Reproductive health services uptake in Private vs Public Health Facility in Benin Republic: Accessing Differences in Access and Use through a Qualitative Study

1. BACKGROUND

1.1. Introduction

Despite the mounting interest to end preventable maternal and child mortality through improving access to and the use of health services, reproductive health services especially, the gains recorded are below expectation. Although, substantial global progress in the reduction of maternal and infant mortality was recorded during the just concluded Millennium Development Goals (MDGs); maternal and under-five mortality rate worldwide dropped to about 50% between 1990 and 2015 (Requejo & Bhutta, 2015; UNICEF, 2015) and the approximate global lifetime risk of maternal death fell from 1 in 73 in 1990 to 1 in 180 in 2015 (WHO, UNICEF, UNFPA, WBG, & UNPD, 2015), numerous women still die in childbirth every day from largely preventable causes (Requejo & Bhutta, 2015; WHO, 2013; WHO et al., 2015) and children below 5 years old still die from preventable diseases.

Maternal mortality and child survival, therefore, remain a major public health issue in developing countries, particularly in sub-Saharan Africa. They remain a core component of Sustainable Development Goals (SDGs) which was formed for the continuation of the unfinished business of the MDGs (UN, 2014). As a result of this, they remain a permanent source of anxiety for policy makers and one of the priorities of a wide range of health sciences researchers and demographers. In response to reproductive health issues, especially to avoid preventable maternal and child morbidity and mortality, continuous care during critical moments of maternal and child health issues is necessary. An effective continuous care involves essential maternal, newborn, and child health (MNCH) packages, throughout adolescence, pregnancy, childbirth, postnatal and newborn periods and into childhood, building upon their natural interactions throughout lifecycle (de Graft-Johnson et al., 2006; Kerber et al., 2007). Determinants of health services uptakes are well documented and differences in access to and use of health services according to the kind of health services are important. But reasons behind users' preference in access to and use of services by kind of health services facility (public vs public) are not well known. Indeed, levels and trends in the use of health services alone do not provide information on the quality of care. Poor quality of care, however, is often correlated with a very low rate of utilizing health services especially in limited settings such as rural and remote areas where health challenges are important. This is often related, among others, to an insufficient number of skilled health providers (particularly in rural and remote areas), lack of standard care and protocols, few drug supplies, and poor attitudes of health providers (Lincetto, Mothebesoane-Anoh, Gomez, & Munjanja, 2006). Studies also reported a wide gap between women's preference for a place of delivery and where they eventually give birth (Lerberg, Sundby, Jammeh, & Fretheim, 2014).

1.2. Research goals

Findings from quantitative analysis from past studies in Benin Republic (Dansou, Adekunle, & Arowojolu, 2017) reported a wide gap in the prevalence of the use of health services according to the kind of health facility (private health facility vs public health facility). Yet, the study context is dominated by public health facilities. Reasons underlying the preference between the use of public and private health facilities in reproductive health matters are not well known with quantitative analyses. Qualitative findings clarified such aspects by exploring experiences of respondents. The study attempts to clarify such aspects.

2. DATA AND METHODS

2.1. Data

2.1.1. Study Population and Mode of Selection

To gather needed information for the study, actors from three different levels were reached according to their contact and influence on the main target (reproductive age mothers with children below the age of 2). They were, according to their level of influence, from primary, secondary and tertiary level. At the primary level, the study investigated the main target while the secondary level reached fathers of children below the age of 2 years (partners of women investigated), fathers in-law, and mothers in-law. At the tertiary level, representatives of community health association (community based organizations like feminine organization), representatives of NGOs specializing in RH, health workers, religious leaders including endogenous leaders were interviewed. All the respondents for the study were selected on the field taking into account inclusion criteria and their experiences and knowledge about RHS issues. Focus group discussions were homogenous to allow convivial discussions within groups.

2.1.2. Selection of Investigation Sites/Localities

On the administrative level, Benin, since the administrative reform of January 1999 was divided into twelve districts or departments (Alibori, Atacora, Atlantique, Borgou, Collines, Couffo, Donga, Littoral, Mono, Ouémé, Plateau, and Zou) with 77 communities, presents the administrative map of Benin Republic with its major ethnic groups across districts / departments. Thereby, based on the administrative map and findings from past studies (Dansou et al., 2017), the country is stratified into three geographical zones: South, Centre, and North. In each geographical zone, one urban area and one rural area were randomly selected. However, Cotonou, which is cosmopolitan in nature and constitutes one department (Littoral), was systematically selected due to its special socio-economic and socio-cultural status.

Table 1 presents the details of communities and the corresponding sites investigated

Table 1 : List of Investigation Sites

Geographical Zone	Place of Residence	Sampled Communities	Site/Locality Investigated
South	Urban	Cotonou	Vodjè Kpota (12th arrondissement); Ayélawadjè1 (3rd arrondissement)
	Rural	Sèmè-Kpodji	Djeho (Aholouyeme); Dja (Tohouè)
Centre	Urban	Bohicon	Hezonho (Bohicon1); Agonvezoun (Bohicon 2)
	Rural	Dogbo	Kpadaha 1 (Ayomi); Agnavo (Dévé)
North	Urban	Djougou	Madina (Djougou1); Bassala (Djougou 2)
	Rural	Bembèrèkè	Bouri (Gamia); Kassarou (Bouanri)

Source: Author's conception

2.1.3. Ethical consideration

Ethical issues were addressed at each phase of the study in compliance with the regulations of the World Medical Association (WMA) Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. Ethical approval was obtained from "Comité National d'Ethique pour la Recherche en Santé (CNERS) of Benin before the study was carried out (see appendices for ethical approval). The ethical approval for research contains the description of the project and its significance, methods and procedures, participants, and research status.

2.2. Methods

2.2.1. Data collection

In addition to document review, the current study relied on Focus Group Discussion (FGD) and individual interviews (key Informant Interviews) and observation to gather necessary data.

2.2.2. Data analysis

At first, transcription of notes from the tape recording of the discussions and interviews was performed. The transcriptions were carefully compared with notes taken during data collection, and a final comprehensive list of the ideas raised by the respondents, then examined and categorized according to the main purpose of the study. Afterwards, they were divided into categories of similar responses according to the study goals. Lastly, the content analysis of records was done highlighting factors which help to understand underlying logics and mechanisms of use and non-use of RHS.

3. KEY FINDINGS

3.1. Demographic Characteristics of Study Participants

Table 1 showed the demographic characteristics of study participants. A total of one hundred and ninety-nine (199) individuals were involved in the qualitative study among which ninety-three were (93) in in-depth interviews while one hundred and six (106) through twelve (12) focus groups discussion. Among them were 102 men and 97 females, out of which 107 respondents dwelled in urban areas.

Table 1 : Demographic Characteristics of Study Participants

	In-depth Interviews (n = 93)			**Focus Group Discussion (n = 106) 12 FGD**			**Total**
	Southern (n =31)	**Centre (n =32)**	**Northern (n =30)**	**Southern (n = 34) 4 FGD**	**Centre (n =37) 4 FGD**	**Northern (n =35) 4 FGD**	
Age groups (years)							
< 30	05	04	06	11	22	11	**59**
30 – 44	09	09	12	21	12	19	**82**
45 +	17	19	12	02	03	05	**58**
Sex							
Male	17	20	16	16	17	16	**102**
Female	14	12	14	18	20	19	**97**
Place of Residence							
Urban	15	14	13	16	16	18	**92**
Rural	16	18	17	18	21	17	**107**

Source: Author's Computation

3.2. Key results

Key themes emerged from discussions and interviews. Among them are poor attitudes of health providers toward patients and lack of skills of some health providers. Indeed, among others, themes pertaining to the physical treatment of users from arrival to the departure from health facilities emerged. In addition, differences in financial level appeared to be the most important deterrent for preferences in private vs public health facility use. Also, lack of qualification of some health providers were also pointed out. Public health facilities were reportedly more affordable than private ones.

Regarding health workers' attitudes toward users, a male participant in in-depth interview narrated some experiences:

> *Regarding these aspects, I acknowledge that some health providers welcome with kindness while some do not, but are very strict. I sincerely think that private health facilities welcome patients better than in public health facilities. In public health facilities, health workers face their phones more than patients. …. Me, I prefer the private health facilities than the public ones due to the quality of care and the attention given to patients* (Father in-depth interview, Djougou).

In addition to poor attitudes, some participants reported some acts of dishonesty and unkindness from some health workers. Among them are overcharging for services than their normal prices and collection of extra money on some services which were not even provided.

A father in focus group discussion narrated:

> *Very often, our wives are subject to bullying from health personnel and care givers who scam them financially. Health personnel ask them to pay for services that were not rendered. Moreover, they do not welcome them with kindness. Our wives are humiliated in public health centres* (Father in a focus group discussion, Djougou).

Such kind of poor attitudes and acts were reported to be more frequent in public health sectors than in private health centres. Users, therefore, discourage and turn back to seek care from another health facility for a better treatment as expressed by a father involved in focus group discussion.

> *That is exactly what leads many to seek care in the clinic of Mrs Dangou who in her clinic, not only welcome well but also follow up women with kindness* (Father, in a focus group discussion, Djougou).

For some participants, the preference given to private health facilities goes beyond the quality of care and cost of services. It seems that private sector users can negotiate to possibly receive care on credit and pay back later when they have money. Such possibility is not available in the public sector.

A health worker in the private sector explains:

> *In addition to the quality of services, some patients prefer private health facilities over public because private health facilities accept the possibilities of providing services on credit, which is not the case in public health facilities* (Health worker in in-depth interview, Dogbo).

However, the level of involvement of communities especially of in-laws in the reproductive lives of their children depends on their own background and experiences. A retired midwife and mother in-law narrated her knowledge and level of involvement in the reproductive life of her daughters. Her experience in the health sector has given her more knowledge in advising and guiding her daughters in the most positive and comprehensive way. She thinks that reproductive health services are of good quality if both provider and users play their part. But, sometimes, health providers fail in their attitudes toward users, she added. Users also, sometimes fail too especially in the way they dress to get to health facilities. Poorly dressed women are less considered and treated well by health workers. Some participants reported to have been insulted by health workers when not dressed properly.

What do health providers think of their poor and unkind attitudes toward patients as reported by users? Majority of health personnel involved in interviews acknowledged this situation. Some tried to give explanations that health providers are human beings. Their attitudes on the job are determined by their mood which is a product of circumstances and situations such as their personal and family life, and their own attitudes and perceptions toward their job.

A health provider (gynaecologist) argued:

We will always say whatever we say, but I think that health providers improve every day in their way of providing services in order to become more righteous and kind toward patients. It is true that everything is not perfect and there are some things that still need to be improved but we first need to know that health providers are human beings. They too, face life's difficulties and have to cast away all their own difficulties and serve others. This is not always an easy thing, indeed, it is often difficult, but we try every day to manage and conciliate all those things (Health provider in in-depth interview, Djougou).

The cases of poor attitudes toward patients were reported by users and even by some health providers to be relatively more frequent in public health facilities than in private health facilities. Therefore, personal and family life conditions and the environment put forward as causes of health providers' poor attitudes and unkindness toward patients need more exploration and understanding assuming the fact is right. Does it mean that public health facilities' personnel live in worse conditions (family and personal, etc.) than their counterpart in private health sector? Perhaps the treatments of employees play an important role. In the public sector, employees often have the guarantee of the payment of their wage that is not conditioned by services and care provided, they have job security. In private sectors, employees are often paid based on services rendered. Wages are based on services and job security is not guaranteed. This could perhaps explain, somehow, the differences in the attitudes of health providers across health sectors.

However, according to interviews with some health providers, the poor attitude reportedly predominant in the public sector is improving positively with the introduction of result-based financing. Results-based Financing (RBF) initiative aims to reward (not based on wages) health providers based on services rendered. A health personnel in private sector thinks that this initiative has drastically changed the quality of services and attitudes of health providers toward patients in the public sector. The RBF has motivated health providers to change their attitudes and quality of care in their job. Health providers' poor attitudes toward users should not exist in the future if the RBF project were to be expanded and well managed over time.

A health personnel working in a private sector argued:

Before launching Result-based Financing (RBF) initiative, the quality of care and health providers' attitudes toward patients in the private sector were better than that of the public sector. But today, they are almost the same. With RBF, health providers in the public sector know then, that, by doing a good work and being kind, patients will give them extra reward (indemnity, etc.) (Health providers in in-depth interview, Djougou).

Unkind and poor attitudes of health practitioners toward patients including women reported by participants during interviews and discussions varied and were at various stages and levels for instance, at the reception and during care. During care giving, especially during delivery, some participants reported that women in labour are sometimes subjected to physical violence. But, according to the statements of some health practitioners, some attitudes are justified and need to be more promoted among people for understanding. Some physical violence during delivery is often instantaneous aiming to save the baby's life. Indeed, during delivery when a woman is about to close her limbs while the head of the baby is already out, the health personnel could involuntarily exercise physical violence upon the woman to prevent her from causing harm to the baby or even kill him. Such acts when not well understood may lead to misinterpretations.

A health practitioner aware of users' perceptions about violent attitudes of health practitioners during delivery explained:

It is true that there were sloppiness, lack of follow-up, and we neglect patients. Women themselves complain that during delivery they are often victims of violence (verbal and physical as well). Yes, it could happen and it is justified because when the health practitioner tries to bring out the head of the baby and the woman is about to close her legs upon the baby, it is a reflex to try to save the baby. People misunderstand this. A midwife quickly

reacts to avoid the woman killing the baby with her legs. It is just to save the baby. Most people perceive it as a punishment for the woman (Health provider in in-depth interview, Djougou).

4. BIBLIOGRAPHY

Dansou, J., Adekunle, A. O., & Arowojolu, A. O. (2017). Factors associated with the compliance of recommended first postnatal care services utilization among reproductive age women in Benin Republic: an analysis of 2011/2012 BDHS data. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology, 6*(4), 1161-1169. doi:10.18203/2320-1770.ijrcog20171378

de Graft-Johnson, J., Kerber, K., Tinker, A., Otchere, S., Narayanan, I., Shoo, R., . . . Lawn, J. (2006). The maternal, newborn, and child health: Continuum of care *Opportunities for Africa's newborns: Practical data, policy and programmatic support for newborn care in Africa* (pp. 23-36).

Kerber, K. J., de Graft-Johnson, J. E., Bhutta, Z. A., Okong, P., Starrs, A., & Lawn, J. E. (2007). Lawn Continuum of care for maternal, newborn, and child health: from slogan to service delivery. *Lancet, 370*, 1358–1369.

Lerberg, P. M., Sundby, J., Jammeh, A., & Fretheim, A. (2014). Barriers to Skilled Birth Attendance: A Survey among Mothers in Rural Gambia. *African Journal of Reproductive Health, 18*(1), 35-43.

Lincetto, O., Mothebesoane-Anoh, S., Gomez, P., & Munjanja, S. (2006). Antenatal Care *Opportunites for Africa's newborns: Pratical data, policy and programmatic support for newborn care in Africa*.

Requejo, J. H., & Bhutta, Z. A. (2015). The post-2015 agenda: staying the course in maternal and child survival. *Arch Dis Child, 100*(Suppl 1), s76-s81. doi:10.1136/archdischild-2013-305737

UN. (2014). *The road to dignity by 2030: ending poverty, transforming all lives and protecting the planet.* . Retrieved from

UNICEF. (2015). *Levels & trends in Child mortality: Report 2015, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*. Retrieved from

WHO. (2013). WHO recommendations on Postnatal care of the mother and newborn. Retrieved from http://www.who.int/features/qa/12/en/

WHO, UNICEF, UNFPA, WBG, & UNPD. (2015). *Trends in maternal mortality: 1990 to 2015*. Retrieved from Geneva: