Understanding the referral pathway from B2CEmONC in humanitarian settings in Nigeria

Advocacy Brief

Overview

While there were impressive declines in global maternal mortality rates up to 2016, the period between 2016 and 2020 shows a general stagnation.[7] The need for more focus on maternal and newborn health is most critically seen within the highest-burden areas – countries affected by conflict and fragility. Many of these deaths can be prevented with evidence-based care for every woman and newborn, and timely identification and management of obstetric and newborn complications. Often, this requires referral to higher-level care, but delays and challenges can significantly impact health outcomes. Therefore, ensuring a strong, functional referral pathway between facilities that are classified to deliver basic and comprehensive emergency obstetric and newborn care (BEmONC, CEmONC) services is critical.

This is particularly true in Nigeria, where many women receive antenatal and intrapartum care at community level or at primary health care facilities that are ideally equipped to provide BEmONC services, with referral pathways to CEmONC facilities for complications. However, evidence shows that pregnant and recently delivered women and their newborns face difficulty getting to CEmONC facilities because of distance, cost, and poor referral transport systems.[8] In particular, in Borno and Yobe states in Northeast Nigeria, some women and girls face significant challenges accessing care, from distances exceeding 70km to the nearest facility, to insecurity along the referral route. Furthermore, the lack of a documented national policy on referral systems has hindered a coordinated approach and standard for referral between facilities and service providers.

- **Nigeria:** 1,047 maternal deaths per 100,000 live births (2020), 34 newborn deaths per 1,000 live births (2022)[1]
- **Northeast Nigeria (Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe):** 1,500 maternal deaths per 100,000 live births, 61 newborn deaths per 1,000 live births[2]
- **Nigeria:** 51% of births attended by skilled health staff[3]
- **Northeast Nigeria (Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe):** 24.8% of births attended by skilled health staff[4]
- **Northeast Nigeria (Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe):** 25.4% of live births delivered in a health facility[5]
- Lifetime risk of dying during pregnancy, childbirth, postpartum, or after an abortion for a Nigerian woman or adolescent is 1 in 22, compared to one in 4900 in developed countries.[6]

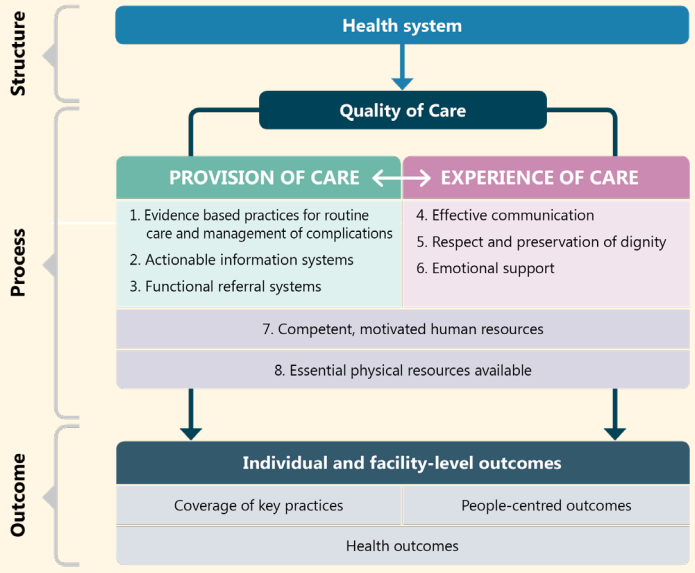
[1] Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023.
[2] National Population Commission (NPC) [Nigeria] and ICF. 2019. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF
[3] UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys. World Bank, 2022.
[4] National Population Commission (NPC) [Nigeria] and ICF. 2019. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF
[5] National Population Commission (NPC) [Nigeria] and ICF. 2019. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF
[6] Meh, C., Thind, A., Ryan, B., & Terry, A. (2019). Levels and determinants of maternal mortality in northern and southern Nigeria. *BMC Pregnancy and Childbirth*, 19(1). https://doi.org/10.1186/s12884-019-2471-8
[7] Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023.
[8] Banke-Thomas, A., Balogun, M., Wright, O., Ajayi, B., Abejirinde, I. O., Olaniran, A., Giwa-Ayedun, R. O., Odusanya, B., & Afolabi, B. B. (2020). Reaching health facilities in situations of emergency: qualitative study capturing experiences of pregnant women in Africa's largest megacity. Reproductive Health, 17(1). https://doi.org/10.1186/s12978-020-00996-7

Research Study

To better understand the feasibility and effectiveness of the referral pathway for clients seeking care for EmONC services, IRC conducted a qualitative research study from June 2023 to July 2024 in Borno and Yobe states, where protracted insurgency and conflict have weakened the health system and increased barriers to care-seeking. The goal of this study was to examine practices and experiences of care along the referral pathway from BEmONC to CEmONC facilities, and identify recommendations for strengthening referrals and improving experiences of care for clients.

To do so, the research team conducted in-depth interviews in English, Hausa, and Kanuri with 34 women and adolescent girls and semi-structured interviews with 32 providers at identified facilities to capture insights around and recommendations related to their perceptions and experiences of care. The research was guided by the WHO Framework for Quality Maternal and Newborn Care (Figure 1), which defines key domains for delivering effective and high quality care. The 66 transcripts were translated into English as appropriate, and then coded and analyzed by the research team, and findings were shared with key stakeholders and a Technical Advisory Group.

FIGURE 1:
WHO Framework for Quality Maternal and Newborn Care



Key Findings

The following represent key themes that emerged from the research study findings.

Provision of Care

As reflection of a sector that requires improved organization, and a standard referral protocol, participants reported numerous ways of organizing and financing referrals. All four humanitarian organizations that participated in this research study had a dedicated referral focal person who is responsible for coordination between referral facilities and clients. Study findings highlighted that this referral focal person plays a key role in tracking and following up with clients as well as providing feedback to the care provider. However, the process for tracking clients and providing feedback between facilities is ad hoc and not standardized.

In interviews, providers were asked to describe recent referral cases in which the system did and did not work well; the factors they've identified are listed below.

System Enablers

- The existence of a dedicated referral officer
- Available functional ambulance for transportation
- Timeliness of service provision
- Timely identification of complications requiring referral
- Skilled referral companions
- Accurate and complete documentation

System Barriers

- Clients in some cases rejected referral
- Supplies shortages or stockouts in facilities
- Unavailable family support during referral and care
- High cost of care at the higher facilities
- Delays in organizing transport
- Delays faced on the road during transportation
- Insecurity, especially in rural contexts

Insecurity

Many of the providers interviewed confirmed that insecurity plays a role in the referral process, as it influences referral decisions, choice of referral facility, and overall contributes to delays in referral. Providers also noted a general unwillingness to work in insecure locations, which consequently leads to understaffing, and facilities not having sufficient competencies to deliver signal functions, therefore impacting the need for cases to be referred.

Audit and Documentation

Providers reported depending primarily on registers and various referral notes and forms for documentation and referral audit. Audits are infrequent, only occurring on a case-by-case basis, and do not focus on the quality of care provided. Even when EmONC-related deaths occur, mortality audits to identify causes of death and corrective actions for patient care and management do not seem to routinely happen - or if they do, providers noted that they are unaware and do not receive feedback on outcomes.

Mother-Baby Dyad

Within the study contexts, it is common to keep the mother and baby together. This was reflected in interviews, as providers emphasized this practice of protecting the mother-baby dyad to maintain maternal-infant bonding, and encourage early initiation and exclusive breastfeeding. However, they also noted that in instances where a medical condition warrants separation, it's not always feasible due to infrastructure limitations such as a lack of nursery rooms or limited space in the specialized baby care unit. As much as possible, the dyad is maintained during referral transport, especially when using an ambulance. However, when ambulances aren't available, families often noted that mother and baby are separated during transport for safety reasons.

Experience of Care

Both clients and providers mentioned significant communication gaps along the referral pathway, noting that this leads to a lack of patient follow-up and an inability to improve care for future patients.

Clients overwhelmingly expressed gratitude and appreciation when asked about their experiences with care-seeking and service provision. Most clients stated a preference for seeking care at BEmONC facilities over CEmONC facilities because of trust in staff, free or subsidized services, and closer proximity. In addition, referral to CEmONC facilities was associated with over-medicalized care, death due to risky interventions, and less respect and empathy for clients. The study findings showed that clients had many misconceptions about referral such as unnecessary procedures at the referred facility, expensive care, and a high probability of death or morbidity. These misconceptions led to fear, anxiety, hopelessness and uncertainty around referral acceptance.

> **"I was so scared when she told me [I needed to be referred] because I was thinking there must be a problem, [as] if there was no problem, they won't refer me."**
>
> *33-year-old, BEmONC client, Borno State*

Overwhelmingly, clients expressed satisfaction with their experiences, even when they had negative outcomes. However, researchers observed a common cultural practice, which is that complaints or targeted dissatisfaction emerged when probed about specific components, despite expressing overall satisfaction. Clients with more severe complications requiring referral to higher-level facilities were more likely to express dissatisfaction, citing factors such as high referral costs, lack of equipment, drug shortages, poor quality of care, negative provider attitudes, delays in admission, administrative and referral procedures, and cost of care. Despite this level of dissatisfaction, clients linked their experiences, both positive and negative, to divine intervention - noting that regardless of the outcome, it was a reflection of God's will.

Communication about referral

In interviews, providers noted that one-way communication between facilities was typical via the use of a referral form from BEmONC to CEmONC facilities. Furthermore, clients noted inconsistent communications about referrals and mixed experiences. Some clients who accepted referral said they received clear communications as to why they were being referred – either by being counseled directly by the provider, or by proxy through their family members who received it on their behalf when they were unconscious or unavailable. However, other clients reported no communication, and most clients had limited understanding of the care that had been provided at the referring facility (with no documentation to point to), due to literacy barriers and lack of general healthcare knowledge. This led to duplicative care at CEmONC facilities, acceptance delays when referral facilities had to redo diagnostic tests, and increased costs for care. This duplicative process contributed to dissatisfaction among clients. The research

team's experience with the region suggests that for many clients this was their first interaction with the health system and as such, they do not know how to engage with the provider, ask questions, or to expect documentation and information sharing.

Respectful Care

While most clients reported feeling respected by healthcare providers, based on researcher experience with the context, clients are often unaware of their rights on respectful care. BEmONC providers were seen to be more empathetic, gentle, and instructive than their counterparts at CEmONC facilities. CEmONC providers were perceived by clients to be more direct, brief, and less thoughtful. Clients reported that instances of rude behavior or lack of empathy from providers detracted from their overall experience. For example, some clients noted they were punished or treated with impatience and lack of understanding if they yelled in pain during labor.

Resources Available: Human and Physical

EmONC Training

Study findings showed variance in the level and frequency of training health providers received. Some reported never receiving training, while others noted it had been many years since their last training. Nurses and midwives reported receiving training, but within a large range of time – 6 months to 4 years. Providers also perceived bias in selection of training participants, noting influence of personal relationships. Respondents highlighted training as an area for improvement, emphasizing the need for routine EmONC training, formal on-the-job training curriculums, and investment in mentorship programs. Specific recommendations included: extending training to CEmONC facilities even if redirection of funding is necessary; developing IEC materials and job aids focused on improved referral counseling that reflects clients' cultural norms and hesitation; and encouraging medical associations to promote and support more women to become doctors. Clients interviewed specifically stated a preference for examinations by female providers.

Transportation

In instances where clients were referred with an ambulance, they expressed gratitude for an efficient and swift referral process. In some instances, when ambulances were unavailable, commercial modes of transport such as tricycle ambulances or other private transportation were used. However, this was not the experience for some clients who expressed dissatisfaction in having to arrange their own transportation amidst their health complications. At facilities that lacked ambulance services, clients reported navigating to the referred facility on their own and the financial burdens associated, such as paying for fuel. In such cases, this often led to prolonged referral times and delays. Overall, the providers noted that the quality of care during transfer is poor, as ambulances often lack necessary medications or equipment and there is no guarantee of an accompanying healthcare provider. Providers validated this, noting that facilities struggle with a shortage of skilled personnel, leaving them unable to provide quality care during transport.

Cost of Care

While the cost of services did not affect clients' experiences at BEmONC facilities, experiences at CEmONC facilities, and during the referral process varied. Some clients reported minimal healthcare costs and while others noted financial requirements throughout the referral process. A few clients reported borrowing money for treatment, which put strain on their families and debts. This had an impact on their decision-making in the referral process.

> **"When they said we should go [to the referral facility, because] they can't treat us, we went back home for two days because we don't have money."**
>
> 19 year old, BEmONC client, Yobe state.

Researchers frequently saw three themes related to cost/financial considerations:

- Cost related to the referral transport itself: examples of this included facilities lacking an ambulance or other driver, clients being counseled to find their own way to CEmONC facilities, and clients having to pay for fuel for the ambulance.
- Cost related to the care at CEmONC, as most services were not free at CEmONC facilities: to receive services at these facilities, patients were required to provide commodities such as supplies and drugs (e.g., gloves, cord clamps, and sanitary pads).
- BEmONC providers communicating false information to clients: telling clients that CEmONC services were free to encourage them to accept a medically necessary referral. Although this may be best for the client's health, it also leads clients to distrust the system.

Recommendations

The following recommendations have been identified by various country stakeholders and experts following data analysis and validation workshops.

Ministry of Health

1. Increase human resources to support effective referral processes.
2. Establish a standardized transport system that includes well-equipped ambulances with necessary medical supplies, equipment, and facilities, competent drivers, and skilled providers to accompany patients during transit.
3. Mitigate improper use of ambulances by ensuring use regulations are followed. Ambulances should be for transportation of emergency patients only and the government should provide specialized alternatives for transporting corpses.
4. Ensure all facilities have facility-based functional phone numbers for communication and feedback sharing between BEmONC to CEmONC.
5. Standardize the communication structure, with particular attention to feedback loop between BEmONC and CEmONC facilities.

Ministry of Health and Humanitarian Partners

1. Improve routine EmONC training, formal on-the-job training curriculums, and investment in mentorship programs.
2. Invest in capacity building for service providers on patient communication, counseling and transparency with clients and documentation.
3. Develop IEC materials and job aids focused on improved referral counseling that reflects clients' cultural norms and hesitations.
4. Identify, and support through sustainable incentives emergency transport systems in each community to support referral processes.
5. Train and engage National Union of Road Transport Workers at every BEmONC facility and other emergency transport system services to assist with and abide by referral procedures.
6. Redirect funding for EmONC training at Primary Health Care facilities to extend EmONC trainings to secondary and tertiary facilities.

State Primary Health Care Development Board and Humanitarian Partners

1. Expand and invest in social behavior change mechanisms such as patient education, awareness raising for the community on danger signs during pregnancy, training the BEmONC providers to improve early identification of danger signs and subsequent referral.
2. Involve community and religious leaders in demand generation for quality MNH services,
3. Dispel community myths and misconceptions about referrals.
4. Integrate TBAs into the referral process to ensure prompt referral and early presentation of patients at the facility.
5. Conduct a mapping for referral pathway from community to tertiary.
6. Develop a referral directory indicating referral pathway and referral center contact details at the facility, Local Government Authorities (LGA) level, and state for ease of access.

Ministry of Health and Training Institute

1. Revise midwifery SOPs to reflect comprehensive scope of practice per global standards such as the International Confederation of Midwives Global Standards for Midwifery Regulation.
2. Encourage and invest in medical associations to promote and support more women to become doctors.

State Ministry of Health, State Primary Health Care Development Board and Hospital Management Board

1. Strengthen maternal and perinatal death surveillance and response (MPDSR) policies to ensure recommendations for improvement are identified and taken up.
2. Advocate for budget allocation to support referral audit.
3. Improve positive attitude towards audit and make it inclusive and transparent.

Ministry of Health, Primary Health Care and Humanitarian Partners

1. Harmonize the referral tools by all partners that feed into the HMIS and DHIS for tracking and audit purposes.
2. Increase financial resources for EmONC services, particularly in the context of weak health systems and humanitarian settings.
3. Equip BEmONC centers to provide relevant signal functions, thereby reducing unnecessary referral to CEmONC centers.

Federal Ministry of Health, National Primary Health Care Development Agency and Humanitarian Partners

1. Develop state- or national-level referral protocol and create a plan for operationalizing the protocol(s).

Study Limitations

- The study focused solely on referrals for obstetric and neonatal complications.
- The experiences of clients from BEmONC facilities to private owned hospitals were not explored in the study.
- In each state, we selected a government-owned CEmONC facility that met our criteria.
- Clients seeking abortion-related services were not interviewed.
- Data was only collected in three LGAs in Borno and two LGAs in Yobe States.
- The data was collected retrospectively, which may lead to recall bias among both clients and providers regarding their experiences.
- The study only focused on IRC-supported facilities at the BEmONC level.

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