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Primary care again under the spotlight

This journal has repeatedly returned to the issue of Nigeria's primary care sector development… or lack of it. We've opined over the complex relationship between Federal, State and local Government, and we've pondered over whether the National Health Act can provide the impetus to deliver the intended service, but we've usually ended up simply wringing our hands at our inability to intervene effectively and make things happen.

This issue ought to hit a few raw nerves. In the two articles by Felix Obi and Shima Gyoh, the abject realities of the situation are laid bare. Primary Health Care (PHC) is not working because it is not funded, and all too often no one is taking responsibility. Health workers are developing a parallel 'service' which involves significant quackery and untold danger to life to those forced into using some of the centres.

We can only hope that the current Federal plan to revitalise 10 000 primary care centres can be rolled out in record time. As Professor Isaac Adewole noted at the launch 'If our PHC system works well, 70% of our health problems will be covered'. But as we all know it is not just about getting funds from the Basic Healthcare Provision Fund allocated, the staff need managing. From our findings, there is a 'wild West' out there of people delivering care with little training and no supervision. It isn't their fault, it is the system which has left them to fend for themselves and do what they believe is the right thing. A mountain of change is needed and it is perhaps encouraging that the National Primary Health Care Development Agency is targeting a realistic initial intervention of just 109 centres for revitalisation. Getting the infrastructure right is a small part of the equation, getting the right staff appointed, motivating them, and then supervising them adequately is the much trickier part of the equation. But unless this aspect is truly addressed, and funds are set aside to ensure continuity of the process, then the initial spend on revitalising the infrastructure will simply be a waste of money and time. Nigerian's deserve better.

A revealing insight in Shima Gyoh's article was the comment that the centre he visited in Benue State was surviving in part because a percentage of the wages of the staff was being paid out of the President's Emergency Plan for AIDS Relief (PEPFAR) funds as distributing antiretrovirals was a part of the centre's role. I wonder if anyone has considered what might happen to the PHC system if President Trump reels in the PEPFAR programme? Indications are that he won't do this (Congress won't let him) but with a president who changes his mind quite as much as this one, who knows! But the reality is that a significant proportion of Nigeria's public sector health delivery is dependent in one way or another on continuing aid flows. It would make for an intriguing study to ascertain how much?

Bryan Pearson

The new push for the revitalisation of Primary Health Care in Nigeria

In the first of two special reports on Primary Health Care, Felix Abrahams Obi reports on the huge challenges facing the sector, and on those wishing to breathe new life into it

Recently, I was part of a federal delegation that visited some primary health centres (PHCs) in one of the states in the South-East. We chose the highest category among the class of PHCs; that catered to a large population within their catchment areas. For the delegates, what we saw shocked us. Majority of the PHCs all operated far below their potential to deliver the basic minimum package of essential services that was envisioned for delivery at the PHC level. We met mainly pregnant women attending antenatal classes and nursing mothers who brought their children for immunisation and other childcare services. While the facilities have not been renovated in the last couple of years, what is more troubling is the sorry state of the delivery couch and lying-in beds and other basic equipment needed for providing care to patients. It is not surprising that although Nigeria has over 30 000 PHCs, only about 20% of these facilities are functional to some degrees.

From this experience, some things stood out for me:

a) PHCs lack operational budgets

The PHCs are expected to be funded by the local government areas (LGAs), but they receive little or no budget to cover their operational costs for essential drugs and consumables. Where drug revolving schemes operate, they literally are run by the PHC staff that is 'in-charge' of the facility, who make arrangements with private pharmacies or patent medicine stores to get their supplies, and patients may not be so sure of the quality of drugs they are provided. With no budget to cover operational costs, patients are constrained to buy the basic things needed for their care: drugs, syringes, gloves, bandages, you name it. Those that have bank accounts hinted that they were opened for them by a donor agency which sends money to PHCs for specific outreaches and immunisation campaigns.

b) PHC staff are owed salaries

Although the PHC staff in most of the facilities we visited were owed salaries for a couple of months, they still did not abscond from their duty posts. On further scrutiny, what became clear was that they had inadvertently turned the facilities into their 'private consulting clinics' where patients are treated and after remitting the needful to the LGA coffers, the rest they used to maintain their families and any excess was used to run the clinics. And if the LGAs are only interested in revenues generated by PHCs they may lack the ethical grounds to confront the problems faced by PHCs.

c) PHCs are underutilised

We visited a PHC facility within a sprawling community but it had only one patient; a woman in labour, and from the records, an average of three patients attend that PHC daily. On further enquiry, we learnt that although lots of women register and attend the antenatal classes, they literally deliver in religious homes or attended to by traditional birth attendants (TBAs), and one would have thought TBAs are only popular in Northern Nigeria where skilled birth attendants are limited in supply. If Nigeria is to provide universal health coverage to population, barriers to access to care at PHCs need to be addressed, otherwise these facilities will only be mere buildings.

d) Supportive supervision of PHC staff

If PHCs are properly monitored and supervised regularly by the state and LGA authorities, some of these operational and technical challenges can easily be identified and addressed promptly. And save for opportunities to attend workshops organised by donor agencies for their respective programmes, majority of PHC staff rarely undergo continuous professional development programmes organised by the state or LGA.

Rebuilding trust in our primary health centres

The neglect suffered by PHCs over the years may have contributed to the general apathy and lack of trust in the quality of services they offer by the citizenry. For the PHC Revitalisation Programme being implemented by the Federal Ministry of Health (FMOH) and National Primary Health Care Development Agency (NPHCDA) to succeed, extensive engagement with the state governments, LGAs and host communities (where Phcs are located) need to be done. Beyond the renovation of dilapidated health facilities and replacement of dysfunctional equipment with new ones, there has to be discussions on how the states and LGAs can ensure the regular provision of budgets to cover operational costs for providing care by these PHCs. Lack of operational budget or impress has been the bane of most PHCs, and

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Photo credit: by USAID Africa Bureau (Angolan woman with children outside health clinic) [Public domain], via Wikimedia Commons

the responsibility lies squarely with the state and LGAs in this era of PHC-under-One-Roof (PHCUOR).

In the proposed 2017 budget, NPHCDA earmarked substantial amount for the revitalisation of about 1000 PHCs across the country, and it is hoped that beyond the refurbishing of these facilities, government will cover their operational costs as well. One headache that PHC advocates grapple with is the sustainable financing of one of the key pillars of PHC; routine immunisation. With Nigeria's graduation from GAVI support on course, one wonders what plans have the state governments and LGAs have put in place to bridge the gap in funding occasioned by this development, against the backdrop of declining government revenue. The FMOH has proposed setting-up an Immunisation Trust Fund to provide financial cushion when donors leave, and sustainable financing of services offered at PHCs should be one that federal and state governments should take seriously. And if other donors will continue to support the delivery of immunisation services at PHCs after the final exit of GAVI, the weak fiduciary systems that encourage embezzlement of government and donor funds need to be strengthened, and it is commendable that the new Executive Director of NPHCDA, Dr. Faisal Shuaibu sees this as one of his priorities.

Addressing workforce challenges through adoption of primary health centres by higher levels of care

Most PHCs lack the right number and mix of qualified personnel needed to provide the basic minimum package of services. Although several schools of nursing and midwifery produce nurses and midwives regularly, many of them remain unemployed while our PHCs suffer from lack of qualified personnel. When not guaranteed the access to quality care, patients are constrained to seek care at general hospitals and tertiary hospitals. Moreover, the referral system in Nigeria lacks gatekeeping process that ensures the seamless referral of cases from lower to higher levels of care. While that may not be sorted out in the nearest future, the idea of secondary and tertiary health institutions adopting PHCs within their catchment areas have been advanced by experts. House officers and resident doctors-in-training can gain additional experience consulting in PHCs, and Society of Gynaecology and Obstetrics of Nigeria (SOGON) have also considered having their members help deliver babies at PHCs where skilled birth attendants are often lacking. When patients within a community know that doctors will visit their PHCs on specific days of the week, their confidence will likely rise and the apathy will fade with time. May it's about time this notion of adopting PHC is institutionalised and sorted out. Managing the fragmentation of duties among PHC cadre staff at the LGA level appears tricky with Environmental Health Officers working in isolation from Community Health Extension Workers (CHEWS). And with the planned engagement of 200 000 Village Health Workers by NPHCDA across the country, there is need to critically review the dynamics that played out since the introduction of CHEWS into the health sector.

Conclusion

Overall, the plan by the government to anchor its universal health coverage agenda on the revitalisation of the PHC system is commendable. It is imperative for the FMOH and NPHCDA to continually interrogate the implementation process and review lessons from past PHC revitalisation schemes to ensure that refurbished PHCs don't end up as abandoned buildings overgrown by grass. The community and LGAs remain a vital link in the PHC value chain, and their engagement, participation and ownership of the whole process is crucial for its success. After all, PHCs belong to the people in the communities where they are located, and for whom they were established.

Unsupervised, unadopted, and unhealthy

Shima Gyoh pays an unscheduled visit to a Comprehensive Health Centre in Benue State. Sadly, his findings are probably typical of many such centres

Nigeria has just produced the third edition of its National Health Policy. The first, launched in 1988 had a three tier structure with primary health care (PHC) as the foundation, secondary health care consisting of general hospitals as its main body, and teaching and specialty hospitals at the apex. It has been tweaked, but the structure remains the same.

There is no doubt that if the country had properly secured the foundation, the picture of the health of the people would have been very different. The foundation was unfortunately neglected, thus compromising the integrity of the entire structure. Comprehensive Health Centres (CHCs) were the most advanced stage of PHC. Often compared to 'cottage hospitals' they were supposed to function as such for relatively minor conditions and to have a resident doctor and Community Health Officers (CHOs). Their services were primarily outpatient, and they would have facilities for rapid transfer of emergencies to their supervisory hospitals. They were supposed to be strong in laboratory services, have portable X-ray facilities and adequate pharmaceutical services to supply the drug needs of patients. The resident doctor would provide outpatient clinics, conduct some minor operations and admit patients that needed observation for a few days. How does the neglect of PHC affect these Centres?

On Tuesday 21st February, I visited the CHC at Garagboghol, Shorov District of Buruku Local Government. Although it is part of the health services of a religious organisation, the NKST, it was involved in the development of PHC networks of the 1980's Federal Government efforts to establish PHC units in a number of states that could be replicated by each State Government to cover its entire area of jurisdiction. These efforts fizzled out and the facilities degenerated, and the state of affairs at this centre represents a stage many might have gone through.

The institution occupies sprawling grounds beside the Gboko—Katsina-Ala road ten minutes' drive from its supervisory hospital at Mkar, though the road itself has become so degenerate that it takes half an hour to sink and rise over the numerous potholes and rubble over the sharp-edged corrugations pock-marking the surface of what was once a tarred road. It is headed by a Community Health Extension Worker (CHEW), who conducted me around and gave the information in this narrative. She said a doctor from Mkar pays about two administrative visits a year, but their 'Health Training Institute' receives more frequent attention.

The CHC has a reception area, a pharmacy, a laboratory and two admission wards. There is a delivery room that also serves as the operating theatre. It has a department of medical records, and a cashier. The pharmacy boasts of a split unit air conditioner in the drugstore and three refrigerating units, but all electrical appliances do not work because the power that occasionally reaches the centre for short intermittent periods is too weak to work any machine, and here is no generator. The staff that runs their email services uses his small personal generator. The facility cannot keep temperature sensitive drugs and vaccines. It has only one borehole with a hand-operated pump, and no installed pipes for distribution of water. It is obvious that hand washing would be quite a process. Lack of power supply would make it difficult to work after dark. The premises also accommodate a busy private mortuary that preserves bodies by embalmment.

The centre has a staff strength of 19 headed by a CHEW of which there are two plus a junior CHEW. There are two lab attendants, five auxiliary nurses

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.

and birth attendants, all PHC trained. The rest of the staff consist of laboratory attendants, a laboratory technician, cleaners and guards. There are no

supervisory clinical visits from anywhere. Although I arrived just before midday when activities should be at their peak, there were no patients around. I was told the average daily attendance was between five and 10, and 10 others attending for HIV services. The Centre is therefore not financially viable, and staff salaries are subsidised by donor agencies that fund HIV and malaria services. It would appear that most patients patronise numerous health institutions situated at Tyowanye, the village market located about two minutes' drive up the road. These are run by private practitioners who were once associated with hospitals as nurses or attendants, but none with formal medical training. Their services include surgical operations!

There is no doctor and no staff of CHO grade. The institution treats malaria, malnutrition, diarrhoea, hepatitis, HIV, and provides midwifery services. They sometimes have cases for operation, like acute appendicitis or strangulated hernias. They call a Theatre Attendant who (illegally) practices surgery.

Theatre Attendants were 'trained' by the health services of the NKST Mission and widely used in the past, resulting in high mortalities and many complications such as urinary and faecal fistulae. Hysterectomies in attempts to arrest torrential haemorrhage were sometimes done without informing the patients as I found out in 2004 when I was at the receiving end as the Medical Superintendent of the NKST hospital, Mkar. I stopped the system at that time, but the activity of these Theatre Attendants masquerading as doctors brings in considerable revenue to the NKST Mission, and despite the powerful reasons I advanced, the church remained ambiguous and silent on the issue. The most frightening nightmare in this Centre is that Birth Attendants are conducting deliveries on pregnant women who did not have antenatal care and in the absence of any ambulance to rapidly covey life-threatening emergencies to the hospital. With the only health institution that could give them reliable services abandoned, the inhabitants, often too poor to seek for alternatives, are constrained to patronise services of quacks and poorly trained practitioners, and to accept without complaint every death and complication as the will of God.

The CHC supports an 'Institute' that trains birth attendants, laboratory attendants and voluntary health workers. The intake for this one-year programme used to be around 30, but is now 22. The students pay fees which constitute the bulk of the remuneration for their teachers. Teaching is supplemented by lectures from the local government staff and some from the private sector. At the end of their training, they are certified by the School of Health Technology at Mkar. They work for NKST, private institutions or set up their own unregulated private practices.

The staff claimed that the Centre receives adequate quantities of antiretroviral drugs which are distributed free to patients. Although it has the staff, the Centre cannot provide laboratory

services for lack of appropriate machines, reagents and power. Blood samples for CD4 count, for example, are sent to Adikpo, further away than Mkar to a laboratory that belongs to an international donor agency that does it free.

The Federal Government has recognised the crying need to resuscitate PHC, but it is not clear which tier of government would do it. The local Governments whose job it really is are presently the weakest tier. In most states, they have been converted into the political agents of state governors. Instead of conducting democratic elections, the governors appoint their political acolytes as caretaker committees. If the government's stated intention to achieve universal health coverage through PHC is to be realised, the present uncertainties surrounding its implementation need rapid solution. I understand that some state governments, namely Gombe and Lagos plan to implement PHC through partnership with the private sector. This would be exciting, but what would be the role of the Local Governments? Comprehensive Health Centres should constitute the seamless interphase between primary and secondary healthcare services and their strength and ability to efficiently transfer emergencies higher up the system are important determinants that would attract the public to use PHC rather than kill it by going straight to the hospitals with even minor complaints.

Co-developing a new kind of partnership to improve the quality of health services in Africa

Lopa Basu and colleagues report on a special USA/Africa initiative to champion patient safety

The partnership-based approach between hospitals is a proven mechanism to strengthen relationships, promote bi-directional learning, and provide a sustainable platform for co-development of ideas and implementation approaches to improve healthcare. One example of a successful partnership is the World Health Organization (WHO) African Partnerships for Patient Safety (APPS) programme that has been implemented in over 20 African countries since 2009. APPS is based on hospital twinning partnerships, whereby a hospital in a high resource setting is partnered with a hospital in a limited resource setting with the goal of improving patient safety and quality. APPS advocates for patient safety as a precondition of healthcare delivery and catalyzes a range of actions to strengthen health systems, builds local capacity, helps reduce medical errors and prevents patient harm. The programme acts as a conduit for patient safety improvements that can spread across countries, uniting patient safety efforts through bi-directional learning through partnership exchange visits and virtual communication through regular phone calls.

The Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality (AI) launched an AI-APPS partnership in 2014 with three hospitals in Africa: 1) Jackson F Doe Hospital, Liberia, 2) Kiir Mayardit Hospital, South Sudan, and 3) Kiwoko Hospital, Ugandan Protestant Medical Bureau (UPMB), Uganda. AI-APPS kicked off its partnerships during a three-day meeting in Baltimore, USA, with the fundamental belief that co-development of solutions is critical for the success and sustainability of any initiative. Attended by staff from three African hospitals, WHO Service Delivery & Safety Department and AI, the partners worked together to define the principles of their partnership and co-developed a partnership plan focusing on key patient safety action areas of interest to the African partner hospitals, including hand hygiene, healthcare waste management, infection prevention, safe surgery, and medication safety.

AI's mission of partnering with patients and loved ones from a place of respect and humility to end patient harm, improve patient outcomes and eliminate waste from the system provided an environment of continual learning. In this setting, validated quality improvement tools that have been widely used in the US were adapted for use in local African hospital settings. Through technical exchange visits and phone meetings, the AI-APPS partnership has highlighted three key learnings:

1) Local patient safety hospital champions are the primary agents for implementation and change;
2) Local innovations for quality improvement has the potential for sustainability and regional spread;
3) South-to-South learning is essential for sustainability. AI's principle of doing things 'with people' instead of 'to people' has shaped the collaborative nature of the relationship, and this principle is the cornerstone of the partnership.

Local patient safety champions are critical in generating ideas, getting buy-in from frontline staff and creating innovative approaches to fit local context. Dr. James Nyontinyo from Kiwoko Hospital in the AI-APPS Uganda partnership is an example of one such champion. A chief surgeon who is well-respected by patients, hospital staff and national level stakeholders, he has promoted the implementation of hand hygiene, health care waste management activities and the Comprehensive Unit-based Safety Programme (CUSP). CUSP was developed at AI and is a systematic approach that has been shown to reduce hospital-acquired infections in the US. Recognising the success of the CUSP trainings for healthcare providers, the AI-APPS team launched the first African CUSP training at Kiwoko hospital that focused on using multidisciplinary teams to understand the science of safety and identify system-level defects to avoid patient harm. Noting that this type of training needs to be adapted to fit the local context, CUSP was adapted in several ways including

Lopa Basu, Nancy Edwards-Molello, and Albert Wu are from the Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality.

utilising local vocabulary in the training materials and extending standard one day of training to two-days to permit more group learning and dialogue. Champions such as Dr. James and lead nursing staff at Kiwoko hospital played a key role in promoting the CUSP model by directly participating in the training and modeling the approaches described in CUSP. Dr. James explained the impact at his hospital: 'Before CUSP there was a sense of despair-knowing what was unsafe but feeling disempowered to speak up and save the day. During the introduction of CUSP it was very difficult to comprehend the concept though we felt we needed a solution to our challenges regarding patient safety. It feels more comfortable to be motivated by patient safety than by fear for litigation. Slowly the hierarchal culture is crumbling and some of the most feared doctors are beginning to embrace and ask for alternative to getting things done mentioning if CUSP could help. During some challenges faced I have heard some staff say 'CUSP will help solve that'.'

Similarly, Dr. Lawrence Sherman from the APPS-AI Liberia partnership is the CEO & Medical Director at Jackson F. Doe (JFD) Hospital in Tappita, Liberia is another local champion. He has engaged with national stakeholders on quality improvement activities and findings from JFD will be shared with other APPS partner hospitals in Liberia, including other APPS Liberian hospitals and their partners including Nagasaki University in Japan and ESTHER France. Dr. Sherman explains: 'The regional spread of information and knowledge within Liberia and other APPS Network has been invaluable, not because it provides information on the methods of how others have achieved sustainable and quality healthcare in their own setting, but because it provides us with an opportunity to participate and design our healthcare practices to conform to the dynamics in our own locale. The APPS Network will continue to be the platform for sharing rather than one of imposition of ideas and realities that may be solely alien and not applicable in all settings.'

In addition to partnership exchange visits with AI team members to JFD, exchange visits have also included national and subnational level stakeholders and other APPS partners working with hospitals in Liberia. The next phase of engagement will include a cross learning session between APPS partners including Nagasaki University staff with AI staff on specific tools and trainings used by each partner group. This engagement will serve to enhance each of the twinning partnerships. National level stakeholders from the Liberia Ministry of Health have been committed to this partnership-based approach and understand the critical need for regional coordination and shared learnings on facility level quality improvement efforts. Continued engagement with national level stakeholders in Liberia and twinning partners in Liberia including ESTHER France are promoting sustainable mechanisms for shared learning both nationally and globally.

In an effort to enhance technical capacity for local patient champions, the APPS-AI team has learned that sharing stories from local context including challenges and successes for quality improvement approaches is a key opportunity. With a focus on hand hygiene for infection prevention, the Kiwoko hospital pharmacist travelled to Kisiizi hospital in another region in Uganda to learn how to produce local alcohol based handrub (ABHR) using the WHO Guide to Local ABHR Production. Kisiizi hospital was one of the first wave APPS partners in 2009 and was well-experienced in producing local ABHR and after the APPS-AI programme launched, the opportunity to have the Kiwoko hospital pharmacist learn from a local Uganda pharmacist on how to produce the ABHR promoted shared learning and also helped to strengthen relationships across the Ugandan Protestant Medical Bureau (UPMB) network, where both Kiwoko and Kisiizi hospitals are partners. Furthermore, due to the security challenges for Hopkins AI staff to travel to South Sudan, Kiir Mayardit hospital staff traveled to Kampala, Uganda twice for in-person patient safety trainings which included hand hygiene, patient safety culture and healthcare waste management. Kiir Mayardit physician and local patient safety champion, Dr. Nyok Bol explains: 'This partnership, with inclusion of South-South learning, builds the capacity of the health care providers in South Sudan and allows us to catch-up and be updated with the dynamic changes that are happening in the field.'

The AI-APPS programme has built a strong foundation of bi-directional learning as a platform for facility-level quality improvement. Engaging with local patient safety champions and promoting technical capacity building training programmes through South-South learning are critical factors in the co-creation of a successful partnership. Solutions that have been adapted to the local context and creating mechanisms both virtual and in-person to strengthen relationships between people have continued to promote knowledge generation on quality improvement efforts at the facility level. This programme is a concrete example of how to reach the Sustainable Development Goal 17 to revitalise global partnerships and can be a model to improve quality health services in Africa and beyond.

African Partnerships for Patient Safety (APPS) was established in 2009 in response to the political commitment on patient safety emanating from the WHO AFRO Region. The programme engages closely with WHO Member States and frontline healthcare professionals in an area of the world where advancing safety and quality of care has been very difficult. APPS has had a recent name change to Twinning Partnerships for Improvement (TPI) as hospital partnerships have expanded beyond the African region.

Please visit the following link to learn more and register for APPS: http://www.who.int/patientsafety/implementation/apps/en/

And to learn more about TPI please visit: http://www.who.int/csr/resources/publications/ebola/twinning-partnerships-package/en/

Reference

http://www.who.int/gpsc/5may/Guide_to_Local_Production.pdf