

## THE CONTRIBUTION OF PRIVATELY OWNED HOSPITALS IN THE PROVISION OF ESSENTIAL OBSTETRIC CARE IN NIGERIA.

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### ABSTRACT:

**Objective:** To highlight the private sector contribution in the provision of essential obstetric care in Abia State, Southeastern Nigeria.

**Method:** Following two workshops a structured questionnaire was used to seek information on the type of facility, ownership, type of services, number of staff, instruments and medical consumables, deliveries and data on clients attended to in the previous twelve months. On the basis of the response the facilities were classified into not essential obstetric care, basic essential obstetric care and comprehensive essential obstetric care.

**Results:** Of 638 facilities visited only 378 offered antenatal and postnatal services. The 13 government hospitals and 173 primary health centers conducted 5601 deliveries. The 146 private hospitals/clinics and 46 maternity homes conducted 21,128 deliveries. Only 121 offered essential obstetric services: 42 basic with 2488 deliveries and 79 comprehensive with 14,489 deliveries. Of the basic essential obstetric facilities that were private, 84.6% were concentrated in the 6 urban local government areas (LGA) leaving 15.4% in the 11 rural LGA. Similarly 85.6% of the comprehensive essential obstetric facilities that were private are concentrated in the 6 urban LGA leaving 14.4% scattered in the 11 rural LGA

**Conclusion:** The private sector, with its greater essential obstetric facilities, is concentrated mainly in the 6 urban LGA. This resulted in 14,970 deliveries as against 2007 deliveries in the government facilities. Although there is an apparent neglect of the other 11 LGA, the deliveries in the private facilities constituted over 79% within the study period. This greater contribution should be noted and considered when planning maternal and infant mortality and morbidity reforms in Nigeria.

### Key words:

### INTRODUCTION

Poor maternal indices of any country are a reflection of a poor socio economic development and a weak health care system.<sup>11</sup> The complications of pregnancy, child bearing and unsafe abortions claim the lives of over 600,000 women per annum worldwide<sup>1-4</sup> About 99% of these deaths occur in the developing world. In Nigeria, the maternal mortality ratio is 1000 - 2420 per 100,000 live births<sup>5,6,7</sup>. The major obstetric causes of maternal and neonatal deaths are ante and post partum haemorrhage, sepsis, ruptured uterus due to obstructed/prolonged labour, pre-eclampsia/eclampsia, complications of induced abortion and ectopic pregnancy.<sup>8,9,10</sup>

Addressing primary health by providing primary health care centers, training of traditional birth attendants and mobilization of women to use antenatal care services even when properly implemented will not be able to address the maternal problems because these services are not able to cope with these major causes of maternal and infant mortality. Worse still is the non-functional referral system in the country and neglected secondary health care system which should handle emergencies arising from the primary sector. The private sector has, therefore, found a gap and supplemented the efforts of the government in providing maternal services to the populace. Unfortunately, over the years, this sector has been neglected by government and international agencies working in the country. In many of our states and cities the private sector remains the beacon of hope to the populace. This is more so during periods of industrial disputes

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when the secondary and tertiary health sectors are totally incapacitated.

This study sets out to highlight this contribution of the private sector in the provision of essential obstetric care focusing on Abia State, South East Nigeria.

## **MATERIALS & METHODS**

**Background:** Abia State, one of the five states of South East geopolitical zone of Nigeria has a population of 1,876,906, in the 1991 national population census. There are 17 local government areas with a total of 638 health facilities located in the different LGAs of the state.

This study was part of a national study on essential obstetric care facilities carried out in 12 states of Nigeria. Two preliminary workshops were held for the investigators to equip them and harmonize the research instruments.

A consultative meeting of the entire stakeholders were held in each of the states to secure their support and obtain preliminary data for the survey.

### **Study Design**

Over a 4-week period, following a 2-day training workshop for 20 senior nurse-midwives and 2 sociologist assistants, a structured questionnaire adapted from Maine et al, Center for population and family health, School of Public Health, Columbia University New York<sup>12</sup> was administered to all the listed health facilities offering maternal services in all the seventeen LGA of Abia State.

Information on type of facility, number of deliveries, ownership, type of services offered, the category and number of staff, instruments and medical consumables available and data on clients attended to in the last 12 months were recorded. This report, focusing on the spread of the facilities and number of deliveries, highlights the contribution of the privately owned establishments.

Facilities that offered parental antibiotics, parental oxytocics, parental sedatives, removal or retained products of conception, assisted vaginal

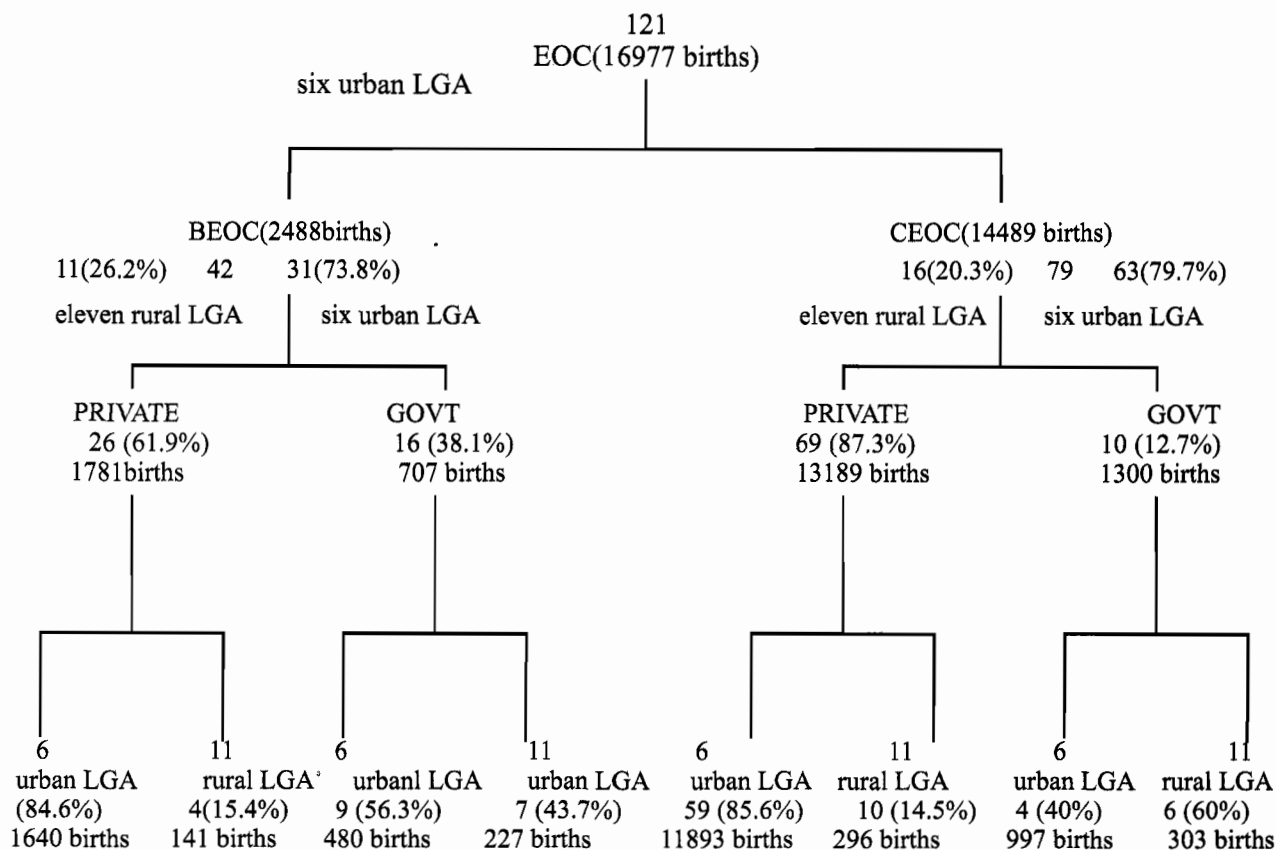
delivery were Basic Essential obstetric Care (BEOC); Facilities that did not offer any of these were Not Essential Obstetric Care (NEOC). Facilities that offered the above plus blood transfusion and cesarean section were classified as Comprehensive Essential Obstetric Care (CEOC),

## **RESULTS:**

There were 638 health facilities in Abia State. Only 58% (378) offered antenatal, delivery, and postnatal services with 26,729 deliveries over the period of the study. There were 13 government hospitals, and 173 primary health centers. Private establishments were 146 hospitals and clinics and 46 maternity homes.

There were 121 facilities that met the Essential Obstetric Care (EOC) status and had 16,977 deliveries. Fig. 1. Basic Essential Obstetric Care (BEOC) was 42 and had 2488 deliveries. Comprehensive Essential Obstetric Care (CEOC) was 79 and had 14,489 deliveries. Of the 42 BEOC, 26 (61.9%) were privately owned and conducted 1781 deliveries whereas 16 (38.1%) government owned conducted 707 deliveries. Twenty-two (84.6%) of the 26 privately owned BEOC conducting 1640 deliveries were concentrated in the 6 urban areas and 4 conducting 141 deliveries were dotted in the rest of the 11 rural Local Government Areas (LGA). The distribution of the 16 government owned BEOC were 9 (56.3%) in the 6 urban areas conducting 480 deliveries; and 7 (43.7%) conducting 227 deliveries were scattered in the 11 rural LGAs. Of the 79 CEOC facilities conducting 14,489 deliveries, 69 (83.3%) conducting 13,189 deliveries were privately owned and 10 (12.7%) conducting 1300 deliveries were government owned. Out of the 69 privately owned CEOC, 59 were located in 6 urban areas with a delivery of 11,893; and 10 in the 11 rural LGA. Of the 10 government owned CEOC. 4 with a delivery of 997 deliveries were located in 6 urban areas and 4 were scattered in 11 others with 303 deliveries

## Distribution of births in the Essential Obstetric Facilities in the LGAs



### DISCUSSION:

Maternal services in the 17 LGA of Abia State are rendered by 186 government and 192 private owned establishments. Over the study period there were 26,729 deliveries. Of these, 16,977 were in EOC centers and 9,959 in non-EOC centers. The government facilities are more evenly distributed in the LGA, whereas the privately owned facilities are concentrated in the urban areas of the state. Also the proportion of private facilities that met the EOC criteria is much higher than that of the government. Thus the private sector not only had a larger number of facilities in the state, but also had facilities that offered more qualitative services to the populace; but these are sited mainly in the six of the 17 LGA. Private contribution becomes more apparent when 14,970 deliveries were carried out in the private facilities as against 2,007 deliveries in the government facilities over the same period. This situation raises some issues: (1) the role of private practitioners in obstetric care and their possible mobilization by government to enhance care; (2) lack of facilities in the government care centers and (3) revolutionizing transport facilities.

With respect to the health services, the most significant factors contributing to maternal deaths include lack of access to essential obstetric services, poor medical care, inadequate numbers of trained personnel and inadequate supplies of drugs and equipment.<sup>13</sup> This study shows that 77.7% (94) of essential obstetric services are concentrated in six urban centers leaving 23.3% (27) dotted over the vast other 11 rural LGA. Although there is regional variation in maternal mortality rates in Nigeria with the south-east and south-west ranging about 500/100,000 births and the north-west and north-east about 2000-2500/100,000 births<sup>5,6</sup>, a major contributor is seen in the sparse distribution of essential obstetric services in the rural communities where 60% of the population live<sup>7</sup>. This agrees with the 1999 census figures in which Abia has a population of 2,320,990 and 903,173 in the urban areas leaving 1,417,819 (63.7%) in the rural areas. This is further complicated by the bad state of our roads and poor transportation services when emergencies occur especially in the nights.

Ekwempu<sup>14</sup> in 2000 agrees that our maternal mortality and morbidity figures have gone from bad to worse over time, and quoting Rosenfield and

Maine,<sup>15</sup> he states that if women who develop complications can have access to a facility where staff can safely complete an incomplete abortion, administer a blood transfusion, provide intravenous antibiotic, oxytocic and anticonvulsant; and provide emergency cesarean section, our figure of maternal mortality and morbidity will improve. We quickly add that if private facilities concentrated in the few urban areas are evenly distributed among the larger rural communities where 63.7% of the populations live, we will be reducing further the mortality figures in Abia. One of the three pillars of safe-motherhood is avoiding delay in reaching an institution that can provide emergency obstetric care. With the present heavily urban biased distribution of essential obstetric care facilities this goal can hardly be achieved. It is, therefore, no wonder that only about 33% of deliveries take place in the hospitals<sup>16,17</sup> where essential obstetric care is available. For some West African countries a change in this pillar has brought effective maternal programs, but this does not seem to be the case in Nigeria. To decrease our high maternal mortality and morbidity, essential obstetric care should be coordinated into one regional obstetric organization. The views of Lawson and Stewart<sup>18</sup> of the 1970s still remain true: "The specialist staff of the central unit must be responsible for the standards of care and for the supervision of the clinical services in all the units which serve its "catchment" area. This does not mean that all the component arts need to be centrally financed. Government hospitals, university hospitals, mission hospitals, local authority services and private nursing homes may all contribute to the maternity service of a region, but their activities ought to be coordinated. There is, therefore, an apparent neglect of the other 11 LGA.

The deliveries in the private facilities constituted over 79% within the study period. This greater private contribution should be noted and considered when planning maternal and infant mortality and morbidity reforms in Nigeria.

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