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FREE MATERNAL AND CHILD HEALTH SERVICES IN ENUGU STATE, SOUTH EAST NIGERIA: EXPERIENCES OF THE COMMUNITY AND HEALTH CARE PROVIDERS

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ABSTRACT

Enugu State, South East Nigeria launched free maternal and child health services in 2007 against the backdrop of high infant and maternal mortality rates in the State. This study determined the experiences and the perceptions of the community and health care providers on the free maternal and child health services. This was a cross sectional descriptive study carried out in Enugu state Southeast Nigeria. Pre-tested interviewer-administered questionnaire survey with 50 healthcare providers at health centers and 150 women of reproductive age were used to elicit information on the awareness, attitude, utilization and factors affecting utilization of MCH services, satisfaction with and willingness to continue use of these services. In addition, service data from the first health center to benefit from free MCH services was collected from 2007 to 2009. Among the women, there was a high level of awareness of the free MCH services. Antenatal (55.3%), maternal tetanus toxoid immunization (47.3%) and childhood immunization (44%) services were the most accessed. Factors likely to affect the intention to use the services were required services not rendered, drugs not available, delayed attention and distance to the health facility. There was a high willingness to continue use of maternal and child health services due to the free services, easy accessibility and availability of drugs. However, a fifth of the respondents paid for the free services. The service data showed an upward increase in utilization between 2007 and 2009. Although the health workers were receptive of the free MCH services, they opined that their workload had increased without any corresponding increase in their remuneration and that patients were making

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unnecessary visits to the health facilities to demand on drugs. There was a significant increase in MCH services utilization between 2007 and 2009. Conclusion: This study shows that the free MCH services have enhanced utilization of health services. However this has greatly increased the workload of health providers and consumers still pay for services. There is need therefore for provision of adequate personnel and infrastructure to cater for this increase. In the interim there should be better remuneration of health workers to motivate them to continue providing health services despite the workload. There is also need to check the reported over visitation of health centers for drugs created by the free MCH services and mechanisms should be put in place to ensure that the free services are really free.

Keywords: Free maternal and child health services, Community, Health care workers, Nigeria.

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Contribution/ Originality

This study contributes in the existing literature regarding the experiences of the community and health care providers towards free maternal and child health services in Enugu State, Nigeria.

1. INTRODUCTION

User fees have been a controversial source of health care financing in low-income country settings [1]. They were introduced in the 1980s and early 1990s as part of structural adjustment policies promoted by the World Bank [2] and in African countries in particular following the 1987 Bamako initiative programme, sponsored by a joint World Health Organization/United Nations Children's Fund and adopted by African Ministers of health Initiative [3, 4]. It became a popular policy in the developing countries because the World Bank and the international monetary fund (IMF) set it as one of the loan conditions for those countries seeking funding support. The justification for the user fees introduction in African countries was as a pragmatic solution to severe under funding as well as part of a broader ideological shift in health policy that emphasized efficiency [5]. In Nigeria and most African countries government budget for the health sector have failed to meet up with the health care needs of the people and population growth lending to widespread implementation of informal and formal user fees.

In sub-Saharan Africa, the current health care financing from government tax revenue is relatively low, particularly in relation to the target of 15% of total government expenditure being devoted to the health sectors agreed to by the African Heads of State in Abuja in 2001 [6]. Evidence from a broad range of developing countries indicates that user fees have rarely generated large amounts of revenue and have too often disproportionately affected poor people [7]. Studies in Africa have also shown that user fees reduced access to health services which grossly reduced health service utilization [8, 9].

It has been proposed that user fees could become more equitable if fees were set at moderate levels and exemption granted to those who cannot pay however such exemptions have been rarely

practiced and not so effective in protecting the poor [10, 11]. Hence to overcome this conflict of interest it is currently suggested that user fees be abolished for all consumers of health, for particular services or for easily recognized groups of people [12].

The process and journey towards abolition of user fees as well as the reasons for that have been different for different African countries. While some have been politically motivated like in Uganda [13] some have been donor-influenced like in Ghana [14]. Whatever the drive, several countries showed interest in scrapping user fees in order to increase the consumption of essential services, especially amongst the poor [15]. South Africa in 1994 made all services free to children under 5 and pregnant women and nursing mothers. In 2001 fees were scrapped suddenly in all Ugandan government health units. Burundi removed fees for maternal and child health services while Zambia removed fees only in rural facilities [15]. In all these countries there was evidence of an increase in patient utilisation of health services when these fees were removed [16-19]. For example, in Uganda, after one there was an increased use of public health facilities of 40% and in six years 163% increase in utilisation rate [15].

1.1. The Free MCH Programme in Enugu State

In 2007, in recognition of achieving the MDGs 4 and 5, Enugu state, Nigeria launched the maternal and child health services. This was against the backdrop of unacceptability high infant and maternal mortality rates in the State as in other parts of Nigeria. The programme is for all pregnant women in the State to have free antenatal, intra natal and post natal services including laboratory tests and blood transfusion services. Specifically the policy document provides free MCH service for women from 12 weeks of pregnancy to six weeks after delivery and children between 0 to 59 months. It was designed to achieve:

(a) Accelerated reduction in the Maternal and Child mortalities in Enugu State through increased access to health care services and removal of user fees.
(b) To provide skilled attendance during pregnancy, child birth and post natal periods.
(c) To strengthen the capacity of individuals, families and communities to improve Maternal and Child Health Services.
(d) To ensure equity in service delivery especially MCH and promote good governance.
(e) To assist in the attainment of the health related MDGs especially goals 4 and 5.

The programme was flagged-off at Udi District Hospital on 17th December 2007, with the then Minister of Health in attendance. Full complement of toolkits is in place including policy brief, implementation guidelines, registration cards, reference forms and invoices. The Local Government Areas (LGAs) bought into the programme and now provide 50% of the estimated 14 million Naira per month fund requirement of the programme. There is regular disbursement of funds to district and local health boards for replenishment of stock at the facility level. Regular monitoring and supervision and review exercises of the programme provide ongoing fine-tuning of implementation. More funds are anticipated for effective operations of the programme

enhancement in view of ancillary enhancement schemes e.g. State ambulance service, mass de-worming exercises, public private partnership initiatives etc.

It is not known what the perceptions are of the community members that are expected to benefit from the programme. Most of the health care services target women and their children and thus they are in a better position to assess services provided at the health centers in the spirit of community participation and ownership. It is also not known what the perceptions of the health workers who are implementing the program are, given the vantage positions of healthcare providers. This paper therefore examines the experiences of health care providers and the attitude of community members towards free maternal and child health services in Enugu, South East Nigeria.

2. METHODOLOGY

2.1. Study Area

The study was carried out in Enugu south local government area of Enugu State in south East Nigeria. Enugu State has the city of Enugu as its capital. There are seventeen LGAs in the state officially recognized by the federal government besides development council areas created by the state. Five of these LGAs are largely urban. Enugu state has an estimated population of about 3,100,000 out of which Enugu South LGA has 237,286. There are seven district hospitals, 36 cottage hospitals and 366 primary health care centres, including comprehensive health centres, health centres, health clinics and health posts. Primary health centres are usually staffed by community health officers and community health extension workers and supported by registered nurses and midwives [20]. There are about 700 private health facilities comprising private and non-profit, private for profit, including faith-based facilities. The state is divided into seven health districts for purpose of healthcare delivery system. Each health district is made up of at least three LGAs. Most of the inhabitants are Ibos with few infiltrates from other tribes.

2.2. Study Design

This was a cross sectional descriptive study involving 150 women of reproductive age group exiting from 10 health centers and 50 health care providers from all the 10 health centers in Enugu south local government area of Enugu State.

2.3. Data Collection

Pre-tested interviewer-administered questionnaires were used to elicit information from respondents on their experiences and attitudes towards free MCH services and its effect in reducing maternal and childhood mortality. Data were collected using three approaches; a patient exit questionnaire, a health worker survey and hospital records review. Respondents who were exiting a health center and who gave consent were interviewed. All workers that were involved in MCH services and were available at the time of the survey were invited to complete the health worker questionnaire. In addition, service data from the first health center to benefit from free MCH

services was collected from 2007 to 2009. The data collectors were trained on procedures for conducting the survey and involved in the pre-testing and revision of the questionnaires.

2.4. Data Analysis

Data entry and analysis was done using SPSS version 18. The frequency distribution of the community members' health workers' responses were computed.

2.5. Ethical Consideration

Ethical clearance was obtained from the ethical committee of University of Nigeria Enugu Campus. Each facility was visited in advance to explain the purpose of the survey to the head of the facility and obtain informed written consent. This was reconfirmed verbally on the day of the actual survey. Also on the day of the interview, the women were explained the purpose of the survey and informed written consent collected from them. The survey questionnaires were pretested on a non-random sample of individuals with characteristics similar to those of the survey population but not chosen for inclusion in the survey.

3. RESULTS

3.1. Community Experiences

Table 1 shows that the majority of the respondents 107 (71.3%) were aged between 30 years and below and the rest were above 30 years. Most of them had formal education with 93 (62%) having secondary education and 33 (22%) post secondary. Very few respondents 4 (2.7%) had no formal education. Most of the respondents 90 (60%) were unemployed and farmers, 40 (26.7%) were labourers and petty traders and 18 (12%) were formally employed.

Table 2 shows that majority of the respondents 130 (86.7%) were aware of the free MCH services with Antenatal care services being the most utilised service 83(55.3%), followed by tetanus toxoid 71 (47.3%) and childhood 66 (44%) immunization. Family planning service was the least utilized 18 (12%). The waiting time to see a health provider varies. While 43 (28.7%) of the respondents waited less than 30 minutes to access care and 107 (71.3%) waited for more than 30 minutes to access care. About 120 (80%) of respondents said they accessed these services absolutely free of charge while very few 30 (20%) said they paid for services like antenatal natal care, family planning and tetanus toxoid immunization as shown in table 3. As shown in table 4, about 129 (86%) of the respondents claimed drugs were either occasionally or always available at the centers while 14% of them said drugs were never available. A good number 104 (69.3%) did not pay for the drugs while the rest paid for all or some of the drugs.

Table 5 shows that a majority of the respondents 130 (86.7%) were satisfied with the services they received and were willing to continue to utilize the services rendered at the health centres 127 (84.7%). The reasons were that services were free 42 (33.1%), easily accessible 33 (26.0%) and availability of drugs 25 (19.7%). A few were not willing to continue using the facilities because the required services were not rendered 10 (43.5%), unavailability of drugs 7 (30.4%), delayed

attention 4 (17.4%) and distance from their home 2 (8.7%). Most respondents asked for improvement in services especially in the area of skilled birth attendants (Doctors and Midwives) and drug provision.

3.2. Health Workers' Perspectives

A majority of the health personnel 28 (56%) were aged above 30 years and the rest 30 years and below 22 (44%). Midwives 22 (44%) and community health extension workers 18 (36%) formed the bulk of the staff strength while doctors were very few 4 (8%) as shown in table 6. Almost all the health workers 48 (96%) knew that MCH services were free. They also claimed that treatment of under 5 years 47 (94%), immunization services 48 (96%), antenatal clinic services 38 (76%) and delivery services 34 (68%) were the most accessed services. Also 38 (76%) of the health workers claimed that there has been increased workload because of the free MCH while 22 (44 %) felt that the free MCH interfered with other duties they usually performed in the facilities. About 19 (38%) of the respondents also felt that the free MCH services led to unnecessary clinic visits by consumers.

The facility data showed an upward trend of uptake of under 5 years, antenatal care and delivery services both in quarters and yearly between 2007 and 2009. Under 5 years services recorded the highest attendances followed by antenatal care visits and delivery visits as shown in figures 1and 2.

4. DISCUSSION

In this study we examined the attitude of the community to and the experiences of the health care providers with the removal of user fees for maternal and child health services in Enugu State in South East Nigeria.

The community respondents were mainly aged 30 years and below. Most of them were educated and had secondary education. This level of education must have influenced the utilization of MCH services. As noted by Nadhedh [21] the level of education correlates with health related decisions. Most of the respondents were unemployed, skilled labourers and/or housewives. This shows that the services are utilised the most by the people who cannot afford it. The demographic information is in line with the findings from an Indian study [22].

Most respondents were aware and indeed agreed that the MCH services were free in Enugu State and indeed really utilized them. However the percentage utilization was low at 53% for antenatal services and even lower for the child consultation services despite these being free. Other factors apart from cost may be responsible for the slightly above average utilization. This was noted in an earlier study in the same study area that showed that most of the women do not utilize these free MCH services [23]. Also in a study in Enugu, Nigeria cost of services ranked lowest as a militating factor to use of PHC services even though mothers in the study ranked free services as number two in the solutions preferred that will enhance service utilization [24]. This was also noted in a study by Graham [25] which found that other factors apart from cost determine the utilisation

of health services and that there are inter-plays of several social and demographic factors. Therefore, these other factors implicated in low service utilization must be taken into consideration when scaling up free MCH services in Enugu State, in Nigeria and in sub-Saharan Africa.

Most of the respondents were satisfied with the services provided and intend to use the services in future. The reason given was that the services were free, easily accessible and drugs were available. However few respondents noted that the services they required were not available and they had to wait for a longer time to be seen by a health worker. This further buttresses the fact that quality of service including type and attitude of health care personnel, long waiting queues, lack of doctors were important determinants of utilisation of health services [4]. Another reason given for non satisfaction with services was non availability of drugs. A similar finding occurred with the removal of user fees in South Africa where with the implementation of removal of fees for health services they recorded limited resources such as drugs and clinic supplies [15]. The long waiting time in this study goes to show that either there is a high utilisation of services with a few health workers available to provide the services or that the process of service delivery is not efficient.

Only 20 percent said they paid for services received and this was mostly for family planning services. A positive finding was that, delivery service which is an important component of MCH services was not paid for, although very few people utilized this service. This study did not explore why some of the services were paid for. Although most of the respondents did not pay for the drugs received, they said the drugs were occasionally available. The respondents requested for improvement in the availability of skilled birth attendants and drug supply. From the suggestion of the respondents it can be seen that the free maternal and child health programme did not take into consideration the attendant burden of this services on resources, both human and materials. There is therefore a strong implication for scaling up resources to meet the required services.

From the perspective of the health workers MCH services were indeed free and well utilised. However the degree and type of service utilised varied. The most utilized being the curative services for under 5 years, which is consistent with a finding by Wilkinson et al. where 77% of respondents accessed curative services. However comparing the health worker perspective to the community experience it can be easily noted that antenatal services were more accessed from the community point of view than the child consultation services.

Most of the health workers agreed that the implementation of free MCH services had greatly increased their workload without a commensurate financial compensation. This finding is similar to that from previous studies in South Africa, Ghana and Uganda which reported a work increase sometimes as much as 47% per health worker [13, 26-29]. Patients have also continued to make unnecessary clinic visits compounding the increased work load of the health workers. These are some of the challenges faced when declaring free MCH services.

Also, service data in a public health facility showed that the free MCH programme, which provides health services for pregnant women and children under the age five free of charge, has led to an increase in uptake of MCH services between 2007 and 2009. There was a lag in uptake of the

programme at the onset, in 2007. This corresponded to the preparatory phase, during which physical structural, staff and commodities' adjustments were made by the supply-side component of the programme. Also, it could have reflected the time taken by the demand-side (consumers) to overcome the initial inertia and apathy associated with doubt of government programmes and policies by the public. However, as the programme continued, all the data elements showed rapid progress. Thus the free MCH services can be said to have produced increased demand for health services as most people didn't have to pay out-of-pocket. These increases in utilization after introduction of free services have also been documented by other authors [12, 30-32].

5. CONCLUSION

All in all, the free MCH services enhanced utilization of health services. Although the degree of increase in utilization from this study is not as high as expected, this has greatly increased the workload of health providers. There is need therefore for provision of adequate personnel and infrastructure to cater for this increase. There is also need to understand the dynamics of free health services and adequately plan for it before introducing it. In the interim there should be better remuneration of health workers to motivate them to continue providing health services despite the workload.

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Table-1. Socio-Demographic characteristics of respondents (N=150)

Variables	n (%)
Age (years)	
30 years and below	107 (71.3)
Above 30 years	43 (28.7)
Educational Status	
No formal education	4 (2.7)
Primary education	20 (13.0)
Secondary education	93 (62.0)
Post secondary education	33 (22.0)
Occupation	
Unemployed/unskilled laborers/housewives	80 (53.3)
Farmers	10 (6.7)
Skilled laborers/petty traders/pensioners	40 (26.7)
Formally employed/regular wage earner/medium scale traders	18 (12.0)
Professionals/big scale business people	2 (1.3)

Table-2. Community awareness of and access to of free maternal and child health

Variables	n (%)
Awareness of free MCH	
Yes	130 (86.7)
No	120 (13.3)
Services accessed at the health centre	
ANC	83 (55.3)
Delivery	30 (20.0)
Tetanus Toxoid immunization for WCBA	71 (47.3)
Childhood immunization	66 (44.0)
Growth monitoring	48 (32.0)
Oral Rehydration Solution	42 (28.0)
Nutrition	53 (35.3)
Family Planning	18 (12.0)
Waiting time to see a health worker	
<30 minutes	43 (28.7)
30- 60 minutes	50 (33.3)
> 60 minutes	57 (38.0)

Table-3. Payment for services

Variables	n (%)
Whether paid for services	
Yes	30 (20.0)
No	120 (80.0)
Services paid for	
ANC	7 (23.3)
Family Planning	9 (30.0)
Tetanus Toxoid immunization for WCBA	7 (23.3)
Childhood immunization	5 (16.7)
Oral Rehydration Solution	2 (6.7)

Table-4. Availability and payment of drugs

Variables	n (%)
Availability of drugs	
Always	57 (38.0)
Occasionally	72 (48.0)
Never available	21 (14.0)
Payment for drugs	
All drugs	16 (10.7)
Some of the drugs	30 (20.0)
None of the drugs	104 (69.3)

Table-5. Satisfaction with services and intention to use facility in future (N=150)

Variable	n (%)
Satisfaction with services	
Yes	130 (86.7)
No	20 (13.3)
Intention to use facility in future	
Yes	127 (84.7)
No	23 (12.3)
Reasons for wanting to use facility in future (N=127)	
Only option	12 (9.4)
Availability of drugs	25 (19.7)
Easy accessibility	33 (26.0)
Free services	42 (33.1)
Less time spent	15 (11.8)
Reasons for not wanting to use facility in future (N=23)	
Required services not rendered	10 (43.5)
Drugs not available	7 (30.4)
Delayed attention	4 (17.4)
Too far	2 (8.7)
Need for service improvement	
Yes	134 (89.3)
No	16 (10.7)
Requested areas for service improvement (N= 134)*	
Availability of doctors	88 (58.7)
Availability of midwives	38 (25.3)
Availability of drugs	40 (26.7)
Other areas	17 (11.3)

*Multiple responses allowed

Table-6. Demographic characteristics of Health personnel (N=50)

Variables	n (%)
Age (years)	
30 years and below	22 (44.0)
Above 30 years	28 (56.0)
Sex	
Male	10 (20.0)
Female	40 (80.0)
Category of health personnel	
Doctor	4 (8.0)
Nurse/midwife	22 (44.0)
Community Health Extension Workers	18 (36.0)
Others	6 (12.0)

Table-7. Health workers' perception of free MCH (N =50)

Variables	n (%)
Whether MCH is free	
Yes	48 (96.0)
No	2 (4.0)
Perception of services used by community members	
ANC	38 (76.0)
Delivery	34 (68.0)
Treatment of under five years	47 (94.0)
Childhood immunization services	48 (96.0)
Consequences of free MCH services on health workers	
Increase in workload	38 (76.0)
Interference with other duties	22 (44.0)
Unnecessary visits to the health facilities and demand on drugs by patients	19 (38.0)

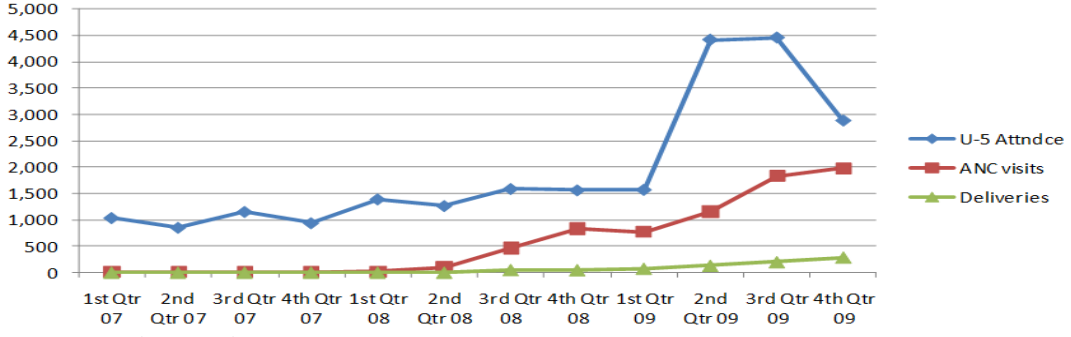

Fig-1. Trend of uptake of Maternal & Child Health services at Poly Sub District Hospital, Asata, Enugu (2007 – 2009 Quarters)

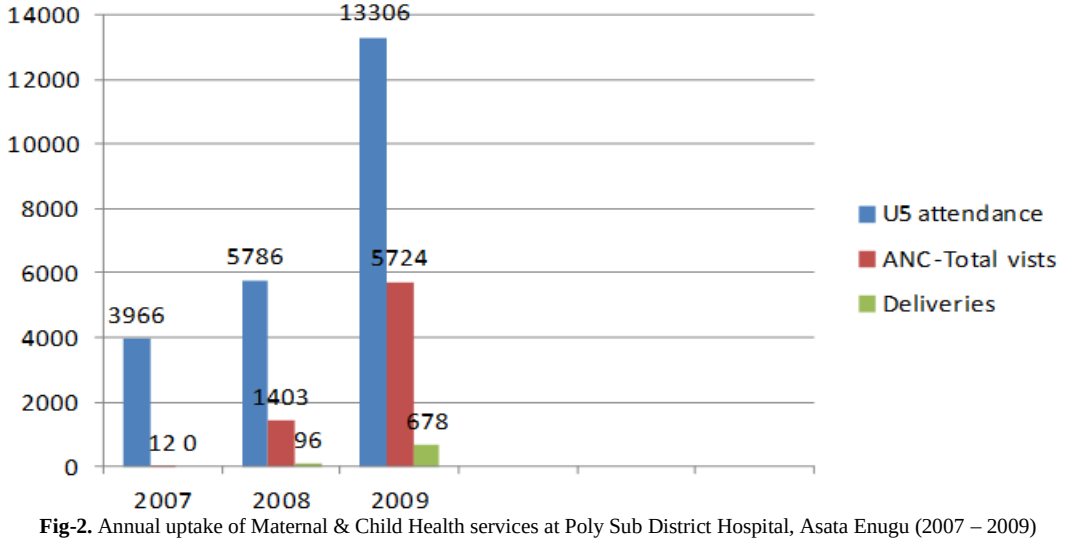

Fig-2. Annual uptake of Maternal & Child Health services at Poly Sub District Hospital, Asata Enugu (2007 – 2009)