Health Insurance and Managed Care in Nigeria

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INTRODUCTION

Insurance is a veritable tool for healthcare financing that comes in different models. It has been used by most advanced countries in its various forms to fund healthcare. Insurance in one form or the other remains a veritable and sustainable tool for financing the hard ware, delivery structure and systems of healthcare. It is only recently being applied by poorer developing nations to address the glaring problem of inadequate healthcare provision, which was hitherto financed exclusively from public taxation.

The health sector can be subdivided into two main categories, healthcare infrastructure and healthcare financing. Health care delivery and infrastructure may be described as the hardware, people and information structures. Healthcare financing is about the wherewithal without which the former can neither be provided nor sustained. Health funding relates directly to all production and financial activities and resources expended on goods and services consumed by or provided to the human population for the purpose of improving health.

Ever since Emperor Otto Von Bismarck of Germany enacted the mandatory legislation on the "sickness funds" for working Germans in 1883, different models of health insurance have continued to evolve worldwide albeit with the same general principles.

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INSURANCE

Insurance is a risk transfer mechanism wherein the proposer (the insured), agrees to make small periodic payments called premium to another person (the insurer) in return for the payment of a larger sum (benefit) on the occurrence of a specified event.

The basis for insurance is to protect the individual from the financial consequences of events with a low probability of happening but with the potential to cause substantial loss. Health Insurance is a social device for pooling the health risks and costs of an exposure unit with view towards predictability. However in Health Insurance, the probability of illness is not low hence the actuarial determinations allow for more variance.

In the context of Health Insurance, the Premium is the amount charged by the insurance company with the promise to pay for any eventual "covered medical treatment" for the designated coverage.

Consequently, health insurance makes it possible to substitute a small but certain cost (premium) for a large but uncertain loss (claim) under an arrangement in which the healthy majority compensate for the risks and costs of the unfortunate ill minority. Pooling of health risk is a fixture of every society and takes many forms. It was even practiced in our traditional societies. The overall contributions are placed into a pool of funds from which payment is made.

PRINCIPLES

Insurance is based on the principle of probability and all parties predicate its sustainability on the law

of large numbers and the meticulous observation of the principles of insurance. From the small contributions of the large numbers, the few who access the system for services are paid for. The following practical principles guide insurance:

- Insurable Interest.
- Utmost Good Faith
- Indemnity
- Underwriting.

Insurable interest: This is the legal right to insure. It defines the relationship that must exist between the insured and the subject matter of insurance. The insured must have something to benefit by the continued existence of the contract and something to loose by the loss of the contract.

Utmost Good Faith: There must be transparency on the part of all parties. All information about the risk being introduced (insured) and about the cover being provided and contract wordings (insurer) must be disclosed. Where there is evidence of fraud or deceit, the contract will be void. In health insurance, the terms, conditions and exclusions in the policy are clearly stated.

Indemnity: The principles of indemnity are centered on Contribution and Subrogation.
The contribution or premium must be actuarially sound and enough to provide the scope of cover and prevent under-insurance, which may lead to market failure. What is promised must be delivered.

Underwriting: This is the method by which the contribution and access to the insurance scheme are determined. The premium must reflect the degree of risk introduced into the scheme. The numbers of insured may determine the level of individual contribution such that, the larger the numbers in the insured pool, the less the individual premium.

Enrollment: For determination of eligibility the applicant must supply photographs for self, spouse and eligible dependants (as applicable). The Insurance Company provides ID card for members of the scheme.

Time of enrollment and renewal: Enrollment periods may be open or closed. Group enrollment may be effected at any time of year while Non-group enrollment may only be effected at specified periods.

Waiting period: Services will be made available to registered and pre-paid members and/or beneficiaries after a specified waiting period of one month or more. Access to certain services may be excluded for up to one year.

Every Insurance scheme or HMO providing health cover must operate according to these principles in order to ensure prompt delivery to services covered and the consequent claims settlement to health care providers.

The Parties in a Health Insurance Scheme

- The Regulator
- The HMO
- The Providers
- The Payers
- The Users

In indemnity type insurance, the insurer reimburses the patients for their medical expenses; in prepayment systems, including managed care, all participants regularly pay a fixed amount and in turn receive defined package of health benefits. In government sponsored social-security insurance, there is a mandate that covers public employees and may include other members of the society. Private employers of labour may also provide health care through health maintenance organisation.

Traditional indemnity insurance has evolved during the past few decades into what is now generically known as managed care.

Benefits to Medical Provider

- Investing in Long-term solution to practice funding.
- Pre-payment affords better planning
- Improved cash flow.
- As volume increases, higher % of patient panel derives from pre-paid schemes.
- Restructuring of practices for levels of care.

THE NATIONAL HEALTH INSURANCE SCHEME

A national health insurance scheme was first proposed in Nigeria in 1962 under a bill that was introduced to Parliament in the same year by then Federal Minister of Health, Dr. M. A. Majekodunmi. The scheme was to commence in Lagos area and provide health services through salaried doctors. Issues that led to the failure of the Bill in parliament are highlighted in Fig .1.

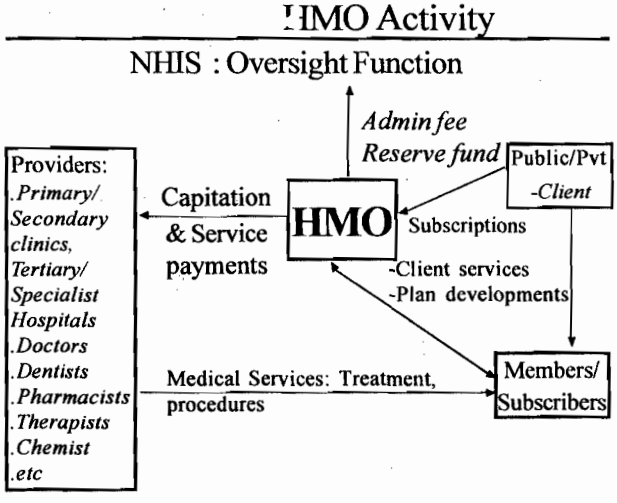

Fig 1:

The main opposition to the bill at the time was from the Nigeria Medical Association whose membership was influenced by Private medical practitioners in L. os (the Bill proposed salaried doctors for delivery). The NHIS idea was resurrected again in 1988 by another Minister, Prof. Ransome-Kuti. This effort resulted in the Eronini Report (1989) on the NHIS which formed the template of the present day scheme. The scheme had been be-devilled with lack of political will by the successive governments and inter-professional rivalry within the ranks of stakeholders. However concrete steps were taken with the passage of Decree 35 (National Health Insurance Scheme) of 1999 by the government of then General Sanni Abacha and the first launch of the scheme took place. This was followed by a period characterized by administrative fumbling and pilot schemes that were ill advised and not backed by legislation.

However, the private sector wherein most of the activity in health takes place took the bull by the horn and launched private health insurance schemes in 1998. There are now over 13 HMOs providing private health insurance schemes in Nigeria (Fig4). The pressure from the private sector and other stakeholders along with the enthusiasm of the incumbent Federal Minister of Health, Prof. Eyitayo Lambo led to the present new-launch of the formal public sector programme of the NHIS in June 2005.

The present-day NHIS shall be a regulatory body providing oversight functions to the organs that will be involved in direct delivery of services to members i.e. HMOs and Providers.

The NHIS shall have several programmes aimed at different segments of society. The health care providers under the scheme shall be a mix of public and private facilities in the spirit of Public/ Private partnership. The members shall be free to choose to obtain services at any one of such registered health care providers.

Health Care Benefits to be provided on the National Health Insurance Scheme

The following benefits are standard components of coverage:

i. Curative care by a provider
ii. Out-patient diagnostic and treat
- ment services
iii. Short-term rehabilitation and physician therapy
iv. Paediatric and adult immunisation services
v. Family planning
vi. Ante-natal and post-natal care
vii. Eye examination but not the provi sion of spectacles
viii. Consultation with specialists
ix. Hospital care in a public or private hospital in a standard ward during a stated duration of stay for physical or mental disorders.
x. Emergencies in and out of the HMO service area.
xi. Detoxification and treatment of substance abuse

xii. Diagnostic and therapeutic radiology services

xiii. Primary Dental care as defined- pain control, extractions, amalgam fillings, etc.

All benefits contemplated or offered or provided under the Scheme shall be provided or administered or made available in Nigeria only.

MANAGED CARE

Managed care is a general term that refers to systems for organising doctors, hospitals and other providers into groups to enhance the quality of health care services. These groups also contain health care costs by discounting the price of services and controlling utilisation of services. With managed care, quality health care services are delivered in a cost-efficient manner. Managed care organisations coordinate all aspects of the delivery system in order to manage all the costs in the system.

Rather than bill patients on a fee-for-services basis, managed care systems set pre-arranged fee structures and utilisation review procedures agreed upon by **contract** between health care providers and the managed care organisation.

The essential principles that govern the delivery of managed care are:

1. Selective provider contracting – using only providers on the preferred network .
2. Utilisation management – enrollment, pre-authorization, encounter data etc.
3. Negotiated payment – capitation, procedures, specialist, per-diem, case payments
4. Quality management – standard treatment guidelines, disease management guidelines etc

Managed care organisations combine the various roles of insurer, provider manager and care provider.

Health Maintenance Organisation (HMO):

HMO is an organisation that offers **pre-paid**, comprehensive health care coverage for doctors' and hospital services. The financial burden of risks of over-using health services are borne by the HMO, its service providers or a combination. The member must receive health care from HMO - approved provider.

Other major characteristics of HMOs are:

- They assume contractual responsibility for assuring the delivery of a stated range of health care services including at least in-patient hospitalisation and ambulatory care services.
- They serve a voluntarily enrolled population.
- The premium is fixed, regardless of utilisation.
- There may be a fixed co-payment (direct or indirect) for use of certain services.
- The HMO assumes some of the financial risk or gain.

HMOs could be staff model, group model or a mix of both. They could also be for-profit or not -for- profit.

Staff model HMO's own their clinics or hospitals and employ their own full-time medical staff.

Group model HMOs operate with independent providers at all levels.

The Mixed model HMOs share group and staff model characteristics. For the NHIS, regulation prescribes that HMOs be Group model.

The HMO is responsible for collection and disbursement of contributions; provision of care; and administration of providers.

FUNCTIONS OF HMO

- Register employers/employees.
- Collect contributions of above
- Register providers, after ensuring they meet minimum NHIS standards
- Ensure qualitative and cost effective health care services to contributors through Health Care Providers (HCPs).
- Ensure proper adherence to referral procedures
- Payment of capitation fees and fee-for-service to HCPs
- Render returns to NHIS
- Maintain ethical marketing strategies
- Put in place effective quality assurance systems
- Ensure smooth change of provider (if requested by the contributor) within the stipulated period
- Organize risk management enlightenment for contributors and providers
- Health promotion and education

Developmental Issues in History of the NHIS

1963	1999	2005
1. *Mandate* Compulsory nature of scheme was the reason for opposition by people of Lagos	Scheme is voluntary Decree 35 of 1999	To be mandatory in stages
2. *Localisation in one part of of the country* The scheme was for the capital city of Lagos alone. Paliamentarians from other parts of the country, particularly the North opposed the idea.	*Localisation in pilot zones of the country* Scheme is nation wide but it is beign wrongly presented as being restricted to certain parts of the country. Pilot projects on CHI in zones.	*Nationwide* Nation wide but commencing in stages with the core Federal civil servants.
3. *Scope of cover* a. It was claimed that the Bill did not lay enough emphasis on preventive care and sanitation. b. Merging of Lagos City Council with other health services was predicted to reduce level of preventive care.	*Managed care* a. Benefits include preventive care and H.M.O's will have to deliver such care to contain their cost. b. Scheme does not affect existence of Public Health Depts. or Primary Care Agency.	HMOs use managed care tools and payment incentives to encourage disease prevention. The issue of Public Health still remain remit of government.
4. *Rates of contribution* Rates if contributions prescribed compulsorily in the Bill were said to be far higher than the estimated expenditure of the people of Lagos on health.	*Rates of contribution* Rates not prescribed compulsorily in the Decree.	Community rating. Flat rate to be used at commencement.
5. *Private Practice* Banning of "private practice" (in section 15 (5)) was opposed by doctors.	*Private Practice* "Private Practice" not an issue.	Public and Private providers to be used.
6. *Consultation with NMA* i Minister - Dr Majekodunmi stated that the Health Bill was based on delibrations of NMA(formally BMA Nigeria Branch) during the period of 12 years that he was the Hon. Secretary. ii. Two factions of NMA emerged in the middle of the argument with the minister	*NMA and Stakeholders* i NMA was invited to health summit in 1995 but did not turn up to present position paper. ii. Invited to and participated at numerous seminars held thereafter. iii. NMA President present at 1997 'launching" of the scheme and the seminar which followed it. iv. Opposition from NMA concerning the use of HMO's and composition of NHIS council.	All stakeholders in health involved but information and issues not passed down to membership. Still issues that need to be thrashed out about operational modalities and health care professionals.

Roles of NHIS

i. Registration of HMOs and Providers
ii. Setting standards
iii. Ensure compliance with standards
iv. Mobilisation and sensitisation of all stakeholders
v. Defining the minimum benefit package
vi. Actuarial determination of premium
vii. Drawing up contracts between stakeholders
viii. Training
xi. Monitoring and evaluation

Preferred Provider Network:

The use of the provider network for access and secondary referrals is a useful tool for controlling costs and maintaining viability. Provider payment mechanisms are agreed in the contract between HMOs and Providers. Referral to specialist care follows guidelines that are managed accordingly.

PROVIDER PAYMENTS

A major goal in establishing a network is agreement on a method and rate of payment for providers on some basis other than billed charges, which are inherently inflationary. The major payment mechanisms currently in use are:

Fee-for-service Payments to doctors, hospitals, and other providers are based on the bill they charge for specific services rendered or products provided. These fees are based on a fee schedule that represents an upper or lower limit on the prices that may be charged.

Capitation A negotiated per-capita (or per-member) rate is paid to the provider, who is then responsible for delivering or arranging for the health services required by the beneficiary over a certain period irrespective of utilisation.

Global Budget. A given amount is paid to the provider(s) as a whole, who are then responsible for covering the total cost of services consumed by beneficiaries during a given period of time; the providers will agree among themselves how they will divide the total budget given to them.

Per Diem. A daily rate is paid to the provider(s) to cover all services and expenses ofthe patient per day of confinement, sometimes adjusted according to type of institution.

Case Payment. A flat rate or "budget" is agreed upon for the treatment of a particular illness, or illnesses in the same category or "diagnosis-related groups" (DRGs). If the cost of treatment is greater than the agreed flat rate, then the provider incurs a loss. If the cost of treatment is less than the agreed flat rate, then the provider makes a profit. This method is generally used for specialist or tertiary services.

Insurers choose a payment method that is acceptable to providers and consistent with its administrative capabilities and a level of payment which is sufficient to attract its preferred network. They use a fixed level of payment for each service or package of services and agree on limits on increases in prices from year to year.

Drug formularies

A formulary is a list of drugs which the providers in a program may prescribe at all times. The formulary is developed in collaboration with representative group of the providers using detailed information on the relative costs and effectiveness of specific drugs.

Generic drugs. Generally brand name drugs patented by the manufacturer are always relatively expensive. On the other hand generic drugs with the same chemical composition and effect are usually cheaper. In developing countries Generic drugs are the major constituents of the Essential Drug List and are usually available and can be substituted for brand name drugs thereby providing affordability. Where members prefer brand –name drugs then they are made to pay the cost-difference in form of a co-payment.

Utilization Management

Utilization management tools are tools and protocols developed to ensure that all services received are appropriate, medically necessary and provided in the most economical cost setting.

Utilization management programs and protocols include:

- Procedures the patient must follow in seeking care (for example, the patient is required to choose one provider as their primary care

provider and have all care by other providers approved in advance by that primary provider)

- Procedures the provider must follow in approving care (for example, the provider may be required to receive approval from the health plan before performing surgery on any patient except in an emergency).
- Procedures the plan may utilize to review care to ensure that providers and patients are complying with plan protocols (for example, the plan may review all emergency hospital admissions to ensure that they were true emergencies)

Regulation

Government has a great role to play in the operation of managed care. Experiences in other nations have however confirmed that the role should be limited to regulation and provision of the enabling environment. A substantial proportion of healthcare is privately provided but the capacity of government to develop and enforce regulations to ensure adequate quality of care is very limited. It is also known that enforcement of complex regulations is associated with high transaction costs. Therefore the importance of informal institutional arrangements such as professional norms and networks are mechanisms that have to be relied upon.

Regulation, Monitoring, Quality assurance processes and administration of the care to the disadvantaged sectors of the population are the main remit of the NHIS. The HMOs actuary procedures must be subject to scrutiny to prevent market failure.

Providers and HMOs

- Affiliate with one or more HMOs
- Sign contract with HMO
- Supply evidence of ability to provide health benefits
- Supply other relevant information to HMO
- Participate in meetings of planning committees
- Provide Encounter data for quality of care and Utilisation measureme

Providers and Subscribers

i. Subscribers will select Provide HMO list.

ii. Providers will offer quality services to the contributors

iii. Subscribers may be required to make co-payment for certain services

iv. A subscriber has the right to change provider on the network

v. A subscriber has the right to seek for redress where not satisfied with services.

Working Capital

Managed care organisations are operated essentially as thrifts. Private sector management techniques are required for making managed care work efficiently.

In order to operate well, they need to be properly capitalised. There is need for adequately trained or trainable professionals to fill the operational organograms of these organisations. Seminars, Conferences and other training programs require a lot of funds. The personnel of managed care organisations are highly mobile and such need to be well paid. The computerization for data collection, analysis and provider monitoring is very capital intensive.

The operating margin for HMOs is indeed very small, between 1% and 4%. It cannot therefore be overemphasized that adequate working capital must be provided to cover the first four to five years of operation. This becomes more necessary when the enrollment figures are still low.

Managed health care has arrived in Nigeria after several years of meticulous planning. There are more than fifteen managed care organisations operating under the umbrella of the Health Insurance and Managed Care Association of Nigeria (HIMCAN). We are at the beginning of a revolution in the provision of affordable and qualitative medical services to Nigerians.

Managed care is not about micromanaging doctors as they practice medicine or about putting profits above patient care. Instead, it is about introduction of business models and management tools into delivery of health care which initially threatens the status quo, but will ultimately raise the quality of health care to everyone. It is about a new system

that will bring about lower costs, higher quality and greater convenience than could be achieved under the fee-for-service system. This is about how to provide the health care that most of us need most of the time in a way that is simpler, more convenient and less costly.

Private HMO Schemes in Nigeria

HMO	Estimated No of Lives – June '04
Total Health Trust Ltd.	27, 500
Hygeia Health Maintenance Ltd.	50, 000
Healthcare International Ltd	11, 000
Southern Rose Nig Ltd.	3, 000
Clearline International Ltd.	25, 000
Premium Health Trust	1, 800
Multishield Ltd.	3, 500
Managed Health Services Ltd	3, 000
First Health Ltd	800
Expat Care HMO	3, 000
Royal HMO	100
Ronsberger Nig	?
United Healthcare International Ltd	1, 000
Premier Medicaid Nig Ltd	?

Source:

Health & Managed Care Association of Nigeria(2004)

BENEFITS OF HEALTH INSURANCE TO THE NATION

(1) Ensuring the provision of the basic health services aimed at communities;
(2) Ensuring access to the poor and underprivileged to health facilities and services;
(3) Ensuring the supply and rational use of drugs, medical supplies and laboratory reagents;
(4) Developing and expanding managed care and health insurance schemes;
(5) Increasing funds for operational and maintenance costs of health facilities.
(6) Sustainable long-term health/nutritio curative preventive, promotive and curative policy improvements.
(7) Assures prompt provider reimbursement for services.
(8) Rebuilding health infrastructure.
(9) Better health information system
(10) Globalisation of health care.

Worldwide, the transition from fee-for-service to managed care has encountered the same problems with payers, providers and users.

There are three major obstacles: patient-resistance, provider-resistance and self-preservation by agents of employers. Each group of stakeholders had a turf to protect. Management of the change has to be gradual and inclusive.

Certain market dynamics such as the desired benefits from economies of scale, take time to manifest. Therefore provider buy-in as a form of investment in future reward is very essential. The providers need to be proactive and consistent identifying and selecting which HMOs to contract with.

As market penetration increases, purchaser preference for "managed" benefits such as lower costs and higher quality of services begin to drive the market. The users have to be well educated on the appropriateness of services provided under managed care. They need to understand that the free-for-all and *laisze-faire* attitudes of fee-for-service delivery has now transited into structured and managed processes. While Managed care is not the solution to all challenges facing us in health care, but managed care does provide us with our best solutions to a lot of new and old problems

Sexually Transmitted Infections in Nigeria - *Professor R. A. Bakare*

Prof. Rasheed A. Bakare, an accomplished microbiologist and venereologist; graduated from the premier University of Ibadan Medical School two decades and a half ago. He is a fellow of the National Postgraduate Medical College (1990) and West African College of Physicians (1995). He has since been a resource person and examiner for postgraduate topics covering Bacteriology, Venereology, and Mycology for the West African College of Physicians and Surgeons and the National Postgraduate Medical College.

He regularly supervises Masters degree student research projects in his chosen field. Currently he is one of the few among his peers with a vibrant and enviable research career. His area of research spans antibiotics sensitivity and therapeutics, epidemiology of sexually transmitted diseases and nosocomial infections amongst others. He is the current Clinical Head, Department of Medical Microbiology and Parasitology, University College Hospital, Ibadan. He is also the current President, Nigerian Venereal Disease Association, a post he has held since 1994. He has several paper presentations to his credit both at the local and international levels. He rose to the exalted position of Professor in October 2002. He is happily married with children.

Prof. R.A. Bakare

Excerpts

Annals: How has it been so far in Academics?

Prof Bakare: I joined the department after my youth service in 1982. I had the intention of joining the department of obstetrics and gynaecology, but this changed after the service year. On returning from service, I initially joined the pathology department but eventually changed over to the department of microbiology because of the venereology aspect of it, and since then I have had no regrets.

Annals: Venereology is a very large aspect of microbiology, what is the current situation in Nigeria?

Prof. Bakare: Things are not too good. Patients no longer come to the hospital to treat STIs since they can easily buy over the counter drugs. One of my residents who is working on quinolone resistant gonococci, for a whole year he could not get an isolate. Another reason why patients do not come to the hospital is because of HIV infection. People are more aware of the dangers of illicit and unprotected sex and now use condoms. This has lead to a reduction in the prevaleance of veneral diseases in the community. These are the two reasons I can tell you now. Although there are other reasons.

Annals: Are there current local research data on STIs?

Prof Bakare: A lot of work has been done in Nigeria, and I have done a lot in this area also. Currently, the commonest agents causing STI in Ibadan are: Chlamydia, trachoma, and herpes virus. These are very common. Chancroid is another common STI. These conditions are also associated with HIV Gonorrhea is popular but not very common.

Annals: How has HIV, affected the epidemiology of STIs?

Prof Bakare: The fear of HIV has led to awareness in the use of protective means of

prevention of HIV and thus STIs. STIs are gradually disappearing as more and more people are using health promotion strategies people are very careful now.

Annals: Are there any specific STIs that are very strongly associated with HIV.

Prof Bakare: Virtually all STIs are associated with HIV.

Annals: Is it possible that people prefer alternative medical practitioner in the area of STIs?

Prof Bakare: I don't think so. These patients eventually develop complications which cannot be handled by traditional healers and they eventually come back to us. There is also a fall in the prevalence of these complicated cases of STIs. The cost of Health care in the hospitals might also explain why these patients are not coming, in the past when health was free we saw a lot of STI cases, but since the introduction of consultation and other fees they've stopped coming. The alternative medical practitioners charge them more than we do here.

Annals: Sir, can you tell us about some current studies going on in the department here?

Pro. Bakare. Most of the studies we do here are either diagnostic and/or preventive and are community based. Some of my resident doctors are currently in the field gathering data.

Annals: Is there a National Network for monitoring STIs?

Prof Bakare: Yes there is, there are many. There is one on ground now an gonococcal infections. Ideally all cases of STIs should be reported to the FMOH.

Annals: Sir, what can we say is the prevalence rate of STIs in Nigeria?

Prof Bakare: That is a very difficult question only few reports have been made and the data we have is mainly on HIV. We do not know the rates of other STIs, and with the syndromic based management specific data for STIs is very difficult. In addition only very few laboratories in Nigeria can isolate these organisms. What we are trying to do now is to report cases based on the syndromic based management.

Annals: Is there a change in the pattern of STI symptomatology in this era of HIV-AIDS?

Prof Bakare: I don't think there is any difference in symptomatology apart from the fact that cases may be more severe ad more complicated. Treatment of STIs in the background of HIV is the same but one should be more aggressive. These diseases progress more rapidly in the background of HIV-AIDS. There is no difference in presentation or mode of management.

Annals: Are you happy with the level of awareness and use of preventive measures in the general populace? Can we do more?

Prof. Bakare: To get the general populace to adopt preventive measures has been very difficult, sometimes frustrating. It has been our experience here to find a boy with chancroid or genital ulcer disease who still engage in indiscriminate sex with no consideration of preventive measures. The reported prevalence rate of HIV/AIDS in Nigeria is the tip of the iceberg. I believe the prevalence rate is above 5% people refuse to listen or change. They don't believe what they hear about HIV or STIs. You'll find young ladies having sexual intercourse twenty one times a day in seven days. There was one that has 228 sexual intercourse within 30 days. This was part of the day in a study. The average sexual exposure amongst these participants from the study was about seven in a week with some of them having more than 28 partners. This was a study on girls on the streets, polytechnic and undergraduate students. Not commercial sex workers. These are pretty young sexually active ladies. The situation is getting worse.

Annals: Sir, what kind of preventive measures will you advocate?

Prof Bakare: I think we deceive ourselves if we ask these people to abstain from sex. I don't believe in that. From my experience I have found that people find abstinence and one partner business impossible to comply with. The use of condom is good it is consistently used. Condoms have been found to be protective roughly 92% effective if consistently used. But then some is the avenues of spread of infection is through ulcers or wounds at the base of the penis or scrotum which are unprotected by condoms. However, people are averse to the use of condoms because of the belief that the pleasure of sex is reduced by condoms. Presently we are trying out the efficacy of microbicides both as anti-infective and possibly contraceptive. I will advocate the use of microbicides and condoms. Unfortunately female condoms are hard to get and very expensive. A cheap and affordable female condom has just been introduced but is not presently available in Nigeria.

Annals: Why has it been difficult to change peoples' habits?

Prof Bakare: People refuse condoms because of the belief that it decreases the pleasure of sex. Some people say using condom is like taking sweet with the wrapper on. People don't enjoy sex with condoms. This is why they have refused to change. Microbicides do not decrease the pleasure of sex and they also serve as lubricants. I hope that sexually active individuals will be more favorably disposed to the use of microbicides.

Annals: Sir, what are the recent advances infields HIV-AIDS?

Prof Bakare: As I mentioned above people are trying out the efficacy of microbicides. Also there are many centre in Africa where vaccines are being tried. I will complete a trial of microbicides within the next 2 months and hopefully will be in the market. About 5 types of microbicides are being tried 2 of them in Nigeria. Locally here we (I and one of my residents) are trying H202 from lactobacilli to prevent bacterial vaginosis. This is a form ofmicrobicide. What it does is to change the pH of the vagina from neutral to acidic creating a hostile environment for microorganisms.

Annals: Why is there a change in nomenclature from STD to STIs?

Prof Bakare: There are so many conditions that are classified as STD, ranging from fixed drug eruptions affecting the genitals to herpes. So the term STIs is more specific. The term veneral disease is being dropped because of stigmatization. STIs are infections transmissible through sexual intercourse.

Annals: Sir, are the cases of MRSA in Ibadan?

Prof Bakare: Yes, there are, with a rate of 7% or so in the past, now is about 28%. There is a committee that monitors the rates of sensitive and resistant isolates in UCH. And this committee, which acts as a sort of surveillance unit, sends regular reports directly to the consultants of every unit in the hospital.

Annals: Did HIV originate from Africa?

Prof Bakare: I and the opportunity of discussion with Robert Gallo the co-discovery of HIV. To the best of my knowledge, I think the virus originated from Uganda, from green monkeys. It is a mutation of the green monkey virus, just like the Bird Flu which is also mutating. Our behaviour has contributed largely to the rapid spread of HIV-AIDS.

Annals: Sir, as Editor-in-Chief of the Nigeria Journal of venereology what are the challenges?

Prof Bakare: The major challenge is marketing and funding. To get papers is not difficult provided authors are aware of your journal. Marketing is the major prob-

lem. Unless one has a regular source of funding, it is very difficult to fund journals. The way out is to have a marketing manager. This also is expensive, it has not been easy.

Annals: Should resident doctors pursue Academic Careers?

Prof Bakare: The fellowship program is as comprehensive as the M.Sc. or PhD programmes and what I think should be done is to emphasis that the postgraduate medical training or fellowship program is equal in every way or even superceedes the PhD prrogramme. This is a fact and should be made very clear to everybody.