How secure are primary health care facilities to provide services for the vulnerable population?: Experience of providers in a maternal and Child Health programme

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Background

Maternal and Child Health (MCH) is a priority in Nigeria. Although mortality rates declined in the MDG years; Nigeria did not meet targets 4 and 5. Access to services remains one of key challenges. Abundant literature exists on supply and demand side barriers to providing and accessing proven effective interventions. However, little literature exists on how security within health facilities affects provision and use of services, especially by vulnerable pregnant women from socio-economically disadvantaged backgrounds.

The Nigerian government, addressed this through a programme which aimed to mitigate both demand- and supply-side barriers to MCH services for the underserved population. During 2012-2015, the programme trained and deployed midwives and community health workers (CHWs) in primary healthcare facilities; upgraded infrastructure (including perimeter fencing in some facilities); provided supplies and financial incentives to pregnant women to access and utilize services. A novel group of CHWs; village health workers, were also trained and deployed to mobilise pregnant women and assist them to access services.

Aim of the study was to evaluate the effectiveness of these interventions towards providing equitable access to services to the rural and underserved population.

Methods

This on-going study employs a phased mixed-methods Realist Evaluation approach to assess how and under what circumstances programme worked to achieve outcomes in Anambra state, southeast Nigeria. We conducted in-depth interviews with facility managers and health workers. Specific programme theories, showing causal pathways of change, have been continuously validated and refined throughout data collection and analysis.

Key Findings

The programme had upgraded facilities and with help of the community attempted to keep facilities secure, for example through erecting perimeter fences and deployment of watchmen. However, most health workers felt insecure at night, due to lack of security guards. As a result most health workers who were all female did not feel confident to provide services at night. The sense of lack of security had detrimental implications for achieving programme outcomes, one of which was to increase facility deliveries by skilled birth attendants.

Conclusion: Poor security contributed to lack of feeling of safety by this vulnerable population group and this directly influenced provision of round-the clock MCH services in an otherwise well-funded and equipped programme. Given that significant proportion of deliveries fall during night time, ensuring adequate security at night will contribute to round-the-clock MCH care and therefore can help address the needs of most vulnerable populations.