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Non-utilization of Primary Healthcare Centres for Skilled Pregnancy Care among Women in Rural Communities in Delta State, Southern Nigeria: Perspectives from Mothers, Fathers, and Healthcare Providers

By Rolle Remi Ahuru¹, Osaretin Godpower Okungbowa², Judith Omon Iseghohi³, Efegebere Henry Akpojubar⁴

Abstract

The study examines the barriers to maternal care utilization in Primary Health Centres (PHCs) in eight randomly-select rural communities in Delta State, Southern Nigeria using qualitative methods. The study is a qualitative exploratory research design. From July 2018 to February 2019, ten focus group discussions (FGDs) and five key informant interviews (KIIs) were held in different locations in the communities. FGDs were held among married women and men in the communities. KIIs were conducted among health services providers. Recorded voices were transcribed in full and analyzed using literary methods. It was observed that a greater number of deliveries were supervised by Traditional Birth Attendants (TBAs), who use traditional techniques and herbs and are not trained in modern midwifery. Women explained that they did not utilize PHCs because of informal monetary charges, distance barriers, and inability to access health care at night. Consequently, women preferred delivery at home supervised by TBAs. Mothers, fathers, and PHC facility managers showed discontent with the quality of care rendered in PHCs. It is recommended that efforts should be made to upgrade the quality of care in order to foster maternal care utilization in PHCs.

Keywords: Non-utilization, Primary healthcare centres, Skilled pregnancy care, Rural communities, Delta State, Nigeria

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Introduction

Maternal health is a key indicator used to assess health system effectiveness and national development. Against this backdrop, goals four and three of the Millennium Development Goals (MDG, 2000-2015) and Sustainable Development Goals (SDGs, 2015-2030) respectively were devoted to maternal health. Within these periods, Maternal Mortality Ratio (MMR), a standard measure of a nation's health care performance, has revealed a worrisome dichotomy across the world. MMR has reduced drastically in Organization for Economic Cooperation and Development (OECD) countries but regrettably appears to be declining sluggishly in developing countries, especially, in sub-Saharan African countries (SSA) (WHO, 2017). Between 1990 and 2015, for example, the global MMR is estimated to have decreased by 44% (Yaya et al; 2019). Although this decrease in percent is phenomenal, a SSA country such as Nigeria has not made significant progress compared to the levels observed in developed countries.

Globally, it is estimated that over 830 women die every day from pregnancy-related complications (Ntoimo et al; 2019). The situation is worse in SSA because it is estimated that 201,000 women die from pregnancy-related complications annually (Yaya et al; 2019). In Nigeria, it is estimated that between 56,000 and 58,000 women die annually from pregnancy-related complications (Ahuru & Iseghohi, 2019). Between 1990 and 2015, Nigeria's MMR decreased by about 40%. This decline may be attributed to pregnant women's increased access to professional care. However, the fact that MMRs remain very high in Nigeria is likely due to unequal access to modern and appropriate health services. The most disadvantaged women live in northern and rural geopolitical zones and majority have little formal education and low socioeconomic position (SEP) (Azuh et al; 2017).

The idea of the Primary Healthcare Centre (PHC) as conceptualized at the Alma-Ata Conference and the Alma-Ata Declaration of 1978, is a grassroots approach towards universal and equitable healthcare for all (WHO, 1978). Consequently, the PHC system has assumed a central role in the provision of healthcare in developing countries where many people live in remote and rural areas and cannot access secondary and tertiary healthcare facilities. The Declaration of Alma-Ata in 1978, the Bamako Initiative, formulated by African Health Ministers in 1987, and the Abuja Declaration, forwarded by African Union Heads of State in 2001, emphasized the inherent benefits of the PHC system. Following the World Health Report (2000) on Health Systems and Improving Performance, reforming the PHC system would help achieve equity in health between rural and urban communities (Kress, Su & Wang, 2016).

There is a relative dearth of research evidence on barriers to PHC utilization for maternal care, and even fewer have used an inductive or grounded theory qualitative approach in Nigeria (see Yaya et al; 2019; Ntoimo et al; 2019). Although, Kress et al (2016) utilizing secondary data from service delivery indicator (SDI) reported the obstacles confronting optimal performance of PHCs in Nigeria. The studies utilized a site assessment report of selected PHCs in Nigeria, and as such, women's and men's opinion were not sought. On the other hand, Ntoimo et al (2019) adopted a demand-side approach to explore the barriers rural Nigerian women face in utilizing pregnancy care in PHCs, but the study participants did not include healthcare providers. This current study—in addition to including healthcare providers as participants—investigated women's knowledge of the policy of free maternal care currently extended to rural communities in Delta State and its effects on maternal care utilization in PHCs. The study utilized in-depth interviews and focus group discussions (FGDs) to explore the barriers rural Nigerian women in Delta State, Southern Nigeria encounter in using maternal health services in PHCs. The purpose of adopting a qualitative approach is to realize a better understanding of the structural, behavioral, and perception-related

barriers women face. The study is motivated by the high number of home deliveries in the study area as evidenced by a quantitative study which has been reported elsewhere (Ahuru, 2020).

Nigerian Context

The Nigerian healthcare system is built on a three-tier structure with responsibilities at the federal, state, and local government levels. The healthcare system is decomposed into PHC system, Secondary Healthcare (SHC) system, and Tertiary Healthcare (THC) system (Yaya et al; 2018). The PHC system is managed by the local government authorities with supervision from Federal Ministry of Health (FMoH).

Nigeria was a co-signatory to the 186 countries that decided to adopt the PHC in 1978. Since 1978, Nigeria's reproductive health policy has been built on increasing the physical presence of PHCs in many communities. Currently, there are over 33,000 PHC facilities in the 774 Local Government Areas (LGAs) in Nigeria. Each LGA has a minimum of ten wards with a population ranging between 5,000 and 10,000 people (Yaya et al; 2018). It is expected that the PHC system should meet the needs of most rural women, thereby reducing the number of high-risk rural women in need of secondary and tertiary healthcare.

The national health policies identify the PHC system as the bedrock of the Nigerian health system (Ahuru and Iseghohi, 2019). According to the national health policy of 2016, a comprehensive healthcare system delivered through PHCs must incorporate maternal and child healthcare and family planning services (NDHS, 2018). The Nigerian government established the National Primary Healthcare Development Agency (NPHCDA) in the 36 States (Okonofua et al; 2018). In 2015, the Nigerian government initiated the policy called Primary Healthcare under one roof (PHCOUR), with the goal of resolving the fragmented structure of PHCs and enhancing effective service delivery through strengthening of the referral system and avoidance of duplication and waste.

In 2014, the Federal Government of Nigeria approved the National Health Act. Among other objectives, the Act was designed to resolve the financial challenges confronting the PHC system. As part of its implementation, the Basic Health Provision Fund was set up and was financed from the Federal Government statutory allocation annual grant of not less than 1% of its consolidated revenue fund. In 2007, the FMoH developed and launched the Integrated Maternal, Newborn and Child Health (IMNCH) policy to promote health equity for women and children. This policy emphasizes the provision of quality care for women right from the time of conception and through pregnancy and the immediate postnatal period. To ensure that this policy can aid the most marginalized women in Nigeria, the Ministry adopted PHC as its main route of implementation. By focusing on the PHC system for implementing IMNCH, the idea is to reach the many poor and rural women at the highest risk of maternal and perinatal mortality.

In spite of the various policy development and increased coverage of PHCs in rural parts of Nigeria, evidence shows that PHCs are underutilized by rural Nigerian women (Ahuru & Iseghohi, 2019). As a result, significant disparity exists in maternal health indicators between rural and urban women. For instance, evidence from the most recent NDHS (2018) showed that whereas 84% of urban women undertake a minimum of four ANC visits, for rural women the proportion was 56%. Also, 61% of deliveries among urban women were supervised by skilled birth attendants, but for rural women it is 29%. Contrary to 61% of urban women who went for postnatal checkups within two days after delivery, for rural women it was as low as 30%.

Methods

Study Communities

The study is a qualitative exploratory research study conducted in eight rural communities in Ughelli North LGA, Delta State, Southern Nigeria. Ughelli North LGA lies between $9^{\circ} 45' \text{N}$ and $8^{\circ} 43' \text{E}$ with a landmass of 818 square km. According to the 2006 Census data, the total population is put at 321,028 with a population density of 460.1 people per square km. The primary source of maternity care in the LGA is PHCs. There are 30 public PHCs in the LGA, with 18 PHCs per 10,000 [*Delta state strategic Development plan (2010- 2015)*]. Health services by private and public health facilities complement PHCs and serve as a referral system in the area. The map for the study area is presented in Figure 1 below.

Figure 1: Delta State Map (inset showing the various LGAs).



Two-stage sampling technique was used in selecting communities for the study. In stage 1, simple random sampling was used to select four political wards out of the eleven political wards. In stage two, simple random sampling technique was used to select two communities per political

wards. The selected communities were Agbarha-otor⁵, Evwereni⁶, Oguname⁷, Ekrerhavwe⁸, Uneni⁹, Umusu¹⁰, Unukpo¹¹, and Saniko¹².

Study Participants

Study participants were comprised of women and men in the communities and health service providers. Participants in FGDs were recruited from the research participatory communities and were comprised of women between the ages 15-49 years who had given birth in the last five years preceding the study and married men between the ages (20-80) years. Participants in FGDs were recruited with the aid of community gatekeepers which were mainly the oldest group of men in the community and community women leaders. These gatekeepers had lived in the community far longer than many of the study participants, and so they were in the best position to help recruit participants for the study. The researchers gave well defined eligibility criteria to the recruiters. This included currently in union (legally married or in a consensual relationship), within the reproductive ages (15-49 years), had given birth in the last five years preceding the study, and understood pidgin English. Participants in KIIs were healthcare providers superintending the PHCs in the study communities. Matrons were recruited because they were not only healthcare providers to women but directly involved in the management of the PHCs.

Data Collection and Procedure

The instruments used in collecting data for this study were FGDs and KIIs. Ten FGDs were conducted in various locations in research communities. Each discussion lasted between 45 minutes and one hour and ended when no further issues were raised. The number of participants in each discussion was between 8 and 10, and they were people who shared similar features. Following the recommendation by Yaya et al (2019), between 8 and 12 participants is small enough to freely express themselves, yet large enough to allow divergent views. The FGDs were held in Pidgin English and were audio-recorded with the consent of the participants to ensure the information was obtained as participants proffered them. Four KIIs were conducted for the Matrons of four PHCs in research communities. KIIs lasted between 45 minutes and one hour. They were held in the offices of the Matrons and were conducted in English. The discussions were conducted by the principal investigators with support from trained field research assistants who were members of the Nigeria Youth Service Corps. Research assistants were given two days training by the lead investigator and members of the technical team who were skilled at conducting quality research. On the last day of the training, the FGDs and KIIs guides were piloted in a

⁵ Agbarha-otor is located in Agbarha-otor political ward with 26 quarters. It has one primary healthcare centre and its activities are governed by an Ovie.

⁶ Evwereni is located in Evwereni political ward. It has about 12 villages and one primary healthcare centre. There are about 43,000 women within the reproductive ages.

⁷ Oguname is located in Agbarho 2 political ward. It comprises 14 villages. It has no primary healthcare centres as the women are forced to use primary health care centres in Ekrehavwen.

⁸ Ekrerhavwe is located in Agbarho 2 political ward. It comprises 14 villages and one primary healthcare centre.

⁹ Uneni is located in Evwereni political ward. It has 11 villages. It has no primary healthcare centres as the women are forced to use primary health care centres in Evwereni.

¹⁰ Umusu is a small community with about five streets. It has no primary healthcare centres as the women are forced to use primary healthcare centres in Unukpo or Ereke.

¹¹ Unukpo is a small community with about three streets. It has one primary healthcare centre and its activities are governed by an Okaro.

¹² Saniko is located in Agbarha-otor political ward. It has no primary healthcare centres as the women are forced to use primary healthcare centres in Agbarha-otor.

neighboring community—Gana—which shared similar socioeconomic characteristics with research communities.

Issues Discussed

The socio-demographic characteristics of the women were collected, in order to better understand the data. Both FGDs and KIIs were conducted with well detailed guides that informed uniformity in data collection. The guides featured open ended questions to enable respondents to fully express themselves on issues. The key aspect of the questions elicited responses on barriers limiting women's access to Healthcare Centre in the study area. Some of the issues discussed in the FGDs are:

- (1) Sources of maternal care in study area
- (2) Barriers and hindrances to access to PHCs
- (3) Possible ways to improve women's access to PHCs

On the other hand, a sample of some of the issues discussed in the KIIs sessions includes:

- (1) Policies enacted to improve PHCs performance
- (2) Factors limiting the delivery of effective PHCs in study area
- (3) Source of financing for PHCs
- (4) The state of infrastructure in PHCs
- (5) Human resource development and training of PHC personnel

Ethical Consideration

The required approval for the research was obtained from the University of Benin Ethics Review Committee. Written approval to access PHCs was obtained from the PHC Board of Ughelli North LGA. Finally, informed consent was obtained from participants. Participants were given a form to fill to show that they understood what was explained to them.

Data Analysis

Audio-recorded voices were transcribed verbatim, and the transcripts were compared with the recordings for accuracy. Transcribers were people who understood both English and Pidgin English. Contextualized thematic analysis was used to deduce important themes central to the study from the transcripts. The transcripts were read several times by the investigator and other assistants. Recorded voices were reported using translated quotations. Literal translations were made for fidelity of respondents' views and also give the readers an idea of the participants' thinking. Free translation was used to enhance the readability of the text where literal translations were not possible due to syntactic and grammatical structures.

Results

Features of Study Participants

A total of 84 individuals participated in the study: 68 women and 16 men. For the educational level, most of the participants reported primary education [48.8%]. Majority of the respondents were Christians and only a few were either Moslems or African Traditional Worshippers. Most of the male respondents reported farming as their occupation, while most of the female respondents were engaged in petty business such as trading, hairdressing, and tailoring.

The number of respondents in civil service was few, and the number of unemployed was negligible. The overall average (\pm SD) age of respondents was 32.15 (\pm 8.99 years).

Findings

The findings of this study which is in conformity with the findings from previous studies are itemized as (i) - (iii).

- (i) Health system barriers with the following themes: lack of medical equipment, non-availability of drugs, providers were hardly on the ground, facility hardly open at night, and non-affordability of delivery charges in PHCs.
- (ii) Community level barriers with distance barrier and poor road network/lack of transportation
- (iii) Individual/household barriers with the following themes: gender disparity, poor household socioeconomic status, and influence of mother-in-law.

Also, this study reported a fourth finding:

- (iv) Policy issues with two broad themes: ignorance of the policy of free maternal/childcare and poor implementation of the policy of free maternal/childcare.

Health System Barriers

Participants in the series of FGDs reported several barriers at the health system level confronting women in the study area from utilizing modern pregnancy care in PHCs. Participants' responses in the various discussion sessions show that they were discontented with the quality of care rendered to them in PHCs. In response to the question, "are you people satisfied with the kind of care they give to you in Primary Healthcare Centers?" Participants unanimously answered "No".

The type of care rendered to women in Primary Health Care Centres in our community is not enough. Women are not properly catered for in Primary Healthcare Centres [*FGD-27-year-old trader from Ekrerhavwe*].

In another FGD, another participant has this to say:

Primary Healthcare Centres do not render quality care to women and children because they lack equipment, particularly those related to malaria treatment such as drugs [*FGD-32-year-old hairdresser from Ekrerhavwe*].

The discussion showed that poor quality of care in PHCs were related to lack of medical equipment, non-availability of drugs, providers were hardly on the ground, facilities were hardly open at night, and non-affordability of delivery charges in PHCs.

Lack of Medical Equipment

Both participants in FGDs and healthcare providers reported lack of medical equipment as one of the factors hindering the effective delivery of services in PHCs. Several of the participants in FGDs complained that there is no need to go to PHCs for care since most of the facilities do not have the basic tool to attend to them.

The condition of Primary Health Centre is not good. The buildings are so old and the government cannot even renovate them. Most of the facilities do not have basic medical equipment *[FGD-25-year-old trader from Umusu]*.

A Matron has this to say:

I do not think there is anything that can make me to be happy because in rural areas Primary Healthcare Centres are neglected. In this Primary Healthcare Centre, we do not have simple tools to work. Sometimes common injection and needle we do not have *[KII with Matron]*.

Non-Availability of Drugs

Participants complained of frequent shortages of drugs. Consequently, women who needed those drugs were consistently referred out to Pharmacists located in faraway urban-areas.

Primary Healthcare Centres do not have drugs to give to patients, not even paracetamol. By the time you get there, they will refer you to Agbarho (a nearby town), and if it is late you may not be able to go anywhere *[FGD-45-year old trader from Ekrerhavwe]*.

Another participant said:

Primary Healthcare Centres are always complaining that they do not have drugs. It is a waste of time to go there. I would rather go to the Chemists *[FGD-32-year-old teacher from Umusu]*.

In response to this, a Matron reported this:

We always lack drugs because the government does not provide the money anymore. Before, the local government used to give us money to stock drugs, but now we used our internally-generated revenue to buy drugs, and when we do not have enough money we run out of stock *[KII with Matron]*.

Providers were Hardly on the Ground

Participants complained that providers were hardly on the ground to attend to clients. The general report is that the Centres were always locked.

There is always a challenge that by the time you get to Primary Healthcare Centre you hardly will meet providers on ground. The facility is always on key and lock. As for me, I always register for ANC in Ereke (referring to nearby communities). I was discouraged the few times I went to primary health care facility in this community and met the place locked *[FGD-25-year-old-Farmer from Unukpo]*.

Participants in FGDs reported that most of the workers in the facilities are engaged in truancy and that some of them have their own private clinics, and as a result they spend more time in their own private businesses. Matrons in KIIs complained that workers of Health Centres are not regularly paid. As at the time of filing this report, workers were owed eleven months' salary. Irregular payment of salary and poor welfare package account for the truancy, and absenteeism of workers of the facilities.

As I am talking to you now they have not pay us since February. By next month, they will be owing us for eleven months. Many of our workers are not focused because they do not pay us regularly. Some of us lived in far cities and need to pay transport to work every day *[KII with Matron]*.

Facilities were Hardly Open at Night

Participants in the FGDs complained that the Healthcare Centres were always locked after 6pm, and that most women seeking delivery care at such times hardly have access to care, hence they are left with the options to explore other sources which include TBAs and auxiliary nurses residing in the communities. Participants reported that they usually experienced labour at midnight when facilities have closed, making it difficult for them to access emergency delivery care.

All these nurses you see in that Healthcare Centre before 6 pm in the evening they will all go home, so if you have case of a woman in labour you will not know where to take her to. When I wanted to deliver my third child, I started experiencing labour around 2 am at night. My husband took me there, but no one to attend *[FGD-28-year-old-Tailor from Ekrerhavwe]*.

It is very hard for you to meet anybody in Primary Healthcare Centre at night. For example, if you go there at night the whole place will be dark and the workers must have gone home. If a woman delivers there will she be the only one in the Primary Health Centre? *[FGD-25-year-old-farmer from Unukpo]*.

Matrons of the facilities admitted they do not work at night because of the insecurity in the environment. The facilities were not fenced, and there were no security on duty posts, making it unsafe for workers to stay in the facilities through the night.

This facility as you can see is not fenced, and there are no securities. At night there is hardly NEPA light and the whole place is dark, hence we usually go home to avoid being casualty. To make matters worse, the residential quarter is bad and no body lived there *[KII with Matron]*.

Non-Affordability of Delivery Charges in PHCs

Participants in the FGDs complained that the cost of delivery care in PHCs were too high, particularly when compared to charges by TBAs. According to them, TBAs charges were modest together with the fact that their payment system is flexible, that is payment can be spread over a period of time. They complained that Matrons in Health Centres imposed various informal charges, which make delivery care utilization in PHCs non-affordable.

In traditional homes, the cost of delivery is low. You may only give the attendant drink and you will be discharged, but in health Centres, you will be required to buy several things like soap, antiseptic and other baby drugs [FGD-35-year old Female trader from Umusu].

Facility managers (in the oral interviews) admitted that women coming to the facilities for delivery were mandated to come with several items and pay some amount of money. The Internally Generated Revenue (IGR) is used for running the facilities as they do not receive subventions from government. They also use the IGR to stock required drugs.

Just as I said before, we go to the market to buy the ones that are not provided by the government. It is malaria drugs, for now, we have a constant supply. Even this morning they supplied us but apart from that, we improvise. We make the provision [KII with Matron].

Community Level Barriers

Distance as Barrier

Distance to the facility was also reported as a barrier to women seeking delivery care. Several participants complained that they did not have PHC facilities in their communities. As a result, they travel long distances to contiguous communities having Primary Healthcare Centres. Many women in this community do not like traveling to Ekrehavwe (neighbourhood community with PHCs).

You know it is a long-distance from this place unless their husbands carry them on motor cycle. Some people when labour occurs at night instead of travelling to another community with PHCs will rather use native sources [FGD-25-year-old - trader from Oguname]

Poor Road Networks/Lack of transportation

Poor road networks also cause delays in reaching health facilities during emergency situations. Lack of access to health facilities was reported by participants in FGDs as a major cause of several deaths in the communities.

A participant had this to say:

As I am talking to you now the road that leads from this village to the neighbouring community where there is Primary Healthcare Centres is so bad. At times you hardly will get motorbike to that place because most of them do not like riding to

that community because of bad road. During rainy season, before anyone will take you there you will be ready to pay N1, 500 (\$4). If you planning to go there at night you will not get motorcycle, and if you see them the price is always high N5,000 (\$14) [FGD-38-year-old - trader from Uneni].

Individual and Household Barriers

Gender Norms/Disparity

Responses from the various FGDs showed that women's access to modern healthcare services was largely influenced by their husbands' decisions. It was obvious that women were submissive to their husbands. Female respondents reported that their husbands make the final decisions in virtually all household issues. Though some women reported they participated in household decision-making, they also agreed that their husbands had the last word.

The prevailing cultural norm in the communities was that of male dominance and women's submissiveness. The women reported that disobedience to husbands was seen as a serious offence and could result in various forms of sanctions, including ostracization by other women in the communities.

It is my husband that pays for my health bills. He also dictates where I utilize care from. I do not use care without his approval because he is the owner of the pregnancy [FGD-25-year old trader from Umusu].

Respondents from both male and female sessions reported that the men were better off in terms of access to economic resources. Female respondents referred to their husbands as "oga" (meaning boss). They also reported that they depended on their husbands for family upkeep including money to access health services:

It is my husband that gives me money to do anything. I depended on him because I do not earn much from my small scale business [FGD- 38- year old trader from Uneni].

From the responses gathered from the FGD sessions, it is obvious that the men were supportive of their wives using modern health services. It can be deduced that the men understood the relevance of pregnancy care and preferred modern care services to traditional methods. The women affirmed that their husbands supported them during pregnancy. Some of the identified support includes giving of money to pay for healthcare services, carrying them on motorcycles to health facilities and reminding them to go for medical checkups:

Yes o. Most men in this community encourage their women to go for care. They provide all necessary assistance which includes money to pay for healthcare [FGD-26-year-old trader from Uneni].

While the majority of the female participants reported limitations in decision-making as touching utilization of modern pregnancy care in PHCs, there were key differences. For example, women that were not educated, those of them without source of income, Islamic women, and those in

polygamous marriages were less likely to participate in making their own pregnancy care decision. A female participant narrated her experience:

It is not the faults of many women who deliver at home. The woman may like to deliver in Health Centres, but the husband may refuse her. Take for instance, when I was pregnant I wanted to deliver the baby in the Health Centre in the community, but my oga (husband) refused and I had no choice. Our Koran and Hadith forbid that we should disobey our husbands [FGD- 38-year-old trader from Umusu].

Another female participant had this to say:

Women in this community do not have the right to make decision concerning their health. May be the woman does not have her own money, hence whatever the husband say she will follow. And you know many women in this community are not educated hence they cannot dictate for their husbands [FGD-38-year-old trader from Uneni].

Participation in decision-making concerning access to modern maternal care services in PHCs appear to be much limited for women whose husbands prefer traditional sources of care. A male participant had this to say:

As for me when I got married and my wife became pregnant I registered her in the traditional Centre because my understanding is that there are medications that are very effective that the hospital cannot give. Though she sometimes goes to the hospital when the time for delivery comes, but she uses more of the traditional home [FGD-25-year-old-farmer from Unukpo].

Poor Household Socioeconomic Status

Husbands were interested in their wives accessing and utilizing modern healthcare services but are sometimes constrained by lack of money to pay for care and services. Some men compromised the quality of care for their wives because of lack of money to pay for the care. Female participants reported that some men do not have sources of income and those working do not earn enough to take care of their families. Poverty was noted as a key barrier to women's access to skilled pregnancy care. It is obvious that poverty is high in the study communities and is responsible for the high rate of non-institutional delivery:

Sometimes women do not have choice. Many women in this community who will like to go to Healthcare centres or hospitals, when their husbands do not have the money they end up going to traditional home. Lack of money is always the reason why several women in this community go to native sources [FGD- 31- year-old farmer from Umusu].

The Influence of Mother-in-Law

From the FGDs, mother-in-laws play a significant role in women's decisions on choice place of delivery. Some women reported how mother-in-laws induce their daughter-in-law to deliver in native homes.

Sometimes it is the mother-in-law that will force the woman into native houses may be the native woman both of them are friends or from one family. Husbands who are not working and do not have money to pay also take their wives there [FGD-26- year-old farmer from Umusu].

Policy Issues

Evidence from the various FGDs revealed that many of the participants were ignorant of the policy of free maternal and childcare, which was implemented in November, 2017. Many of the participants attested that they have not heard of the policy or benefitted from it

I have not heard that the government has stopped the PHCs from collecting money from women and children. They are still collecting money, and that is the reason why many women do not deliver in those centres [FGD- 32-year-old hairdresser from Umusu].

Another participant had this to say concerning the policy of free maternal care in the state.

I heard that the policy was only for those in general hospitals. I have not heard about it in this community Health Centre. If they can actually stop collecting money it will be a welcome development, and it will encourage many women to be going there for checkups [FGD-28-year-old trader from Uneni].

Though few participants attested that they have heard of the policy of free maternal and childcare, and that is currently in operation in rural parts of Delta State, they stated that they have not benefited from it.

Even when the government asked the Health Centres to stop collecting money they will never adhere. In Nigeria, people will never obey instructions from the government. In the Primary Health Centre in this community they are always collecting money [FGD-43- year-old farmer from Ekrehavwe].

Another participant has this to say:

Even when they do not collect money for antenatal care, the many drugs you will buy will be so high that there will be no benefit from the free maternal care policy. There are several other things to collect money for [FGD-29-year-old trader from Oguname].

Poor Implementation of the Policy of Free Maternal and Childcare in PHCs

The matrons in the facilities reported that the policy of free maternal/childcare has been implemented and extended to the Primary Healthcare Centres in rural parts of the State. However, they attested that the government has not been fully supporting the policy. They revealed that the Health Centres do not receive any form of financial support from the government, making it impossible for the centres to render free maternal and childcare services to the people in the communities. One of the matrons reported this:

Government only announced the free maternal and childcare policy, but the implementation is not optimal. For instance, financial supports for the centres are completely lacking, making it impossible for the centres to render free maternal and childcare services to women in the community [*KII with Matron*].

Another matron added this:

How does the government expect us to render free care services without statutory allocations to the Primary Healthcare Centres? The Primary Healthcare Centres are run through internally-generated revenue, which we use to buy drugs and other consumables. If the government wants us to render free care services to the people then they should fund us properly [*KII with Matron*].

Discussion of the Results

This study examined the various factors that serve as barriers to women's access to PHCs in rural parts of Delta State utilizing in-depth interviews. Previous Nigerian studies conducted in rural parts of the country reported the underutilization of PHCs for various maternal care needs (Okonofua et al; 2018; Ahuru & Iseghohi, 2019). This study is motivated by a recent quantitative study which we conducted in the same communities. The results revealed that 30.9% of the women delivered either at home or in the homes of traditional birth attendants, and slightly above average delivered in PHCs (Ahuru, 2020). The high rate of home delivery by women in rural part of Delta State was reported by Azubuike and Odaqwe (2015). We believed it would be helpful to hear women's and men's voices on why they do not utilize pregnancy care in PHCs. Barriers from the in-depth interviews were related to health system barriers, community level barriers, individual/household barriers, and poor implementation of the policy of free maternal and childcare in the State.

Poor quality of care as reflected in habitual absenteeism, frequent out of stock syndrome, lack of basic medical equipment, informal payment imposed on women seeking delivery care in Centres, and facilities not operating at night posed major barriers to maternal care utilization in PHCs. This finding is consistent with the report made by the Center of Population and Environment Development (CEPD), which examined the state of PHCs across Nigeria (*Omuta et al; 2014*). The study reported poor performance of PHCs in rural parts of Nigeria. Notable among other issues reported was that PHCs in rural parts of Nigeria lacked manpower, and often facilities were managed by a nurse assisted by a clerical staff. This may result in crushing workload and drop in quality of care. Consistent with our findings, CEPD reported that PHCs in rural Nigeria face dearth of manpower and lack of basic medical equipment. Evidence has showed that maternal mortality will reduce drastically when women are treated by diverse health personnel (Okonofua et al; 2018).

The study reported gender disparity and power imbalance at the nucleus family level as several women lack the power to unilaterally make decisions without getting approval from their husbands. Lack of women's autonomy reported in this study corroborates the findings of a Ghanaian study (Ganle et al; 2016) and some Nigerian studies (Fawole & Adeoye, 2015; Singh et al; 2012; Yaya et al; 2019). It is imperative to enhance women's bargaining power within households' structure, but it is equally necessary that men and mothers-in-law get integrated into

women's reproductive health concerns (Ganle et al; 2016). Integrating men into reproductive health will particularly be useful as has been suggested by several studies (Yaya et al; 2019; Bazzano et al; 2008; Mill & Bertrand, 2005; Ahuru, 2019). In the literature, two strategies were suggested for men to be effectively integrated into reproductive health: The establishment of male-friendly maternity clinics and couple counseling (Ganle et al; 2015; August et al; 2016).

Household socio-economic status significantly influenced the place of delivery in the study area. The fact that most husbands were not gainfully employed and did not earn enough income to support their wives for modern health services compelled them to compromising the quality of their wives delivery care. While the women depended on their husbands for health service-related costs, most men were not financially capable of fulfilling this obligation. Therefore, gender norms intersect with household socio-economic characteristics to limit women's access to evidenced-based delivery care in the study area. A recent Nigerian study reported that women depended on their husbands for healthcare related needs, and those whose husbands were poor were compelled to utilize delivery care from TBAs (Yaya et al; 2019). A similar study reported a strong positive relationship between men's income and women's use of maternal care (Wai et al; 2015).

Furthermore, distance was reported as a major barrier to utilization of delivery care in PHCs in the study area. This same report was made by a Nigerian study (Yaya et al; 2019). Studies that reported strategies on increasing access to skilled pregnancy care recommended that factors such as distance, lack of transportation, and family choices should be addressed (Cheptum et al; 2017; Bryne et al; 2016).

Conclusion and Recommendations

The study has reported that barriers existed at both individual/household and health system levels in deterring women from delivering in PHCs in the study area. Prominent among the barriers were lack of 24-hour service provisions, informal payments in PHCs, and lack of basic medical kits and equipment. Hence, intervention programmes should be implemented to redress the barriers. The federal and state government should undertake a complete renovation of PHCs. The core areas which include buildings, premises, and manpower should be reorganized. The government should employ more workers in the centres. Workers should be rotated on shift with the condition that there should be at least one qualified midwife in the facility at any time. Multi-pronged approaches should be used to improve the socioeconomic conditions of households in the study area and other rural parts of Nigeria. To redress distance barriers more PHCs should be sited in underserved communities and the government should improve on the road network, particularly in rural parts of the country.

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Availability of Data and Materials

The dataset used and analyzed during the current study is available from the corresponding author on reasonable request.

Conflict of Interest

The authors declared they have no conflicts of interest.

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