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 were 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 services at 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 host communities in the discharge of their duties. The primary health centers should be adequately fenced and personnel employed for security purposes as this will improve access primarily and then good quality care. There is also the need to train the health workers specifically 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 provided were poor. They also attributed this poor quality care to two factors, those emanating from the clients themselves and those that were 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 facilities. 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 at the primary health centers.

In Nigeria, the challenges to 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 and when combined with those of providers will be of value to policy makers. It will also assist in the design of interventions with the aim of improving maternal health in Nigeria. This study was designed to determine 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 which is one of the five states 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 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 areas generally. Hence their selection was based on their involvement in the delivery of maternal health services at 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 (HOD) of health in the local government areas selected for the study and 18 Officers-in-Charge (OIC) of the primary health centers selected for the study.

2.4 Conceptual framework

The study was based on the International Planned Parenthood Federation (IPPF) framework of quality of care. It is one of the rights based approach to 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, 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. The focus of the study was to determine how the training, supplies and infrastructure at the disposal of the providers influenced their perception of quality of care and constraints to the delivery of quality maternal health services. It also assessed the guidance and encouragement that are available to the providers for the delivery of quality maternal health services.

2.5 Data collection

Data was collected from the 24 providers at the primary health care level using an in-depth interview guide. 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 45 minutes. It was one interview session per participant however for four of the participants in the study, follow up visits were done for the purpose of clarification of views.

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 discussed and compared the initial codes and reconciled differences. The identified themes that emerged from each interview were reviewed by the researcher and grouped together under wider themes. Six themes emerged from the study and included the providers perceptions of utilization of services at the health centers, quality of care and ways to improve the quality of care at the health centers. Others included the role of the local government authorities, measures they have adopted to ensure that clients are satisfied and constraints to the delivery of quality maternal health services at the health centers. Summary statistics were obtained from the data and this was presented based on the location of the health center, urban and rural.

2.7 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.

3. RESULTS

Participants' profile

Eleven of the 24 providers were qualified Community Health Extension Workers (seven of them were in the rural primary health centers) while five were Community Health Officers. Two providers (one each in the two study groups) were Nurse/Midwife. Three of the providers had a university degree. Eighteen of

the providers have been in their current positions for less than five years while others have stayed five years and above. Nineteen of the providers are female.

Perception of health service utilization at the health centers

Fifteen of the 24 providers interviewed were of the opinion that the primary health centers were well utilized for maternal health services. This perception of good utilization was as expected based on the turn out of clients for services at the health centers. An OIC in rural summed it up this way *".the women, they come well in their numbers, they are always here"* The remaining nine providers were of the opinion that the health centers were poorly utilized for maternal health services. Most of these providers attributed this poor utilization of services to a specific cause like lack of equipment, poor location or lack of adequate manpower. An OIC in urban who held this view had this to say "*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) attributed the good utilization of the health centers to the fact that government always employ trained health workers in all their health 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" This was collaborated by another* OIC in rural who remarked thus *"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 also based on an increase in the number of clients utilizing services at the health centers. Two providers, one each in urban and rural were of the view that the free maternal and child health programme of the state government contributed to the good utilization since clients who otherwise could have been deterred by cost now utilize the health centers for services.

Providers perception of quality of care in the health centers

Thirteen of the 24 providers perceived the care at the health centers to be of good quality (see Table 1) Of these providers, seven were in the rural area. The reason for the rating however differed among the

two study groups. In the urban, the major reason for rating the quality of care as good was that results were achieved. This impression of achieved results was expressed by the providers in various ways. According to an OIC (urban) *"....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"* Another OIC in the urban linked achieved results to continuity of services, from antenatal to delivery, then immunization and other child health services and presented it this way " ..our patients stick to us, they come for antenatal care here, may deliver here and same child is brought here for immunization and other services"

In rural, the major reason why the providers rated the quality of care they rendered to clients as good was because of their perceived hard work in overcoming the numerous institutional challenges they face in the discharge of their duties. An OIC noted it this way *"We see this work as our own, as such we put in the best we can to see that things are moving on well"* Four providers (two each in urban and rural area} perceived the quality of care in the health centers as good based on their observations that the health centers were well utilized for maternal health services. The providers further justified their perception of quality of maternal health care as good by stating that they do not record maternal deaths. An OIC in urban summarized it this way *"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"* Eleven of the providers perceived the quality of care in the health centers as poor and like those who were of the opinion that the health centers were poorly utilized for services also proffered reasons. These reasons were based on limited service delivery and lack of adequate manpower. An OIC in urban 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"*

Table 1: Providers perception of quality of care in the health centers

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 at the health centers

On ways the authorities could improve the quality of care provided at the health centers, 16 of the providers (ten in the urban) emphasized on the need for constant training of health workers. The providers had favorable views on manpower development. 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 also *"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 was a huge gap between what she knew before and after the training) Six of the providers, four of them in rural were of the view that medical doctors should be employed in the health centers as a way of ensuring quality health service delivery. An OIC in rural area presented 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"* Two providers, all in rural area wanted operational laboratories in the health centers as a way of improving the quality of care. An OIC noted it 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 in quality maternal health services

Thirteen of the providers, including ten from the urban area were dissatisfied with the role of the local government authorities with regards to support to the providers and the quest for quality maternal health care in the primary health centers. They were of the opinion that they should be alive to their responsibilities in the area of health service delivery in the various local government areas. A HOD health in rural area expressed it 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 made her point this way *"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 were less critical of the role of local government authorities in health service delivery. They however wished for more support from the authorities in the discharge of their duties. An OIC in rural had this to say "…I believe they (local government authorities) can do more than what they are doing now"

Measures to ensure clients are satisfied with services at the health centers

The providers had several views on measures they have adopted or intend to adopt aimed at ensuring clients satisfaction with maternal health services at the health centers (see Table 2) Nine of the providers (seven from urban) said they have relied on good work attitude in ensuring clients satisfaction. This they explained further to mean being friendly with the clients and also use of home visits to strengthen ties with the clients. Six providers including five from the rural area expressed the opinion that provision of incentives serve as good encouragement to the clients and as such will make them satisfied with services they receive at the health centers. This they have obviously learnt from the activities of the traditional birth attendants in the locality. An OIC in rural brought this into focus this way *"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 who seem to have seen the gains in using incentives for clients also barred her mind this way *"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" In agreeing with use of incentives in ensuring clients satisfaction, an OIC in the rural expressed her intention this way* "*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 make them satisfied and they will come more for antenatal care, delivery, etc"* Similarly, 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 summed it up this way *"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 were 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, said they have done their best in reducing the waiting time and this to them was to ensure that clients were satisfied with services they receive at the health centers.

Table 2: Measures to ensure client satisfaction with services at the health centers

Variable	**Urban (n=12)**	**Rural (n=12)**	**Total (n=24)**

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

**multiple responses encouraged

Constraints to delivery of quality maternal health care at the health centers

Among the providers in urban and rural areas (eighteen in all) the major constraint to delivery of quality maternal health services in the primary health centers is the issue of insecurity (see Table 3) This ranged from absence of perimeter fencing or a well secured gate at the health centers and in situations where these two items are available, the absence of a functional security man. These security challenges according to the providers 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 expressed this issue of insecurity 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 have 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 on security*"They (the women) 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 by the providers is inadequate number of health workers. This was expressed by thirteen of the providers and eight of them were from the urban area. The providers were also concerned because reduced staff strength also inhibited round the clock service provision at the health centers. This an OIC in urban presented this way *"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"* Also, a HOD health in rural area had this to say *"There is nowhere one health worker can work for 24 hours, the civil service rule (Nigeria) has it that 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 (seven from urban) were of the view that amenities were lacking in the health centers and as such constituted a constraint to the delivery of quality maternal health services. This by the assessment of the providers also reduced the utilization of services at the health centers. This was how an OIC in urban area brought this issue of poor amenities to focus *"Now tell me which woman 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 urban, viewed poor incentives to health workers as a limiting factor to the delivery of quality maternal health care in the health centers. The definition of poor incentives was however peculiar to each study participant that expressed this idea. An OIC in rural area who felt that her facility was not enjoying supportive supervision like those around hers, since a Non Governmental Organization has been actively supporting primary health centers in the state viewed this as 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 and 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 perceived poor remuneration as 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 concluded that late payment of salaries was also a disincentive and added to the issue this way *'The pay does not come regularly, our month in the local government is about 49 or 50 days" Four providers including three from the urban area were of the opinion that the non availability of medical doctors in health service delivery at the primary health care level does not favor quality maternal health services.*

Table 3: Constraints to 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 perceived the quality of maternal health services in the primary health centers as good, and this was based mainly on the fact that results were achieved. The evidence for this achieved result is the 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 arriving at the health center and ever before services were rendered. Another basis of achieved result is on continuity of services from antenatal care to delivery and then immunization services. To an extent, these achieved results were not backed by established facts. It could be inferred that the providers perceived good quality care to be good utilization of services at the health centers from their own perspective.

Also, the reasons the providers gave to justify good quality care were based on their perceived good utilization of services at the health centers. Perhaps they reached this conclusion based on the fact that they record low mortality or none at all and were also prepared to refer cases that were 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 of services. This finding is however different from that from a study in Malawi on service providers perception of quality of emergency obstetric care where the providers rated the quality of care they provided as poor and attributed same to client and health system factors [4]

Most of the providers in the urban area adopted good work attitude as a measure to ensure that clients were satisfied with services they received at the health centers. This is of importance as dissatisfaction among clients of maternal health service had been associated with rude and arrogant behaviors on the part of the providers, which encouraged some of the women to patronize the traditional birth attendants [15] Also, in a study in Maharashtra, India, the clients perceived the care in public health facilities to be of poor quality and because of this the women preferred 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 were aware of the need for good work 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 affect their satisfaction with services from the traditional midwives. There is a likelihood that the providers in the rural view the traditional birth attendants as major competitors for clients and so were adopting the same measures the traditional birth attendants use to retain clients. They may have concluded that they will only be relevant when the health centers are well utilized for services hence they searched for measures to ensure that the clients continue to utilize the health centers. Hence all the measures the providers were using to ensure clients satisfaction were to ensure good utilization of services at the health centers. This may also support some of the providers view of quality maternal health care as extra work on the part of the health workers for the sake of service provision.

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 were 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 were 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 that 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 relied on the town unions and neighborhood watch just to make sure that access to services at the health centers was guaranteed.

Security challenges inhibited a 24 hour coverage of the health centers in the study area 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 by clients 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. There may be the need to involve the providers in decisions regarding manpower planning for the health centers since their practical experiences may be of assistance. 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]

From the results of this study, the providers of maternal health services in the primary health centers appear very willing to work and seem to be in dire need of recognition and institutional support. This could explain why absence of supervisory visits could be viewed as a disincentive and trainings were 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] and should be encouraged. However these measures are useful mainly to encourage health service utilization at the health centers and not as a quality assessment mechanism.

The use of incentives and planning of baby shows may also be the providers unique ways of gaining community appeal with the result that the health centers may be well utilized. However, even though the use of incentives could be viewed as a way of drawing the clients to utilize the health centers for services instead of going to the traditional birth attendants, the baby show could eventually be a good quality assessment tool if well harnessed. It should also be noted that all that the providers presented as constraints to delivery of quality health care are mainly societal and health system factors and none were 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 at 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 services at 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 host communities in the discharge of their duties. The primary health centers should be adequately fenced and personnel employed for security purposes as this will improve access primarily and then good quality care which eventually will lead to an improvement in maternal health in the study area. There is also the need to train the health workers specifically on good quality care.

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 also assured that all information provided through the questionnaire will be kept confidential.

REFERENCES

1. World Health Organization. World Health Report 2006. Working together for health. Geneva. World Health Organization. 2006.
2. Lantis K, Green C, Joyce S. Providers and quality of care: In New Perspective on Quality of Care. Washinton, DC: Population Reference Bureau and Population Council; 2002.
3. Ndhlovu L. *Quality of Care in Family Planning Service Delivery in Kenya: Clients' and Providers' Perspectives* (Nairobi, Kenya: Population Council Africa OR/TA Project, 1995).

4. Chodzaza E, Bultemeier K. Service providers' perception of the quality of emergency obstetric care provided and factors identified which affect the provision of quality of care. Malawi Medical Journal. 2010;22(4):104-11.
5. World Health Organization. Trends in Maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA and the World Bank estimates. 2012. Geneva: World Health Organization
6. De Brouwere V, Tonglet R, Van Lerberghe W. Strategies for reducing maternal mortality in developing countries: What can we learn from the history of the Industrialized West? Trop Med. Int Health, 1998; 3: 771-82.
7. The World Bank, Working for a world free of poverty. Rural population (% of total population) Data. Available at www.data.worldbank.org/indicators. Assessed 12th February, 2015.
8. National Population Commission (NPC) (Nigeria) and ICF International. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA. 2014. NPC and ICF International.
9. Yar'zever SI, Said IY. Knowledge and barriers in utilization of maternal health care services in Kano State, Northern Nigeria. European Journal of Biology and Medical Science Research. 2013; 1(1);1-14.
10. Onasoga AO, Osaji TA, Alade OA, Egbuniwe MC. Awareness and barriers to utilization of maternal health care services among reproductive women in Amassoma community, Bayelsa State. International Journal of Nursing and Midwiferry. 2014;6 (1):10-15.
11. Federal Republic of Nigeria Official Gazette 2007. Lagos. Nigeria.
12. Enugu State Ministry of Health Enugu. Nigeria: Planning, Research and Statistics Department. 2013. Enugu State Ministry of Health.
13. Federal Republic of Nigeria. Revised National Health Policy. September 2004. Abuja. Nigeria.
14. Huezo C, Diaz S. Quality of care in family planning: clients rights and providers' needs. Advances in Contraception 1993;9(2):129-39.
15. Ogunniyi SO, Faleyimu ON, Makinde EA, Adejuyibe FA, Ogunniyi FA, Owolabi AT. Delivery care services utilization in an urban Nigerian population. Nigerian Journal of Medicine. 2002;9:81-85.

16. Griffiths P, Stephenson R. Understanding users' perspectives of barriers to maternal health care use in Maharashtra, India. Journal of Biosocial Science. 2001;33(3): 339-359.
17. Kabakian-Khasholian T, Campbell O, Shediac-Rizkallah M, Ghorayeb F. Women`s experiences of maternity care: satisfaction or passivity? Social Science & Medicine. 2000;51:103-113.
18. Kyomuhendo GB. Low use of rural maternity services in Uganda: Impact of women`s status, traditional beliefs and limited resources. Reproductive Health Matters. 2003;11:16-26.
19. Grossmann-Kendal F, Filippi V, De Koninck M, Kanhonou L. Giving birth in maternity hospitals in Benin: testimonies of women. Reproductive Health Matters. 2001;9:90-98.
20. Anwar I, Kalim N, Koblinsky M. Quality of obstetric care in public sector facilities and constraints to implementing emergency obstetric care services: evidence from high and low performing districts of Bangladesh. J Health Popul Nutr. 2009;27(2): 139- 55.
21. UNFPA. Making Safe Motherhood a reality in West Africa. Using Indicators to programme for results. UNFPA. New York. 2003.
22. Ali M, Bhatti MA, Kuroiwa C. Challenges in access and utilization of Reproductive health care in Pakistan. J. Ayub Med Coll Abbottabad. 2008; 20(4):3-7.
23. Graner S, Mogren I, Duong LQ, Krantz G, Klingberg-Alvin M. Maternal health care professionals' perspectives on the provision and use of antenatal and delivery care: a qualitative descriptive study in rural Vietnam. BMC Public Health. 2010;10:608- 18.
24. Faxelid E, Ahlber BM, Maimbolwa M, Krantz I. Quality of sexually Transmitted Diseases` care in an urban Zambian Setting: The providers` perspective. Intl Journal of Nursing Studies. 1997;34(5):353-57.
25. Obionu CN. Primary health care for developing countries. 2nd ed. 2007. Enugu. Delta Publications.