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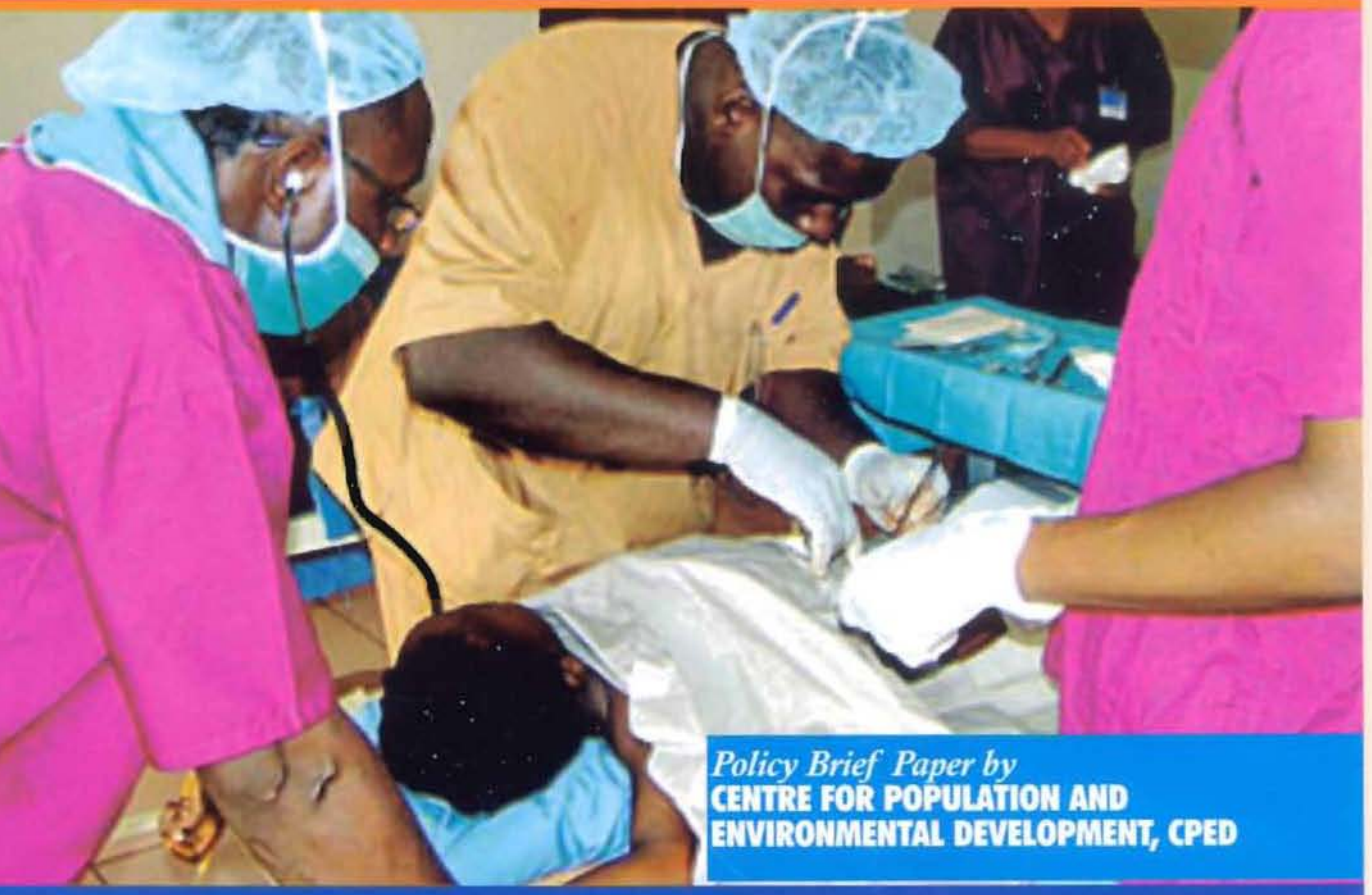
Patients' Utilisation of Maternal and Child Health Services In Primary Health Care Centres In Delta State



Policy Brief Paper by
CENTRE FOR POPULATION AND ENVIRONMENTAL DEVELOPMENT, CPED

This Policy Brief is supported by the *Think Tank Initiative Programme initiated* and managed by the ***International Development and Research Centre (IDRC)***

PATIENTS' UTILISATION OF MATERNAL AND CHILD HEALTH SERVICES IN PRIMARY HEALTH CARE CENTRES IN DELTA STATE

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PREFACE

This policy brief is the first in the series of communication to policy and decision makers on the on-going research project of the *Centre for Population and Environmental Development (CPED)* titled *"Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region" funded by IDRC and WAHO.*

The policy brief series is designed to draw attention to key findings and their policy implications as the project is being executed. This edition which focuses on the challenges facing the utilisation of maternal and child health services provided in PHCs is based mainly on the outcome of the qualitative survey in which key stakeholders participated in the research process through key informant interviews and focus group discussions.

We are particularly grateful to IDRC and WAHO as well as the *Think Tank Initiative* for the support to CPED which has enabled the Centre to carry out the study and the publication of this policy paper. We also appreciate the corporation of the Delta State Government and other stakeholders within and outside Delta State in collaborating with CPED in the execution of the on-going research project so far.

Andrew G. Onokerhoraye
Editor

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Introduction

It is well known in many parts of Nigeria that despite the progress and achievements made so far in the implementation of the primary health care programme, the services provided are grossly under-utilized. In Delta State where some aspects of health services are free such as free maternal and under-five child health services, a significant proportion of the women, especially in rural communities do not utilize these services. Despite the need and availability of antenatal care, its utilization by pregnant women is low, leading to the high rate of maternal morbidity and mortality. In most Nigerian communities, expectant mothers prefer to put to bed at home and this has implications on the health of mothers and infants. It is not uncommon to hear or find cases of maternal complications and subsequent death due to the ineffective utilization of ANC by expectant mothers. The high rate of deaths of women during pregnancy, childbirth or in the immediate postpartum period is due to different influencing risk factors. These are directly linked to socioeconomic, reproductive and health service factors. The general socioeconomic status of mothers, ability of women to manage resources and make independent decisions about their health has an impact on reduction of maternal mortality. Women and children are among the major stakeholders of health and the most vulnerable group in the society and bear the brunt of the consequences of the deteriorating health system. Most of the health care services target women and their children and thus they are in a better position to assess and evaluate services provided at the PHC centres in the spirit of community involvement and ownership.

The utilization of maternal health services is a complex phenomenon and it is influenced by several factors. Therefore, the factors affecting the use of these services need to be clearly understood from the perspective of the users and other stakeholders. This can provide the appropriate evidence-based policy formulation. This policy brief is based on the findings of

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an on-going research on *"Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region.* The project is funded by the Canada's *International Development Research Centre (IDRC)*, Ottawa and the *West African Health Organization (WAHO)*. The general purpose of the research programme is to contribute to a body of evidence on the strengthening of the health system in Nigeria that can influence the improvement and implementation of policies on equitable access to health care. Thus, the component of the study that led to this policy brief attempts to find out through qualitative surveys, the knowledge of women and other stakeholders about the maternal and child health services offered at the PHC centres, how frequent they use these health services and their views about the quality of the services received. The study also assesses, from the perspective of the users and other stakeholders, the factors acting as deterrents to the effective and efficient use of the available maternal and child health services in PHCs and the proffered solutions. It is expected that the findings will assist the stakeholders of health in making evidence-based decisions and policy formulations that will enhance primary health care services performance as well as form a data base for future interventions on the part of policy makers, other healthcare providers and indeed consumers.

The policy brief therefore presents the findings of the qualitative surveys of primary health centres and the localities in which they are located across nine Local Government Areas (LGAs) in Delta State entailing key informant interviews and focus group discussions with key stakeholders and groups. The brief is based on the views of the users and other stakeholders with respect to the factors influencing their utilisation of maternal and child health facilities provided in PHC centres in their locality. It also presents the policy recommendations the users and other stakeholders provided to improve the utilisations of maternal and child health

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services in primary health care centres in Delta State.

Ethical Considerations

Approval and permission to conduct the study was granted by the Delta State Government of Nigeria through the State Ministry of Health Research. The research protocol entailing the research methodology and the survey instruments were approved by the Delta State Ministry of Health's Ethical Review Committee. For each participant interviewed, informed consent was obtained. Similarly focus group participants also gave their consent before being asked to participate in the discussions. The project research team informed the participants regarding the purpose, methods and procedure of the study. The participants made an informed choice to take part in the study, and did so freely and voluntarily. They were asked to sign or thumb print on a form to indicate that they had given their informed consent to be interviewed, and were informed that they could refuse to answer any question or discontinue their participation at any time. The privacy of the participants was respected throughout the surveys and all information collected has been kept strictly confidential. The participants' anonymity was sustained by substituting their names with numbers or codes. Participants were treated fairly and any unclear information was clarified for them during the study.

Methodology

A qualitative, descriptive and exploratory research design was used to examine a variety of issues relating to primary health care delivery and utilization in the project localities including the health workforce situation. The population of the qualitative survey comprised health professionals of various categories working in primary health centres, student nurses in nursing schools, community leaders in localities where primary health centres are located, users of primary health services, women, especially those of child bearing age. The participants were selected randomly from the communities and from the staff of the primary

the results for each FGD, based on the issues examined in the discussions. The summaries were reviewed by an external expert to test whether the summaries were good representations of the FGDs and these summaries were then revised based on her comments. Finally, an overall summary of the discussions was made.

Findings of the Qualitative Survey

The responses from qualitative data (key informant interviews and focus group discussions) were grouped into the six dominant themes as follows:

- Awareness of skilled maternal and child health services;
- Distance to available Primary Health Centres;
- Quality of services provided in PHCs;
- Household decision making pattern;
- Cost of Maternal and child health services; and
- Belief in pre-destination.

Awareness of Skilled Maternal and Child Health Services

Key informant interviews and participants at the focus group discussions consistently pointed out that lack of awareness on the part of users of maternal and child health services provided in PHCs is a significant factor contributing to the poor utilization of maternal and child care services in their communities. It was pointed out that many women in rural communities, especially those in remote localities with poor access roads, of the target LGAs are not even aware of the need to seek maternal and child health care due the lack of adequate enlightenment and health education. It was pointed out during discussions and key informant interviews that women do get knowledge on the importance of skilled maternal care provided in PHCs and hospitals in different ways such as (i) previous exposure to skilled maternal services; (ii) health education campaigns of some PHC health staff; (iii) community based health education, through community media often carried

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out by some civil society organisations; and (iv) the educational status of mothers and their husbands. In most cases women with at least one antenatal or post natal care in previous pregnancies tend to be motivated to use skilled maternal and child health care. It was pointed out during discussions that skilled maternal care during pregnancy, delivery, and postnatal period increased steadily with the educational level of women because those with secondary and above education are associated with antenatal and delivery care by a skilled provider.

A key informant who is a health worker in one of the PHCs stated that: *"Some pregnant women don't know about skilled maternal and child health care services and that is why they do not attend, especially the women in the rural areas are not aware".*

"Many of the users particularly in these rural communities are not aware. On the other hand, in the urban areas most of the users are aware and they visit health centres, but in the rural areas I think many of them are not aware. This prevailing ignorance situation is compounded by poverty, to even access health services because for many of the patients to transport themselves to the health centres are difficult...."

Another health staff pointed out that:

'... We usually inform the mothers on maternal health services, and they do have awareness about the service but most of them need to be motivated every time to use the service...'

Finally, one of the community leaders, who is a key informant re-emphasised the issues of awareness by users of maternal and child health facilities when he stated that:

"I think maternal and child health service utilization in our PHCs depends on the educational status of women especially in this community. Initially the more educated women tend to search for maternal and child health care while the less educated ones remain at home, they never even attend a single antenatal care before delivery and they will deliver at home, they will manage their children, and funny enough some of

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them don't turn out to have problems."

Distance to Available Primary Health Centres

Participants and key informants pointed out that distances from their homes to PHCs is a major constraint to the use of PHCs for matemal and child health services, especially in the remote, rural wards of their local government areas. Some participants complained that in some rural communities which are relatively far from the existing PHCs, people needed to walk on foot for up to one hour to reach the nearest centre. This according to them is stressful for a woman who is pregnant. In case of a child, the mother may not be able to carry him or her and walk long distances. They pointed out that the popular motor cycle which is a common means of transport in many communities may not be convenient for use by women and their childrcn. In some of the communities motor cycles are not available because of the nature of the terrain. This shows that even womcn that are aware of the matemal and child health care services provided in PHCs may not use them due to the distance constraint. One of the focus group participants reported that:

'... A community health worker educates us about vaccination and how to care for our children but we fail to do because the health post is too far and our husbands mostly did not allow us...'

A similar view was expressed by a health extension worker when she stated that: *'... there are villages very far from here with no health extension workers so for such areas voluntary members of a society gave training and some services to mothers, but when we go for vaccination every month it is difficult to say they are getting the care ...'*

Another key informant observed that: *"Some women are lazy and feel that they cannot walk from the house and come to the PHC. This makes them not to attend while others say they have a lot of work to do in the house that they cannot come to the* clinic"

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Quality of Services Provided in PHCs

Participants in focus group discussions pointed out that many users are discouraged from using the maternal and child health services provided in PHCs because of their assessment of the quality of services provided in some of them, especially those located in the remote rural communities. But because of work load and inadequate staff health workers' visit are quite limited in the target communities. At the health facility level the availability, readiness, and quality of services as well as the type, competence and caring behaviour of providers are very important for maternal services. Participants complained about the limited availability of maternal and child health services particularly equipment and drugs: mainly in remote areas where vaccines are less available in PHCs. Health workers' visits have a significant influence on the utilization of full antenatal care and postnatal care services among rural adolescent women. Yet these are not common in most of the communities.

A key informant respondent who is a health staff in one of the PHCs noted that:

"Functioning obstetric facility means performing the essential services for normal situations and complications and these services should be available 24 hours a day and 7 days a week. The presence of all signal functions reflects better performance (quality) of a health facility."

Closely related to the issues of lack of equipment and drugs is that of the perceived attitude of health staff which they regard as discouraging women from visiting the PHCs. Some women participants in the focus group discussions admitted that the attitude of health workers is not encouraging at all and hence does not motivate the women to attend PHCs for maternal and child health services. A female participant in a focus group discussion pointed out that:

'... When my child gets sick there is no drug at the health post and full service even if they informed us about

the care...' Only they vaccinate our children in our ward, there is no satisfactory service here and there is no drug ...'

One major constraint mentioned by mothers was absence or frequent travel of health staff out of their station. She observed '... *I gave birth before three months but when I went there after a first month for vaccination the health workers were not available. I did not go back again as I was not sure I will meet anybody if I go...'*

Another key informant respondent noted as follows:

To be candid some women like to come for maternal and child health care but they are afraid of the attitude of the health workers who shout and treat them in a hostile manner. That is why some say let them stay at home and use traditional means and then refuse to attend the clinics for the ANC.

Furthermore, another respondent confirmed the statement: *"Health workers should stop shouting or abusing the pregnant women. You see this is not good it even make a woman not to attend."*

A further indicator of the quality of services which the focus group participants highlighted relates to the waiting time in PHCs before attention. This issue, the participants observed, prevents women from visiting PHCs when they need the services provided by them. A participant narrated as follows: *"If the pregnant women attend once they don't normally come back, the women normally say that if they attend once when they come back again it is not likely for them to receive the maternal services on time."*

A health worker respondent pointed out that: *"most of the pregnant women think of maternal health care as a stress because of coming to the clinic and waiting for longer hours before they are finally seen, may be in the late afternoon hours. Therefore, some of the pregnant women cannot wait or stay for longer time at the clinics and this distracts them from attending clinics."*

Household Decision Making Pattern

Research has shown that the ability to make a decision has a major role to play in the utilization of maternal and child

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health care. It is reported that mothers who can make a decision were more likely to use maternal and child health services than those who cannot make a decision. The possible reason for mothers not to make a decision might be the community belief about the hierarchy of authority in the household and economic dependency of mothers on husbands. Some participants in the focus group discussions observed that some women fail to visit PHCs for maternal and child health services because their husbands and in-laws do not allow them to attend despite the fact that they appreciate the importance of using the maternal and child health services provided in the PHC centres.

There is no way they can disobey their husbands' directives. A participant in one of the focus group discussion noted that: *"What I want to say is that most of the problems are from husbands. For instance I had the experience of consoling a crying woman who was pregnant but her husband and her mother in-law refused to let her attend PHC for maternity services. Most of the problems are from men and when childbirth comes it is the woman who suffers not the men."*

A key informant respondent who is a staff of a primary health centre reaffirmed the situation by stating that: *"...sometimes it is the husbands who have the problem. They don't have the money to give their wives to come to the health centre."* She pointed out furth that *"Some husbands do not have sufficient money to pay for the hospital bills so they cover up, and pretend that they do not want the women to attend maternal health care services."*

From the cultural perspective another participant pointed out as follows: *"Any pregnant woman in our community who does not deliver at home is believed to have been unfaithful to her husband when she delivers in the health facility. She is believed to be hiding something from the husband and the family. This is a belief that still holds to date,"*

Another focus group participant stated that *"Pregnant women in this community usually deliver at home under the care of a traditional birth attendant—even though delivering at*

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home can be extremely dangerous, and the health centre itself is new and presents an ideal environment for delivery."

Cost of Maternal and Child Health Services

Women's health seeking behaviour in the target communities is also influenced by the cost of maternity services and their capacity to cover the expected expenses. For instance, a substantial proportion of antenatal care users among the focus group participants and key informant interviews did not deliver or use postnatal care by a skilled provider because they claim that maternity services, especially delivery care, are expensive. Participants in the focus group discussions agreed that despite the claim of free maternal health services by the government, payment requirement at the time of delivery was an important barrier to using PHC services. They observed that there are many other costs which they must bear if they visit PHCs for maternity care. For most households, maternal health care could take more than half of their annual income.

One PHC health staff observed with respect to the resources available in PHCs as follows: *"Actually, I need to speak the truth. Most of the work we do is achieved using personal materials and funds. We require facilities such as a nutrition demonstration room which is not available. In fact, I am not satisfied. Personal funds are used to pay for photocopying of documents in a bid to keep records and statistics."*

Cultural Belief in Pre-Destination

The cultural belief in some communities that going to health institutions for delivery is not necessary is strongly prevalent in some rural communities covered in this study. Some participants at the focus group discussions pointed out that there were those in their communities who strongly believed in pre-destination, meaning that whatever happened to them was the will of the Creator. Some participants did not feel the need for PHC services unless their children were sick after delivery.

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A PHC staff during the key informant interview stated that: *"....Yes this is a known fact among many households in the communities because they believe that their ancestors and God will deliver them of their children safely."*

Another focus group participant stated that: *"Since I did not get sick I did not go to the health post and never used family planning..."*

Recommendations by Participants to Inform Policy on Improving the Quality of PHC Services

Participants observed that although utilisation of maternal health service delivery has increased over the last few years the rate of utilisation of those services remains low, especially in remote rural communities. Improving community awareness and perception on skilled providers and their care by targeting women who prefer non-skilled providers and those who do not have any awareness is very important. The vast proportion of the participants in the qualitative surveys appreciated the importance of using maternal and child health services provided by skilled personnel in PHCs in their localities. However, they made recommendations that could enhance the use of skilled health facilities as outlined below:

(i) There is need for increased attention to safe motherhood education using the available communication networks in the rural communities;

(ii) There urgent need for informational campaigns in the remote rural communities so as to improve the awareness and perceptions of women with regard to the importance of skilled maternal and child health services provided in PHCs;

(iii) Ensuring the improved performance of basic essential obstetric care facilities in PHCs is also very critical, especially for improving the rate of skilled attendance at birth;

(iv) Increasing availability and accessibility of maternal health centres to rural women in underserved communities, especially in

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the wetland areas of the state;

(v) There should be vigorous campaigns against social norms that are harmful to women's health;

(vi) Efforts should be made to increase women's socio-economic status in society, especially in rural communities;

(vii) Campaigns with respect to the utilisation of maternal and child health services should specifically target men so that they can support their wives in maternal and child health care provided in PHCs;

(viii) Improve the access of rural communities to PHCs through improved roads and other means of transportation;

(ix) Conscious efforts must be made to ensure the provision of PHCs in localities that are at present too far from the existing ones;

(x) Health workers should be trained on the need to be nice to their patients so that they are not scared away;

(xi) One policy action suggested by participants is to institute regular customer- relations training courses run professionally to help staff improve or maintain good inter-personal skills;

(xii) Complaint desks should be established at all PHC facilities with assurance that concerns would be addressed effectively, while allaying fears of victimization;

(xiii) Drugs should be made available and affordable in the PHCs, so that they could receive all their prescriptions at one place;

(xiv) Health workers, especially nurses and doctors whenever they are available should thoroughly examine patients so that the patients can have confidence in the health staff in terms of being capable of handling their health challenges;

(xv) Lastly, the national drugs policies and essential drugs list need to be reviewed, making them more responsive to patients' needs and improving availability.

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Conclusion

It is widely accepted that the use of quality maternal health services helps in reducing maternal morbidity and mortality. The qualitative surveys of utilisation pattern of PHCs in Delta State show that a significant proportion of the participants in rural communities have a negative perception toward maternal health care services. Utilisation of the most crucial elements of maternal and child health care is still very low as large segments of mothers utilize only immunization services. Place of residence, distance from health institutions, antenatal follow-up, previous visit by community health agents, and the ability to make decisions were identified by respondents and focus group participants as significant factors that influence utilization of maternal services. Policy makers and providers of maternal and child health services need to respond to the prevailing situation by adopting and implementing the recommendations made by the participants of the qualitative surveys as outlined above.

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