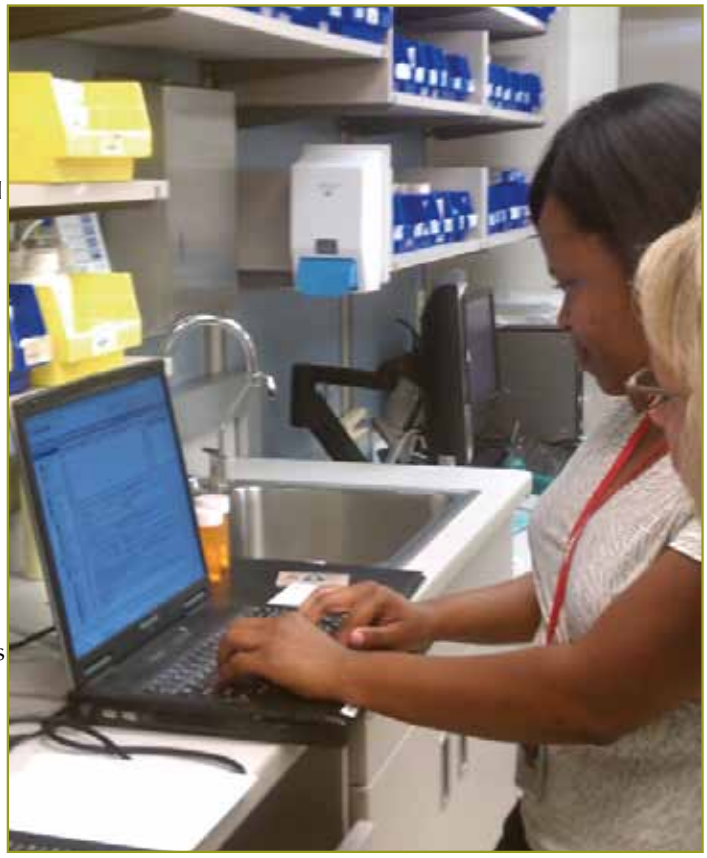
'Doctors from developing countries are much better online for giving medical tips. As they know how to manage various situation sometimes without a lot of medical facilities. The idea of Doctor Gratis is to be giving tips, reducing people's stress and offering them a good orientation. Nigerian doctors are good at this, so we are happy to open the service to Nigerian patients. We give personalized answers to anyone.'

Sometimes the difference between a dead patient and one that lives through a health condition is the speed at which they can access medical advice. Even the simplest and seemingly trivial health information can save a patient's life if given by the right person at the appropriate time. This fact coupled with the boom of smartphone usage in the country has helped and will continue to help telemedicine and digital consultation practice thrive in the health industry.

'In Nigeria, the number of smartphone users is booming, and these users need to have access to rapid and simple medical tips. Yes, we are just a hotline, but people can interact with doctors as if it were a real physical consultation. It is very easy to explain what people suffer and their symptoms. During epidemic crisis, it's always better to educate people and avoid panics or bad behaviors. Using live chat is also the best way to collate the symptoms and reduce peoples' stress,' Dr. Jacques said.

Dr. Jacques revealed that most of the inquiries made on the Doctor Gratis platform are mostly about women's health and they are the major users of the platform.

He said: 'They inquire about pregnancy, sterility, and gynaecological problems. Our live chat is anonymous as we don't ask for the real name of the person, so women feel more comfortable to discuss their personal problems with our doctors. We are glad to help women in Nigeria to get simple and rapid information but it is worthy to note that we don't replace a consultation to a doctor, we just give tips and orientation. We see that conversation in Nigeria are more straight forward than in Asia. Nigerian women and men are asking very direct questions about their medical issues. We also have conversation about kids.'



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Speaking on future plans and dream for Nigeria, Dr. Jacques said: 'We are looking to go very progressively in Nigeria, the first step would be to make a bigger promotion and learn more from the new traffic it will generate to adapt the concept to the local culture. If we find a local sponsor who wants to support our action in the media or with existing stakeholders in the healthcare sector, we will be happy to work with them on the service. The idea is to help Nigerians to visit the doctors if they need it. We will like to work with local partners to establish the continuum of care.'

'We are a social enterprise; we will be happy to have a Nigerian in our company who will be the person in charge of all Africans countries for Doctor Gratis. Someone who has the passion to make Nigeria the best showcase of what free telemedicine can do to improve health outcomes at a large scale, and present this success to other African countries.'

According to him, Nigeria has the capability to take the lead in telemedicine for the continent and his platform is willing to take active roles in ensuring that the nation achieves just that.

'We are open to promoting Nigerian partners and colleagues in our global expansion as 'Ambassadors' of the benefits of Doctors Gratis for African countries. More people from Nigeria will use our service, it will be an African success story because size matters. We are already happy with what we have started. Our Nigerian doctors are helping US patients every day and these patients are happy about the doctors' services. So the dream is already a reality, we just need to make it bigger,' he said.

Making the transition to Universal Health Coverage: matters arising

Dr. Tarry Asoka highlights the complexities of delivering UHC when the extent of health services, and of financial resource are both seriously deficient

There is good evidence[1,2] to suggest that the reason why the vast majority of the population in Nigeria cannot use the healthcare services they need is partly because the services are not available or the direct out-of-pocket payments that are needed at the point of care prevent them from having access. Therefore, the idea of Universal Health Coverage (UHC) as a major component of the Sustainable Development Goals has been a welcome development, whereby people who need healthcare services are able to gain access to the healthcare they need without experiencing financial hardship as a result.[3]

However, worried by the unsatisfactory state of healthcare delivery systems to deliver UHC across the globe (in high-, middle-, and low-income countries), a very recent editorial in the *BMJ*[4] concludes that '… good intentions are a start but they are insufficient'. This author[5] much earlier also expressed such concerns that a good quality healthcare delivery system is vital to achieving universal access and financial risk protection for all citizens in Nigeria. But of greater concern to the *BMJ* editors and their colleague is the fact that there is vast gap between the two interrelated components of UHC - (i) coverage with needed health services (prevention, promotion, treatment, rehabilitation, and palliative); and (ii) coverage with financial risk protection. Moreover, 'that vast gap is mainly due to deficiencies in knowledge about both optimal approaches to financing and effective models for healthcare delivery'.[4] They assert that this is so because each nation is unique with a different set of needs and a different path to achieving UHC. In addition, little is known about how best to deliver what is known to work.

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We are not unaware that previous attempts at improving the equity and efficiency of health service delivery in many developing countries (including Nigeria) through health sector reforms were very disappointing due to several perceived reasons. First, it was observed that the complexities of organising better service provision in the health sector go beyond technical fixes to include political dimensions that require the proactive management of stakeholder interests.[6] Moreover, the lack of success with health sector reform was blamed partly on over-concentration of attention on the content of the reforms; while neglecting the actors involved in policy reforms; the processes contingent on developing and implementing change; in addition to the context within which policy is developed.[7] But of serious concern was the wholesale transfer of new ideas that were being tried out in advance health systems to the developing world.[8]

Consequently, short of allowing history to repeat itself, those of us in Nigeria that are helping the Federal Government along with its federating units - the States, to make progress towards attaining UHC must help them to make better decisions on how best to achieve the goals of UHC in the face of scarce resources. As the *BMJ* editorial suggested,[4] we need to further our knowledge and insights on how to do UHC properly by undertaking research that is context specific even where there are generalisable principles. In Nigeria, this would translate to obtaining localised-knowledge beyond State and Local Government Area administrative levels, but in relation to where established populations are situated - in cities, towns and villages, in line with their history, culture and values.

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A responsibility towards palliative surgery

Shima Gyoh argues passionately for surgical respect for those living with awful and debilitating cancers. They may have presented too late, but that is no reason to send them away

The Nigerian surgeon's work in the last few decades has been dominated by late presentation of diseases. It got a little better, but has recently got worse again: a reflection of economic circumstances. Patients with cancer arrive with their disease at the stage usually described as 'inoperable', meaning it has gone past the stage where any curative operation is feasible. The stage is marked by widespread metastases in the liver, lungs, peritoneum or skull. The patients are often very sick and many cannot withstand major operations. Should we simply give up, withholding measures that would increase their strength and prolong their lives even if for only a few days? When you come up against such ethical issues, do you adopt the hard scientific line, convincing yourself that, 'This is a poor country. We have severely limited resources and we should deploy them for the patient with a reasonable chance of surviving for a reasonable length of time at a reasonable quality of life?' Thereafter you send the patient back to the village to die in the company of their relatives, usually expected to be within a period of a few months? Such thinking, in my view, strictly belongs to a machine into which clinical and economic data are fed. The machine has no eyes, ears or emotion, and knows nothing about the distress of relatives. The responsibility of doctors to their patients is different, and can be summed up in these lines (I cannot remember their source):

To comfort – always,
To heal – sometimes,
To abandon – never!

Doctors should strive at all times to save and preserve life, and to give up only when it slips away beyond grasp. This is a highly loaded principle that can lead to complicated if not loss of logic in the worship of human life that returns like a boomerang to confer machine-like reasoning to the holder! We are here concerned with patients with advanced conditions, whether one should do an expensive palliative operation when the patient is not expected to live beyond a few days.

Figure 1 is the picture of advanced carcinoma of the breast, locally invasive of the chest wall, with evidence of metastases in the liver and lungs. It is a huge fungating ulcer giving off such offensive stench that becomes the dominant discomfort within a few minutes of her entering a room. It was a punishment for any other person to remain in the same room with her for any length of time. The doctor has an obligation to do something to enable relatives and friends keep her company without the ordeal of fighting overpowering nausea. It is always possible to do a non-curative removal of the ulcer and cover the huge area with skin flaps or graft, accepting that the prevention of local recurrence is not necessarily the objective.

Figure 1 Another similar problem is malignant melanoma

Figure 2

of the foot that has metastasised to the liver and lungs and produced a huge fungating ulcer at its secondary deposits in the inguinal lymph nodes through which the femoral vessels course. Many surgeons conclude that the tumour cannot be removed without diving these vessels, and offer the patient amputation. Some of the patients, well aware that they do not have very long to live cannot see the point of losing their mobility in the few days left to them and reject amputation. The doctors decline to do less and discharge them. Although the tumour invades the tissues around the femoral vessels, desperate efforts to do something for these patients led me to attempt removal of the ulcers. I was to find that, where there is no ischaemia of the leg, the growth hardly penetrates beyond the vessel adventitia. Consequently, it is often possible to carefully peel it off and preserve the bloos aupply in a 'walk of tight-rope surgery', remembering that one is not attempting a curative procedure. One can do a lot with blunt finger dissection. Bits of tumour are often left rather than risk damage to the vessels, thus raising the possibility of local recurrence. My attitude is that when I reach the bridge of local recurrence, I would consider how best to cross it. Patients are delighted to be rid of huge offensive groin mass without losing their leg. They often go with dignity before any local metastases have time to present a similar nuisance again.

It is not that one is always able to do palliative procedure as some of the problems defy even the most innovative approach, mostly because they present at a stage when the general health of the patient is also on the knife edge, and the family cannot afford even the basic clinical investigations. Figure 2 shows a young boy who was in an extreme condition of inanition. The size of the sarcoma on his chest made any attempts at its removal, even if only 'debulking' a major operation. Efforts to improve his health resulted in faster growth of the tumour, and there was no visible benefit from chemotherapy. We did not have radiotherapy, and he was too weak to survive the journey to the nearest centre where it was available: five-hour drive over very rough roads at the end of which his family would hardly be able to afford the hospital registration fees! They were very poor, and we had been supporting his feeding and medical investigations. The state social services had nothing to offer.

This is an exceedingly common ethical conundrum we face in our work even for patients with perfectly curable conditions. Doctors in private practice often discharge such patients and advise relatives to take them to public hospitals. We in public service are subjected to these highly brutalising factors in our professional lives from which we cannot escape. This has contributed to my feeling that every Nigerian surgeon should be deft at palliative operations, for sometimes they are the only assistance you can give the very poor at the time when neither the social services nor the health insurance scheme are anywhere near help.