Commentary

QUALITY OF REPRODUCTIVE HEALTH CARE IN NIGERIA: A CRITICAL APPRAISAL.

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ABSTRACT

Introduction: Reproductive Health is a concept that caters for the complete health of humans from conception to the grave. Currently, the concept has undergone an expansion of its scope beyond the elimination of mortality and physical morbidity:
Methods: Issues such as respect for women's autonomy; rights, preferences, dignity and right to informed choice, as well as shared decision-making process were brought under the spotlight. The quality of reproductive health services available in a nation reflect on the overall health of the citizens and assesses the relationship between the three key components of health care, including the Client, Healthcare providers, and the relationship between the two. Indeed, the technical aspect of medical practice (diagnosis and treatment) is as important as the human, physical and the contextual setting in which the health care service is rendered. Developing countries like Nigeria must start to look beyond addressing morbidity and mortality in quantitative forms and consider the mental and psychological wellbeing of their citizens as well.
Outcome: The Structures, Processes and Outcomes of reproductive health care in Nigeria were critically appraised, and suggestions for improvement were made as appropriate in this article.
Keywords: Quality of care; Reproductive health; Maternal mortality; Maternal morbidity; Standards of care.

NigerJmed 2020: 178-181

INTRODUCTION

Reproductive Health is defined by the World Health Organisation as a state of complete physical, mental, social and spiritual wellbeing in all that pertains to the reproductive system, its functions and processes; and not merely the absence of disease or infirmity of the reproductive organs. It is a concept that caters for the complete health of humans from conception to the grave. Not only has this concept endured, but it has, in fact, expanded and advanced steadily over the decades. Reproductive health became a global phenomenon through the vehicle of some historic international conferences, most notable among which were the Fourth World Conference on Women (Beijing, 1995), the International Conference on Population and Development (ICPD), (Cairo, 1994), the Five-year Review of the implementation of the Beijing Declaration and Platform for Action (Beijing + 5, 2000), the 2000 United Nations' Summit (New York, 2000; culminating in the Millennium Development Goals), and the United Nations' Summit in 2015, with subsequent formation of the Sustainable Development Goals.

With about 200million pregnancies occurring worldwide every year, reduction of maternal mortality and elimination of physical morbidity complicating the reproductive process are crucial to the actualisation of the reproductive health and safe motherhood goals and targets. Collaborative efforts in this regard over the years have yielded commendable results, with the global annual maternal mortality falling by 44% (585,000 to 303,000) between 1990 and the end of the Millennium Development Goal era in September 2015. To sustain this positive trend, the United Nations launched the Sustainable Development Goals (SGDs), a set of 17 goals with 169 targets, and the 'Global Strategy for Women, Children and Adolescents' Health 2016-2030'. (1-3)

Since most maternal mortalities are the culmination of Severe Maternal Obstetric Complications, reduction in physical morbidity for parturients will expectedly result in a reduction in maternal mortality globally.(4) Over the last three decades, reproductive health has undergone an expansion of its scope beyond the elimination of maternal mortality and physical morbidity. Issues such as respect for women's autonomy, rights, preferences, dignity and right to informed choice and shared decision-making process have been brought under the spotlight.(5)

The intense emotional experience of pregnancy and delivery can leave a parturient with a lasting experience of personal fulfilment, or if not handled properly, may simply transform her into an emotional wreckage who

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abhors any future contact with the health system, even in future pregnancies.(5) A loss of confidence in the health system often translates into decreased utilisation of available facilities, with a consequent adverse effect on reproductive health. It therefore became necessary not only to assess the reproductive health care rendered to women in terms of quantitative morbidity and mortality figures, but also with respect to the totality of qualitative care rendered to such women. This line of thought heralded the concept of Quality of Care in Reproductive Health.

QUALITY OF CARE IN REPRODUCTIVE HEALTH: DEFINITION AND HISTORY

Quality of care (QoC) is inevitable for health services. It is a concept that assesses the relationship between the three key components of health care, including the CLIENT, the Healthcare providers, and the relationship between the two. Donabedian(6) emphasised over three decades ago that "quality" is an important characteristic of medical care, based on his observation that the technical aspect of medical practice (diagnosis and treatment) is as important as the human, physical and the contextual setting in which the health care service is rendered.

Although it had been mulled for years, the formal framework for the definition of QoC was perhaps formally laid by Judith Bruce and Anrudh Jain between 1989-1990.(7-9) The duo described Quality of Care as"the way individuals and clients are treated by the system providing services". As the duo were both researchers in the Population Council, the concept of QoC was understandably developed with respect to family planning and contraceptive services. They identified six core themes of QoC in family planning, including choice contraceptive methods, Information given to patients, technical competence, Interpersonal relationships, continuity and follow-up and the appropriate constellation of services.

The Bruce-Jain framework for QoC in Contraceptive services was later adopted by the World Health Organization and promoted at other international conferences, especially the ICPD in 1994, where the concept was concretised.(10)In further recognition of the need for standard-setting and quality assurance, QoC has been expanded and incorporated into other components of the reproductive health service beyond contraceptive services.(11)

OTHER DEFINITIONS OF QUALITY OF CARE

As the concept of quality was very dynamic, it was no surprise that many attempts were made to generate an encompassing definition. Goodlee(12) further defined Quality Care as a "clinically effective, safe and a good experience for the patient", while the Institute of Medicine (IOM)(13) defined it as "A care that is safe, effective, patient-centred, timely, and equitable". The latter definition encompasses three important considerations in rendering quality care, including: clinical (safe and effective), interpersonal (patient-centred) and contextual to emphasising the client-centred approach to providing high-quality health care as a basic human right.(5, 10, 14)

COMPONENTS OF QUALITY REPRODUCTIVE HEALTH CARE

The components of Quality Reproductive Health Care are listed and defined as follow(8, 11, 15);

Management: considered to be all the activities involved in utilising the people and coordinating the resources (human and otherwise) invested in reproductive health care.

Client - Provider Relationship: this is largely human dependent, and describes the interaction between the health care provider and the client.

Provider Competence: refers to the training, technical know-how and experiences of the providers, and how these are utilised in the process of rendering care.

Information Exchange: describes the discussion between the provider and the recipient of care. A productive discussion depends largely on technical competence, appropriate environment for the nature of the discussion, as well as a warm and compassionate health care provider.

Continuity: defined as a set of mechanisms that strengthen the progress of care, including follow-up visits, referrals and linkages to other components of reproductive health as appropriate.

It is important to understand that health care is a continuum, and there is considerable overlap in the components listed above. For clarity and functionality, these components may be re-categorised under three themes, including 1) The structure; 2) Processes and 3) Outcome of quality reproductive health care.(15)

The **"Structure"** defines all input into reproductive health care services, including manpower, buildings and equipment. It is a stock of all investments, human and material that have been committed into the provision of the care. This, on the overall, determines the technical ability of any reproductive health facility.

The **"Processes"**interface between the "Structure" and the "End users", which in this instance are the clients/patients. These processes determine how respectful, efficient, timely, equitable and appropriate reproductive health services are, taking into context the needs and socio-cultural peculiarity of the population involved.

The **"Outcome"**assesses the result of the interaction between the structure and processes. Physical morbidity and mortality are assessed as immediate impacts of these interactions, while the long-term health benefits are assessed by evaluating the clients' satisfaction with the health system, as well as her willingness to return to similar facilities for health care in the future.

MEASURING QUALITY OF CARE

Measuring quality of care in reproductive health is daunting due to the wide spectrum of the components of reproductive health services. Indeed, the demands of a benign gynaecological service are completely different from that of gynae-oncology. Not uncommonly, these in turn completely differ from the expectations of obstetric services. In addition to these, patients' expectations are significantly influenced by a host of other factors, including their preferences, previous experiences, needs and societal permissiveness. Nevertheless, attempts have been made at establishing some standards of care for reproductive health services by regulatory bodies such as the WHO, and the National Colleges of individual countries (RCOG, ACOG, SOGC), Ministries of Health,

and even individual health facilities through guidelines and position papers on best clinical practices.

The White Ribbon Alliance (WRA)(5) introduced the Respectful Maternity Care (RMC), a concept that considers quality health care as "a universal human right that is due to every childbearing woman in every health system". The WRA described disrespectful and abusive care to women, irrespective of whether they are pregnant women, adolescent, ethnic minorities or those with disabilities as appalling. The Alliance further identified clearly seven common areas of abuse, including Physical abuse, Non-consented care, Non-confidential care, Non-dignified care, Abandonment or denial of care and Detention in facilities. Although this concept was described with specific reference to childbearing women, it, in fact, applies to all areas of care in reproductive health.

STRATEGIES TO IMPROVE THE QUALITY OF REPRODUCTIVE HEALTH SERVICES IN NIGERIA.

Strengthening the quality of reproductive health care in Nigeria demands a holistic approach, directed at addressing each of the three aspects and components of Quality of Care, as discussed earlier. The current "structures" of the country, including financing, health facilities and health care workers must be addressed in totality. Some measures are suggested below;

THE STRUCTURE

Modification of Training Curriculum

The Medical training curriculum at both undergraduate and postgraduate levels should consider the introduction of training programmes on Quality Improvement, Quality Assurance, Interpersonal and Communication skills. This ensures that such students at the completion of training are in no doubt about what standard and quality care should be, and are not left to the overwhelming influence of whatever practice obtains at their place of deployment. The introduction of competency-based programmes will be an alignment with the contemporary trends in postgraduate training globally.

Health Care Financing

Health care financing constitutes a significant determinant of the quality of care that clients receive. Indeed, the current "out-of-pocket" payment structure in the country imposes significant challenges on the health system, as practitioners often must strive to achieve the delicate balance between "optimal" and "affordable" care. "Out-of-pocket" payment also constitutes the crus of detention in health facilities due to inability to pay for emergency obstetric services rendered to women in genuine need of such facilities. This invariably places a moral burden on the health care service providers of the country. Universal Health Coverage (UHC) has been discussed extensively by the Federal Government of Nigeria, and achievement of substantial coverage of the Nigerian citizens must be prioritised for any meaningful impact to be made.

Staffing

Inadequate staffing often puts the health system under undue strain. The consequent unmet demand for basic care leaves many patients at risk of severe adverse maternal morbidity and mortality. Furthermore, overworked medical staff are especially prone to avoidable errors. While humans are understandably not infallible, human errors can be minimised by meeting appropriate staffing needs of all health care facilities; otherwise, the healthcare-personnel may become frustrated and poorly motivated.

Available and Accessible Health Facilities

Health facilities should be readily accessible and available to render 24-hour services everyday, with dedicated information desks for enquiries. In developed climes, accessibility has indeed advanced beyond physical entry into hospitals, and now include dedicated, toll-free emergency service lines, ambulance services for urgent referrals, secure on-line appointment system, virtual consultation and follow-up services, automated voice prompts and directory systems among a host of others. Introduction of these into the current practice in Nigeria has become necessary now more than at any other time.

Orientation Programmes and Job Descriptions

It is not uncommon that newly appointed members of staff often resume without a clear-cut idea of the expectations from them. This indeed has created an environment riddled with unnecessary rivalry and animosity among health care workers in Nigeria, with patients often at the receiving end of the backlash. At recruitment, all health institutions must strive to provide orientation programmes for their staff, with updated handbooks specifying job specifications, the duty to patients and colleagues, as well as supervisory and reporting lines while on duty.

Establishment of Standards of Care and Upgrade of All Tiers of Health Care

The different visions and missions of creating primary, secondary and tertiary tiers of health care in Nigeria have been eroded, with primary health care almost disappearing into oblivion. Consequently, the secondary and tertiary health facilities are overburdened with burgeoning patient loads, leaving the severely ill patients, for whose benefits tertiary care was established in a long queue. This makes it impossible to render timely and efficient care. The Nigerian Government, at all levels, must consider the urgent revitalisation of the Primary Health Care System in the country to facilitate the provision of qualitative health care.

THE PROCESSES

Communication Skills

This is paramount in the establishment of quality reproductive health services. While empathising with clients, health care providers must be pristine clear in their opinions and utilise both verbal and non-verbal means of communications effectively without any attempt at coercion. While this concept appears to be well-grounded in the developed climes, there still exists a clear deficit in communication between health care providers and clients in Nigeria. This is potentiated by the wide knowledge-gap between health care providers and their clients, due to sub-optimal literacy levels and limited access to information. This is, however, expected to improve as patients' awareness and female literacy improves, such that clients would eventually retain a significant share of the decision-making process relating to their health. Importantly, it is imperative that health care providers ensure that patients understand clearly the information that had been given and put it to rational use to arrive at a decision.

Appropriate Environment for Consultation

The provision of optimal quality of care requires an environment that is appropriate for the specific components of reproductive health. Clearly, the infrastructural demands for adolescent health and reproductive services differ significantly from that of sexual and domestic violence. Circumstances, where victims of sexual assaults are reviewed and examined at busy emergency units, should be discouraged. It is not uncommon in Nigerian health care facilities to witness consultations involving two or more patients simultaneously in the same room, within earshot of each other! This is a clear violation of patients' rights to privacy and confidentiality, and such practices must be discontinued.

Standards of Care

Health facilities in Nigeria should endeavour to generate clinical protocols and guidelines for common clinical conditions within their clinical service units, such that all patients are managed by at least the basic acceptable standard by international recommendations. This eliminates individual preference and bias of the health care provider, and clients are managed based on the best available chain of evidence. In addition, serial review of the guidelines will ensure that every member of staff not only understands the first-line treatments and suitable alternatives for clients but can clearly identify stipulated criteria for referral or escalation of concerns to senior Personnel. Overall, clients will enjoy quality care irrespective of the cadre of health care staff providing the service.

THE OUTCOME

Evaluation of the quality of care is key to improvements in the quality of reproductive care services and has come under the spotlight in recent years, with the aim of assessing other factors that may not be easily determined using the morbidity and mortality indices. Nigerian hospitals must establish a culture of regular clinical and administrative audits using international standards and benchmarks; unbiased, confidential enquiries into serious/adverse incidents; random on-line and telephone surveys; use of mystery patients and anonymous patient feedback. Currently, only a few, if any of the public health facilities in Nigeria utilise these outcome assessment tools to evaluate their performance.

CONCLUSION

The quality of reproductive health services available in a nation reflects on the overall health of the citizens. Developing countries like Nigeria must start to look beyond addressing morbidity and mortality in quantitative forms and start to consider the mental and psychological wellbeing of their citizens as well.

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