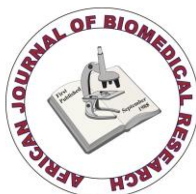

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Research Article

Maternal, Newborn and Child Health (MNCH) Services Utilization: A Comparative Case Study of Tertiary and Primary Health Care Facilities in Cross River State, Nigeria.

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ABSTRACT
High rates of mortality of reproductive-aged women, newborn and under five-year-old children are of global concern. This situation is worse in economically less developed areas of the world especially in Nigeria in sub-Saharan Africa and India in southern Asia. These mortalities are mostly associated with unskilled health attendance. Despite maternal, newborn and child health service designed to promote health, the mortality rates in these groups are still high in Cross River State. Therefore, this study aimed to examine how mothers utilize the services in a tertiary and a cluster of Primary Health Care facilities. Qualitative case study design was used and participants were selected through purposive sampling. Data were generated through twenty-three in-depth personal interviews of mothers and three focus group discussions with healthcare providers. Following thematic data analysis, the following five themes emerged: (1) mothers' awareness of available maternal and child health services, (2) maternal satisfaction with services, (3) factors influencing mothers' continuity with utilization, (4) motivators for service utilization, (5) barriers to service utilization. Family, trust in health providers and self-determination motivated service utilization. Barriers to utilization included consumers' issue such as ignorance, fear of caesarean section and superstitious beliefs; systemic issues for example, high cost and infrastructural problems; providers' issues like poor relational attitudes, undue delay in service delivery and staff shortage; cultural/religious issues including influence of traditional birth attendants and Church. Conclusion is that utilization of maternal and child health services is inconsistent; thus, mothers and their children are predisposed to morbidity and mortality.

Keywords: *Maternal health; newborn health; child health; health service utilization; case study; qualitative study.*

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INTRODUCTION

Mothers and their newborns constitute vulnerable groups in the population with regard to health. Globally, high rates of maternal and neonatal mortality have been reported. Most recent global data show an estimated maternal mortality ratio of 211/100,000 live births with about 295,000 maternal deaths (WHO et al., 2019a). Data also revealed that 5.4 million children under five years old died in 2017 (WHO, 2018). These phenomena have a higher occurrence in the developing world than in the industrialized areas. In the developing world, sub-Saharan Africa and southern Asia are most affected. World Health Organization (WHO) revealed that at country level, Nigeria in sub-Saharan Africa and India in south Asia had the highest number of estimated maternal deaths and accounted for about one third (35%) of these deaths in 2017. Specifically, Nigeria accounted for approximately 67,000 (23%) and India, 35,000 (12%) global maternal deaths (WHO et al., 2019b). Neonatal and infant mortality also follow the trend of maternal mortality as the survival of neonates depends on maternal health (van den Broek, 2006). The burden of infant mortality is also greatest in sub-Saharan Africa and Nigeria has Infant mortality rate of 70/1000 live births(Joseph and Earland, 2019).

The causes of maternal and child morbidity and mortality have been found to relate to lack of skilled birth attendants. The use of antenatal and childbirth services provided by skilled attendants can result in significant reduction of maternal and newborn morbidities and mortality due to early detection of complications and prompt intervention (WHO et al., 2010). Studies have shown that only about 35% of Nigerian women are attended by skilled birth attendants and that MNCH services are underutilized (Ronsmans and Graham, 2006, Ibekwe and Ibekwe, 2008, Okonofua et al., 2011, WHO, 2011b). In recognition of this tragedy of high maternal and infant mortalities, maternal, newborn and child health (MNCH) service was designed to promote the health of mothers and children under five years of age. However, despite this effort by the government, maternal and infant mortalities are still high in Nigeria as shown in WHO estimates (WHO et al., 2019a). Whereas, it has been observed that MNCH service is an effective strategy in reducing these deaths (Kuhut and Vollmer, 2017). The low demand for contemporary health services have been found to be consequent upon cultural beliefs and practices as well as lack of trust in the health care system (Archibong and Agan, 2010, Adegoke et al., 2010, Mboho et al., 2013, Esienumoh et al., 2018).

The effect of the MNCH intervention strategy does not seem to have a great impact in Cross River State as relatively high levels of maternal, neonatal and child mortalities still occur. Therefore, it is necessary to investigate how mothers utilize MNCH services in a cluster of health facilities which includes both tertiary in the urban and primary health care settings in the rural areas.

The study aimed to examine the maternal newborn and child health care services utilization among childbearing women in one tertiary (Urban) and a cluster of primary health care facilities (rural) in Calabar and Akpabuyo Local Government Areas (LGAs) of Cross River State, Nigeria respectively. The study explicated the barriers and facilitators associated with MNCH services utilization in both settings. Findings from this study will inform the development of programmes that seek to improve health services uptake by childbearing women in these settings.

MATERIALS AND METHODS

Case Study Design: Qualitative case study design as described by Stake (1995) was used for this study. Case-study design is appropriate for the investigation of highly-contextualized phenomena that occur within the social world (Creswell and Poth, 2018). Case-study design is considered a pragmatic approach that permits employment of multiple methods and data sources in order to attain a rich understanding of the phenomenon under investigation. This approach to mnch service utilization facilitated an exploration of the issue from multiple perspectives including that of the childbearing women themselves and that of other stakeholders such as midwives. A key feature of case study research is the gathering and convergence of data from multiple sources including document review (Stake, 1995). The intent in this approach to research is to understand the issue being studied in real life-context (Stake, 2005).

Description of the 'Case' / Study Site: For the purpose of this case study research, Cross River State was the main case and two study LGAs or study sites were considered the two sub-cases. While each site was a sub-case, each has many subunits that were sources of data and were sampled, for example, childbearing women, midwives and community health extension workers [CHEWS] (Stake 2005). This qualitative comparative case study was conducted in Calabar municipality and Akpabuyo LGAs of Cross River State (CRS), Nigeria. Cross River State is in the South-South Geopolitical Zone of Nigeria with Calabar as the capital. In this study, we used a tertiary and two primary health care settings in Calabar and Akpabuyo respectively as real-life illustrations of the issues influencing maternal, newborn and child health services utilization in Cross River State can easily be explored from these. The primary health care setting represents basic health facilities which serve the grassroots where most of the rural dwellers attend while the tertiary is a referral health facility located in the urban area of the State. These selected health care facilities were critically examined for how MNCH services are provided and utilized by childbearing women. CRS has eighteen Local Government areas with a population of about 2,900,000 (National Population Commission (NPC) and ICF International, 2014). The State shares common boundaries with Cameroon Republic in the East, Benue State in the North, Enugu and Abia States in the West and the Atlantic Ocean and Akwa Ibom State in the South. There are many dialects in the State with English as the official language. The vegetation varies from tropical rain forest in the south and savannah in the north. The people of Cross River State are predominantly farmers and fishermen with a few petty traders and civil servants. The demographics in CRS show that women and under-5 year old children who are the most vulnerable, constitute 22% and 20% of the total population of the State respectively. The primary health care services and the overall functioning of the health system in Cross River State seem to be inadequate over the years as evidenced in the poor health status of people of the State. Available data on disease specific morbidities show that Cross River State has an HIV prevalence of 8% (National Population Commission and ICF, 2019). Health indicators such as maternal (2000/100,000), under-five (80/1000) and infant (60/1000) mortality rates ranked Cross River State amongst the States with the highest maternal, newborn and child deaths in Nigeria.

Sampling and Data Collection: The sampling strategy was purposive, supported with complementary strategies such as snowballing also referred to as opportunistic or nominated recruitment technique. Snowballing is also known as solicitation (that is, "cold call invitation" to key informants in relevant organizations where participants act as recruitment agents) (Morse, 2012). Inclusion criteria for this study were women who have had childbirth within the previous five years or were currently pregnant prior to the data collection time, as well as midwives and other healthcare providers. Data sources

were in-depth individual interviews (IDIs) and focus group discussions (FGDs) with childbearing women and healthcare providers respectively. A total of 23 (twenty-three) participants were interviewed individually. These comprised of 12 participants from the tertiary hospital and 11 from the Primary Health Care (PHC) settings. These were all women between the ages of 15-49 years based on the inclusion criteria. Three FGDs involving healthcare providers were carried out in the various health facilities. One FGD involved midwives in the tertiary hospital while the second and third were with community health extension workers (CHEWs) at the two PHC settings. These healthcare providers have worked in the health system for over a period of two years. Two years are good length of time for providers to understand the system in which they practice, and to be able to articulate system enhancers and challenges. All the IDIs and FGDs were audio-recorded.

Data analysis: Data generated from within and across groups were analysed with Braun and Clarke thematic analysis framework (Braun and Clarke, 2006). All the individual interviews and focus group discussions were transcribed verbatim. This process was followed with the development of a coding framework informed by questions from the interview guides and a systematic approach that involved: (1) familiarizing with the data by reading and re-reading the transcribed data to identify initial ideas and recurrent patterns; generating initial codes. This involved the labeling of ideas identified in the data and it entailed coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code; (3) identifying potential themes through collating codes with similar ideas; (4) reviewing, defining and naming themes; (5) interpreting the narratives and the overall story the analysis tells; and producing the report (which is a concise, coherent, logical account supported by vivid examples).

Ethical approvals: Before commencing the research, ethical approvals were obtained from the Research Ethics Boards (REBs) of the affiliated institutions in each country. That is, the Cross River state ethics committee in Nigeria and the University of Ottawa REB in Canada. The implementation of the project adhered strictly to the ethical standards set out in the research protocol and ethics application. Consent was also obtained from the health facilities and the respondents involved in the study.

RESULTS

Following thematic data analysis of the focus group discussions and in-depth personal interviews,–five themes were derived from the data as follows: (1) Awareness of available services, (2) Maternal satisfaction with services, (3) Factors influencing mother's continuity with care (4) Motivators for utilization and (5) Barriers to service utilization.

Awareness of available health services: This theme emerged with two sub-themes namely: providers' acknowledgement of available services and consumers' awareness of available services. Providers acknowledged the availability of MNCH services in the study settings. These were reproductive health services which include family planning, prevention and management of sexually transmitted infections (STIs) and HIV. The other services were prenatal, intra natal, post natal as well as neonatal and child health care as stated:

'*We provide all services pertaining to reproductive health such as family planning, prevention and effective management of all STIs including HIV. Our other services are care during pregnancy, childbirth, immunization for children as well as health education to mothers on healthy living and care of their children' (TFGD 5).*

Another health provider also stated the following:

'We also attend to pregnant women who suffer from complications. For example, some of the women come with various complications which include heavy vaginal bleeding, vulval itching, headache and STIs. We assess the condition and attend to them to best of our ability and refer the ones that are beyond our capacity to a secondary health facility' (PH2FGD 4).

However, the mothers' awareness of services provided were limited, as physical availability of services in health facilities did not translate into women awareness of these services. Generally, the mothers were aware of some of the MNCH services available in the health facilities they attended at both primary and tertiary levels. At the tertiary level for example, '*in this health facility we are given antenatal care, delivery and infant care*' (T1). Other women confirmed that but also specifically mentioned immunization; the services here are *'antenatal care, labour / delivery care and Child Welfare/ Immunization' (T10).*

Similarly, participants from Primary Health Care setting affirmed awareness of services as narrated below.

'…They take care of pregnant women. Do tests, to know how the baby is lying in the womb. They give vaccines and drugs. They give treatment when someone is not well' (PH 1 Int 4).

'I am aware of services like testing of urine, examining the abdomen, measuring blood pressure and weight as well as delivering women. But I don't know if they do any other thing apart from that… I would have loved to see a doctor to tell him how I feel, this is what is happening to me because there were times I felt pains but the drugs the health workers prescribed could not solve the problem. … I complained of my heart beat falling and falling to the health worker who was on duty but she only reassured me that my symptoms were as a result of the pregnancy' (PH 1 Int.1).

Additionally, another mother commented on child care and family planning as stated:

'…the health workers are really trying here. I received my antenatal care here, and immunization for my second daughter; yes I did her immunization here. Also when my child was sick, they treated the child. I know they have family planning services because I once came with my baby to Child Welfare Clinic and they said women should come for family planning' (PH 1 Int. 2).

Another mother also commented on child care service in the health facility she attended.

'Here too, even if your child is not well, you can also come here and they will take care of the child. For example, when my baby was sick, she had fever, I brought her to this Health Centre and she was treated by the health care providers' (PH 1 Int. 3).

Nonetheless, some only associated health services with pregnancy and child care as stated:

'I come to the hospital because I am pregnant and want them to take care of my baby when I deliver. After that, the health care providers also give immunization which makes the baby strong and grow well' (PH 1 Int. 3).

For some, immunization service was all they cared about as stated:

'Well for me, I am aware of care during pregnancy and I've been receiving it , but I deliver with traditional birth attendants. I also come to hospital for immunization of all my children ... As for bringing my children, I don't think there is any barrier, but at times to be sincere, like if you are being spiritually attacked in the pregnancy, prevention is better than cure. Most of our people here (nurses, health care workers) don't even know how to pray; there are times, when you come to put to birth and you are being spiritually attacked with one problem or the other, so I think that is one of the main reasons why women including myself, don't deliver in the hospitals' (PH1 Int. 2).

Being aware of the available services did not translate to satisfaction with the services they utilized. Their state of satisfaction with the care / services they utilized are presented in the next theme.

Maternal satisfaction with health services: Two sub-themes revealed the various aspects of maternal satisfaction namely: facility-based satisfaction and factors hindering facility-based satisfaction. The sub-themes illuminate variation in satisfaction between the two levels of health care system. While those in primary health care facilities expressed high level of satisfaction in terms of service provision and providers' attitudes, participants from tertiary institution expressed mixed feelings towards their satisfaction with MNCH services they received. Many voiced dissatisfactions as a result of delay in receiving care and high cost. While majoring on delay, a participant stated: '*Hmm… you come very early but go back late*' (T3). Another said: '*Wasting time is a problem here, you only know about the time you arrive and not when you are going back…My only challenge is the problem of unnecessary delay before getting attention in the antenatal clinic' (T5).*

Some women expressed dissatisfaction with cost as stated: '*The cost is high for me and so I only struggle to use the services because I have no other choice*' (T1).

'Maternal and Child health services are not as free as speculated and there is too much expenditure even when one is under the National Health Insurance Scheme (NHIS). There is so much time wastage before one is attended to… The services are partially satisfactory because of the reasons I just gave' (T12).

In spite of dissatisfaction with delays and high cost, some were satisfied with availability of expert / proficient health care providers as narrated:

'When you think of highly qualified health professionals they are more in this hospital, ... but my experience is that though there is expert care, there is too much time waiting before we receive attention' (T11).

Similarly, another affirmed satisfaction with care received in spite of delays as narrated:

'I am however satisfied with care received in the long run, this is in spite of the waste of time. I feel relaxed by the knowledge that I am cared for by professionals who know their job. That makes me try to cope with the unnecessary delay before receiving attention' (T9).

Reasons for delay were said to include waiting for a long time for laboratory test results, sorting out clients' *folders* (records) as well as waiting to be examined by the few health workers that were on duty.

'My experience has not been pleasant. We (the women/ patients) are unduly delayed; sometimes the folders (containing our records) are mixed up thereby making us go home late. Staff do show favoritism sometimes and this does not go down well with the other clients. Ah! There are too many strike actions. In the delivery / Labour ward, there are many mosquitoes, therefore that experience is not comfortable at all' (T10).

Some care providers also attested to the undue delay in getting laboratory results.

'Generally the women complain of unnecessary delays about some hospital procedures because of the impression that they have concerning procedures like laboratory tests for example, blood test' (TFGD 1) .

It was also explained that delay in attending to the women at the tertiary health facility was due to large number of women who turn out for antenatal care and the relatively few health care providers. This assertion is supported by health staff.

'Currently we do not have enough hands to attend on time to the women. The health providers are not enough, for example two midwives taking care of thirty-six (13736) mothers and twenty-six (26) babies. You can see that this is grossly inadequate' (TFGD2).

On the contrary, most of the mothers who received care from the Primary health Care facilities in the rural area expressed satisfaction with the care they received in spite of whatever deficiencies they observed. Their satisfaction was based mostly on good attitudes of the health care providers.

'Services rendered by the health workers are Ok in terms of when you come, they do what they are supposed to do, I like the way they relate to us, not as if we are bordering them.

The way they welcome and care for us are the things I really like about them' (PH1 Int.1).

Similarly, another added:

'I was satisfied using the services here because of the friendliness of the health worker in charge of this health facility. She influences all other health care providers to be friendly with the women who attend the Health Centre' (PH 2 Int. 3).

As stated below, another participant affirmed satisfaction in spite of being physically abused by a healthcare provider:

'I was satisfied with the services although a healthcare provider slapped my thigh while in labour for my second baby. I think it was for my own good because I was afraid of pushing out the baby due to pain. After that slap, I pushed out the baby. In spite of that experience, I still enjoy the services I received from this facility. The services were good' (PH 2 Int.1).

Having discussed the state of satisfaction of the mothers with the MNCH services received, some factors were found to influence their continuity with care. These are presented in the next theme.

Factors influencing mothers' continuity with care

The factors influencing mothers' continuity with care are expatiated in four sub-themes which are consumers' relatedness, culture / tradition, providers' perspectives and health institutional factors. Data also revealed that although the various MNCH services were available, there was no guarantee that all the women would utilize them judiciously. Of particular note is the ante-natal care. Some of the women who received care during pregnancy were said not to return to the health facilities to have their babies because of ignorance of the benefits of skilled birth attendance. This consumer-related factor was observed by the care providers at both the tertiary and Primary Health Care levels as stated here: '*Some women don't come back to have their babies in this hospital after receiving antenatal care. They do this in ignorance of the benefits of being attended by skilled attendants'* (TFGD 2). A provider at PHC level also confirmed that '*Many women registered in our health facility but only few came for childbirth*' (PH1FGD 1).

In confirmation of the observation made by the providers as regards the women not returning to have their babies at the health facilities, some of the women narrated the following: '*I registered here and had immunization but as the labour started at night, I did not bother to come to the Health Centre, I had my baby in my house assisted by a TBA' (PH1 Int.3).* Another woman gave her reason for not giving birth at the health facility to be due to spiritual problems as stated below:

'Spiritual problems for example, those of us who are married may experience spiritual attack from our husbands' families or from our own families and they would not want us to give birth. With such attack, the woman must go to church and pray for help. In cases when women know they are attacked spiritually, they may not come to put to birth in the hospital because I have had interactions with some young women like myself and one of them said she would not deliver in the hospital because she has a spiritual problem. This is despite full attendance at the antenatal clinic. To be sincere, her delivery was very difficult but we thank God it was in a church that she put to birth' (PH1 Int.2).

Healthcare providers remarked on a common occurrence in their PHC facilities that some women who did not register to receive antenatal care were usually brought in a state of emergency for care. For example: *'unregistered patients are sometimes brought because of complications like difficult labour and breech presentation' (PH1FGD 6).* Another said *'some are brought bleeding in late pregnancy' (PH1FGD 5).*

Institutional factor like provision of incentives was observed to attract pregnant women to register for antenatal care and continue with care on to childbirth. As an example, a provider stated:

'Some women come for registration because of the incentives given by some NGOs for example, Pathfinder and Hello Mama. Pathfinder's incentive is a safe delivery kit containing Comfit perineal pad, baby wrapper, tissue paper, cotton wool, Dettol antiseptic solution and Dettol soap, a pair of gloves and a cord clamp. Hello Mama's incentive pack contains Dettol antiseptic, cord clamp, baby's cap and T-shirt for the mother. The incentives are now given only when a woman comes in labour because it has been observed that some women registered in the ANC just to collect the incentives but would not show up for childbirth' (PH1FGD 6).

Similarly, at the tertiary level, a provider also noted that provision of incentives to the women could enhance their continuity with utilization of care from antenatal period to childbirth and subsequently.

'Provision of incentives such as free mosquito bed nets, haematinics and antiseptics like Dettol as well as free diapers for babies and other attractive and useful items for babies and mothers may encourage the women to use our services. This strategy has worked in some settings' (TFGD 5).

Traditional birth attendants (TBAs) and faith-based organizations have cultural / traditional undertone in the utilization of MNCH services. These groups have been identified in this study as determinants in the continuity of utilization of care at both tertiary and PHC levels. A provider at the PHC level noted that some TBAs encouraged their clients to attend antenatal clinic at the contemporary health facilities to receive immunization and have some investigations done after which they would return to the TBAs for childbirth. For example: *'TBAs do encourage their clients to come for registration at the Health Centre in order to be screened for HIV status plus other investigations and get immunization; after which they should return to TBAs for childbirth' (PH1FGD 5).*

At the tertiary level, a healthcare provider also stated that '*it is a common phenomenon here that some women don't come back to this hospital to have their babies after receiving antenatal care, rather, they go to TBAs for childbirth …' (TFGD 2).*

With regard to the influence of faith-based organisations, a provider commented as follows: '*Most of the women chose to deliver in the Church for fear of death, but they would attend the antennal clinic for immunizations and laboratory investigations* (PH1FGD 2). A health provider at the tertiary level also added that *'... the women tell us during history-taking that they prefer having their babies in the Church because these spiritual Churches pray for them. This gives them assurance of protection against evil spirits ...' (T2).*
Utilizing full care from ANC to labour and other MNCH services may be triggered by some motivators as presented in the next theme.

Motivators for service utilization: Two sub-themes namely, extrinsic and intrinsic motivators were derived from the main theme, 'motivators for service utilization'. The mothers revealed various factors that motivated them to use the MNCH services. These were categorized into extrinsic and intrinsic motivators. The extrinsic factors are motivating factors outside the individual woman and these include proximity to health facility, support from family and trust in health care system / the health care providers. The intrinsic motivators are innate in the individual woman. Factors that are extrinsic as revealed in the interviews of the women at the tertiary health facility were as follows:

'Proximity to my house ... makes me feel comfortable to use this facility. This facility is a place that has expert professionals and in addition there are a wide range of equipment to use in attending to the women' (T2).

Additionally, another woman commented on the trust she has for in the health care providers. *'I trust the health providers for saving the life of my child ... that trust continues for my own care' (T5).*
Extrinsic motivators at the PHC level also included proximity to health facility and confidence created in the minds of the women by the availability and competence of the health care providers. These were stated as follows: '*My house is close to this hospital and that makes it very convenient for me to utilize the services provided' (PHC 1 Int. 5).* Furthermore, another woman asserted that:
'The healthcare providers are always available to attend to us and our children at any time of the day, so this gives me confidence to seek care from this health facility because I know they will take care of me' (PHC Int. 4).
Professional competence of the service providers also served as a motivator for service utilization. Some of the women said that they were encouraged by the awareness that the health care providers have requisite knowledge and demonstrated competence in assisting their patients / clients especially during complications. Their narratives included the following:
'In this hospital, there is contribution of ideas or team work among the health care professionals, therefore, the care rendered is not one person's idea. This gives confidence that you are getting the right service or care. There is availability of a variety of health professionals with high level of knowledge' (T11).

Similarly, another woman stated:
'The midwives and other healthcare providers in this hospital are skillful, they know how to deliver mothers of their babies and also attend to complications. One woman in my compound had a baby at home but the placenta could not be delivered. So we brought her here, the health provider just put her hand into the woman's vagina and immediately, the placenta was delivered. I know that these providers are competent (PH1 Int. 5).

Good attitudes of the health care providers also attracted women to utilize the services. '*The attitudes of the health providers here are very good; they make us feel relaxed, there is no tension between them and the users of their services'* (PH2 Int. 3).
Also at PHC level of care, the extrinsic motivators stated by the women also included support from family and the community as narrated:

'My husband encourages me to attend this health Centre' (PH2 Int.1).

Additionally, another woman stated:

'My husband supports me, he even gives me money for transportation to come to clinic. My family also supports me to come here because we know that immunization is good for the baby. Our community is also supportive because even as I've come here, they gave me phone number of the motorbike man that I can call to come and carry me if the baby is born; even if labour starts at night, the motorcyclist can bring me to the hospital. Also, the 'nurses' (Midwives) here are good, they treat us well. My Church also supports because our Pastor tells us to go to the hospital when we are sick' (PH1Int.3).

Husbands' support was also expressed by women at the tertiary level of care. In affirmation a woman added:

'*My husband's support is a great encouragement to me. This health facility has well experienced professionals and in spite of the high cost, I still manage to attend this place for my healthcare needs; I owe it to my husband' (T1).*

Intrinsic factors expressed by the women are the inner desires by the individual to obtain the best care in order to preserve her life and maintain good health. As an example, a woman stated:

'Having had four children already, I feel that with this fifth pregnancy, I need expert care so that I do not suffer complications. I need to be in the hands of experts and they are available in modern health facilities. That is why I have registered here to receive antenatal care and I have decided to have my baby here also' (T7).

Autonomy of self-determination was also an intrinsic motivator as stated:

'My strong personal decision influences me to use the services. No other thing influences me; if anything goes wrong with my health or that of my baby, it affects me directly and not the community, family or cultural belief ...' (T5).

Similarly, another woman affirmed the right to self-decision as indicated: *'I know what is good for me, I do not want to risk my life by going to TBAs' (PH2 Int.1).*
Conversely, while there were motivators to utilize health services, there were barriers which deterred service utilization, these are presented in the next theme.

Barriers to utilization of care: As previously presented in this paper, availability of services does not guarantee their usage. The women and providers presented several barriers to the utilization of MNCH. These were categorized into four sub-themes based on consumers', institutional, providers' and cultural barriers. Fear of caesarean section (C/S) was a major barrier in service utilization.

> *'Some multiparous women do not utilize modern healthcare services because somebody out there had advised them against C/S and they tend to associate hospital birth with caesarean section' (TFGD 2).*

Similarly, a woman added:

> '*You know my major fear is C/S, I do not want my pregnancy to end up that way, I still have problems of holding superstitious beliefs about caesarean section. A fulfilled mother should have her babies through the natural birth canal. I hope I will be able to overcome it someday' (T7).*

Ignorance was also identified as a contributing factor to non-patronage of health facilities as narrated:

> *'Ignorance is another major factor. Many women fail to utilize modern healthcare facilities (hospital) for delivery because of ignorance; they prefer TBAs and are brought back when they develop complication. In some cases, they are brought to the hospital when it may be too late to save their lives' (TFGD 2).*

Another participant mentioned that some women unduly delay their decision to utilize health service and this acts as barrier, for example: *'Some women take decision late or are careless about their health and they do not come on time to be attended to when they have health challenges' (T1).*

The health care providers observed that women with lower level of formal education do not mostly comply with utilization of care.

> *'Level of education has a part to play. Graduates from higher level of education, for example, from Universities and Polytechnics register early and follow up with care. The High school and lower levels graduates register late and mostly do not continue with care' (T5).*

Additional obstacles in some consumers were language barriers and late registration for antenatal care by a particular sect. A provider reported: *'the challenge we have with women of a particular sect is poor communication, that is, language barrier ... we observe that those women register late for antenatal care. They commonly come during the 3rd trimester of pregnancy' (TFGD 5).*

Some seasonal cultural activities in the rural community also posed as barriers to utilization of MNCH services at the PHC level. For example, a group of masquerades known as *'Akata'* which operates at night prevents women from going out. If the woman has need to go to the health facility, it becomes impossible.

> *'Akata Masquerades are cultural displays which pose a big problem because they prevent females from moving out of their houses at night; so if labour starts at night or the woman has any health challenge, she cannot go out at night. This is usually from August 31st to December 31st yearly' (PH2FGD 1).*

This observation about the masquerades was confirmed by all other members of the FGD.

There were some other issues in the community that threatened the utilization of the MNCH services by the women. These were prophecies by some Churches as well as cultural beliefs as stated: '*Prophecies in some of the Churches openly warn the women against use of services from any modern health facility'* (PH2FGD 5). Likewise, another participant added that cultural belief was a great impediment to service utilization as narrated below:

> *'…cultural beliefs drive fear into the women that pregnancy and childbirth are periods which evil spirits attack the women. Due to fear, such women would either have their babies in the Churches assisted by TBAs or go to independent TBAs' (PH2FGD 1).*

Health institutional barriers were also found to pose a challenge to the utilization of MNCH services. These included long distance to the nearest healthcare facility and some infrastructural problems such as lack of means of transportation, poor water and power supply. As stated by a healthcare provider: *'Distance and lack of transportation if the woman needs care at night also served as barrier*' *(PH2FGD 7).* Similarly, another participant added that transportation assistance rendered previously by Pathfinder was no more operational: '*initially Pathfinder provided emergency transportation service to convey pregnant women, but this is no more obtainable since Pathfinder's contract has ended' (PH2FGD 1).* Additionally, other institutional barriers included lack of functional lavatories which discouraged the women from utilizing the health services at one of the PHC facilities. Where they managed to use such healthcare facility, it implied that they sacrificed their comfort as stated: *'There are no functional toilets due to lack of water, this a major problem to us. I feel very uncomfortable when I have need to use the toilet' (PH2 Int. 2).*

Another woman affirmed a similar situation as narrated:

> *'The major challenge in this facility is that there is no water. Although there are water system toilets, we cannot use them due to lack of water. It is usually a big problem when one needs to ease herself while at the health facility. I have no choice but to come here because I made up my mind not to go to TBAs' (PH2 Int 3).*

Additional barriers posed by health care system were high cost and undue delays in attending to the women. A healthcare provider stated: '*Like I said earlier, the women feel that our services are too expensive*' (TFGD 2). This situation was confirmed by another provider:

> '*Some of the women complain of high cost of service. This new policy and high cost of services scare women away from using our services…If a woman is admitted, she must pay a compulsory fee of N25,000.00 (twenty-five thousand Naira) for feeding for five days… if she stays longer, she has to pay more…Of course yes, that is the policy in this health facility' (TFGD 1).*

Another participant affirmed the escalating cost for 'booking' (registration) as stated:

'Booking fee, that is, registration fee for antenatal care is N4,500.00 (four thousand, five hundred Naira), and for each subsequent visit, the woman pays N1,000.00 (one thousand Naira), which is too much for us'(TFGD 5).

Furthermore, a participant said: '*If the woman goes in for elective Caesarean section, she has to pay close to N50,000.00 (fifty thousand Naira) …*'(TFGD 2). Additional fee was required if the woman comes with complications:

'Women who come with complications from Churches or TBAs must pay Ward deposits, buy folder for their records, also an additional fee of N25,000.00 (twenty-five thousand) is deposited for feeding' (TFGD 2).

Provider's attitudes also posed as a barrier and interfered with service uptake. This issue differed between health facilities. Additionally, in the tertiary healthcare facility there were inadequate number of healthcare staff which contributed to delay in service delivery. While majoring on providers' attitude a participant at the tertiary health facility stated:

'Attitude of healthcare providers is one of the barriers to service use … using abusive words and talking in a harsh way to the women. This is discouraging … each time I want to go to the hospital and I recall the unfriendly disposition of the providers, I would usually feel sad' (T5).

On the contrary, the women enjoyed better provider – consumer relationship at the PHC level, for example: *'… the attitudes of health care providers are very friendly and kind and so I like coming here' (PH2 Int. 1).* This was confirmed by another participant thus: *'Another thing that encourages me to attend this facility is that the health care providers relate well with their clients' (PH2 Int.4).*

Undue delay in attending to the women was also reported at the tertiary health facility. A woman narrated:

'We waste a lot of time, especially when we go for laboratory tests, it is as if we are also working in the hospital because of the long hours spent, we spend between 4-5 hours for antenatal care services alone' (T1).

The providers acknowledged that the delay was secondary to lack of human resources as stated:

'Currently we do not have enough hands to attend on time to the women. The health care providers are not enough, for example two midwives taking care of thirty-six (13736) mothers and twenty-six (26) babies. You can see that this is grossly inadequate … obviously care would be better if there are more midwives' (TFGD 2).

Lack of basic amenities were facility associated barriers with utilization of health facilities at PHC setting as narrated:

'The major barriers that discourage use of our health facility are lack of water and power supply. Though we have a borehole but we cannot get water out because our pumping machine was stolen. We the healthcare providers go out and fetch water from the neighborhood for our patients. Sometimes we buy water from private borehole owners' (PH2FGD 3).

Another participant added:

'We don't have steady power supply and there is no alternative source of power supply like generator; there is no potable water supply. Also, our drainage system is poor, there is no drainage in our Health Centre environment. This makes our facility always flooded and inaccessible any time it rains. These issues certainly pose as barriers to utilization of our services' (PH1FGD 2).

In summary, MNCH services were available in this setting, however, the utilization was inconsistent based on several barriers which included limited awareness of available services and their benefits by the women, high cost, providers' and systemic issues as well as cultural beliefs / practices and faith-based organizations' issues.

DISCUSSION

The consistent and effective use of maternal, newborn and child health (MNCH) services are essential for the prevention of morbidity and mortality in mothers and children. As outlined in the results of this study, there were many factors that prevented childbearing women from fully using health services in their communities. For example, while MNCH services such as family planning, antenatal care including health education, intermittent preventive treatment for malaria (IPT), HIV screening and treatment of those who are positive may be available at the health facilities, systemic and individual level problems which pose as barriers may not allow women to use the services. Other available MNCH services in this setting were intra natal, post-natal and child health services like immunization, education of mother on breastfeeding / infant feeding, general care of the newborn and children under five years old as well as provision of emergency care. Literature has revealed that the package for MNCH include reproductive health with emphasis on contraception; maternal and newborn health which comprise of preparation for safe birth and newborn care, micronutrient supplementation, nutrition education, IPT, education on family planning and promotion of HIV testing. Other components are management of labour and childbirth of low risk women by skilled attendants, care of the post natal woman and the newborn including breastfeeding (Black et al., 2016). These services connote the importance of skilled attendance to reduce morbidity and mortality in mothers, newborns and older children under five years old.

The MNCH strategy if effectively implemented and utilized can facilitate the attainment of the sustainable development goal (SDG) 3 and targets 1, 2 and 7. SDG 3, target 1 states that maternal deaths should be reduced to less than 70 per 100,000 live births. Target 2 states that preventable deaths of newborns and children under 5 years should be ended; while all countries should aim to reduce neonatal mortality to as low as 12 per 1,000 live births and under-5 mortality to as low as 25 per 1,000 live births. Goal 3.7 is about ensuring universal access to sexual and reproductive health-care services, including family planning information and education as well as the integration of reproductive health into national strategies and programmes (WHO et al., 2015). WHO recommends skilled attendance as a strategy to reduce maternal, newborn and under-5 mortalities (WHO et al., 2015). However, as revealed in this study, these skilled services were not fully utilized by some women despite their availability. The problems with the utilization of MNCH services ranged from individual level issues to systemic /

institutional, providers', TBAs / faith-based leaders and cultural issues.

Barriers to the utilization of MNCH services at the individual woman's level found in this study included limited awareness of the availability of services and ignorance of their benefits, low level of education and superstitious belief about caesarean section (C/S) which generates fear about this procedure. Other personal level barriers were delayed decision in seeking care and language barrier. Poor awareness and ignorance of the benefits of MNCH services coupled with delayed decision to seek care were evidenced in some of such women receiving antenatal care and defaulting to have their babies at either the traditional birth attendants' or at the Church; also some women do not receive antenatal care at all but only come to the health facilities for care in a state of emergency either before or during labour. These findings also support the results from other authors at some other settings in Nigeria (Esienumoh et al., 2018, Mboho et al., 2013, Adegoke et al., 2010, Osubor et al., 2006). This practice has been found to be dangerous as TBAs do not have the capacity to cope with obstetric emergencies thus may result in mortality (Etuk et al., 1999).

Additionally, superstitious beliefs and fear about C/S as barrier to utilization of MNCH services have also been identified in other settings within and outside Nigeria. This operative abdominal procedure for delivery is associated with hospital delivery by some women and is seen as taboo which rubs women of their ability to give birth through the natural process. Thus, women who undergo C/S are regarded as reproductive failures in their communities because normal vaginal birth is a symbol of woman's power and ability (Lawani et al., 2019, Roudsari et al., 2015). Some authors found that the lower the level of education, the higher the tendency to hold superstitious beliefs and the less likely such people are to make correct judgments about capabilities of various categories of healthcare providers and places for childbirth (Adegoke et al., 2010, Osubor et al., 2006). As seen, these findings can significantly affect the utilization of MNCH services, therefore, individual and community education should be carried out to raise awareness on the available MNCH services, their benefits and correct the existing misconceptions.

Language barrier was also found in this study to interfere with adequate provision of service to a particular group of women at the tertiary facility. Language barrier is a major cause of miscommunication between healthcare providers and patients. Evidence has shown that this negatively affects the quality of healthcare delivery and patients' satisfaction, thus resulting in poor outcomes (Shamsi et al., 2020, Squires, 2018a). To overcome this, the effective use of interpreters or bilingual healthcare professionals is recommended. This is expected to ensure technical accuracy of the information communicated as well as culture-specific phrasing (Squires, 2018b). Where obtainable, an interpreter may have to accompany the woman to the health facility. Generally, the interpreters should be bound by a code of ethics to uphold clients'/ patients' confidentiality.

Consequent on the individual consumers' issues, institutional level issues also posed as barriers to the utilization of MNCH services. These were long distance to the nearest health facility, high cost, infrastructural problems such as lack of means of transportation and poor water and power supply. Long distance to the nearest healthcare facility had been identified as major barrier to the utilization of health services. This corroborates the findings of some other researchers in Nigeria who studied barriers to antenatal care use (Fagbemigbe and Idemudia, 2015). Based on this, as a primary health care strategy, the WHO advocates bringing care closer to the people in settings in close proximity and direct relationship with the community (WHO, 2008). The farthest static health facility should not be more than five kilometers from where the people live and work. In addition, mobile services are attached to the static health facilities to increase coverage and facilitate reach to the people in order to mitigate the challenge of long distance, This PHC strategy should be reinforced.

It was also revealed in this study that some of the women could not pay for their healthcare, therefore, could not utilize the services. This was mainly at the tertiary healthcare level, especially when the women developed complications and were admitted into the wards for a closer attention. As observed by the providers, some of such women do not report to the wards at all, only for some to be brought back to the hospital after some days or weeks as emergencies because their conditions have deteriorated. This finding is similar to those of other researchers in Nigeria who identified lack of money as a factor which militated against the utilization of the services of skilled healthcare providers (Adegoke and van den Broek, 2009, Lawoyin et al., 2007).

Although the World Health Organization had recommended about ten years ago that no one should be subject to financial hardship while seeking healthcare (WHO, 2010), financial inaccessibility is still a challenge to many people. The National Health Insurance Scheme (NHIS) was established to ensure that all Nigerians have access to healthcare without any financial hardship (Federal Government of Nigeria, 2004).. However, this study has revealed that not all Nigerians are benefitting from this scheme. Currently, it is observed that only those in formal Federal government sector employment benefit from the NHIS. This scheme should be extended to the private and State government sectors especially women of reproductive age and their families.

Additionally, the lack of essential amenities such as water, power supply and lavatories were identified at the PHC level. The unhygienic situation consequent on poor water and lavatory conditions aside from being potential cause of sepsis also created a sense of helplessness and dissatisfaction with service provision in both the providers and the consumers. Poor power supply can imaginably pose a great challenge to rendering healthcare particularly at night when it is dark. Also at a PHC facility, poor environmental drainage system was highlighted. This made the surrounding of the facility water logged during the rains thus posing a challenge to physical accessibility to MNCH services. Accessibility which comprises several dimensions is a right to health, therefore, health facilities should be physically accessible to everyone (WHO, 2020a).

Data revealed that several issues prevented the healthcare providers from rendering optimal MNCH service. At both

tertiary and PHC levels, the providers complained of inadequate number of healthcare providers to cope with the number of clients. This was particularly more emphasized at the tertiary health facility and that coupled with delay in obtaining laboratory results contributed to unnecessary delay in attending to the women. Delay in attending to patients have been found to be one of the causes of dissatisfaction among the recipients of health services in Nigeria and some other African countries (Odetola and Fakorede, 2018, Gitobu et al., 2018, Amu and Nyarko, 2019).

Undue delay was related to shortage of midwives at the tertiary health facility. This resulted from the few available midwives struggling to do what more hands would have done. Currently, the human resources for health is in crisis globally and this is the most critical constraint to efficient healthcare delivery (WHO, 2020c). Evidence has shown that unfavourable working conditions have been responsible for massive migration of health workers from developing to industrialized nations causing significant depletion at home (WHO, 2020c). Scarcity of health workers as documented by WHO may also result from lack of capacity by the public sector to employ health workers due to budgetary constraint. This results in the paradox of health worker unemployment co-existing with unmet healthcare need (WHO, 2020b). The issue of staff shortage particularly at the tertiary health facility needs to be addressed to improve service delivery.

At the PHC health facilities, the women were dissatisfied with the conspicuous absence of midwives and medical personnel. Absence of midwives generally deprives the women who attend those PHC facilities of their right to skilled attendants as described in the International Confederation of Midwives Bill of Rights (ICM, 2011). Midwives are trained to competencies that enable them attend to the needs of women throughout the pre pregnancy, that is reproductive health, pregnancy, childbirth and postnatal periods, care of the newborn and infant including life-saving skills as well as contribution to the health and welfare of the family and community where they serve (WHO, 2011a). Furthermore, the midwifery workforce has been credited as being critical to the provision of quality health services (WHO, 2013). Therefore, the substitution of midwives with CHEW at the PHC level of healthcare clearly indicates a gap in MNCH service provision. Poor relational attitudes of the healthcare providers was identified in this study at the tertiary health facility. This is a negative attribute and grossly unethical. Negative attitudes of health care providers culminate in disrespectful maternity care and has been found to create discontent with health care by the women and discourage use (John et al., 2020). The implications of these barriers are that the women may implicitly utilize the services of unskilled health attendants like TBAs which may result in morbidity and mortality. It is found that more maternal deaths occur at the TBAs (Etuk, 2000).

As part of the barriers, some church prophecies were said to instill fear in the women that hospital/Health Centre care is associated with mortality because spiritual matters are not usually addressed. Consequent on that, some women would rather prefer to have their babies in such Churches to being attended in the contemporary health facilities. In line with this belief a participant at the PHC level in this study had suggested that although some of the healthcare providers pray with them, the way they pray needs to be scaled up to be powerful enough to ward off evil spirits. Although prayer has been described as a harmless cultural practice which could be encouraged in a culturally congruent care (Esienumoh et al., 2016), the need for client/community education on the scientific causes of maternal and child morbidities and mortality should not be overlooked. Evidence has shown in a study that community education to facilitate empowerment of the people to take action to prevent maternal mortality resulted in repudiation of some cultural beliefs that could jeopardize the lives of women during pregnancy and childbirth. Consequent on the repudiation of some cultural beliefs in that study there was resumed utilization of MNCH services in that community after these were abandoned for about twelve years (Esienumoh et al., 2020).

The influence of TBAs as shown in this study is almost identical with that of the Church because these also discourage the women from full utilization of MNCH services. The practices of TBAs are generally embedded in cultural and superstitious beliefs, for example, that pregnancy makes the woman vulnerable to attacks by evil spirits and so the woman would usually be required to be attended to by birth attendants who have spiritual powers such as TBAs or Church (Esienumoh, et al 2018, Mboho et al 2013, Adegoke et al 2010, Osumbor 2006). This practice instills fears into the women by making them believe that skilled birth attendants' skill are deficient because they cannot cope with cultural/spiritual matters associated with childbirth (Mboho et al., 2013). Additionally, cultural practices of masquerades preventing women from going out at night is compounded if the pregnant woman has an emergency during such hours. These issues need to be addressed by using health education strategies that promote empowerment of the people through critiquing their beliefs and practices in comparison with modern scientific knowledge. Such strategies have been found to bring about positive change (Waterman et al., 2007).

In spite of the barriers to the use of MNCH services, there were some motivating factors at both tertiary and PHC levels and these should be strengthened. The motivators were categorized into both intrinsic factors within the woman and extrinsic factors in her eco system. The intrinsic factors explained the desire for self-protection from harm as expressed by some of the women. These served as a driving force to choose good healthcare system with skilled attendants rather than risk their lives by patronizing unskilled healthcare providers such as TBAs. A study of factors influencing health-seeking behaviour in Ibadan, Nigeria showed that good service delivery was the most common factor for seeking skilled healthcare (Latunji and Akinyemi, 2018). This implied the need for self-preservation which is the instinct to act in one's best interest. Motivating factors within the women's ecosystem included support from spouses/family, trust in the health system and proximity of health facilities to some clients' homes. Others were incentives like gift packages which could be obtained from the health facilities.

Generally, the state of satisfaction of the women with health service they received was also revealed. Only a few of the women at the tertiary level were fully satisfied with the services while some were only partly satisfied. Whereas most

of the women at the PHC level were satisfied with the care they received regardless of the infrastructural deficiencies. A cross-sectional survey in southern Mozambique corroborates this finding that mothers who received care from the primary level were more satisfied with the healthcare than those who were cared for at the bigger hospital (Sibone et al., 2019). Mostly, the state of satisfaction of the respondents in this study was based on the proficiency of healthcare providers at both PHC and tertiary level of care as well as good attitudes of the healthcare providers at the PHC level. As shown in the results of this study by both providers and consumers of MNCH, gaps have been identified which need to be addressed to facilitate improved utilization of the services. These include need for reduction of cost of care, positive attitudinal disposition of providers, provision of relevant infrastructures in the health facilities, proper time management, adequate staffing and improvement of staff mix of providers.

MNCH services utilization is a complex phenomenon and is often influenced by several factors which include socio-economic, health system / healthcare providers' factors, health beliefs and personal circumstances of the women. A good understanding of issues surrounding MNCH utilization would be useful for improving services and for planning future programmes by the relevant stakeholders including nurses / midwives.

In conclusion, some childbearing women in this setting do not fully utilize MNCH services. The inference is that the women and their babies have potential risk for morbidities and mortality. Several factors have been identified as barriers to utilization of these services which include consumers', health systems, providers' and cultural issues. This situation requires prompt intervention by government and other stakeholders to address the health systems issues including staffing. Additionally, a more engaging pragmatic interventions such as community education and involvement should be undertaken. This aims to facilitate empowerment of the people to improve their understanding of MNCH issues with the expectation that health service utilization might be enhanced.

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