INTRODUCTION

There is an immediate need to improve and provide quality health care among children in rural areas and suburban. This is necessary so as to avert the number of death that comes from that part of the country. Various health programs have been instituted in Enugu state aimed at providing and carrying out health care services in remote communities in Enugu and Ebonyi states where PHC operates.

Many countries in the world have also taken several steps to strengthen the surveillance system especially for non-communicable diseases which have slowly and steadily been spreading their tentacles from the developed to the developing countries. For the health system of a developing
country to thrive, the activities of her health centre powered by Primary health care should not be overlooked.2,3

Primary Health Care was defined by the World Health Organization in 1978 as essential health care; based on practical, scientifically sound, and socially acceptable method and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination.4 Primary health care is based on the overlap of mutuality, social justice and equality. As a strategy, primary health care focuses on individual and community strengths (assets) and opportunities for change; maximizes the involvement of the community; includes all relevant sectors but avoids duplication of services; and uses only health technologies that are accessible, acceptable, affordable and appropriate.4 Indeed, Primary health care need to be delivered close to the people. It is obvious that the purpose of PHC in the country is defeated since the government puts more emphasis on secondary and tertiary health care. This could be the reason why we have high burden of infant and maternal deaths.5

Poor and inappropriate management of our primary health care system and health centre in particular has contributed immensely to childhood morbidity and mortality. For instance, in 2001, 19 percent of global deaths were among children and 99 percent of all child deaths took place in low- and middle-income countries. The disability-adjusted life years (DALYs) lost was attributed to the under fives, maternal and perinatal conditions, nutrition deficiencies, and endocrine disorders.6,7

This study was therefore aimed at evaluating the activities of a health centre in a suburban in Enugu state and to determine the pattern and presentation of various diseases in the health centre. The findings from this study may help to improve management of children in health centers. In addition, it would also form a data base upon which further studies can be carried out.

METHODS

This is retrospective study undertaken in a primary health care centre in Abakpa Nike in Enugu east LGA of Enugu State. The health Centre serves as a major primary health care for patients from Smaller villages such as ugwuago, ugboonye, ugbone, ugbowa etc. Abakpa Nike primary health centre was newly renovated by the Chairman of Enugu east LGA and provides services on immunization, integrated management of child hood illnesses, common and uncomplicated deliveries, and rarely management of non communicable disease.

Data on the activities of this health centre was collected from December, 2011 to 31st December, 2013). This was extracted from the admissions register. Data extracted from the case record files included: age on admission, gender, Immunization pattern, IMCI procedures, family planning techniques, disease surveillance, diarrhea illnesses and management of non -communicable disease.

This study was aimed at assessing the activities in a health centre located in a rural region in Enugu state.

Ethical clearance for the study was sought from the chief nursing officer of the health centre. The data retrieved were collected with the aid of a structured study proforma and entered into a personal computer and analyzed with SPSS Version 18. Data were arranged in tables.

RESULTS

Total number of children that attended immunization program in the health centre over 20 months period was 25,438 (12,348 males and 13090 females), however only 17745 children (7998 males and 9747 females) were actually registered in the hospital records. Table-I.

None of the children was immunized for DPT2 and OPV 0 and HBV 1 in the course of this study. Table-II. The dropout rate using DPT1, 2 and

Table-I: Age and gender of children attending the health center.

| Age Group | M  | F  |
|-----------|----|----|
| 0-28 days | 1101 | 1001 |
| 29 days -11 months- 12 months- | 5753 | 6723 |
| 12 - 59 months | 630 | 603 |
| 5 years - 14 years | 277 | 150 |
| >15 years | 237 | 1270 |
| Total | 12,348 | 13090 |

Table-II: Immunization coverage.

| Vaccine | M  | F  |
|---------|----|----|
| BCG     | 1331 | 1635 |
| OPV1    | 1925 | 1956 |
| DPT1    | 2043 | 2138 |
| HB0     | 521  | 514 |
| OPV3    | 1621 | 1831 |
| HB3     | 1625 | 2001 |
| DPT3    | 500  | 346 |
| Measles | 1504 | 1306 |
| Yellow fever | 1278 | 1363 |
| Total   | 12,348 | 13090 |
Immunization coverage rates for BCG, OPV0, OPV1, DPT1, HBV0, OPV3, HBV1, DPT2, DPT3, HBV1, measles and yellow fever were 11.7%, 0%, 15.3%, 16.4%, 4.1%, 13.6%, 14.3%, 0%, 3.3%, 0%, 11% and 10.3% respectively with mean coverage rate of 8.3%. Family planning activities were poor, showing oral pills as mostly used family planning technique 107(79.3%), followed by condoms 11(8.1%), IUCD 10(7.4%) and least is injectables (5.2%). Table-III.

Two thousand, three hundred and eleven (2311) malaria cases were managed in the health centre over a 20 month period with 1172 males and 1139 females giving a male female ratio of 1:1.1. Out of these cases, 99 of them were severe malaria which were all referred. Table-IV.

Integrated management of childhood illnesses program was also carried out in health centre but at very low level. A total of 147 children benefited from this simple case management of diarrhea, cold, cough and fever.

Twenty one cases that were managed in the health centre were non communicable disease with hypertension 9(43%) being the commonest. Disease surveillance in this health centre was very poor as only cases of dysentery and diarrheal disease were being surveyed.

**DISCUSSION**

This study had shown the level and importance of primary health care in this environment. Children under the age of five are in the majority that attended the primary health activities in this study. This includes immunization, management of common childhood disease such as malaria and integrated management of childhood illnesses. The reason for this high number of under fives in the health centre is obvious. This is because the mortality and morbidity of diseases in Nigeria is commonly seen among the under fives. For instance, one in every five children dies before their 5th birthday; most of these deaths can be prevented by immunization. In Nigeria, significant effort has been made in the past two decades towards the reduction of childhood morbidity and mortality through introduction of policies like improved immunization coverage, provision of good health facilities and increase in the number of health personnel. Despite these efforts, childhood mortality rate is still high. Recent data report infant and under-5 mortality rates of 88 and 14 deaths per 1000 live births respectively.

From this study, it is also pertinent to note that more female children attended all the services in the health centre when compared to males. This is gratifying as parents are beginning to understand the importance of girl child and the need to implement the first “F” component of child survival strategy.

We noted with dissatisfaction the low immunization coverage rates in the health centre in view. Immunization coverage rates for BCG, OPV0, OPV1, DPT1, HBV0, OPV3, HBV1, measles and yellow fever are 11.7%, 0%, 15.3%, 16.4%, 4.1%, 13.6%, 14.3%, 0%, 3.3%, 0%, 11% and 10.3% respectively with a mean coverage rate of 8.3%. This is lower than the mean coverage rate of 69.3% in West Java and 43.5% obtained in India. However our result is even similar to the report of national coverage in Nigeria for full immunization, which is less than 13%, one of the lowest rates in the world. The reason for this lower coverage rates is mainly due to the insurgency in the northern part of the country. For instance, some states in northern Nigeria have coverage rates below 1%, and the average for the whole North West Zone is just 4%. Other reasons that can be offered for this low coverage rate in this study is non availability of some vaccines like OPV0, DPT2 and OPV3 in the time of study.

We also noted a very high dropout rate of 494% (assessed by the number of DPT1 and DPT3 that was given to the child over a year) in this study. This is due to unavailability of DPT2 in the course of study. We could not offer any reason for the unavailability of the vaccine. In 1990, reported three doses of diphtheria-pertussis-tetanus (DPT3) coverage in infants (<12 months of age) reached an estimated 56%. During the years following the global Universal Childhood Immunization efforts
that culminated in 1990, immunization coverage rates in Nigeria declined significantly. Preliminary results of a 2006 national coverage survey reported 36% DPT3 coverage.

Management of uncomplicated malaria and integrated management of childhood illnesses (IMCI) activities were seen in the health centre within the study period, but this is at lower level. The health centre also recorded no management of severe malaria as such cases are referred to secondary health centre. Integrated management of childhood illnesses (IMCI) is a strategy developed by the World Health Organizations’ Division of Child Health and Development and UNICEF. It has been introduced in more than 30 countries around the world to address morbidity and mortality in children under five years. The strategy focuses on the child in its whole entirety, rather than on a single disease or condition. Children often arrive at primary health care facilities with a number of diseases and have to be managed in an integrated manner at home and at the clinic. This strategy (IMCI) has helped to curb childhood mortality and mortality to a greater extent.

Non communicable diseases seen in the health centre were very few. This could be due to lack of trained professionals and facilities in the health centre. Most of the communicable diseases are often referred. This health centre has a very good referral system. For instance most of severe illnesses and complicated pregnancies are often referred to higher and well equipped government hospitals. This could account for the zero mortality rate that was documented in the hospital. This is surprising, because In Nigeria health centers, referral system can be said to be non-operational. This is shown by the low coverage rate, high dropout rates, poor IMCI implementation and poor disease surveillance system. However the health centre had a well knitted referral system.

We noted much discrepancy between the numbers of children that attended immunization program in the health centre over 20 months period (25,438) and the number of children that were actually registered (17745) in the hospital records. This simply showed that the health centre in view had a poor recording system. Medical Record keeping had been a disturbing issue in some hospitals in Nigeria. For instance Afolabi noted that record management practice in Nigeria has a number of problems which may include insufficient skilled and experienced record management personnel and possibly, low priority of record management in the scheme of things. This was also corroborated by Awe. Hospitals are information intensive enterprises; hospital managers must understand that only those with a strong information management system can have a smooth running of the enterprise. In health care organizations, medical record is the principal repository of a patient’s health care information, so every health organization needs a medical records department that is organized and staffed to provide adequate information.

CONCLUSION

The major fulcrum of events in the health centre which include immunization coverage, IMCI, and management of common illnesses are simply non operational. This is shown by the low coverage rate, high dropout rates, poor IMCI implementation and poor disease surveillance system. However the health centre had a well knitted referral system.

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