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<td>CHUKUDEBELU, W.</td>
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<td>IKEME, A., OKARO, J.</td>
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Involving the private sector in improving obstetric care, Anambra State, Nigeria


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Abstract

Proximity studies: Of 11 facilities providing obstetric services in the Njikoka Local Government Area, four were private, for-profit institutions. Focus group discussions in seven communities revealed a preference for private facilities due to flexible payment schedules, proximity, reliable availability of a medical doctor and poor quality government services. Each of the private facilities had one doctor and one midwife and the bulk of patient care was performed by health aides with no formal midwifery training. Interventions: In 1992, 13 aides from the private facilities were trained in the recognition and management of obstetric complications. The training consisted of one week of classroom instruction and two weeks of practical training in local missionary hospitals. Results: Improvements were assessed by a written test. The percent of trainees obtaining a passing test mark increased from 33% (pre-training) to 61% (post-classroom) to 77% (post-practicum). Costs: The cost of this intervention was approximately US $15,000. Conclusions: Auxiliaries’ skills can be improved with classroom and practical training. The involvement of private sector institutions is important where they provide a substantial proportion of emergency obstetric services. However, maintaining improvements requires sustained effort.

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Keywords: Africa; Nigeria; Maternal mortality; Obstetric services; Training; Auxiliary personnel; Cost

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1. Introduction

The International Safe Motherhood Conference of February 1987 in Nairobi stressed the need to strengthen community-based maternal healthcare delivery systems, upgrade existing facilities and create new ones if necessary. While these actions may fall mainly into the political orbit of government, there is also a need for collective efforts to reduce maternal deaths in the private sector. In many areas of the Third World, private hospitals, clinics and maternity homes are major providers of healthcare. In light of the dwindling financial resources of the government, affecting the efficiency of government owned medical facilities, the privately established facilities often operate better. However, these private centers do suffer from limited numbers of trained personnel. Recognizing the importance of this resource for safe motherhood, the Prevention of Maternal Mortality (PMM) Network team in Enugu collaborated with private sector institutions in an operations research project to improve the skills of their staff in emergency obstetric care.

2. Study area

The study area consists of rural communities in the Njikoka Local Government Area (LGA) of Anambra State, Nigeria. The area has one general hospital, one comprehensive health center and five health centers — all government owned. It also has three private hospitals and one private maternity home. The private hospitals, which admit obstetric and non-obstetric cases, are each staffed by a single, general duty doctor capable of performing abdominal operations (including cesarean sections) as well as other obstetric procedures, such as vacuum extraction, forceps delivery and manual removal of placenta. Only two of the three hospitals, however, have the facilities for cesarean sections. The maternity home is owned by a midwife.

3. Situation analysis

Recognition of the need to involve the private sector in the prevention of maternal mortality was largely based on preliminary studies, including focus group discussions conducted in the communities, observations, reviews of private institution records and discussions held with the proprietors of each of the private institutions. Our findings are listed below.

- Four of the 11 health institutions involved in maternal care in the study area are private and so constitute a sizeable proportion of the available facilities.
- None of the private facilities have more than one trained midwife in its employ. The staff that carry out most of the midwifery work are aides who are not formally trained. They obtain their experience through on-the-job exposure and are not recognized by the government as midwives. For the proprietors, they provide a much cheaper alternative to trained midwives.
- The private institutions are more pragmatic in the matter of settling bills. Unlike government institutions, they do accept installment payments. Although their fees may be higher, this method of repayment is more convenient for the rural people.
- For some of the communities, the private hospitals are closer than the government hospital.
- People consider the government services to be unreliable because of frequent strikes.
- The issue of poor interpersonal relations between staff and patients is one of the major obstacles to utilization of health facilities.

4. Project development

The situation that the Enugu PMM team selected for intervention was the aides’ lack of training for the work they perform. The strategy
we adopted, which took place in 1991, was to write to the proprietors of the private institutions and introduce a proposed training project. Next, we paid individual visits to the proprietors to fully explain the aims and objectives of the project, the activities planned and why we believed that the private sector should participate. We explained that we would expect them to release their employees for training, keep good records and cooperate with our monitoring efforts. We then listened to their concerns and constraints and tried to reach a mutually agreeable position. They needed reassurance that our intention was purely to find ways to reduce maternal mortality and not to pry into or unduly interfere with their establishments.

Following our discussions with the proprietors, they welcomed the idea of training the aides with the objective of improving the aides' capacity to provide first aid for emergency obstetric care. They promised to cooperate with us fully.

In order to select training sites for practical experience, the team visited hospitals within Enugu and Onitsha urban areas. We assessed their suitability as training centers in terms of case load, case mix, available obstetric staff (both medical and nursing), willingness to cooperate with our objectives, preparedness to accept the aides and permit hands-on experience and availability of living accommodations close to the hospital.

Out of six hospitals visited, three were selected as practical training sites. The three hospitals were all missionary institutions, two of which were maternity hospitals and the third was a general hospital with a large maternity service. We avoided the teaching hospital as we did not want the training done at a level of care that would be too far removed from the trainees' own working environment.

Extensive discussions were held with each hospital's management, obstetricians and nursing staff to brief them on our goals, objectives and expectations, to obtain their cooperation and to listen to any constraints on their part. The PMM team made some financial contributions to the selected hospitals to take care of the increased logistics and expenses that were inevitable with the addition of extra hands in the system. The response of the hospitals was altogether excellent. During the PMM team's extensive internal debate on the issue, some concerns were voiced on possible problems that could arise. For example, we were uncertain how the Ministry of Health officials would view the project. We wondered if they would feel that we were giving the aides unwelcome support and legitimacy that the government did not want. We were also concerned that the nursing authorities, in particular, might feel that we would be sanctioning the encroachment on their professional turf. These reactions might have engendered negative attitudes in the Ministry to our entire project. There was also the fear that our training could influence the aides to go beyond their auxiliary role in carrying out their duties.

We decided, however, that the expected benefits in reduction of maternal deaths outweighed the possible negative aspects and that we should go ahead but try to involve the Ministry as much as possible. In fact, the reactions we feared did not materialize and no serious opposition was encountered.

5. Interventions

A total of 36 aides (15 from the private sector, 21 from the public sector) attended training programs during 1992. The training consisted of one week of theoretical instruction and two weeks of practical sessions. Unfortunately, in spite of our efforts at persuasion, no privately employed registered midwife was trained, because the proprietors could not afford to release their facilities' only midwives for three weeks.

The training program was carried out in two groups, one of public sector midwives and one of aides. In order to ensure adequate exposure and experience, they were further divided into small groups and posted to each of the hospitals. These small groups also ensured that not too many hands were absent from any base institution at the same time.

The didactic training consisted of instructions on basic anatomy and physiology, with particular
emphasis on the vagina, uterus, fallopian tubes and ovaries, pelvis and fetal skull. Other topics included antenatal care, intrapartum care, infection prevention, obstetric hemorrhage, blood transfusion, shock and its management and first aid in obstetrics. Attitudes toward work and inter-personal relationships and communication with patients were stressed.

Much time was spent on practical and participatory components, such as role plays, case studies and problem-solving. For example, role plays focused on topics such as reacting to hemorrhage and good and bad nurse-patient relationships. There were demonstrations showing correct normal delivery procedures and management of the third stage. There were also question and answer periods and experience-sharing sessions. These provided the trainees with opportunities to ask questions on topics or problems in obstetrics and also enabled us to discover and correct any erroneous practices and notions they had. The training was conducted in the local language (Igbo) for better comprehension, because we discovered that the participants' knowledge of the English language was rather poor.

Each hospital was visited by the PMM team on a weekly basis to monitor the progress of the trainees and discuss the program with the staff. The monitoring visits soon revealed that there were many misconceptions and gray areas on record keeping, so we conducted a one-day seminar specifically on that topic. Thereafter, uniform, pre-formatted model registers for maternity records were designed and produced by the PMM team and distributed to the health institutions. We also designed and distributed booklets of referral forms to each institution since prompt referral was one of the issues stressed during the training.

6. Program costs

As Table 1 shows, the added cost of the private sector collaboration was the equivalent of US $18,100, all of which was paid by the PMM project. The development line item includes the cost of preliminary visits to officials of the Ministry of Health, the Hospitals Management Board and the LGA and private institution proprietors, to brief and mobilize them for the project. Training covers the actual cost of both theoretical and practical training, including design, curriculum development, per diems for trainees' accommodations, meals and travel and lecture fees paid to resource persons. The salaries of the trainees continued to be paid by their employers during the training. Monitoring includes honoraria for hospital staff, supervision costs for the PMM team, travel, stationery and the production of monitoring instruments.

7. Results

Three methods were used to assess the effect of the training. First there were the scores of written tests: one given before the training, one after the classroom theoretical component and one after the practical component. The second source of data was in-depth interviews with the four private facility proprietors and all the trainees who were still working in the institutions in February 1996. The in-depth interviews were conducted during that month by the PMM team's social scientist and obstetrician. Third, post-training monitoring visits were made to the trainees' places of work. Monitors checked the registers to assess the quality and accuracy of record keeping and, when possible, observed the trainees at work.

Scores of 86% of the trainees increased from the pre-training test to the intermediary post-theoretical training test (see Table 2). The proportion of those obtaining a pass mark increased substantially, from 33% before training, to 61% after just the classroom theoretical training and
Table 2
Maternity aides' test scores before training, after theoretical training only, and after both theoretical and practical training, Anambra State, Nigeria, 1992

<table>
<thead>
<tr>
<th>Score Type</th>
<th>Before training (%)</th>
<th>After theoretical training only (%)</th>
<th>After both theoretical and practical training (%)</th>
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<tr>
<td>Average score</td>
<td>40</td>
<td>51</td>
<td>60</td>
</tr>
<tr>
<td>Obtained pass mark</td>
<td>33</td>
<td>61</td>
<td>77</td>
</tr>
<tr>
<td>Improved on before-training score</td>
<td>—</td>
<td>86</td>
<td>83</td>
</tr>
<tr>
<td>Improved on after-theoretical score</td>
<td>—</td>
<td>—</td>
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—, not applicable.

to 77% after the practical training. An index of the value the aides attached to the training was the fact that no participant withdrew from the three-week program.

During the in-depth interviews of the proprietors and the aides, all but one reported definite improvement. The exception was the one proprietor whose cooperation with us had been limited. He reported that he noticed no change in the performance of his employees since the training. Nevertheless, according to most of the proprietors, the trainees were more confident in themselves, so much so that in one of the hospitals one trainee is nicknamed 'the midwife' because of her confident handling of deliveries, including breeches. Some of the aides who had been hesitant about taking deliveries now showed more enthusiasm. Two of the hospitals’ doctors reported not being called for minor problems as often as before and being called more promptly when they are really needed. The doctors also reported that, upon arriving at the hospital, they found that the aides had already taken some appropriate first aid measures.

The proprietors also reported considerable improvement in relationships between the aides and the patients. One proprietor reported more com- mendations and appreciation of his workers from the patients and their relatives than before, but added that continued periodic reinforcements of the lessons they learned were necessary.

The aides themselves reported increases in confidence and skill in handling obstetric cases. During the in-depth interviews they were asked to describe how they would handle certain problems that were dealt with during training, such as post-partum hemorrhage. We found them to be quite well informed. For example, ‘rubbing up’ of uterine contractions has now become part of their routine. They were very enthusiastic about the training and requested more. The observation was made during monitoring visits that trainees were much more inquisitive than before and showed considerable eagerness to learn. Most of the aides were still working in the facilities four years later, except for three who relocated after marriage.

Another area of positive impact of the project was standardized record keeping, about which (by their own admission) the private proprietors were usually casual. There has been considerable improvement in records at the private institutions, with the one exception already mentioned. Regular entries in the registers were made and neat case records were kept.

8. Discussion

The results show that it is possible to obtain the cooperation and involvement of the private sector in public oriented programs and that hostility should not be assumed. Only one of the four proprietors failed to cooperate fully. The others willingly sent their aides for training for the entire three weeks.

As a result of initial contacts and later in-depth discussions, the training was warmly welcomed by the proprietors and enthusiastically received by the aides. Based on the aides’ self-reporting and the opinions of the employers, we conclude that there was increased confidence and skill among the trainees, as well as better attitudes toward...
patients. The latter was important because poor interpersonal relations had been a major problem identified in the preliminary focus groups in the communities.

Practical, hands-on experience in carefully selected hospitals was essential to the training package. We believe that teaching hospitals should be avoided as training sites. Not only is it unlikely that the management would accept the hands-on practice by the aides, but practice and conditions at such hospitals would be unrepresentative of conditions at their base institutions.

Improvement in recordkeeping, an essential part of the training plan, was achieved by not only conducting a special one-day workshop but also by making model preformatted registers available at each health institution. Referrals have been facilitated by referral forms now available in each facility.

The total cost of the training would be money well spent if the desired results of reducing maternal deaths were achieved. However, in the present economic climate of Nigeria it is likely to be an uphill task to convince the government to spend that amount on the issue.

One of the few constraints in involving the private sector was that profit motive was a major consideration not too distant from any actions they took. They were unable to release any of their trained midwives for our training program because there were only one or two in each institution. Also, it was difficult for one proprietor (whose cooperation was limited) to see what immediate gain he would reap from the program.

We found, however, that dialogue with the proprietors can break down traditional suspicions of government and build mutual confidence. It should not be assumed that private sector providers will be unreceptive to programs such as this. The aides they use extensively for maternal care are trainable with curricula carefully developed to address common and basic problems in maternal care in a simple fashion and, as much as possible, in the vernacular.

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