*Trop J Obstet Gynaecol, 22 (2), October 2005.*

# Role of the Private Sector in the Provision of Essential Obstetric Care in Abia State, Nigeria

***Christian C. Ibeh[1] and John E. N. Okonkwo[2]***
Departments of [1]Community Medicine and [2]Obstetrics and Gynaecology, Nnamdi Azikiwe University Teaching Hospital, Nnewi.

**Abstract:**

***Objective***: To examine the role of the private sector in the provision of essential obstetric care in Abia State, Southeastern Nigeria.
***Method***: A structured questionnaire following two workshops was used to seek information on the type of facility, ownership, type of services, number of staff, instruments and medical consumables, 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***: There were 638 facilities visited and only 378 offered antenatal and postnatal services. These were 13 government hospitals, 173 primary health centers 146 private hospitals/clinics and 46 private maternity homes. Broadly 186 were government and 192 were privately owned. 121 offered essential obstetric services: 42 basic and 79 comprehensive. 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 has greater essential obstetric facilities, but these are concentrated mainly in the 6 urban LGA to the neglect of the other 11 LGA. With vision and goodwill, it should be possible to evenly distribute/have all government and private essential obstetric services into an efficient team in the interests of the pregnant women whose welfare they all seek to serve. One way by which the government can do this is to advance a lucrative rural insurance scheme, which will attract the private sector to the majority rural dwellers.

## Introduction

An estimated 600,000 women die from complications of pregnancy, child bearing and unsafe abortions world wide [1-4]. About 99% of these deaths occur in the developing world. The maternal mortality ratio for Nigeria is 1000 - 2420 per 100,000 live births [5,6,7]. Out of a population of 27 million women of reproductive age in the country, it is estimated that 2 million will not survive either pregnancy or child birth[6] .The major obstetric causes of maternal 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.[8,9,10] The poor maternal indices in the country are a reflection of a poor socio economic development and a weak health care system.[11]

Though the thrust of the nations' health care policy is on Primary Health Care, the strategies put in place to contain maternal morbidity and mortality are ill conceived, ineffective and poorly implemented. The mere provision of Primary health care centers, training of traditional birth attendants and mobilization of women to use antenatal care services even when properly implemented is not able to address the maternal problems in the country as these services are not able to cope with the major causes of maternal mortality. This is worsened by the non-functional referral system in the country and total neglect and near collapse of the secondary health care system (General hospitals), which should handle emergencies arising from the primary sector.

In the midst of this ugly situation, the private sector has arisen to fill the gap and supplemented the efforts of the government in providing maternal services to the populace. Unfortunately, over the years, no attention has been given to this sector both by government and international agencies working in the country. In many states and cities of the country, the private sector remains the beacon of hope to the populace. This is more so during periods of industrial disputes affecting the secondary and tertiary health sectors, which has become a common phenomenon in the country. This study sets out to investigate the role of the private sector in the provision of essential obstetric care in Abia State, South East Nigeria.

## Materials and Methods

Abia State is one of the five states that make up the South East geopolitical zone of Nigeria. It is located in the tropical rain forest with a population of 1,876,906, in the 1991 national population census.) It has 17 local government areas. There are 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.

***Correspondence:*** *J. E. N. Okonkwo, P. O. Box 8282, Enugu, Nigeria.*
***E-mail:*** *jenokonkwo@yahoo.com*

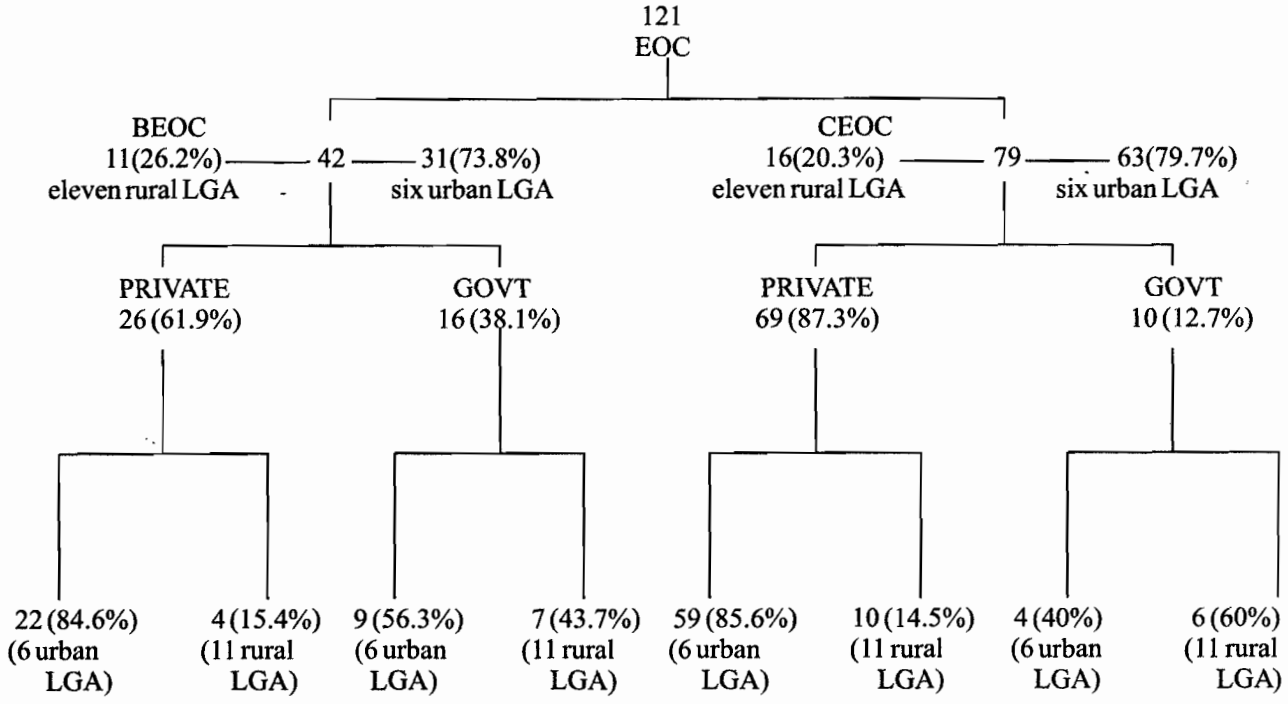
A consultative meeting of the entire stake - holders were held in each of the states to secure their support and obtain preliminary data for the survey.

A facility-based assessment of essential obstetric care was carried out in Abia state to investigate the status of health facilities offering maternal services (antenatal, delivery and postnatal). All the seventeen LGA, of the state were enlisted into the study. A list of all health facilities in each LGA was used to conduct the survey. A structured questionnaire adapted from Maine et al, Center for population and family health, School of Public Health, Columbia University New York[12] was used. It sought information on type of facility, 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. Based on the type of services offered, as listed in 1-7 below, facilities were classified into Basic Essential Obstetric Care (BEOC), Comprehensive Essential Obstetric Care (CEOC) and Not Essential Obstetric Care (NEOC).

1. Parenteral antibiotics
2. Parenteral Oxytocics
3. Parenteral Sedatives
4. Removal of retained products of conception
5. Assisted vaginal delivery
6. Blood transfusion
7. Caesarean section

Facilities that fail to offer any of the services in 1-5 is classed Not EOC facility. One that offered all the services 1-5 is classed as Basic EOC. Facilities that offered all the services are classed as Comprehensive Essential Obstetric Care. A two-day training workshop was organized for the field workers (20 senior nurse midwives and 2 sociologist assistants). The filed workers visited each of the health facilities and conducted the interviews, which lasted for a period of 4 weeks.

**Figure 1**
**Distribution of the Essential Obstetric Facilities in the LGAs**




**Results:**

Out of the 638 health facilities in Abia State, only 378 (58%) offered antenatal, delivery, and postnatal services. They were made up of 13 government hospitals, 173 primary health centers, 146 private hospitals and clinics and 46 private maternity homes: (186 government facilities and 192 private facilities) Table I. Only 121 facilities met the Essential Obstetric Care (EOC) as follows: 42 Basic Essential Obstetric Care (BEOC) and 79 Comprehensive Essential Obstetric Care (CEOC). Of the 42 BEOC, 26 (61.9%) were privately owned and 16 (38.1%) government owned. Twenty-two (84.6%) of the 26 privately owned BEOC were concentrated in the 6 urban areas and 4 dotted 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 and 7 (43.7%) were scattered in the 11 rural LGAs.

**Table 2**
**Distribution of facilities offering essential Obstetric care facilities according to ownership (Private and Government).**

| LGA | Basic EOC | | | Comprehensive EOC | | |
|---|---|---|---|---|---|---|
| | Private | Govt. | Total | Private | Govt. | Total |
| Aba North | 2 | 1 | 3 | 15 | - | 15 |
| Aba South | 9 | 1 | 16 | 21 | 1 | 22 |
| Arochukwu | - | 1 | 1 | - | 1 | 1 |
| Bende | 2 | 5 | 7 | - | 1 | 1 |
| Ikwuano | - | 0 | 0 | 0 | 0 | 0 |
| Isiala Ngwa N. | - | 0 | 0 | 3 | 1 | 4 |
| Isuikwuato | - | 0 | 0 | 2 | 0 | 2 |
| Ohafia | - | 0 | 0 | 0 | 2 | 2 |
| Obingwa | - | 1 | 1 | 2 | 0 | 2 |
| Osisioma | 4 | 2 | 6 | 8 | 1 | 9 |
| Ugwunagbo | 1 | 3 | 4 | 1 | 0 | 1 |
| Ukwa East | 0 | 1 | 1 | 1 | 1 | 2 |
| Ukwa West | 1 | 0 | 1 | 1 | 0 | 1 |
| Umuahia N. | 0 | 0 | 0 | 10 | 1 | 11 |
| Umuahia S. | 0 | 1 | 1 | 2 | 1 | 3 |
| Umunneochi | 0 | 1 | 1 | 1 | 0 | 1 |
| **Total** | 26 | 16 | 42 | 69 | 10 | 79 |

**Table 1**
**Distribution of Health facilities offering Maternal services (antenatal, delivery and postnatal) in the LGAs in the state**

| LGAs | Number of Health Facilities | | | | Total |
|---|---|---|---|---|---|
| | Private | | Government | | |
| | Maternity | Hosp/Clin | P.H.C center | Hospital | |
| Aba North | 0 | 20 | 2 | 0 | 22 |
| Aba South | 17 | 48 | 2 | 1 | 68 |
| Arochukwu | 1 | 2 | 12 | 1 | 16 |
| Bende | 3 | 4 | 41 | 2 | 50 |
| Ikwuano | 4 | - | 11 | - | 15 |
| Isiala Ngwa N. | 5 | 4 | 12 | 1 | 22 |
| Isiala Ngwa S. | 2 | 4 | 6 | - | 12 |
| Isuikwuato | 2 | 7 | 24 | 1 | 34 |
| Ohafia | 1 | 7 | 7 | 2 | 17 |
| Ibingwu | - | 3 | 7 | - | 10 |
| Osisioma | 2 | 18 | 14 | 1 | 35 |
| Ugwunagbo | 2 | 3 | 6 | - | 11 |
| Ukwa East | - | 1 | 3 | 1 | 5 |
| Umuahia N. | 4 | 12 | 4 | 1 | 21 |
| Umuahia S. | 3 | 4 | 5 | 1 | 13 |
| Umunneochi | 1 | 5 | 13 | - | 19 |
| **TOTAL:** | 46 | 146 | 173 | 13 | 379 |

Of the 79 CEOC facilities, 69 (83.3%) were privately owned and 10 (12.7%) government owned. Out of the 69 privately owned CEOC, 59 were located in 6 urban areas and 10 in the 11 other LGA. Of the 10 government owned CEOC. 4 were located in 6 urban areas and 4 were scattered in 11 others. Fig 1 summarizes this distribution.

**Discussion:**
The facilities that offer Essential Obstetric Care (EOC) in the 17 LGA of Abia State are 186 government and 192 private owned. Whereas the government facilities are more evenly distributed in the LGA, 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 better services to the populace; but these are sited mainly in the six of the 17 LGA. This situation raises some issues: the role of private practitioners in obstetric care and their possible mobilization by government to enhance; lack of facilities in the government care centers and 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.[13] This study shows that 77.7% of essential obstetric services concentrated in six urban centers leaving 23.3% dotted over 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 500/100000 births and the north-west and north-east about 2000-2500/100000 births[5,6], a major contributor is seen in the sparse distribution of essential obstetric services in the rural communities where 60% of the population live[7]. This agrees with the 1999 census figures in which Abianhas 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 compounded by the bad state of our roads and poor transportation services when emergencies occur especially in the nights.

Ekwempu[14] in 2000 agrees that our maternal mortality and morbidity figures have gone from bad to worse over time, and quoting Rosenfield and Maine[15] 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 population 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[16,17] 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[18] 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. With vision and goodwill it should be possible to bring them together into an efficient team in the interests of the pregnant women whose welfare they all serve."

One of the possibilities by which government can mobilize the private sector to enhance the obstetric care especially in the rural communities is to advance a lucrative health insurance scheme for the rural populace. This will entice the private sector to the rural areas and will help to spread the better facilities in their possession.

**Acknowledgement**

This survey of assessment of Essential Obstetric Care facilities in Abia state was funded by the United Nations Population Fund (UNFPA) as part of a national survey. Due acknowledgement is hereby given to UNFPA for their support.

## References

1. World Health Organization, Geneva : *Maternal mortality in 1995: estimates developed by WHO. UNICEF, UNFPA. WHO/RHRO1*, 2001; 9.
2. Ghosh MK. Maternal mortality. A global perspective. *J Reprod Med*, 2001; 46(5): 427 433.
3. Bouvier-Cole MH; Quedraogo C; Dumont A; Vangeenderhuysen C; Salanave B; Decam C. Maternal mortality in West Africa. Rates, causes and substandard care from a prospective survey. *Acta Obstet Gynecol Scand*, 2001; 80(2): 113 -119.
4. Ahman E, Shah I. Unsafe abortion: worldwide estimates for 2000. *Reprod Health Matters*, 2002; 10(19): 13 -17.
5. Adamu YM, Salihu HU, Sathiakumar N, Alexander GR. Maternal mortality in Northern Nigeria: a population-based study. *Eur J Obstet Gynaecol Reprod Biol*, 2003; 109: 153 159.
6. Ekwempu CU. Structural adjustment and health in Africa. *Lancet*, 1990; 336: 56 57.
7. Okonkwo JEN, Ngene J. Determinants of poor utilization of orthodox health facilities in a Nigerian rural community. *Nig J Clin Pract*, 2004; 7(2): 74 78.
8. Aisien AO, Lawson JO, Adebayo AA. A five year appraisal of cesarean section in a northern Nigeria University Teaching Hospital. *Nig Postgrad Med J*, 2002; 9(3): 146 150.
9. Sule-Odu AO, Olatunji AO, Akindele RA. Complicated abortion in Sagamu, Nigeria. *J Obstet Gynaecol*, 2002; 22(1): 58 61.
10. Orji EO, Ogunlola IO, Onwudiegwu U. Brought-in maternal deaths in south-west Nigeria. *J Obstet Gynaecol*, 2002; 22(4): 385 388.
11. Minkoff H. Maternal mortality in America: lessons from the developing world. *J Am Med Womens Assoc*, 2002; 57(3): 171 - 172.
12. Maine D, Akalin MZ, Ward VM, Kamara A. The design and evaluation of maternal mortality programs. *Center for population and family health. School of Public Health, Columbia University, New York*, 1977.
13. FIGO Maternal mortality In: "Reproductive Health: Global Issues". *FIGO Manual of Human Reproduction. Vol 3*. NJ USA: Parthenon Publishing Group. 1991; 77 99.
14. Ekwempu CU. Alleviation of Maternal Mortality and Morbidity in the New Millennium. Time for change? *SOGON: The fifth O. K. Ogan Memorial Lecture*. Abuja, Nov. 2000.
15. Rosenfield A, Maine D. Maternal mortality A Neglected Tragedy: Where is the M in MCH? *Lancet*, 1985; 2: 83 -85.
16. National Population Commission (NPC) [Nigeria] and ORC Macro. 2004. *Nigeria Demographic and Health Survey 2003*. Calverton, Maryland: p xxv xxvi.
17. Okonta PI, Okali UK, Otoide VO, Twomey D. Exploring the Causes and Risk factors for Maternal Deaths in a Rural Nigerian Referral Hospital. *J Obstet Gynaecol*, 2002; 22(6): 26 629.
18. Lawson JB; Stewart DB. The Organization of Obstetric Services In: *Obstetrics and Gynaecology in the Tropics and Developing Countries*. London: Colchester Publishers, 1970; 305 312.