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Nigeria profile of the sexual and reproductive health services available at primary care level

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Assignment

Design your country profile of sexual and reproductive health services available at primary care level (The role of primary care in enhancing sexual and reproductive health – Laura Guarenti).

Introduction

Nigeria is the most populous country in Africa with a population of over 140 million. The reproductive age is 15-49 years and it constitutes about 50% of the Nigerian population. Available statistics shows that the reproductive health situation in Nigeria is poor. Reproductive health indices in Nigeria are improving but it's still not good enough. For example the total fertility rate is 5.7; maternal mortality is 545 deaths per 100,000 live births; contraceptive prevalence of 13%; HIV prevalence of 4.4%; low utilization of reproductive health services, etc.[1]

To address the reproductive health situation, the Federal Ministry of Health developed the reproductive health policy to guide the provision of reproductive health services in the country. The policy provides the responsibility of the federal, state and local government in the provision of reproductive health services.

Various laws (statutory, customary and religious) are in force to address different areas of reproductive health. However many of these laws do not reflect the reproductive health concept and are inadequate in actualizing reproductive health rights of Nigerians. There are a lot of policy documents meant to address reproductive health issues of Nigerians. These policy documents include National health Policy and Strategy (1998) which emphasizes PHC as the key to health care delivery; National Policy on Population for Development, Unity, Progress and Self Reliance (1988); Maternal and Child Health Policy (1994); National Adolescent Health Policy (1995); National Policy on HIV/AIDS/STI control (1997); National Policy on the Elimination of Genital Mutilation (1998). These policies shape the provision of reproductive health services in Nigeria stated in Revised National Health Policy (Federal Ministry of Health, 2004).[2]

The Nigerian health system

The Nigerian health system is based on the National Health Policy. The policy was promulgated in 1998 as the first comprehensive national health policy. Health is on the concurrent list of the Nigerian constitution meaning all tiers of government (federal, state and local governments) are responsible for the provision of health to its citizens. In the policy it was stated that "*The federal, state, local governments and private health sector of Nigeria hereby commit themselves and all the people to intensive action to attain the goal of health for all citizens, that is, a level of health that will permit them to lead socially and economically productive lives at the highest possible level".* Federal, state and local governments shall support, in a coordinated manner, a three-tier system of health care. Essential features of the system shall be its comprehensiveness, community involvement and collaboration with non-governmental providers of health care. It was stated in the policy that Primary Health Care is the key to attaining the goal of health including sexual and reproductive health for all the people of this country. It shall form an integral part both of the national health system, of which it's central function and main focus is the overall social and economic development of the community.[2]

There are three levels of care according to the national health policy namely primary, secondary and tertiary whose responsibility lies with local, state and federal governments respectively.

Primary health care

Primary health care (PHC) was defined as the essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full involvement and at a cost that the community and state can afford to maintain at every stage of their development in the spirit of self-reliance. It shall form an integral part both of the national health system, of which it's central function and main focus is the overall social and economic development of the community.

The Local Government is responsible for the provision of primary health care in Nigeria. Primary Health Care shall provide general health services of preventive, curative, promotive and rehabilitative nature to the population as the entry point of the health care system. The provision of care at this level is largely the responsibility of Local Governments with the support of State Ministries of Health and within the overall national health policy. Private sector practitioners shall also provide health care at this level.

The PHCs are mainly located within communities at the Local Government level. There are 774 Local Government Areas in Nigeria.[3] In each of these Local Government Areas there are a lot of PHCs that provide services at the grass roots. The private hospitals are located within communities and provide primary care. Sexual and reproductive health is one of the components of services being provided at the PHC. However it should be noted that in Nigeria, sexual and reproductive health services are provided at all levels of care (tertiary, secondary and primary).

Service provision, human resources for health and competencies in the provision of SRH services

All cadres of staff (doctors, nurses, midwives, community health officers (CHO), community health workers (CHW), provide sexual and reproductive health services in Nigeria. All persons in Nigeria (male or female, young or old) are provided with reproductive health services. Staffing for the provision of SRH in Nigeria depends on the level of care. For instance at tertiary and secondary levels of care, doctors and nurses will provide high tech SRH services like vasectomy, bilateral tubal ligation, etc. All SRH services are offered in health facilities in Nigeria, it could be at a private hospital, primary health centers, secondary hospitals or tertiary hospitals.

Thirty four percent of countries have community health care workers (CHW) provide door to door SRH service. However there is a wide variation within and across regions with nearly 70% of countries in the West Pacific region offering door to door SRH service compared to 10% in countries from the American region. In the African region 28% of countries have CHWs who provide door to door SRH services. All African countries offer SRH services in health centers and 80% of such services are offered by health professionals.[5]

For the stated category of staff to provide quality services, these staff needs to be trained. In Nigeria CHEWs are trained for 2-3years, nurses (3-4 years), midwives (2-3 years), doctors (6 years). Other trainings to be provide SRH could be on the job, short course of between 1-3

weeks. These trainings are meant to build the competencies of staff in the provision of health care including SRH. In most countries midwives receive more than 18 months training.[5]

Based on staff competency, a survey conducted by WHO on competency of SRH care providers shows that midwives in the African region are the most involved in carrying out family planning (FP) and infertility services than in other regions. Nurses and CHW also play important roles in the provision of FP services.[5]

A study was conducted on SRH which analyzed the activity of service providers and the duration of training. The study looked at the various activities being provided at ANC, child health care, newborn care, and the different care providers (CHW, nurse, midwife, doctor). Services being provided were assumed equal. It showed that the longer the training of midwives the more activities to deliver the optimum amount of SRH activities. Doctors have the highest role to play in the provision of FP services in the European region followed by midwives in the African region. Doctors have the major responsibility to play in the provision of sexual and reproductive tract infections (STIs) but in African region the midwives have the same level of involvement.[5]

All health care providers should have the competency to deliver quality SRH based on the WHO attitude and 13 competencies for the effective provision of quality SRH services.[5]

Sexual and reproductive health services not being provided at the PHC level

The following are SRH services not being offered in Nigeria at the PHC level:

- Cervical cancer screening.
- Provision of human papillomavirus vaccine.
- Imaging for breast cancer screening (mammography).
- Screening for prostate cancer (prostatic specific antigen testing).
- Management of abortion complications.
- Emergency cesarean section.
- Permanent method of family planning like vasectomy and bilateral tubal ligation.[2]

Barriers to accessing SRH services

There are a lot of barriers to accessing sexual and reproductive health services in Nigeria. The following are the list of barriers in accessing these services.

Inadequate funding

Political will and government commitment to the provision of quality SRH services is hindering access to these services. Lack of political will translate to lack of financial commitment. In developing countries Nigeria inclusive, governments do not have the capacity to provide universal access to SRH services. There are not enough resources (manpower, materials and money) to provide such services. In most countries there are not enough inadequate reproductive health commodities and supplies like drugs, reagents for investigation etc. However programs like Presidential Emergency Plan for AIDS Relief in Africa (PEPFAR), the Global Fund to fight

AIDS, TB and Malaria (GFATM) have both international and local government commitment. HIV/AIDS services are being provided free to people living with HIV/AIDS in countries supported by PEPFAR and GFATM.[3]

Whilst reproductive health targets and rights have been agreed in international negotiations and universal access to reproductive health services incorporated into the MDG5, many countries do not recognize sexual health as being distinct from reproductive health and the need for sexual health services and information as going beyond those concerning reproduction and HIV. Sexual health services have generally been neglected because providing them requires governments to acknowledge sexual rights including sexual pleasure and sexual orientation; and address issues such as gender roles and power imbalances within relationships.

Lack of good infrastructure

Poor communications and transport infrastructure can prevent access to services in rural areas, especially in maternal health care where transport to referral services with adequate facilities is an essential component of dealing with emergencies and preventing mortality. Most hospital in Nigeria were SRH services are being seek are mere consulting clinics and most people prefer to not access these hospital because they might drugs.

Social taboos

Sex and sexuality issues are taboo in many cultures including Nigeria, and perceived stigma and embarrassment can lead to a reluctance to discuss and address sexual health issues. Taboos are even more pronounced for people who do not conform to socially accepted norms of behavior such as adolescents who have sex before marriage. Vulnerable groups like the adolescent have limited access to SRH due to social norms. Unmarried adolescent who are proven to unwanted pregnancies, STIs and unsafe abortion will be able to access SRH due to perceived social norms.

Gender roles

In most societies in Nigeria and Africa, men are perceived as macho and women as passive. This gender role makes women and especially transgender people vulnerable in different ways to SRH problems, and inhibiting access to SRH services. For example, men may associate masculinity with taking risks in their sexual relations which expose them to HIV and STIs, and may be reluctant or too embarrassed to seek out appropriate health information and care. Women who are financially, materially or socially dependent on men may have limited power to exercise control in relationships, such as negotiating the use of condoms during sex. Social expectations about how women should behave can place women in subordinate roles and increase their risk of being sexually assaulted, contracting STIs and having unwanted pregnancies, and also limit their access to SRH services. In Northern Nigeria, women have to ask their human to access any form of SRH services like use of contraception and this makes the women vulnerable to contracting STIs including HIV/AIDS. The contraceptive prevalence is very low in Northern Nigeria due to the fact that the husbands of these women have to consent before they access any form of contraception.[4]

Religious factors

Religion plays a great role in access to SRH in Nigeria. Nigerians are religious and believe in their faith. There are two predominant religions in Nigeria, Christianity and Islam. Fundamentalisms expressed through policy and funding decisions undermine progress towards achieving universal access to SRH services for example the catholic faith have their reservation in the use contraception.

Lack of information

Information is an important tool for providing access to SRH services in Nigeria. A lot of people don't have access to information to know such a service exist in hospitals. If information is not shared on the availability of SRH services, clients will not access such services.

Attitude of health care workers

Attitude of health care workers in Nigeria contributes to barriers in accessing health care services. A lot of times health care workers are not welcoming and friendly to clients. Clients come and wait for hours to access services and due to the attitude of such staff even if such services are being provided at the hospital clients will not access such services.

Lack of trained health care providers

Lack of adequate human resources (doctors, nurses, midwives and CHWs) is a barrier to accessing SRH. Government will build health centers, clinics and hospital but will not employ adequate staff to provide all range of services in the hospital. Therefore the health care workers will prioritize and hinder access to SRH services.[5]

Addressing barriers to SRH services

Addressing barriers to SRH services involves everybody from the clients (individuals), communities and governments. Government to show political will and commitment demonstrated by increasing funding to health especially SRH. Technocrats, law makers and governments enact laws, policies that will improve access to SRH. Training and re-training of health professionals on SRH should be a priority, and programs aims at addressing attitude problems in health facilities should be started. Information on SRH should be widely available, government and non-governmental (NGOs) should embark on community awareness and sensitization on SRH. Adolescent friendly centers, vulnerable or special groups like Men having sex with Men (MSM) centers should be built and staffed to address their special needs. Religious and community leaders should to be trained to address barriers to accessing SRH.

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