Family Planning in Fragile States: Overcoming Cultural and Financial Barriers

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Edited Transcript—Karima Tunau

Good afternoon, ladies and gentlemen. My name is Karima Tunau. I am an obstetrician/gynecologist at the Usmanu Danfodiyo University Teaching Hospital in Sokoto, Northern Nigeria.

First, let me give you some background on Nigeria. We are the giant of Africa and have a population of above 150 million. I am sure the vast majority of you have heard of Nigeria for not too good reasons, mainly political instability and regional unrest over the past several years. Much of this unrest is in the oil producing Delta area, where there have been some conflicts, and also in Plateau State, some clashes are ongoing.

There are three major ethnic groups in Nigeria—the Hausa, Yoruba and the Igbo. Over 400 languages, however, are spoken nationwide. We are also a religiously diverse nation, approximately 50 percent of Muslim and 50 percent Christian.

I believe only a few of you have heard of Sokoto State, where I come from. Sokoto is in northwestern Nigeria. It is one of the most peaceful places in Nigeria, with about four million hardworking citizens. The majority of the population—that is, about 80 percent—live in rural areas. Most are Muslim.

Nigeria has one of the highest maternal mortality rates in the world—about 800 deaths for every 100,000 live births. Our total fertility is also high—about five children per woman on average—and our nation's contraceptive prevalence rate is very low: only about 10 percent of couples use family planning. These figures are even more troubling in Sokoto State, where the literacy level is very low. In my area, one out of every 18 women will die in childbirth. That means in every family, somebody's sister or mother or aunt or niece will die. It is unacceptable.

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That is why when I was choosing a medical specialty, I decided to become an OB/GYN. The Usmanu Danfodiyo University Teaching Hospital where I work serves as a referral center for not only the populous of my state, but also for people from neighboring states, such as Kebbi and Zamfara, and even neighboring countries, like the Niger Republic. The total population in these three states is about 10 million people. The predominant ethnic groups are the Hausas and the Fulanis. Our center is a tertiary hospital, meaning we provide the most advanced level of services and receive transfers from lower level health facilities. My hospital takes care of all aspects of reproductive health, ranging from safe motherhood, issues related to fertility, prevention or management of genital tract malignancies like carcinoma of the cervix, child health, and more.

It would not be possible at this forum to discuss issues related to each of these areas, but I would like to try and highlight two of our most pressing issues; maternal mortality and access to and use of family planning. I am in charge of family planning and fertility issues at our hospital. In our center, we have about 3,000 maternal deliveries every year. The maternal mortality ratio in the state is about 850 deaths per 100,000 live births, but in our hospital, which typically receives the most complicated pregnancy cases, maternal mortality rate in the year 2005 was over four times the state average: we had a rate of 3,000 deaths per 100,000 live births.

Why? Because over 90 percent of births were emergency drop-in patients who often receive no care during pregnancy, suffered from extreme poverty, and came to our hospital too late during their labor.

The good news is that a number of innovative interventions have enabled us to cut this figure by more than half over the past four years. How did we achieve this drastic reduction? For one, we set up an emergency fund to pay for the care of any woman who came to us any time during pregnancy and labor. I should explain that unlike in the United States, most hospitals in Nigeria either require payment upfront for facilities such as antibiotics and anesthesia before providing services or they require a waiver process, which can take many days for approval. Therefore, poor patients often experience long delays at the hospital waiting for care or delay seeking care until they can secure funds. In our institution, therefore, our emergency fund enabled us to quickly and efficiently provide obstetric care immediately when someone arrived at the institution, thereby dramatically increasing survival rates.

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I also mentioned that I wanted to talk about contraceptive availability and use, and I earlier on said that our use rate was quite low. I did not, however, mention why. One major issue is that we face continuous, frequent cases of inadequate supply. In Nigeria, we get our family planning commodities from the Federal Ministry of Health at a highly subsidized rate. Unfortunately, there are times where many months have gone by without the Ministry delivering any contraceptives.

For instance, for close to a year now, we have not had a supply of the subdermal implant. It is the most requested contraceptive in our clinic because it is long-lasting and, once implanted, it can control fertility for three years without additional hospital visits. Presently, we have a list of over 100 women waiting for it to be made available. Waiting endlessly, these women are at risk of unplanned pregnancies. The same situation exists for a number of other contraceptives. When contraception is not available, it discourages our clients from returning to our clinic and also creates a negative image within the community, as they do not bother to come into our hospital because the contraceptive agents are not available for them to access.

Another challenge is the issue of cost. In Nigeria, an injection of the hormonal contraceptive, for instance, costs about $1.30. While this cost may seem small, it may not be affordable to a number of women in Nigeria. Apart from the direct cost, there are some hidden costs, such as the cost of transport, as many of our clients have to travel from afar to come and access our services.

How have we met these challenges? One thing that we have done to solve the problem of inadequate supplies was to establish a revolving fund and a committee to ensure a steady supply of commodities. This way, if we are running out of supplies and cannot get supplies from the Ministry of Health, we have an in-house fund that allows us to buy supplies directly from other retailers in our state. Unfortunately, this is much more expensive and requires many more resources.

Second, we have established a full-fledged family planning clinic from scratch. This allowed us to provide services all days of the week from 8 a.m. to 4 p.m. Previously, family planning services had only been provided twice a week, and we found that only 14 percent of the women who delivered in our center had been using contraception. Our family planning clinic started in October, 2007 with just $1,600, which we borrowed from the hospital management. We were assisted by the United Nations Population Fund in Sokoto, and they

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provided us with some office equipment.

You would be pleasantly surprised to learn that we have already seen and counseled over 4,400 women about contraception and reproductive health since its inception two and a half years ago. And guess what happened to contraceptive use among the women delivering in our facility? Within this short period it doubled to nearly 29 percent. We discovered that once our family planning services were regularly available, women informed one another, we found ourselves managing troops of women in need of our services even without banners or advertisements.

Apparently, ignorance and lack of access to client-friendly services were some of the major contributing factors to our high, unmet need for contraception. The majority of our clients—over 90 percent of them—are Muslim housewives, about 35 percent of whom do not even have formal education. The number of deliveries are high, with an average of five children per client.

Interestingly, we now have a significant number of women who come together with their husbands, as a couple. This was an unusual finding, as it is not the usual practice for Muslim wives to be seen with their husbands in family planning facilities. What this suggests is that there is an improved level of acceptance of family planning services among our men folk, as couples learn about the positive impact of family planning and the improvement that it has on the health of the mother, the newborn, and birth spacing to the healthiest intervals. We find that acceptance of family planning increases.

In conclusion, I am hoping that as the United States decides upon its investments in global health and development, the government will take our experience in Nigeria into account and prioritize three areas: emergency surgical care services, contraceptive security, and female education. On emergency obstetric care, our success in reducing our maternal death rate shows that providing creative financing and space for immediate care for patients in childbirth make an enormous difference. Why not ensure that every tertiary hospital can insure the funding to do the same?

Second, related to contraceptive security, our hospital used creative financing to ensure a steady supply of commodities. But that is not enough. Perhaps it is high time that contraceptive providers and other agencies involved in the provision and promotion of contraception deal directly with remote centers like ours in order to reduce the bureaucracy

involved in the past. This, I believe, would ensure continuous and constant availability of contraceptive agents.

Third, it is our belief that if we really want to see a difference and improvement in reproductive health in the predominantly Muslim northern Nigeria, one of the simplest and most important ways is to invest in female empowerment and education. An educated women is more likely to be better nourished, marry later, and avail herself for care when she becomes pregnant. She is also more likely to be better positioned to take care of her family and would likely choose to appropriately space her births. An educated woman is an empowered woman. An investment in female education is a long-term investment that promotes the existence of healthy families whose sizes are determined by the choice of the women, not by chance.

Lastly, I would like to thank CEDPA for inviting us here once again. We are particularly grateful to the UN Foundation for making this trip possible and to the Woodrow Wilson Center for giving us the opportunity to tell you about our work. I hope that in the future you will sponsor more women like us, whose interest it is to safeguard the healthy wellbeing of women. We fervently hope that this liaison will translate to the betterment of the lives of the majority of women worldwide. Thank you very much.

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