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Original Research Article

Increasing use of reproductive health services through community-based and health care financing programmes: Impact and sustainability in Abia State of Nigeria

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Studies have shown that the governments' central role to guarantee access to reproductive health care is to provide and finance services at all levels. In Nigeria, budget constraints limit this role. The question is, how do individuals in rural areas access sexual and reproductive health (SRH) care services? Study explored health care financing mechanisms and burdens the mechanisms impose on reproductive health needs within the context of free and informed choices. In-dept interview which was recorded and transcribed was conducted with 24 key informants within the ages of 25-58years. The informants are made up of 8 women and men respectively, who are community leaders in the study area. Also interviewed are 8 nurses in charge of primary health centers in the study area. Data collection and analysis were qualitative. Measures of social connections through coordinated analyses of ethnographic data and enabling conditions for scale-up were emphasized. Findings showed that the government provided little or no reproductive health care services in rural areas. The study identified myriad ways in which community members financed SRH services. These include "isusu"(weekly out-of-pocket contributions), palm fruit harvesting levies, community-based monthly levies and individual donations. The amounts generated from these methods are paid into community common purse. From this common purse, sexual and reproductive health (SRH) services are paid for. The study noted that individuals who did not contribute towards this fund are usually denied the benefits of these services. In the words of three respondents," we ensure that we pay for our health care bills through community efforts. We do not want our wives and children to continue to die while waiting for free services from government which will never come". Two respondents specifically maintained that we have lost a good number of our children through this neglect. We shall continue to assist ourselves" Given the numerous health, social and economic problems inherent in the rural areas in Nigeria, a mixture of public and private financing of health care services is preferable. This will ensure more accessibility of reproductive health care services, and thereby, help to reduce maternal and child mortality in the rural areas. This study constitutes valuable tool for those interested in identifying how maternal and child mortality rates could be minimized in the rural areas.

Keywords: mortality, health financing, reproductive health, accessibility

INTRODUCTION

United Nations (UN) General Assembly in 2006 adopted universal access to reproductive health care. Even as the importance of access to reproductive health has been highlighted by international agreements, many countries including Nigeria still do not give priority to sexual health as a justifiable health issue, and therefore, financing sexual and reproductive health (SRH) services (apart from HIV) has not been a priority. Studies have

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shown that high cost of health care services contributes to inaccessibility of SRH services resulting to limited information on sexuality, contraception, prevention and healthcare thereby limit people's ability to make their sexual and reproductive health choices (Lynch et al., 1998; Kaplan et al., 1996; Ross et al., 2000) The central role of any government including that of Nigeria is to guarantee access to reproductive health care by giving free health care services. Providing free health care services will increase health care seeking behavior, thereby, help to reduce maternal and child mortality rates. In a developing country like Nigeria, where a considerable portion of the population lives in absolute poverty and as such, may not afford to pay for basic medical care. Therefore, if government should provide and finance health care services, it will help to reduce morbidity and mortality rates in the rural areas. In addition to government providing free health care services, government should also ensure that a stable system of health care is in place in the rural areas (Wilkinson, 1996; Wilkinson, 1997; Wilkinson, 1997; Gravelle, 1998; Wolfson et al., 1999). In developing countries, government budgets are usually strained because of competing priorities such as security, education, food production and others, it is unlikely that the governments in such countries will provide health care needs including reproductive health especially in rural areas (Lynch et al., 2000; US Census Bureau, 1988; Fuchs, 1974). The question is to what extents does government of Abia State of Nigeria finance reproductive health care to increase its access in rural areas? How accessible and/or affordable are reproductive health services to individuals in the rural areas? In this study, accessible health care includes access to information and services on prevention, diagnosis, counseling, treatment and care that would allow individuals the opportunity to make informed choices on sexuality and reproduction. Accessible health care also includes provision of services that will enable couples to have safe and satisfying sexual life that is free from violence and coercion. Such services will consist of services that enable couples to avoid unwanted pregnancy so as to experience pregnancy and childbirth safely (Grossman, 1976; Hadley, 1982; Backlund et al., 1999; US Public Health Service, 2011). The study provides community based health financing strategies currently used to improve access to health care services in rural areas. Assessing methods in which sexual and reproductive health (SRH) services are provided in rural areas is necessary because studies have shown that high cost of service delivery and the discriminatory practices that marginalize women and deny them opportunity to seek care for their SRH limit access, and increase morbidity and mortality in rural areas (World Health Organization, 1991; Jones and Weinberg, 2000; US Census Bureau, 1989; Maddala, 1988). In some countries, discussions on issues around sex and sexuality are regarded as taboo, and the perceived stigma and embarrassment that accompany such discussions can lead to reluctance in addressing sexual health issues. The taboos are more pronounced for adolescents especially those who do not conform to socially accepted norms of not having sexual relations before marriage (Marmotand Wilkinson, 2001; Kawachiet al.,1997; Davey et al., 1998). Culturally, women are financially, materially and socially dependent on men, and as such, they may experience constraint in accessing services that would prevent unwanted pregnancies and sexually transmitted infections. These social expectations on how women should behave place them in subordinate roles and further limit their access to SRH services (Gregg and Machin, 1999; Solon, 1992; World Health Organization (WHO), 1998). Study explores strategies in which individuals in the rural areas access SRH services as well as the burdens these strategies impose on the reproductive health of such individuals.

METHODS

Study was both exploratory and descriptive. In-dept interview was conducted with 24 key informants between the ages of 25-58 years. These key informants consist of 8 women, 8 men and 8 health workers resident in the rural areas. The 8 men and 8 women studied are the community leaders, while the health workers are nurses who are the heads of the primary health centers located in the study area. The interview conducted with the respondents was recorded and transcribed. Interview questions centered on methods of financing sexual and reproductive health (SRH) services in the communities, how the financing methods are integrated into the overall health system approach, the roles of government in providing health care, and the accessibility and affordability of SRH services in the rural areas.

Study examined how women are assisted to delay, space, and limit their pregnancies so as to achieve the healthiest outcomes within the context of free and informed choices. The study noted the social processes that are linked in the financing of reproductive health care services and identified how these processes in turn influence local thinking about using reproductive health services. The study highlights the necessary enabling conditions for scale-up. Qualitative methods of data collection and analysis were adopted.

RESULT

The result of the study showed that though there are primary health care centers located at strategic positions in the study area, funding of sexual and reproductive health services was poor. In the words of four respondents,

"the government has utterly neglected health care services in this rural area. We pay taxes but do not get the benefit of such taxes. The government during political campaigns keeps on promising us free health care services in the primary health centers but has never kept to this promise. We are pleading with the government to consider our area whenever national health care services are carried out."

Another respondent emphasized that

"reproductive health care services should be provided and financed either entirely by government, or entirely by private sector or jointly by government and private sector and not to be financed by individuals in the rural areas who are already overburdened with payment of children's school fees."

Also in the words of three health workers,

"private sectors are encouraged to assist in providing and financing health care services so as to help reduce government's fiscal burden on health care services. If private sectors assist government in financing health care, it will enhance accessibility and affordability of health care services in the rural areas. Government alone should not be expected to finance all health services."

In the words of five respondents

"health care delivery is very expensive. We pay as much as US $50 for hospital bills each time a family member goes to hospital. For child delivery we pay a bill as high as US$120."

Study identified four strategies in which healthcare is financed in the rural areas. These strategies include "isusu" (specific weekly out-of-pocket contributions), palm fruit levies, community-based levies and individual donations.

The most common of these strategies for financing reproductive health care was levies from palm fruit harvesting. Finding showed that community leaders fixed particular periods in the year for harvesting palm fruits. At the end of the harvest, each individual is expected to pay a specific amount into the community common purse. After the contribution, 60% of what each individual contributed will be saved in the community common funds while 40% will be returned to the contributor for personal upkeep. This method is part of the survival strategies employed in the rural areas. The finding noted that those who defaulted by not participating in either palm fruit cutting or contributing financially towards this fund are usually excluded from benefitting from the community pre-paid reproductive health care services.

Other strategies identified for raising money for health care services include payment of fines for failing to participate in communal activities/functions such as marriage, wedding and burial ceremonies, clearing communal bushes and/or path ways, environmental sanitation exercises and others. In the words of three respondents,

"we ensure that we pay for our health care bills through community efforts. We do not want our wives and children to continue to die while waiting for free services from government which will never come".

Two respondents specifically maintained that

"we have lost a good number of our children through this neglect. We shall continue to assist ourselves"

The result of the study noted that traditional rulers, opinion leaders and community leaders functioned as social mobilizers, and implementers. They mobilized individuals to raise funds and also ensured that all funds contributed are pooled together and used for financing developmental projects such as health care, education, electricity, water supply and others. According to four respondents,

"we now enjoy regular provision of reproductive health care services from the health workers now that we pay for the cost of services than when we were not paying."

Specifically, the finding noted that the services individuals in the communities paid for were family planning, including information on methods of fertility regulation, treatment of sexually transmitted diseases (STDs); gynecological and obstetric services including obstetrical complications, drugs and immunization. The result of the study noted some discrepancies in the accessibility of sexual and reproductive health care services in the rural areas. Using the words of six respondents,

"we are concerned about the chastity of our children. Culture forbids unmarried youths, 16 and 18 years from using reproductive health care services and as such, we restrict the health workers from giving such services to the youths."

The health workers confirmed this and added that

"even the married women are constrained from using contraceptives without the permission of their husbands for fear of being accused of promiscuity".

The health workers also stressed that,

"unmarried adolescent girls are denied access to SRH services on cultural basis even though they are more vulnerable to violence, sexual abuse, and they have higher consequences of unwanted pregnancies and abortion than the married adults."

Two health workers specifically said

"we do not extend family planning services to unmarried adolescents because it is morally wrong and will distract their attention from pursuing their education. Moreover, we exclude them from family planning services because we have to respect their parents' views."

One of the health workers confirmed that,

"the only service health workers provide to adolescents is sex education and such service only focus on abstinence as the basic method of Preventing unwanted pregnancy, sexually

transmitted infections including HIV and AIDS."

One important finding in this study is the improved measures of social connections which are important indicators for family well-being in the rural areas. These social connections were measured by the assistances rendered to the less privileged, like orphans, aged and infirm by some individuals through paying education fees , providing food , and access to health care services. This idea of social connection is a strength to this study because good spirited individuals who are not necessarily relations, paid accrued levies and fees for those who could not afford to pay so as to avoid being sanctioned by the community leaders for their default. Other individuals in the community also provided cooked food to those who could not afford to do so especially the orphans, aged and infirm. By this measure, part of the problems of this group has been alleviated. According to three respondents,

"we are each other's helper. We share things in common."

DISCUSSION AND CONCLUSION

The fact that community members adopt strategies to provide SRH services for married couples at the expense of the adolescents shows lack of knowledge of the complexities and realities of young peoples' lives. Adolescents are at risk of rape and sexual coercion as unmarried girls, and therefore require family planning services as much as the married adults. It is unethical for the health workers to deny the adolescents reproductive health services just because of cultural bias. Health workers must see cultural issues as entry points rather than obstacles to be surmounted. Health workers should realize that the adolescents need information on contraceptives and safe abortions and should take action to improve adolescents' access to SRH services.

The practice of government not providing free reproductive health care services helps to exacerbate marginalization of adolescents on health care services. Free health care services will normalize the inequities in service delivery and guarantee SRH services to all individuals irrespective of their marital status. Government's inability to provide free SRH services in the rural areas translates to lack of political will. Baring the present harsh economic conditions in Nigeria, financing health care services should not be left exclusively to individuals in the rural areas. Health care services should be provided by both the government and the private sector for effective and efficient services. Therefore there is need for health workers to create awareness and sensitivity to the government on the importance of extending free SRH services to the rural areas.

In the light of these findings, government and other stakeholders should provide affordable health services and interventions to encourage strong mechanisms for coordinating partner support of health sector in the rural areas. This will enable policy planners to ensure equitable access to health services for sustainable national health financing needed to achieve health-related Millennium Development Goals (MDGs) and national health objectives. Therefore, given the variety of health problems and of the social and economic circumstances in Nigeria, a combined public and private provision and financing of health services is recommended.

Findings indicate over-reliance on community out-of-pocket contributions to finance costs of health care services in the rural areas. This over-reliance could adversely affect individuals' health particularly that of poor and vulnerable groups who might be further impoverished after making the contributions.

This study constitutes valuable tool for those interested in knowing how community based financing methods help to improve access to reproductive health services and how they respond to local needs in national health programs and initiatives .

Study recommends setting up of structures that will strengthen participation and accountability mechanisms in the rural areas so that funds contributed for health care services will be judiciously used to accomplish the desired goals. The study further recommends joint financing of SRH services which will involve the government, private companies and individuals in the communities. This will help increase access to SRH services as well as improve health seeking behavior in the rural areas.

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