Original Research Article

Providers' perception of quality of care and constraints to delivery of quality maternal health services in primary health centers of Enugu state, Nigeria

ABSTRACT

Aims: The aim of the study was to assess providers' perception of quality of care and constraints to delivery of quality maternal health services in urban and rural primary health centers of Enugu state, Nigeria.

Study design: This was a qualitative descriptive study.

Methodology: A descriptive study design using qualitative data collection and analysis method. Data was collected through a face to face in-depth interview using an interview guide between May and June 2013. A total of 24 providers participated in the study. They included six heads of department of health of six local government areas and officers-in–charge of eighteen primary health centers in urban and rural areas of Enugu state, Nigeria.

Results: Most of the providers perceived the quality of maternal health services in the primary health centers as good and they attributed this to results that are achieved. On measures the providers adopted to ensure clients satisfaction, most of the providers in the urban favoured good work attitude while those in the rural relied on provision of incentives. Inability of the health centers to remain open round the clock was identified as the major constraint to the delivery of quality maternal health care in the health centers and this was attributed to the prevailing security challenges in the study area. Other constraints included, inadequate number of health workers, poor amenities, and inadequate equipment.

Conclusion: The providers in the study area perceived good quality care to be the same as good utilization of the health centers. This has made them to adopt client friendly measures like good work attitude and use of incentives to encourage the clients to utilize the health centers. This may invariably lead to good quality care. Also, they view situations that limit access to services at the health centers as

constraints to delivery of quality maternal health care. The providers need adequate support from the local government authorities who are the custodians of primary health care in Nigeria and they should also involve the communities in the discharge of their duties. The primary health centers should be adequately fenced and personnel employed for security purposes as this improves access primarily and then good quality care. There is also the need to train the health workers on good quality care.

Keywords: Constraints, quality of care, maternal health, primary health center, Nigeria

1. INTRODUCTION

Health service providers as recognized by the World Health Organization, (WHO) are people who deliver health services, whether personal or non personal.(1) These providers of health services play a major role in identifying and meeting clients healthcare needs being the main point of contact between the client and the healthcare system. Their response to the needs of clients depend on their individual technical and interpersonal skills, the infrastructure present, and on the clients` view of what constitutes high quality care [2] Knowledge of providers` perspective on quality of care is very limited, however in a study in Kenya, poviders and clients agreed on the significance of certain elements of care as determinants of quality. These elements included affordability, convenient location, good provider attitudes, privacy and confidentiality and availability of supplies [3]

The United States Agency for International Development`s Maximizing Access and Quality Initiative identified 25 indicators of quality of care and of these, thirteen were related to providers' job performance. This reveals the importance of the providers' job performance as a determinant of quality of care [2] In a study in Malawi, health care workers were of the opinion that the quality of essential obstetric services they provide were poor. They also attributed this poor quality care to two factors, those emanating from the clients themselves and those that are associated with the health care system. Such health facility factors that resulted in poor quality care were identified as inadequate resources, inadequate staffing, poor team work and poor supervision [4]

Nigeria has the second largest burden of maternal death globally, (5) There is evidence that countries that achieved low maternal mortality rates embraced good quality care, [6) hence the need for quality maternal health services. This is of importance if the 5th Millennium Development Goal of improving maternal health and the post 2015 development agenda are to be realized. Also, in most rural areas of Nigeria, the primary health centers are the predominant health institutions. In these rural areas, 54% of the population reside, (7) the health workers are fewer and the health indices are poorer [8] than that of urban inhabitants. This supports the quest for quality maternal health services in the primary health centers.

In Nigeria, the challenges to the utilization of maternal healthcare services include amongst others distance to the health facility and cost of services [8] Lack of finance was also reported as the main barrier to utilization of maternal health services in Kano State, Nigeria [9] However in a community based study in Bayelsa State, Nigeria, the major barriers to utilization of maternal health services were identified as poor knowledge of services available, previous bad obstetric history and attitude of the health care providers.[10] All these are the viewpoints of clients of maternal health service hence this study was designed to obtain the provider's perception of quality of care and their own identified constraints to delivery of quality maternal health services in urban and rural primary health centers of Enugu state, Nigeria.

2. MATERIAL AND METHODS

2.1 SETTING AND SAMPLE SELECTION

The study was conducted in Enugu State in the southeast geo-political zone of Nigeria. It has a population of 4,881,500 people within a total area of 7,618 sq km.[11] Administratively it consists of 17 local government areas, (of which 5 of them are designated as urban), and 291 political wards. The inhabitants are mainly of Igbo ethnic nationality and are predominantly Christians. The major occupation of the people in the urban areas are trading and formal employments while in the rural area, it is mainly subsistence farming and animal pasturing.

Enugu State operates the District Health System and has a total of seven district hospitals, (namely Awgu,, Udi, Enugu Ezike, Agbani, Nsukka, Isi Uzo, and Enugu Metropolis), 40 cottage hospitals, 440 primary health centers , two specialist hospitals , two teaching hospitals and 384 private health facilities.[12] Enugu state at the time of this study offered free maternal and child health services in all its health facilities including the primary health centers. The Nigeria National Health Policy is based on the Primary Health Care approach, and the control of its activities is under the third tier of government, the Local Government Authorities.[13] The primary health care system is linked with the secondary and tertiary health services through a two way referral system.

A two stage sampling method was used for the study. In the first stage, a simple random sampling technique of balloting was used to select three local government areas each in urban and rural areas of the state. The heads of department of health of the selected local government areas were then purposively selected for interview. In the second stage, three health centers in each of the six selected local government areas were randomly selected by the balloting method. Also, the officers-in-charge of the selected health centers were purposively recruited into the study. All the providers included in the study participated.

Inclusion of the officers-in-charge and the heads of department of health in the study was to capture diverse views of the providers. The officers-in-charge of the health centers are the chief service providers in the various health centers. The heads of department of health by their constant interactions with the officers-in-charge of health centers including visitations to all the health centers at intervals are fully aware of the health situation in the local government area generally. Hence their selection was based on their involvement in the delivery of maternal health services in the health centers and also policy formulation in the various local government areas.

2.2 Study Design

This was a qualitative descriptive study and information was obtained using an in-depth interview guide for providers of maternal health services in urban and rural primary health centers.

2.3 Study Participants

The study participants consisted of 24 providers of maternal health services and included six heads of department of health in the local government areas selected for the study and 18 officers-in-charge of the primary health centers selected for the study.

2.4 Conceptual framework

The study is based on the International Planned Parenthood Federation (IPPF) framework of quality of care. It identified ten rights of clients and recognized that a client centered service should include the perspective of the providers who are in direct contact with the clients. Thus it addressed 10 needs of providers to include training, information, supplies, guidance, supplies, infrastructure, back up, respect, encouragement and self expression. It also extended the definition of the client to everyone in the community who is in need of services [14] and not just those who come to the health care system for services.

2.5 Data collection

Data was collected from the 24 providers at the primary health care level using an in-depth interview guide. Information was obtained on how they perceive the utilization of the health centers, their rating of the quality of maternal health services delivered at the health centers, the measures they have employed to ensure the satisfaction of clients with the services provided and the constraints to the delivery of quality maternal health services at the health centers.

The interviews were conducted after working hours by the researcher with the assistance of a trained note taker who summarized the responses of the providers in detailed notes. The interviews were recorded with a digital voice recorder and was conducted in English. Follow up questions using probes were asked during the interviews so as to have a deeper understanding of any subject if the explanation was unclear. The average duration of each interview was about 50 minutes.

2.6 Data analysis

The recorded interviews were transcribed verbatim following each interview. This was compared with the written notes from the note taker for completeness, accuracy and as a data quality assurance measure. Each typed transcript was checked against the audiotape by an independent reviewer. In-order to verify the quality of translation, tapes were double transcribed. The written transcripts from each interview were read and key words and significant statements were highlighted.. The manuscripts and more importantly the quotes of the participants were returned to them for comments and approval. Coding of transcripts was done based on predetermined themes as they were consistent with the categories of interest. This is because these pre determined themes formed the basis of the interview guide. The independent reviewers then discussed and compared the initial codes and reconciled the differences. The identified themes that emerged from each interview were reviewed by the researcher and grouped together under wider themes. Summary statistics were obtained from the data and this was presented based on the location of the health center, urban and rural. The Statistical Package for Social Sciences (SPSS) version 20 statistical software was used for data entry and descriptive analysis of the participants socio-demographic data.

3. RESULTS

Table 1: Socio-demographic characteristics of providers

Variable	Urban n=12	Rural n=12	Total (%)
	N (%)	N (%)	
Age category			
40- 49 years	8 (66.7)	8 (66.7)	16 (66.7)
≥50 years	4 (33.3)	4 (33.3)	8 (33.3)
Age. Mean (SD)	47.58±4.6	48.75±3.9	
Sex			
Male	3 (25.0)	2 (16.7)	5 (20.8)
Female	9 (75.0)	10 (83.3)	19 (79.2)
Designation			
Head of department of health	3 (25.0)	3 (25.0)	6 (25.0)
Officer-in-charge	9 (75.0)	9 (75.0)	18 (75.0)
Years of service in present office and health center			
1-4 years	9 (75.0)	9 (75.0)	18 (75.0)
≥ 5 years	3 (25.0)	3 (25.0)	6 (25.0)
Qualification			
Community Health Officer	3 (25.0)	2 (16.7)	5 (20.8)
Community Health Extension Worker	4 (33.3)	7 (58.3)	11 (45.8)
Nurse/Midwife	1 (8.3)	1 (8.3)	2 (8.3)
Pharmacy technician	1 (8.3)	1 (8.3)	2 (8.3)

Bachelor degree	**1 (8.3)**	**1 (8.3)**	**2 (8.3)**
Master degree	**1 (8.3)**	**0 (0)**	**1 (4.2)**
Diploma public health	**1 (8.3)**	**0 (0)**	**1 (4.2)**

Table 1 shows the socio-demographic characteristics of the providers. Twenty four providers of health service participated in the study and these included 18 Officers-in-Charge [OIC] of health centers and 6 Heads of Department [HOD] of health of the Local Government Areas selected for the study.

Utilization of health center

Fifteen of the 24 providers interviewed were of the opinion that the primary health centers were well utilized for maternal health services. An OIC in rural said, *".the women, they come well in their numbers, they are always here"* An OIC in urban who was of the view that the health center is poorly utilized said, "*The utilization of this health center is poor, somehow they (the women) know we do not have any equipment and so they do not come".* The reasons for rating the utilization as good were very similar among the two study groups. Nine of the providers, (urban;4 and rural 5) say it is because the government always employ trained health workers in all their facilities. A HOD health in urban said, '*The people know that government always employ trained* health workers *and this gives them the confidence to utilize government health facilities'* An OIC in rural said *"The community people all know that we were trained by the government that is why they come here well well"* Two providers each in urban and rural attributed the good utilization to improvement in service delivery, however this improvement in service delivery was based on an increase in the number of clients utilizing the services in the health centers. Two providers, one each in urban and rural said that the free maternal and child health programme of the state government is the reason for the good utilization.

Perception of quality of care

Thirteen of the 24 providers (54.2%), perceived the care at the health centers to be of good quality. (see Table 2) The reason for the rating however differed in the two study groups, In the urban, the major

reason was that results were achieved. According to an OIC, *"....we see the smile in their faces as they come, that means that they are happy, you see once they are happy, we ourselves are happy also."* In rural however the providers attributed the rating to the extra hard work on the part of the health workers, who not minding the numerous challenges they face in the course of their duties do their best to provide quality health care. An OIC in rural said, *"We see this work as our own, as such we put in the best we can to see that things are moving on well"* An OIC in urban, however perceived the quality of care in the health centre as poor and noted it this way, *"The quality of care is poor, we have a lot of equipments but we do not know how to use them, we have delivery kits but we do not conduct delivery, we don't even have a functional bed".* On why they justify quality maternal health care and whether morbidity and mortality were taken into cognizance in that regard, an OIC in urban answered, *"The thing is that we don't record deaths and serious cases because this is primary health care where we handle minor ailments and normal delivery"*

Table 2: Providers perception of quality of maternal health care

Variable	Urban (n=12) N (%)	Rural (n=12) N (%)	Total (n=24) N(%)
Rate maternal health care as good	6 (50.0)	7 (58.3)	13 (54.2)
Reason for rating quality of maternal health care as good			
Achieving good results	3 (25.0)	2 (16.7)	5 (38.5)
Good utilization of the health centers	2 (16.7)	2 (16.7)	4 (30.8)
Health workers work hard to overcome challenges	1 (8.3)	3 (25.0)	4 (30.8)

Ways to improve quality of care

On ways the authorities could improve the quality of care provided at health centers, 16 of the providers (66.7%) emphasized the need for constant training of health workers. An OIC in rural area remarked thus, *"You see these trainings give a lot of joy to the health workers, you know it lifts them up so much and it helps them to put in their best."* Another OIC in rural had this to say, *"I have been taking delivery for many years, but this year I was trained on delivery and it has been very rewarding"* (rewarding in the sense that there is a huge gap between what she knew before and after the training). Six of the providers, four of them in rural emphasized the need to employ medical doctors in the health centers. An OIC in rural area put it this way, *".....also let them send us a doctor, the women are always excited whenever they hear that they would meet a doctor each time they come."* Also, 2 providers all in the rural area wanted operational laboratories in the health centres. It was noted this way, *"I used my money to buy hemoglobin estimator and reagent for urine test, I found out that our clients love to do test a lot, and for me it is a way to encourage them to be coming."*

Role of Local Government Authorities

Thirteen of the providers, including ten from the urban area were full of knocks for the local government authorities who are constitutionally in charge of the primary health care system in Nigeria. They were of the opinion that they should be alive to their responsibilities. A HOD health in rural area remarked this way, *"The local government is not supportive at all, you see health issues are things you cannot quantify, like add this to this and you get this, so the politicians cannot quantify health issues hence they see democracy dividends as road construction and cannot see women having safe deliveries in our health centers as being significant."* Another HOD health in urban remarked, *"Since primary health care is under their responsibility, (the local government) they are supposed to make things work"* An OIC in rural said, *"The local government do not perform what is expected of them, I found out that their major concern when you complain about anything that is relevant to health, is for you to write and write, but without action, so I decided to co-operate with the facility health committee in-order to improve our work."* Eleven of the providers, nine in the rural area wanted more encouragement for the health workers from the local government authorities.

Measures to ensure clients are satisfied

On measures to ensure client satisfaction, (see Table 3) nine of the providers (seven from urban), were in support of good work attitude on the part of the health workers. However five providers in rural and one in urban area, were of the opinion that incentives should be provided to the clients as a form of encouragement. An OIC in rural said, *"The traditional birth attendants give them (the women) tea to drink when they attend antenatal care and when they give birth, they are served food, and they said we do not give them any of these extra services."*

An OIC in urban, remarked thus, *"Presently when they deliver in our facility, we give them gifts like pampers, baby cream and soap supplied by a Non Governmental Organization and they gave all these to us so as to support the mothers"* Thinking in the same line, an OIC in rural said, "*We are still contemplating that when they come for immunization, we would ask everyone of them to pay a little sum of ten Naira (0.05 cents), and with that amount we intend to start making "kunu".(a local drink) so that when they come, we would give them the 'kunu' and tell them that government said that we should start giving this to them. We hope that when we do this well it would help make them satisfied and they will come more for antenatal care, delivery, etc"* Another OIC in rural area is also making future plans and noted it this way, *"I am planning a baby show, during which all the women that delivered in the health center will come and display their babies to the whole community, and we will have the local government chairman and the chiefs in attendance, so that the community members themselves can testify to our good works."*

Seven providers (five of them from urban), were of the opinion that good health facility environment will help to ensure satisfaction of clients. An OIC in rural area had this to say, *"To me, the first treatment is good environment and provision of water in the health center."* Five providers, (four from rural), saw the relevance of facility health committee in ensuring that the clients are satisfied. An OIC in rural said, *"We are always in touch with the facility health committee to make sure we carry everyone along and make everybody satisfied with our services".* Two providers, one each in urban and rural, view attempts at reducing the waiting time as a measure of ensuring client satisfaction.

Table 3: Measures to ensure client satisfaction with the services at the health centers

Variable	Urban (n=12) N (%)	Rural (n=12) N (%)	Total (n=24) N (%)
Measures to ensure client satisfaction with services at the health centers**			
Good work attitude of health workers	7 (58.3)	2 (16.7)	9 (37.5)
Good facility environment	5 (41.7)	2 (16.7)	7 (29.2)
Incentives to clients	1 (8.3)	5 (41.7)	6 (25.0)
Use of facility health committee	1 (8.3)	4 (33.3)	5 (20.8)
Reducing waiting time	1 (8.3)	1 (8.3)	2(8.3)

**multiple responses encouraged

Constraints to delivery of quality maternal health care

Among the providers in urban and rural area, the major constraint to the delivery of quality maternal health services is the issue of security. (see Table 4) Security challenges ranged from absence of perimeter fencing or a well secured gate and in situations where these are available, the absence of a functional security man. These security challenges inhibit optimal utilization of the health centers by ensuring that some of the health centers do not remain open all the whole hours of the day. An OIC in rural area noted it this way, *"We need protection and you know the security challenges presently, that we are community health workers, does not mean that we should be exposed to danger unnecessarily, there has been instances whereby health workers have been assaulted at night so this is a very serious matter."* Another OIC in rural area put it thus, *"My number one challenge is security, I do not have security, (personnel), I have informed the town union so that the neighborhood watch can come and*

patrol and secure us at night." An OIC in urban had this to say, *"They are saying that this place is not secure because of no fencing; that if they deliver here that armed robbers can come in and deal with them"*

Another noted constraint is inadequate number of health workers, an OIC in urban had this to say, *"The problem we have in this state is lack of staff; we don't have staff. For instance, like I am now, I am the accounting officer; a lab technician, a doctor, (I consult) a midwife, and I am also the clinic attendant…..its just two staff that they brought to me. We are no longer in the dark age, let them employ more people in the primary health care sector."* A HOD health in rural area said, *"There is nowhere one health worker can work for 24 hours, the civil service rule says normal working hours is 8 hours, one person cannot do morning afternoon and night duty the same time, and in some of our health facilities, only one person work there."*

Half of the providers pointed to the fact that amenities are lacking in the health centre. An OIC in urban area remarked thus on the issue of poor amenities, *"Now tell me which women in her right senses will come to this kind of place (the health center) for delivery; a situation whereby lantern is used for delivery. We need power supply, I mean, light"* Five providers, four from rural, viewed poor incentives to health workers as a limiting factor to the delivery of quality maternal health care. An OIC in rural area who felt that her facility is not enjoying supportive supervision like those around hers, since a Non Governmental Organization has been actively supporting primary health centers in the state saw this as a poor incentive and captured it this way, *"We will be happy if one day when our clients are here, they will see that government people from Abuja or Enugu (national and state capital), have come to see what we are doing here, with this, they (community members), will understand that what we are doing here is important, please tell them to be coming to see us here".*

A HOD health in urban area was of the view that poor remuneration was a disincentive and had this to say, *"Support, Incentives no way, a few years ago health workers in the state went on strike for CONHESS (a new pay package for health workers as approved by the Federal Government of Nigeria), and up till now it is not being paid, so grudgingly people are working"* Another HOD health in rural area

added to the salary issue this way, *'The pay does not come regularly. Our month in the local government is about 49 or 50 days."* An OIC in rural area summed up the issue of salary this way, *"No amount will be too much for health workers by virtue of the type of work they do. They are exposed to all forms of hazards, they deserve every form of encouragement"*

Table 4: Constraints to the delivery of quality maternal health care

Variable	Urban (n=12) N(%)	Rural (n=12) N(%)	Total (n-24) N (%)
Constraints to the delivery of quality maternal health care in the health centers**			
Security challenges	10 (83.3)	8 (66.7)	18 (75)
Inadequate number of health workers	8 (66.7)	5 (41.7)	13 (54.2)
Poor amenities	7 (58.3)	5 (41.7)	12 (50)
Inadequate equipment	5 (41.7)	4 (33.3)	9 (37.5)
Poor incentives	4 (33.3)	1 (8.3)	5 (20.8)
Non-availability of doctor	3 (25.0)	1 (8.3)	4 (16.7)

**Multiple responses encouraged

4. DISCUSSION

Most of the providers perceive the quality of maternal health service in the primary health centers as good, and this was based on the fact that results were achieved. The evidence for this achieved result is the close observance by the providers of the smile on the faces of clients which they linked as sign of satisfaction and of good quality care. It did not matter that the smiles were observed at time of coming before services were rendered. In all, it appears that the providers perceive good quality care to be good utilization of the health centers from their own viewpoint.

The reasons the providers gave to justify good quality care were based on good utilization. Perhaps they are reaching this conclusion based on the fact that they do not record mortality much and are also prepared to refer cases that are beyond their competence. Even the officer-in-charge of a health center that perceived the care to be of poor quality was indirectly complaining of poor utilization. In a study in Malawi on service providers perception of the quality of emergency obstetric care, the providers rated the quality of care they provided as poor and the health system factors that contributed to this poor perception included inadequate resources, inadequate number of health workers, poor teamwork and poor supervision [4]

On measures the providers adopt to ensure satisfaction of clients with maternal health services delivered in the primary health centers, most of the providers in the urban area, attested to good work attitude on the part of the health workers in their relationship with the clients. It has been found that dissatisfaction among clients of maternal health service had been associated with rude, arrogant and neglectful behaviors on the part of the providers, which make some of the women to patronize the traditional birth attendants [15] However it could also be viewed that the providers are conscious about utilization and as such are adopting measures to retain clients. In a study in Maharashtra, India, the clients perceived the care in public health facilities to be of poor quality and this encouraged the women to deliver at home [16] and this will not improve maternal health outcome. That the providers of maternal health services in the primary health care system in the study area are aware of the need for good attitude towards the clients is of importance as this ultimately will lead to good quality care

In the rural area however, most of the providers were of the opinion that incentives should be provided to the clients at the primary health care level as a way of ensuring their satisfaction with services rendered at that level of care. They perceived such incentives to serve as motivation to the clients especially as they were aware that the traditional birth attendants have been offering incentives to their clients with good results. There is a finding that women who utilize modern health facilities do complain of lack of psychological support as opposed to the empathy that is shown to them by the traditional midwives [17,18] and this positively affects their satisfaction with services from the traditional midwives. It appears that the providers are conscious of their training as being superior to that of the traditional birth

attendants. There is also the likelihood that the providers in the rural view the traditional birth attendants as major competitors for clients when compared to the providers in the urban hence their adoption of the measures the traditional birth attendants use to retain clients. They are also aware that they could only be relevant when the health centers are utilized hence they search for measures to ensure that the clients are coming. This may also support some of the providers view of quality maternal health service, as the extra work on the part of the health workers to overcome institutional challenges.

The major constraint to the delivery of quality maternal health services as identified in this study was the inability of the health centers to function optimally by being open all the hours of the day due mainly to security challenges. These security challenges ranged from lack of perimeter fencing at the health centers, to the absence of a well secured gate, or even when the two items mentioned above are present, the absence of official security personnel. This reveals that existing societal problems invariably affects the health care system also, as this is an obvious fall out of the current security problems in Nigeria. In the southeast geo-political zone of Nigeria, these security challenges have manifested in form of armed robbery, and kidnappings for ransom.

Most health centers now fail to provide round the clock services even in situations where there are adequate number of skilled health workers, and also adequate equipment, due to the fear of attack by armed robbers and criminals alike, especially at night. It has always been noted that for the delivery of good quality maternal health care, human resources must be available at the health facilities, and at all times too [19] It could be reasoned that the providers view the state of insecurity as inhibiting access to health services in the primary health centers hence directly affecting utilization. This could also explain why some of the health centers in the rural area turned to the direction of the neighborhood watch just to make sure that access is guaranteed.

Security challenges inhibit a 24 hour coverage of the health centers which is essential in the provision of quality maternal health services. Previous studies have established inadequate staff strength as a major reason why health facilities do not open all the hours of the day [,20,21, 22] Also, in a qualitative study in rural Vietnam that focused on providers perception of maternal health care at the primary health care

level, the major structural constraint indentified in the study was lack of human resources for health and this was attributed to poor financing of the primary health care system [23] However, in a study on awareness and barriers to utilization of maternal health services among women of child bearing age in Amassoma community, in Bayelsa State, Nigeria, the major barriers identified were amongst others, poor knowledge of existing services, previous bad obstetric history and poor work attitude on the part of the providers [10]

Another constraint identified in this study was inadequate number of health workers. There is evidence that trained health workers are in short supply in developing countries when compared with the developed ones [1] and in Nigeria access to skilled providers for maternal health care is more in the urban than rural [8] However, from the results of this study, more providers in the urban perceived inadequate number of health workers as a constraint. It could be that the providers have different views on what constitutes adequate health workers based on individual facility experiences. In a study in Zambia, heavy workload which is a reflection of poor workforce, lack of equipment and drugs, poor salary and lack of continuing education was reported as elements of dissatisfaction on the part of the health workers [24] Other barriers from the result of this study included poor amenities in the health centers, inadequate equipment for the provision of care, poor incentives to the health workers, and the absence of medical doctors in the primary health care system.

From the results of this study, the providers of maternal health services in the primary health centers seem very willing to work and are in dire need of institutional support. This could explain why absence of supervisory visits could be viewed as a disincentive and trainings are well appreciated. It could be that when this support is not forthcoming from the custodians of primary health care, the local government authorities, they adopted innovative approaches in a bid to continue to provide services hence remain relevant. This is more pronounced in the rural areas. The use of facility health committee in reaching out to the community and use of neighborhood watch to provide security are all forms of community participation in health care which is one of the principles of primary health care [25] Also, the use of incentives and planning of baby shows may also be their own way of gaining community appeal with the

result that the health centers will be well utilized. The result is that the constraints to delivery of quality health care are mainly societal and health system factors and not that associated with the health workers. In the study in Malawi, the health care workers viewed factors associated with clients and health system as reasons for poor quality care [4].

An important limitation of this study is that the results though relevant to the study area may not be generalized to other settings. This is because the study being of qualitative design, the views of the providers are a reflection of their level of training, their work experience and their perception of what constitute quality health care. Also, some peculiarities of the study area like the state of insecurity and the free maternal and child health programme of the state government (which was in operation at time of the study) might have influenced the outcome of the study. Moreover there is scarcity of literature with regards to providers perception of quality of care especially in the primary health care system in Nigeria and other developing countries.

5. CONCLUSION

The providers in the study area perceived good quality care to be the same as good utilization of the health centers. This has made them to adopt client friendly measures like good work attitude and use of incentives to encourage the clients to utilize the health centers. This may invariably lead to good quality care. Also, they view situations that limit access to services at the health centers as constraints to delivery of quality maternal health care. The providers need adequate support from the local government authorities who are the custodians of primary health care in Nigeria and they should also involve the communities in the discharge of their duties. The primary health centers should be adequately fenced and personnel employed for security purposes as this improves access primarily and then good quality care. There is also the need to train the health workers on good quality care.

CONSENT

Participants were required to sign or thumb print to a written informed consent form before the interview and the nature of the study, its relevance and the level of their participation was made known to them..

Also, the confidentiality of the participants were protected throughout the study by ensuring that no personal identification of data was recorded during the period of data collection and analysis and all interview recordings were erased after transcription.

ETHICAL APPROVAL

Ethical approval for the study was obtained from the Research and Ethics Committee of the University of Nigeria Teaching Hospital Ituku-Ozalla, Enugu. Participation in the study was voluntary. Also, respondents were assured that, there would be no victimization for those who refused to participate or who decided to withdraw from the study after giving consent. Respondents were assured that all information provided through the questionnaire will be kept confidential.

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IDI Guide for Providers on the Perception of Quality of Maternal Health Care and Constraints to Delivery of Quality Maternal Health Service.

Introduction. And other formalities including permission for audio recording of the interview and signing of informed consent form

1. What are the maternal health services that are obtainable in your health center/LGA.
2. How do you rate the utilization (attendance) of these maternal health service in your health center/LGA.
3. What are the reasons for the current utilization rates.
4. How will you define quality of healthcare, also quality of maternal health care/service?
5. How do you rate the quality of maternal health services delivered in this health center/LGA.
6. What are your reasons for this rating you have made.
7. What aspects of maternal health service do you consider to be of good quality or not of good quality in this health center/LGA.
8. What are your reasons for rating these services as good or not good.

9. What do you think can be done to improve the quality of maternal health service in your health center/LGA?
10. What do you think can be done by health workers to improve quality of maternal health service in your HC/LGA.
11. What is your view about the state of equipment/facilities/drugs for providing maternal health services in your health facility/facilities?
12. What factors do you think make women not to assess maternal health service in the health centers.
13. What factors do you think make the women not to deliver in the health canters even after attending antenatal care there.
14. What measures are in place to ensure patient satisfaction with services rendered in the area of maternal health in your health center.
15. What measures are in place to ensure the continuity of those aspects of maternal health services you have rated as good.
16. What are the difficulties/constraints in the delivery of quality maternal health care generally.
17. What are the constraints to the delivery of quality maternal healthcare in your HC/LGA.
18. What do you think can be done to overcome these difficulties.
19. What are the roles of the health workers in the provision of quality maternal health care.
20. What are the roles of the Government/LGA Authority in the provision of quality maternal health care.
21. Do you have any method/methods of getting feedback from the clients on care given, eg use of suggestion box.
22. Are there any form of supportive supervision in place at the health facilities.
GIVE INSTANCES.