IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 19, Issue 6 Ser.4 (June. 2020), PP 48-54
www.iosrjournals.org

Evaluation of Reproductive Health Services Delivery by Private Sector Facilities in Benue and Nassarawa States, Nigeria

EREMUTHA, Francis[1]*; ADINMA, Joseph Ifeanyi Brian[2];
GABRIEL,Veronica Chizoba[1]

[1]*Women Friendly Initiative (WFI), Plot 85A, AAI Employment Area, Off Funtaj College Road, Kuje. P. M. B. 15324,*
Wuse Post Office, FCT. Abuja.
[2]*Department of Obstetrics and Gynaecology, Nnamdi Azikiwe University, Awka, Nigeria.*
Corresponding author: **Dr. Francis Eremutha, Women Friendly Initiative, Kuje Area Council, Abuja FCT, Nigeria,*

Abstract: *In Nigeria, as in many developing countries, the private health sector provides a significant proportion of reproductive health services. However, the quality of the reproductive health services provided by personnel operating in this sector remains a concern. This study evaluated the delivery of reproductive health services in 24 Planned Parenthood Global supported private sector health facilities over a period of 3years in Benue and Nasarawa states of Nigeria. A mixed methods approach, exploring qualitative and quantitative data from Benue and Nasarawa states, was adopted to assess the aim.The quantitative assessment involved a questionnaire survey of 16 private sector health facilities in Benue states and 8 facilities of Nasarawa state; an End-line survey of knowledge and Perception on abortion among community members in both states. Qualitative assessment involved a Focus Group Discussion (FGD) with healthcare providers in both states. Antenatal services were offered in 87.5% of facilities in both states, whilst 95.8% of the health facilities do not offer Prevention of Mother to Child Transmission (PMTCT) services. FGD findings included poor procurement and replacement of dilapidated and old equipment and poor funding of public enlightenment programs on reproductive health to the rural areas. Suggested methods of overcoming identified challenges included, targeted funding, capacity building for staff, increased stakeholder participation and political will.*

Keywords: *Reproductive Health Services, Private Sector Health Facility, Family Planning,*

Date of Submission: 26-05-2020 Date of Acceptance: 13-06-2020

I. Introduction

Reproductive health has been recognized to be an immutable factor to the socio-economic development of any nation. Abortion and its complications have played a major role towards the un-salutary maternal mortality situation in developing countries.The benefits of increased access to and use of modern reproductive health services are many and varied. Aside from the direct benefits of offering women and men greater control over their fertility decisions and slowing the rate of population growth, there are also indirect benefits. In particular, Family Planning is essential to meeting the Sustainable Development Goals (SDGs) and leads to better health and well-being (1).

According to the World Health Organization, approximately 830 women die every day from preventable causes related to pregnancy and childbirth (2). More worrisome is the fact that 99% of all maternal deaths occur in developing countries [2]. In Nigeria, as in many developing countries, the private health sector provides a significant proportion of reproductive health services. However, there are concerns about the quality of the reproductive health services provided by personnel operating in this sector. Few interventions exist to improve the quality of reproductive health services being provided by private practitioners.

The improvement of the reproductive healthcare system in Nigeria cannot be overstretched, and it is a vital aspect of sustainable development. Planned Parenthood Global (PP Global) aNon GovernmentalOrganisation with headquarters based in the United Staes has been working in several states of Nigeria to improve reproductive healthcare, these include, Delta, Edo, Lagos, Oyo, Benue, Nasarawa and to an extent Taraba state. Monitoring and evaluation of activities at service delivery points are an integral aspect of this healthcare partnership. This study aims to evaluate the delivery of reproductive health services in PP Global supported private sector health facilities over a period of 3years in Benue and Nasarawa states of Nigeria, It

furthermore conducts an end-line assessment of PP Global safe abortion projects in the two states. It also makes recommendation on the basis of the assessment findings on ways to improve reproductive health services in the states.

II. Materials and Methods

A mixed methods approach, exploring qualitative and quantitative data from Benue and Nasarawa states, was adopted to assess our aim.The quantitative assessment involved a questionnaire survey of private sector health facilities supported by Planned Parenthood Global (PP Global) The quantitative assessment was conducted in 16 facilities in Benue states and 8 facilities of Nasarawa state, also an End-line survey of knowledge and Perception on abortion was administered to a total number of one hundred and forty four respondents from Benue state and seventy one from Nasarawa state and conducted among community members in both states. Qualitative assessment involved a Focus Group Discussion (FGD) with 16 healthcare providers in Benue and 6 in Nasarawa states respectively. The FGD was essentially on assessment and fact-finding visit to evaluate the activities of the healthcare providers and to ascertain the challenges and constraints to their delivery of reproductive health services; it allowed participants to discuss topical issues in detail, perceivedobstacles to the delivery of RH services, as well as helping them explore and clarify their points of view, thus enhancing in-depth discussions were carried out.

Quantitative findings were collated and analysed using SPSS version 17.0and expressed in tables and figure using comparative percentages.

III. Results

3.1. Main characteristics of facilities and respondents for states

The distribution by type of facility, location and provider for states as shown in Table 1.1 indicates that there were sixteen (16) facilities studied and all were private with six (37.5%) and five (62.5%) respectively in Benue and Nasarawa states being located in urban areas, and ten (62.5%) and three (37.5%) respectively in Benue and Nasarawa located in rural areas.

Similarly, the distribution by age, sex and occupation of respondents for states as shown in Table 1.2 indicates respondents were aged between 18-71 years, but the majority of them came under the 21 – 30 years age range; sexes of the respondents were almost evenly distributed in both states. Majority of respondents from Benue state were students (24.3%), while those in Nasarawa state were mainly farmers (22.5%).

1.1 DISTRIBUTION BY TYPE OF FACILITY, LOCATION AND PROVIDER FOR STATES

	Location	
Characteristics	**Benue N (%)**	**Nasarawa N (%)**
Type of facility		
Public	0 (0)	0 (0)
Private	16 (100)	8 (100)
Location		
Urban	6 (37.5)	5 (62.5)
Rural	10 (62.5)	3 ((37.5)
Type of Provider		
Physician	1 (6.25)	0 (0)
Nurse-Midwife	2 (12.5)	3 (37.5)
Nurse	2 ((12.5)	2 (25.0)
Others (Community Health Extension Worker)	12 (75.0)	5 (62.5)

1.2 DISTRIBUTION BY BIO-SOCIAL CHARACTERISTICS OF RESPONDENTS, FOR STATES

	Location	
	Benue	**Nasarawa**
Characteristics	**N=144 %**	**N=71 %**
Age		
11 – 20	16 (11.1)	6 (8.5)
21 – 30	62 (43.1)	34 (47.9)
31 – 40	41 (28.3)	18 (25.4)
41 – 50	16 (11.1)	3 (4.2)
50 plus	5 (3.5)	9 (12.7)
NR	4 (2.8)	1 (1.4)
Sex		
Male	63 (43.8)	36 (50.7)
Female	73 (50.7)	31 (43.7)
No Response	8 (5.6)	4 (5.6)
Occupation		
Health worker	15 (10.4)	14 (19.7)
Civil servant	16 (11.1)	5 (7.0)

Teacher	18 (12.5)	3 (4.2)
Student	35 (24.3)	5 (7.0)
Trader	17 (11.8)	15 (21.1)
Farmer	20 (13.9)	16 (22.5)
Others	11 (7.6)	8 (11.3)
No Response	12 (8.3)	5 (7.0)

3.2. Description of Results

The quality of Reproductive Health Services offered by 24 private sector health facilities in Benue and Nasarawa states were assessed following a 3years support by PP Global, the below tables is a representation of the findings of the survey:

2.1 DISTRIBUTION BY TYPE OF SERVICES RENDERED IN FACILITIES FOR STATES

	Location	
Characteristics	**Benue N (%)**	**Nasarawa N (%)**
Antenatal care	14 (87.5)	7 (87.5)
Vaginal delivery	14 (87.5)	6 (75.0)
Caesarean section	6 (37.5)	2 (25.0)
Safe Abortion/Post Abortion Care	10 (62.5)	8 (100)
Family planning	16 (100)	8 (100)
Emergency contraception	10 (62.5)	8 (100)
Endometrial biopsies	0 (0)	0 (0)
Male sterilization	0 (0)	0 (0)
Female sterilization	5 (31.3)	1 (12.5)
Infertility treatment	4 (25.0)	2 (25.0)
Cervical Cancer Sreening	0 (0)	0 (0)
SexualyTransmitted Infection (STI) screening	13 (81.3)	5 (62.5)
SexualyTransmitted Infection (STI) treatment	14 (87.5)	8 (100)
HIV screening	15 (93.8)	7 (87.5)
Pregnancy test	16 (100)	8 (100)
Blood transfusion	10 (62.5)	5 (62.5)
Others (Prevention of mother-to-child transmissionPMTCT)	1 (6.3)	0 (0)

2.2 DISTRIBUTION BY FAMILY PLANNING SERVICES FOR STATES

	Location	
Characteristics	**Benue N (%)**	**Nasarawa (%)**
Family planning services		
Yes	16 (100)	8 (100)
No	0 (0)	0 (0)
No Respone	0 (0)	0 (0)
Family planning methods available in facility		
Barrier	9 (56.3)	2 (25.0)
Oral	15 (93.7)	8 (100)
Injectable	16 (100)	8 (100)
Implants	10 (62.5)	5 (62.5)
Intra Uterine Contraceptive Device (IUCD)	9 (56.3)	4 (50.0)
Traditional	1 (6.3)	1 (12.5)
Voluntary Sterilization	3 (18.8)	0 (0)
Natural	2 (12.5)	2 (25.0)
Others	1 (6.3)	0 (0)
No Respone	0 (0)	0 (0)
Family planning methods usually accepted in facility		
Barrier	7 (43.8)	1 (12.5)
Oral	13 (81.3)	7 (87.5)
Injectable	15 (93.7)	8 (100)
Implants	10 (62.5)	6 (75.5)
Intra Uterine Contraceptive Device (IUCD)	7 (43.8)	3 (37.5)
Traditional	0 (0)	0 (0)
Voluntary Sterilization	2 (12.5)	0 (0)
Natural	0 (0)	1 (12.5)
Others	1 (6.3)	0 (0)
No Respone	1 (6.3)	0 (0)
Family planning to post abortion patients		
Yes	16 (100)	8 (100)
No	0 (0)	0 (0)
Not Available	0 (0)	0 (0)
No Respone	0 (0)	0 (0)
Contraceptive stocked or offered at place of Safe Abortion/Post Abortion Care provision		
Yes	13 (81.3)	6 (76.0)
No	9 (56.3)	0 (0)

No Respone	0 (0)	2 (25.0)
Providers ask post abortion patients who receive a method on site to return for resupply		
Yes	13 (81.3)	7 (87.5)
No	0 (0)	0 (0)
No Respone	3 (18.8)	1 (12.5)

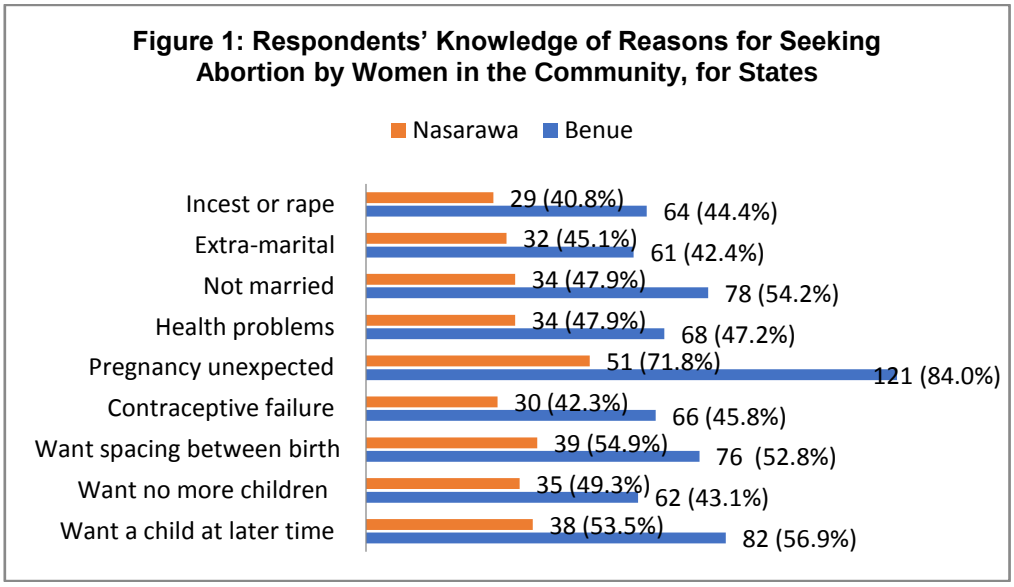
TABLE 2.3 DISTRIBUTION BY OTHER RH SERVICES FOR STATES

	Location	
Characteristics	**Benue N (%)**	**Nasarawa N (%)**
Provision of RH services to post abortion patients		
Yes	16 (100)	6 (75.0)
No	0 (0)	1 (12.5)
Not Available	0 (0)	0 (0)
No Respone	0 (0)	1 (12.5)
RH services provided by facility to post abortion patient		
STI screening	15 (93.7)	5 (62.5)
STI treatment	15 (93.7)	7 (87.5)
HIV/AIDS counselling	16 (100)	7 (87.5)
HIV screening	15 (93.7)	5 (62.5)
Cervical cancer screening	0 (0)	0 (0)
Infertility management	6 (37.5)	1 (12.5)
Others	1 (6.3)	1 (12.5)

In addition to the quality of reproductive health services available to clients, the study also conducted an end line assessment of other quantitative variables related to reproductive health services listed in the tables below:

TABLE 2.4 DISTRIBUTION BY PERCEPTION OF RESPONDENTS ON ABORTION PRACTICE BY WOMEN IN THE COMMUNITY, FOR STATES

	Location	
Characteristics	**Benue N=144 %**	**Nasarawa N=71 %**
Woman's decision on number of children		
Yes	85 (59.0)	44 (62.0)
No	59 (41.0)	27 (38.0)
No Respone		
Woman need consent to have an abortion		
Yes	112 (77.8)	30 (42.3)
No	32 (22.2)	41 (57.7)
No Respone		
Whose permission does she need to have abortion		
Husband	103 (71.5)	56 (78.9)
Mother-in-law	18 (12.5)	2 (2.8)
Mother	31 (21.5)	8 (11.3)
Father-in-law	18 (12.5)	0 (0)
Father	9 (6.3)	0 (0)
Others	32 (22.2)	0 (0)
None	3 (2.1)	7 (9.9)
No Respone	6 (4.2)	0 (0)
Why will a woman go to quack for abortion		
Privacy	98 (68.1)	32 (45.1)
Cost	62 (43.1)	28 (39.4)
Convenience	32 (22.2)	6 (8.5)
No Respone	12 (8.3)	5 (7.0)



Findings from the Focus Group Discussion highlighted Key challenges and constraints in the delivery of reproductive Health Services to include difficulty in financing the trips to their partners monthly learning and sharing meeting; difficulty in the procurement of quality and cost effective RH commodities i.e. misoprostol and genuine Manual VaccumAspirator(MVA) plus; financial challenges in the procurement and replacement of dilapidated and old equipment such as couches, bed etc with newer and more modern ones; staff attrition and the need for training of more healthcare providers with re-training of in-house staff to update knowledge and skill; difficulty in the provision of community based distribution of RH services especially to remote area; and inability to expand their membership beyond their present location.

Other challenges highlighted includes poor resources in funding public enlightenment programs on reproductive health to the rural areas; poor financing and training of media practitioners on coverage for RH services in the hinterlands; inability of clients to pay for procured services; and the resistance of the police towards co-operating with the members to offer Post Abortion Care (PAC) services.

IV. Discussion

Because the attitude towards RH service procurement can be influenced by the type of provider in the facility (3) the research first sought to establish the number of providers available in the studied facilities, findings showed that majority of the healthcare providers in both states were trained community health extension workers – twelve (75.0%) in Benue state and five (62.5%) in Nasarawa state (Table 1.1). There were altogether four (25.0%) Nurses/Midwives in Benue and five (31.2%) Nurses/Midwives in Nasarawa state, and only one (6.25%) doctor, in Benue state alone. In both states, the most common type of services rendered in the health facilities (Table 2.1) were found to include antenatal care (87.5% vs 87.5%); family planning (100% vs 100%); pregnancy test (100% vs 100%); HIV screening (93.8% vs 87.5%); and STI treatment (87.5% vs 100%); respectively for Benue and Nasarawa states in each case. Other RH services provided to clients were found not to include cervical cancer screening, similarly, one of the facilities in Nasarawa state was found not to offer PAC services to post abortion clients (Table 2.3). It was evident from the quantitative survey findings (Table 2.1) that served clients were satisfied with family planning methods offered in these facilities with 100% of all supported facilities providing the services and bearing in mind that private sector facilities are profit oriented, this gives an indication of an increased acceptance of family planning as evident in the end line assessment of abortion services in both states (Table 2.4) where respondents (59% vs 62%) were of the opinion that a woman has a decision on the number of children she is to bear in the family; the findings has also shown that studied facilities were aware and offered varied number of family planning options to clients (Table 2.2) in both Benue and Nasarawa states, and that the provision of the different methods of family planning was high among studied facilities implying that health care workers were knowledgeable about these services. Overall implication of this is that contraceptive prevalence is likely to increase in future with its attendant effect on fertility rate. Findings showed that the least family planning methods usually accepted in facilities (Table 2.2) were the traditional (0,0), voluntary sterilization (12.5%, 0%) and natural methods (0, 12.5%) in Benue and Nasarawa respectively, this is similar to findings from other studies (4,5). Furthermore, the availability of antenatal services (Table 2.1) in 87.5% of the facilities in rural and urban areas in both states is an indicator of PP Global supported facilities concerted efforts towards achieving the SDG's (6). The availability of antenatal services will lead to a potential reduction of maternal mortality rate caused by inadequate antenatal care services in target

communities.However, despite the high level of availability, awareness and provision of family planning methods observed in both states in the quantitative survey, the end line assessment on abortion services shows differentials in Knowledge of participants reasons for seeking abortion by women in the community, as high as 84.% (Benue) and 71./8% (Nasarawa state) thought that abortion services can be procured for purposes of unexpected pregnancies whilst lesser percentage (47.2 and 47.9% respectively for Benue and Nasarawa states) thought abortion should be procured for the purpose of health problems (Figure 1), this skewed differentials exposes factors that affect the level of knowledge of different segment of a population about contraceptive use (7, 8) seen amongst respondents in this study (Table 1.2), this skewed differences was also observed in similar studies in Northern Nigeria (8). The uneven level of awareness and knowledge among different respondents in the population may have the potential to hamper efforts to increase FP uptake if not properly addressed (9).

The FGD findings have demonstrated the need for funders to prioritize the financing of public enlightenment programs on reproductive health to reach out to the rural areas and the training of more media practitioners to cover the remote areas at the grassroots on RH services, targeted funding will ensure the provision of adequate information to Women of Reproductive Age to enable them make informed decisions about contraceptive uptake (10), and the attendant reduction of mortal mortality rate that would occur from its absence.

V. Recommendations and Conclusions

This study assessed the provision of reproductive health services by 24 PP Global supported private sector health facilities in Benue and Nasarawa states respectively and the perception of community members on abortion services in both states.

The study shows that majority (95.8%)of the health facilities do not offer Prevention of Mother to Child Transmission (PMTCT) of HIV services despite the availability of HIV counselling services. There is need to ensure that PMTCT is offered in all the facilities in the states in the light of the high incidence of HIV transmission to the unborn child through the mother. Similarly, Cervical cancer screening should be offered in all the facilities to encourage early detection and prevention of cervical cancer among women.

Despite the fact that providers are well informed about the need to provide reproductive health services to clients, they however have no arrangements for the provision of adolescents and youth friendly services in their facilities to adolescents and young adults. Having youth friendly facilities is necessary because health providers are agents of community education and directions for youths who should be educated to understand, accept and respond to the specific situations of pubescent children, of early, middle and late adolescents, and of youth (11). On a global scale reproductive health problem remains a preserve of the young people, with about 40% of all newly acquired HIV infections in the world occuring among those between 15 and 24 years [12], hence the need to prioritize its inclusion in RH services in the facilities in addition to the provision of a safe and supportive environment that contributes to sound mental health of this group.

The study revealed that all the family planning methods were available in all the health facilities in the states with injectable and oral contraceptives, followed by implants identified to be the most commonly accepted by the clients. Facilities and funders however, need to put in more effort to increase the amount and quality of time they spend educating clients on reproductive health. It is recommended that the capacity for advocacy and application of the long lasting contraceptive methods such as implant and Intra Uterine ContraceptoveDevice (IUCD) be built among the healthcare providers to enable them encourage greater acceptability of these long lasting contraceptives by the clients. Furthermore, given the contextual factors uncovered by this study, community-based contraceptive delivery should be given more attention as this can help to remove the problem of fear of stigmatization plaguing single Women of Reproductive Age (WRA) seeking contraceptives. When delivered by persons within to the community, it also stands a chance of gaining higher acceptability.

Funding was identified as a major challenge and should therefore be made available as much as possible to provide for transportation logistics, outreach advocacy visits to hinter-lands including media advocacy to reach out to whole state and training of healthcare providers in other parts of the states. Advocacy on reproductive health that will include safe motherhood, unwanted pregnancy and family planning should be periodically conducted for members of the communities to enlighten them more on safe motherhood and abortion related issues thereby improving their knowledge and perceptions of these conditions.

Difficulty in procuring genuine standard drugs and equipment also constitute a key challenge. It is recommended that the healthcare provider be given the addresses of dealers that stock genuine drugs and equipments especially MannualVacuum Aspirators (MVA) and Misoprostol and also concerted efforts to support and strengthen facilities to provide skilled emergency obstetric care will potentially lead to significant reduction of MMR, therefore, it is recommended that re-training of already trained providers and training of new ones be given priority attention.

As part of strategies that will boost the provision of quality RH services, the study recommends the support and strengthening of the activities of the Network of the Bar, Bench and Police to assist the healthcare providers in the states, should they be accosted by law enforcement agents in the provision of RH services especially PAC services.

This survey has demonstrated that to rapidly scale up access to a range of reproductive health services in line with the SDG's, private sector facilities when funded will contribute significantly to the achievement. This therefore, is an opportunity for government, international NGOs and development partners to design reproductive health interventions that have private health facilities at all levels of practice at the heart of its delivery.

Acknowledgements

The authors acknowledge Planned Parenthood Global who are the funders of this research, management and staff of the private healthcare facilities in Benue and Nasarawa states, as well as all respondents who participated in the endline assessment and focus group discussions during the survey.

Financial Support and Sponsorship

Nil

Conflict of Interest

The authors declare no conflict of interest.

References

[1]. Starbird E, Maureen N,Rachel M. "Investing in family planning is key to achieving the sustainable developmentgoals." Glo Health Sci Pract.2016; 4(2):191–210.
[2]. World Health Organization. Fact sheets. 2018
[3]. Mathews C, Guttmacher SJ, Flisher FC, Mtshizana YY,Nelson T, McCarthy J,Daries V. The Quality of HIV Testing Services for Adolescents in Cape Town, South Africa: Do Adolescent-Friendly Services Make a Difference? J of Adol Health 2009; 44, 188–190.
[4]. National Population Commission (NPC) [Nigeria] and ICF Macro. Abuja, Nigeria: National Population Commission and ICF Macro; 2009. Nigeria Demographic and Health Survey 2008.
[5]. Oyedokun AO. Determinants of Contraceptive Usage: Lessons from Women in Osun State. Niger J Hum Soc Sci 2007;1(2):1–14.
[6]. Lincetto O, Mothebesoane-Anoh S, Gomez P,Munjanja S. Antenatal Care. In: Opportunities for Africa 's newborns: practical data, policy and programmatic support for newborn care in Africa [Internet]. Cape Town: Mills Litho; 2006 [cited 2018 May 2]. p. 51–62.
[7]. Odimegwu CO. Family planning attitudes and use in Nigeria: a factor analysis. International Family Planning Perspectives 1999;Jun 1:86-91
[8]. Wolf M, Abubakar A, Tsui S. and Williamson NE.Child spacing attitudes in northern Nigeria, FHI, Arlington;2008
[9]. Austin A. Unmet contraceptive need among married Nigerian women: an examination of trends and drivers. Contraception 2015;91:31–38.
[10]. Anjum S, Durgawale PM, Shinde M. Knowledge of Contraceptives Methods and Appraisal of Health Education among Married Woman. Int J Sci Res 2014;3:584–590
[11]. Eremutha F,Gabriel VC.Barriers Limiting Youth Access to Reproductive Health Services by Primary Health Care Facilities in Nigeria. Uni J Pub Health, 2019; 7(1), 36 – 43.
[12]. UNAIDS. AIDS epidemic update: December 2007

Dr. Francis Eremutha, et. al. "Evaluation of Reproductive Health Services Delivery by Private Sector Facilities in Benue and Nassarawa States, Nigeria." *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, 19(6), 2020, pp. 48-54.